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National Open University
National Centre for Disability Studies

MCFT-007

Counselling and Family Therapy: Applications and Interventions

Block

1

WORKING WITH CHILDREN AND ADOLESCENTS

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MCFT-007 COUNSELLING AND FAMILY THERAPY: APPLICATIONS AND INTERVENTIONS

COURSE INTRODUCTION

We welcome you to the second year of M.Sc (CFT) programme of study of IGNOU. You will study 'Counselling and Family Therapy: Applications and Interventions' as a compulsory Course in the programme of study in the second year. It comprises both theory and supervised practicum components. The theory paper on this is MCFT-007 and supervised practicum is MCFTL-007. You have to complete and clear both these components separately. For theory paper MCFT-007, you will have continous evaluation through an assignment and a term-end examination. For MCFTL-007 you have to work under the supervision of the academic counsellor allotted from the study centre you are attached with. In the end as per the details given in the Supervised Practicum Manual, you have to submit your file to the study centre.

This course is designed to make learners aware of the applications and interventions in the counselling and family therapy context. The course provides comprehensive knowledge about various contexts and situations wherein principles and theories of counselling and family therapy are applied. The course provides knowledge and understanding about use of counselling and family therapy interventions in our daily life as well as with special populations. Further, the course focusses on human life span needs and interventions.

The course would help you to develop the understanding that is required of counsellors/family therapists to have deeper knowledge about the client's family life dynamics. The course consists of four theory Blocks and one supervised practicum Manual.

The Blocks

Block 1 is on "Working with Children and Adolescents". This Block provides you indepth knowledge and understanding about the issues and concerns in counselling and family therapy among children and adolescents. The Block focusses on some important problems among children and adolescents like emotional and behavioural problems among them, school difficulties faced by children and adolescents, children and adolescents with disabilities and their problems. We have tried to cover the important and relevant aspects of children and adolescents in this Block. Further parent management training for parents of children/adolescents has been discussed in detail. On studying this Block, you will be able to understand the overall issues and concerns involved in working with children and adolescents during counselling and family therapy interventions.

Block 2 is titled " Working with Couples". This Block consists of four Units. The first two Units deal with conflict among couples; in marital relationships and in non-marital relationships. Another Unit explains the issues and concerns involved in extended and joint families. The last Unit of this Block deals with alternate sexual identities. This Block helps you understand the varied couples and be able to apply counselling and family therapy interventions with them.

Block 3 is on "Working with Physical Illness and Self Abuse". This Block has five Units. These Units deal with the different physical illnesses and self abuse a person is vulnerable to. This Block makes you understand how to work with person(s) suffering from chronic illness, HIV/AIDS, substance abuse or deliberate self harm problems. After studying the block, you will be able to understand and develop an insight for working with physical illness and self abuse problems prevalent commonly in society these days.

Block 4 is on "Crisis and Trauma Counselling and Family Therapy". It consists of five Units. Psychosocial support in disasters to children, adolescents, families and individuals has been discussed in the first two Units. Need and application of counselling and family therapy interventions in the context of gender and mental health problems has also been discussed. Sexual harrassment and abuse has also been elaborated upon. Geriatric problems and disorders have also been discussed. The last Unit of this Course focusses on the benefits of yoga.

The Supervised Practicum Manual

This Block will provide you the framework for hands on experiences. The supervised practicum has been planned with the applied aspect in mind. As a part of practical work, you need to carry out observations and interviews with families and individual around you. The Manual provides you step wise directions for doing the practical activities and recording the same.

HOW WILL THIS COURSE HELP YOU?

The course will provide you a new vision for perceiving applications and interventions of counselling and family therapy applications in exacting circumstances of real life situations. You will be able to get an insight and apply principles that will facilitate your work as a counsellor/family therapist later.

BLOCK 1 WORKING WITH CHILDREN AND ADOLESCENTS

Introduction

The Block "Working with Children and Adolescents" will acquaint you with the applications and interventions involved with working with children and adolescents. The Block consists of five Units.

Unit 1 is entitled "Issues and Concerns in Counselling and Family Therapy". This Unit begins with the basic concepts in family therapy. It focusses on the principles of counselling children and adolescents and critically analyses child therapies. It further outlines conditions in which counselling and family therapy would help children and adolescents. This Unit will help you in understanding the significance of issues and concerns involved while working with children and adolescents.

Unit 2 is on "Emotional and Behavioural Problems". The focus of this Unit is on emotional and behavioural problems in children and adolescents. Identification and assessment of these problems has been discussed. Management of emotional and behavioural problems among children and adolescents has been dealt with in detail. Various therapeutic processes have been described which can be used to deal with the problem. The Unit helps you to understand family based intervention — counselling and family therapy that are used to deal with emotional and behavioural problems among children and adolescents.

Unit 3 on "School Difficulties", begins with the introduction of the concept and discusses the prevalence and symptoms of school difficulties in children. It is important to understand the causes of school difficulties. Assessment of school difficulties has to be done. Later impact of school difficulties on child and family are discussed in the Unit.

Unit 4 is on "Child/Adolescent with Disability". It focusses on the children and adolescents with disability. Early identification of disability is important to provide necessary and timely interventions. Management of the disability is important. The later part of this Unit deals with application of counselling and family therapy for family members of child/adolescent with disability.

Unit 5 entitled "Parent Management Training", describes parenting styles and gives parenting tips for handling behavioural problems in children and adolescents. The focus of the Unit is on parent management training. Use of behaviour modification techniques is outlined.

UNIT 1 ISSUES AND CONCERNS IN COUNSELLING AND FAMILY THERAPY

Structure

1.1 INTRODUCTION

Counselling aims to help people cope better with situations they are facing. This is true for counselling children and young people too. It involves helping the child to cope with their emotions and feelings and to help them make positive choices and decisions. The 'Goodness of Fit' model (Chess & Thomas, 1984) proposes that changes in the child-environment relationship will produce stress in the child, which the child will resolve through impulse and avoidance rather than mastery. Counselling can provide the ways to resolve these issues through extension of personal skills which helps the child to maintain social competence and self confidence.

Counselling provides people with the opportunity to talk with someone who listens and is supportive. Counselling generally takes place over regular multiple sessions with each session lasting up to one hour. The range of psychological treatment approaches available to counselling psychologist responding to difficulties of childhood is highly diverse. Approaches can be categorized as community approaches (e.g. school), family approaches, group approaches and individual approaches.

Family therapy is a type of psychotherapy that involves all members of a nuclear family or stepfamily and, in some cases, members of the extended family (e.g.,

grandparents). Most widespread form is based on family systems theory which regards the family, as a whole, as the unit of treatment, and emphasizes such factors as relationships and communication patterns rather than traits or symptoms in individual members.

Family therapy tends to be short-term treatment, with a focus on resolving specific problems. It is not normally used for very long-term or intensive restructuring of severely dysfunctional families. Family therapy involves multiple therapy sessions, usually lasting at least one hour each, conducted at regular intervals (for example, once weekly) for several months. The number of sessions depends on the situation, but the average is 5-20 sessions.

A family therapist usually meets several members of the family at the same time. This has the advantage of making differences between the ways family members perceive mutual relations as well as interaction patterns in the session apparent both for the therapist and the family. For children and adolescents, family therapy most often is used when the child or adolescent has a personality, anxiety, or mood disorder that impairs their family and social functioning, or when a stepfamily is formed and there are difficulties adjusting to the new family life. In this Unit, we will talk about various issues that arise in counselling and family therapy especially with children and adolescents.

Objectives

After studying this Unit, you will be able to:

- Learn about what differentiates counselling children from counselling adults;
- Understand the general principles of counselling and family therapy involving children and adolescents;
- Describe the overview of management of various issues; and
- Explore and analyze the implications of issues concerned with providing counselling and family therapy to children and adolescents.

1.2 BASIC CONCEPTS IN FAMILY THERAPY

1.2.1 The Identified Patient

The identified patient (IP) is the family member with the symptom that has brought the family into treatment. *Children and adolescents are frequently the IP* in family therapy. The concept of the IP is used by family therapists to keep the family from scapegoating the IP or using her or him as a way of avoiding problems in the rest of the system.

1.2.2 Homeostasis (Balance)

Homeostasis means that the family system seeks to maintain its customary organization and functioning over time and it tends to resist change. The family therapist can use the concept of homeostasis to explain why a certain family symptom has surfaced at a given time, why a specific member has become the IP, and what is likely to happen when the family begins to change.

1.2.3 The Extended Family

The extended family field includes the immediate family and the network of grandparents and other relatives of the family. This concept is used to explain the

intergenerational transmission of attitudes, problems, behaviours, and other issues. *Children and adolescents often benefit from family therapy that includes the extended family.*

1.2.4 Differentiation

Differentiation refers to the ability of each family member to maintain her or his own sense of self, while remaining emotionally connected to the family. One mark of a healthy family is its capacity to allow members to differentiate, while family members still feel that they are members in good standing of the family.

1.2.5 Triangular Relationships

Whenever two members in the family system have problems with each other, they will "triangle in" a third member as a way of stabilizing their own relationship. The triangles in a family system usually interlock in a way that maintains family homeostasis. Common family triangles include a child and her or his parents; two children and one parent; a parent, a child, and a grandparent; three siblings; or, husband, wife and an in-law.

1.3 GENERAL PRINCIPLES OF COUNSELLING CHILDREN AND ADOLESCENTS

The differences exist when counselling the child as compared to when counselling an adult. The issues of developmental change, individual variation, problem comorbidity, diversity of parent and family arrangements as well as wide contextual variation in which the child behaviour and development is located contribute to the complex nature of children and adolescent counselling and therapy.

Key points to be borne in mind when conducting counselling/therapy involving children and adolescents are given below:

- Do not assume childhood distress and dysfunction is the same in origin and experience as it is for adults.
- Do not assume that all children are psychologically alike and can be treated in the same way.
- There is need to recognize and where possible to work with the child's primary social context which usually is the family.
- Counselling may be provided to children and adolescents individually or as part of family counselling.
- Counselling a child requires a relationship to be established between the child and the counsellor, known as 'joining'. Methods to do this depend on the age of the child.
- Counselling children and adolescents requires skills in talking and listening to children and young people.
- Special tools like drawing, telling stories, play and drama can be used to help communicate with children and young people.
- It is important to be aware of and respect the child's family values, beliefs and practices.

Things to Do

Following are some salient things to do, that a counsellor/therapist must adhere to when working with children and adolsecents:

- Establishing a relationship with the child,
- Helping the child tell her or his story,
- Listening carefully,
- Providing correct information,
- Helping the child make informed decisions,
- Helping the child recognize and build on her or his strengths, and
- Helping the child develop a positive attitude to life.

Things Not to Do

Some of the things that a counsellor/therapist should avoid while providing counselling or therapy to a child are given below:

- Making decisions for the child,
- Judging, interrogating, blaming, preaching, lecturing or arguing, and
- Making promises that you cannot keep.

1.4 CRITIQUE OF CHILD THERAPIES

- **Is Therapy Effective?**

Eysenck (1952) claimed that approximately two-thirds of all neurotics who received non-behavioural psychotherapy improved substantially within two years and that equal proportion of neurotics who had not received treatment also improved within same time period. He argued that clients might have improved due to events which occurred outside the counselling setting. To look for the validity of Eysenck's arguments, changes were brought in the methodology of various studies looking for effectiveness.

Bergin and Lambert (1978) in a study found that rate for spontaneous remission was less and that substantial changes occur within initial eight to ten sessions in psychological treatment rather than two years time frame for spontaneous remission. Stated as percentage of studies supporting the efficacy of psychotherapy, Bergin (1978) found 37 per cent, Meltzoff and Kornreich (1970) 80 per cent, Luborsky (1975) 78 per cent. Lambert and Bergin (1994) thus asserted that there was little doubt that psychological treatments are, overall and in general, beneficial, although it remains equally true that not everyone benefits to a satisfactory degree. Psychotherapy at times may not resolve mental or emotional conditions and psychiatric medication is required. The reluctance to seek and use appropriate medication may contribute to worsening of symptoms or increased risk for poor outcomes.

- **Is One Kind of Therapy More Effective Than Another?**

In 1960 the rapid development of behaviour therapy within the domain of clinical psychology raised a logical question if these newer therapies were more effective

than for example, verbal (dynamically oriented) therapies. Findings from the UK study by Shapiro et al. (1994) compared cognitive-behavioural therapy (CBT) with psychodynamic interpersonal therapy (IPT) in two durations (8 and 16 sessions) and reported only a small advantage to CBT over IPT on Beck Depression Inventory (Beck et al., 1961) but not on any other measures. It is now said that technically different therapies result in broadly similar outcomes, a conclusion referred to as 'equivalence paradox' (Stiles et al., 1986). It is also not disputed that there is some advantage of CBT over other therapies but the size of this advantage is relatively small. How much this advantage adds to clinical outcome is still to be studied.

Shapiro et al. (1992) combined CBT and IPT and found the integration to be successful. Whether integrating different therapies together is beneficial as compared one therapy is still to be confirmed. Though integrative therapies are more palatable to practitioners but this is a clinical preference.

Is Long Term Counselling/Therapy Better Than Short Term?

The debate over long and short term counselling is the central focus in particular among those who have interest in providing cost effective therapy. Howard et al. (1986) found that percentage of clients showing improvement following specified number of sessions were as follows: 24 per cent after single session, 30 per cent after 2 sessions, 41 per cent after 4 session, 53 per cent after 8 sessions, 62 per cent after 13 sessions, 74 per cent after 26 sessions, 83 per cent after 52 sessions, 90 per cent after 104 sessions.

It was also noted that while the number of clients benefiting increased with the number of sessions but the greatest improvement occurs early in the therapy and then there are diminishing smaller and smaller gains made later on in the therapy in response to provision of more sessions. Almost half of the studies had a median of 15 or more sessions, considerably more than the often quoted averages (Taube et al., 1984). Factors affecting the duration are :-

i) ***Severity of the illness:*** More the severity of the illness, more sessions might be required for the desired effect.

ii) ***Individual differences:*** Some clients take longer time to establish therapeutic alliance and in such cases longer therapies are appropriate.

- **Is Therapy More Beneficial For Some Children Than For Others?**

No single approach is beneficial for all the children. Individual differences in responsiveness are seen and some of the factors contributing to this are nature and characteristics of the problem, stage of development, characteristics of the child such as gender, age and ability. Blagg (1992) in a review of psychological and behavioural approaches to school refusal stated that the treatment outcome is same for children between 7 and 10 years irrespective of treatment approach. However, the treatment approach did matter for children 11-16 years of age.

- **Psychotherapy versus Pharmacotherapy**

Lambert and Bergin (1994) stated that psychological intervention is as effective, if not more effective, as medication. Studies have shown that combined psychotherapy and pharmacotherapy has better outcome than single therapy in a person. Psychotherapy is often accompanied by treatment with drugs to help reduce psychological symptoms. Drugs may reduce the need for psychotherapy

and effective psychotherapy may reduce the need for drugs, or may make lower doses, and hence fewer side effects, possible. Drugs may interfere with the effectiveness of psychotherapy if mental functioning is impaired as a side effect of the drug. Some medications have psychological or emotional side effects such as anxiety, depression, impaired cognitive functioning or impaired sleep.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. State whether the following statements are 'True' or 'False':

   i) Children are psychologically different and need to be treated differently.

   ii) Children can't think for themselves, so the counsellor should decide for them.

   iii) Duration of therapy required is influenced by the severity of psychological problem as well as characteristics of the individual.

1.5 CONDITIONS IN WHICH COUNSELLING AND FAMILY THERAPY MAY HELP

Indian children and adolescents not only face developmental problems but they are also in a conflict over exposure to various cultures. They are caught between the expectations of traditional family values and the majority culture around. Various epidemiological studies (Cox & Rutter 1985) indicate that 5-15 per cent of children exhibit emotional or behavioural disturbances which affect their everyday life. It is this group of people that require counselling services. Various situations where counselling and family therapy is advised are as follows:

1) ***Adjustment disorder:*** Psychoanalytically-oriented psychotherapy may reduce depression associated with adjustment disorder.

2) ***Aggressive behaviour:*** Individual, group and family therapy may help aggressive youth reduce the severity of anger problems.

3) ***Anorexia nervosa:*** Psychotherapy may improve outcome, prevent relapse, improve sexual and social adjustment, and encourage weight gain in patients with anorexia nervosa.

4) ***Attachment disorder:*** Child-parent psychotherapy may improve quality of attachment (ability of young children to bond or interact appropriately) and socio-emotional functioning of anxiously attached infants and toddlers of depressed mothers. Preventative psychotherapy for parents might reduce occurrence of impaired neurological development of very low birth weight, premature infants.

5) ***Bulimia (binge eating):*** Psychotherapy, especially cognitive behavioural therapy, may help bulimics reduce binge eating, purging and relapse, and improve dietary restraint and attitudes towards body shape and weight. Prescription medication may be used with psychotherapy, but may not be as successful alone.

6) ***Depression:*** Psychotherapy may help treat depressed adolescent patients. Cognitive behaviour therapy may be more effective for depressed adolescents than other types of therapy.

7) ***Post traumatic stress disorder (PTSD):*** Various forms of cognitive behaviour therapy may be very helpful for patients with post traumatic stress disorder. Group therapy may not be as effective as individual therapy.

8) ***Sex abuse:*** Psychotherapy may be helpful for children who are sexually abused. Group therapy and individual therapy may be equally effective, although individual therapy may address post traumatic stress symptoms more effectively.

9) ***Anxiety:*** Children 8-15 years of age, who maintain active involvement in therapy may respond well to cognitive behavioural psychotherapy. More studies are needed in this area.

10) ***Cognitive enhancement:*** Child therapy may improve children's language proficiencies, and individual therapy may be more successful than group therapy. Further research in this area is needed.

11) ***Attention deficit hyperactivity disorder (ADHD):*** Psychotherapy may not improve parenting, enhance academic achievement or improve emotional adjustment for children of age seven to nine with ADHD. It is unclear whether psychotherapy will reduce the use of stimulants, such as methylphenidate, in these children. More studies are needed in this area.

1.6 OTHER ISSUES AND CONCERNS IN THERAPY

1. Relationship with the Child

Counsellor first needs to establish a relationship with the child which is called *joining*. Methods for 'joining' depend on the age of the child and are very different from methods used with adults. For example, for a child under 5 years of age, this may involve getting on the floor to play a game that they like. Up to seven years of age the child shows little appreciation of other's feelings and it might be difficult to develop adequate therapeutic alliance with the child.

2. Special Skills and Approaches

In comparison to adults, children are more likely to be restricted to present rather than past and relevance of past to present. Also, they are likely to exhibit their difficulties behaviourally rather than verbalizing it. They are also less inclined to self-reflective and more oriented to experimental learning. In view of the above, the therapist needs to have special skills to handle all these issues. One approach in children less than 7 years of age is, to initially have more number of sessions per week, to develop an enduring relationship. Indirect therapeutic activities like play therapy and analogy may have impact via emotional or unconscious process.

3. Issues of Developmental Capacity for Choice of Therapeutic Method

The therapist needs to be aware of developmental milestones in various domains; be it cognitive or social, during the childhood and adolescent years, and appreciate that each child's development is unique. Attention to child's developmental capacity

for self reflection must be an early consideration. The capacity for self reflection as seen in adults is a result of biological maturation, social experience and cognitive development over a period of time and is weak in children.

- **Infancy and Early Childhood**

In early years the child needs to experience primary attachment relationships which provide the child with sense of safety, sense of being positively valued and sense of personal competence. Efforts should be made to assist the family and parents to bring changes that improve the quality of relationship.

- **Early School Years (4-7 Years)**

At this age there is an increase in extra familial contacts and the child experiences a challenge to personal developmental resources. At this stage the child's concept of self is limited to primarily two areas: general competence (for example, clever, athletic) and social acceptability (for example, liked by others). The child shows little appreciation of other's feelings and their report of interpersonal conflict will omit their own contribution. Chronic problems especially anxiety develop if the child is not given supportive and sensitive environment.

- **Late Middle Childhood (8-12 Years)**

Social refinement occurs at this stage. The child behaves independently and with greater responsibility. This developmental phase has conscious thoughts and ideas about the situation. In therapy, children of this age are likely to be defensive and guarded about revealing their thoughts and there is a need to respect the child's concern and desire to remain in control. The children are able to talk about their qualities, assets and perceived self worth rather than just demonstrate in their behaviour (Harter, 1985). The children view the situation with their ideas and communicate indirectly and are less receptive to explanation and reassurance, unless and until it matches their own view.

- **Adolescence**

At this stage, social and physical changes are associated with the change in the way an adolescent views self. For the first time, the adolescent is capable of locating her or him as object in the personal history (past, present and future). It would still be a mistake to assume it to be at the level of adults. The presence of metacognitive capacity opens up the possibility of insight oriented therapies; whether cognitive behavioural or psychotherapeutic. The therapist needs to be honest as compared to the childhood period as the adolescent is more sensitive to personal concealment and duplicity.

Implications of Developmental Abilities for the Choice of Therapeutic Method

By now it is clear that changing socio-cognitive capacities of the children and adolescents demand specific therapeutic approaches. The very young child cannot enter any therapeutic approach which demands self reflection and evaluation. Young children do not have capacity to understand cognitive process. The child at this stage learns through repeated, active, experimental process and guiding attachment relationship. The commonest forms of intervention at this stage are indirect and likely to include elements of developmental counselling and advice on parental management of difficulty.

If the child trusts and obeys the therapist, then via the process of modeling, skill rehearsal, active desensitization and training in relaxation skills can be carried out in children of four years of age. For cognitive behavioural therapies the features of development begin to appear in late middle childhood. Higher level CBT such as interpersonal problem solving approaches can be carried out in children 8 to 12 years of age. The cognitive restructuring techniques are unlikely to be evident before pre-adolescence and are more likely to be reliable in late adolescent years. The goals and methods of therapy should be decided on made considering the child's developmental competence and ability.

4. Personal Issues

The therapist is more likely to be effective where:

i) The therapist is adequately trained in therapy, and sensitive to psychological and developmental concepts regarding childrena

ii) The therapist has flexible interpersonal skills, that is being active and controlling at times and supportive and passive when appropriate, and

iii) The therapist is aware of research findings in specific areas like divorce, bereavement etc., that may help in working with children and teenagers.

5. Legal and Ethical Issues for Counsellor/Therapist

Ethics is a moral philosophy or science of morality, which seeks to establish guidelines by which human character and action may be judged as good or bad, right or wrong. For Mill, the ultimate criterion of what constitutes human well being is whatever would be preferred by people whose choices were not constrained by ignorance and irrationality (Holmes & Lindley 1991). Ethical issues are all the more critical when working with children and adolescents, given their vulnerability.

- **Ethical Issues Arising Within the Counsellor/Therapist**

i) Validation of self image and esteem: There is a difference in the way each person perceives self and the way they believe they are perceived by others. Ethical dilemmas can arise when the therapist is confronted by the views of the client. The promotion of personal values and beliefs in the guise of counselling and therapy violates the principles of autonomy and fidelity. Any discriminatory attitude about race, gender, disability and religion should not be allowed to affect counselling practice.

ii) Competence: Counsellors/therapists working beyond their competence is unethical practice. The British Psychological Society (BPS, 1993) codes that it is the duty of the therapist to recognize and work within limits and to identify and get over the factors that restrict it. Difficulty may arise when the client wishes to continue the therapy with less competent therapist as per respect for autonomy. In this instance principle of non-maleficence (act of no or minimal harm) may provide the guideline. From time to time, the therapist should review their personal and professional behaviour in relation to ethical standards.

- **Ethical Issues Arising from Counsellor-Client Relationship**

The client is in a vulnerable position and the effectiveness of the therapy depends upon the quality of relationship between the therapist and the client (Elton and Barkham 1994).

i) ***Respect for autonomy:*** Ethical issues arise when client's beliefs, values and morals differ from the therapist's. Differences may exacerbate if the therapist does not respect or is not ware of the client's cultural and racial beliefs. The psychodynamic emphasis on transference relationship implies that the therapist knows better than the client about the situation and what is best for the client at this stage. The question then arises that to what extent is the client in a position to reject the same, and choose irrational behaviour or to what extent is the client free to challenge or reject the interpretation. Ethics become important when the client challenges the perceived wisdom of theory, in case of unexpected outcome or when the client does not respond to the treatment opted by the authority or the therapist.

ii) ***Contracting and informed consent:*** The client must be able to give valid consent that he/she has completely understood the nature of therapy (BPS 1993). Client must be given information regarding the therapeutic process, sessions in terms of number, place, time and confidentiality; possible outcome, responsibilities of the client, termination of therapy and payment before the work begins. A clear contract gives freedom of choice to the client and promotes the principles of fidelity and beneficence. This aspect may need to be adapted to the situation, and the parents brought into the picture, if the client is a child or young teenager.

iii) ***Confidentiality:*** It is one of the most difficult areas to be taken care of. Therapeutic relationship depends upon the client being sure that his/her secrets are safe with the therapist. One of the most difficult situations is to break the confidentiality in case of suicidal threats, homicidal threats or physical/sexual abuse of the child. Promising total confidentiality is unethical because it denies the contractual obligation to colleagues and requirement for access to supervision by parents in case of children. In the event of client's death the BAC code specifies that: agreement about confidentiality continues after client's death unless there are over-riding legal or ethical consideration (BAC, 1993).

iv) ***Sexual harassment:*** Sexual harassment is not only unethical but also against the law. It can occur irrespective of the gender and sexual orientation of the client. It is not easy to identify sexual harassment but unacceptable touching, sexual advances and vulgar training material is easy to point out.

v) ***Dual relationship:*** Dual relationship that are of personal loving or sexual nature and have arisen because of professional relationship between the therapist and the client are always unethical. Exploitation is never the fault of the client (Russel, 1993).

6. Counselling with Children from Different Cultures

Characteristics of culturally competent counsellor are as follows:

- The counsellor is aware of his/her own values and biases and how they may affect the clients.
- The counsellor is comfortable with differences that exist between themselves and their clients in terms of race and beliefs.
- The counsellor acknowledges and is aware of his/her own racist attitudes, beliefs and feelings.
- The counsellor must possess specific knowledge and particular information about the group he/she is working with.

- The counsellor is aware of his/her helping style, recognizes limitations and can anticipate the impact upon culturally different client.

7. Gender Issues in Counselling

There are gender differences in self-concept and identity in adolescence. Males generally define themselves in terms of individual achievement and work and females more often in relational terms (Gilligan, 1987). Also during adolescence, conflicts around self-image and body image become and can be expressed differently for boys and girls. To a particular change in life the boys may respond in the form of restlessness, non-compliance and angry, aggressive outbursts, while the girls may show pattern of self absorption, social withdrawal and tearfulness. Male and female therapists can view a patient's life experiences differently, particularly if these experiences are gender specific (Shapiro, 1993). Some therapists have indicated that disclosure of their sexual orientation to patients may be beneficial in therapy (Isay, 1989). Patients give many reasons for their choice of therapist which are often based on stereotyped views such as that men tend to perpetuate patriarchal values, or that women provide more nurture. Group behavior both between group members and with the leader is affected by gender (Forsyth et al., 1997). Gender of the therapist might be more relevant in supportive psychotherapy, in which identification with the therapist and restoration of defenses is more critical.

8. Issues of Personal Well Being and Safety

The psychological, emotional and physical well being of the therapist should be at the level to help the clients effectively. Therapists are required to monitor their own personal functioning and to seek help or withdraw from counselling when their personal resources are depleted sufficiently (BAC, 1993). The client should not be put at risk due to therapist's reduced ability to perceive and respond.

9. Issues in Counselling Research

Meara and Schmidt (1991) consider that the main problem for research in counselling lies in significantly different values, priorities and practice of research and counselling. Much cannot be said with certainty in this area due to methodological flaws in conducting studies and research in the field of counselling. Absence of true control groups, psychological intervention at various levels i.e. children, parents and teachers, inadequate description of psychological treatment reduce the power of the studies to claim the effectiveness of these therapies. Shrik and Russel (1992) said that comparison of treatment approaches is premature, and the bias of criteria is in favour of behavioural therapies. Similarly Barnett et al. (1991) argue that comparison between behavioural and psychotherapeutic studies are invalid due to methodological differences. Some of the common flaws are

i) Use of small, unspecified samples.

ii) Absence of control groups, making it difficult to credit the benefit to psychotherapy alone and not to any other factors outside the counselling setting.

iii) Use of global outcome measures only.

iv) Failure to monitor the integrity of treatment.

v) Absence of meaningful follow-up.

10. Issues Related to Setting, Socio-Economic Status, Co-Therapists

Sessions for children normally take place at the counselling centre and although there may be exceptions, it is generally not helpful for a child to receive counselling at home. This is because a child may feel inhibited at known place own space and may be reminded of the assault by unknown triggers around them. In a counselling centre a child gets a sense of not being the only one in this situation. They see other children's drawings and are able to recognize that there are other kids who have been hurt by adults. They are able to identify the counselling room as a safe and neutral place.

The therapist who comes from the middle or upper socio-economic status, may find it difficult to relate to circumstances affecting the client who lives in poverty; for example poverty may lead to many children working at early age and thereby leading to truancy and poor performance in school which may be interpreted as unmotivated or delinquency by the therapist. The expectations of the minority class who has never been exposed to such therapy may be different from those from upper class. Even the situations and problems of the lower socio economic class child like homelessness, lack of basic education, broken families etc. will be different from those of upper class.

11. Concerns Related to Lack of Trained Therapists

The change in social reforms and industrialization of India has transformed life styles. Children and people in increasing numbers are now in need of counselling and therapy due to increase in stress and awareness about illnesses. Counselling services are poorly defined and presently anyone at all with little or no training can offer these services. Available counselling services are largely based on Western approaches to psychology. These approaches have been widely criticized as not being relevant to the Indian cultural context. A relevant and culturally valid counselling psychology therefore has remained a fledgling discipline. There is lack of counsellors and family therapists who are trained adequately in relevance to the Indian context (Gideon 2007).

12. Counselling Children with Special Concerns

Children with learning difficulties and subnormal intelligence require special consideration. The problem is to balance their rights to free choice against their ability to understand the arguments for and against treatment. There is also need to look for different therapeutic ways keeping in view the limited ability of the child to understand the intervention. These children may require more sessions and greater time in establishing the therapeutic alliance.

13. Issues Related to Group Counselling with Children

Within group differences have to be considered when working with two different groups of children at the same time. Because of differences in culture and beliefs the approaches appropriate may not be useful for the others. The type of problems, the process and goals might be different in a child from rural background than from urban background. Group counselling can be useful especially in Indian context where there is importance of extended family network. The counsellor/ therapist can work on strengths that exist within different families and culturally accepted group format during the therapy. Group identity can be build by participation in games and activities like singing and dancing. As trust is built, within group feelings of distrust and frustration can be explored.

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. Fill in the blanks:

   i) Children are more likely to express their difficulties..... than .....

   ii) ..... problems, especially anxiety, develop if the child is not provided a supportive and sensitive environment.

1.7 LET US SUM UP

i) Counselling and family therapy are useful therapies in various situations which affect the development of the child.

ii) The therapist should be aware of differences in practice when handling children and adolescents as compared to when dealing with adults.

iii) The therapist needs to have specific skills and training when dealing with children and adolescents as clients.

iv) Various issues like the developmental capacity of the child, ethical issues, gender issues, types of therapy, issues related to research etc can arise which the therapist should be trained to handle effectively.

1.8 GLOSSARY

Equivalence paradox : The phenomenon of technically different therapies resulting in broadly similar outcomes.

Joining : A relationship that needs to be established between the child and the counsellor, which is essential for counselling to be effective.

1.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. i) True

   ii) False

   iii) True

Check Your Progress Exercise 2

1. i) behaviourally, verbally

   ii) chronic

1.10 UNIT END QUESTIONS

1. Giving examples, discuss the do's and don'ts in counselling/therapy involving a child or adolescent.
2. Discuss the salience of ''joining'' in the context of child therapy.
3. Suppose a child, identified as very aggressive, has been brought to you for therapy. Analyse the implications of developmental abilities of the child for your choice of therapeutic method to be employed.

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UNIT 2 EMOTIONAL AND BEHAVIOURAL PROBLEMS

Structure

2.1 INTRODUCTION

Children and adolescents experience a range of emotional disturbances and have a variety of behavioural disturbances. For the convenience of scientific communication, these disturbances are put under the categories of syndromal emotional and behavioural disorders. Children can be anxious, depressed, fearful, aggressive, hostile, can have scholastic backwardness, psychosomatic problem, severe mental illness etc. In the majority of childhood psychological disturbances or problems, the family has varied role to play. Family environment, quality of parental relationship, disciplining style, interpersonal communication within family,

family reactions to child's behaviour pattern, experience of stress in the family, problem solving mechanisms used by the family are some of the important aspects of the family system which influences children's psychosocial development and adjustment.

Objectives

After studying this Unit, you will be able to:

- Appreciate problems of children and adolescents in the context of the family;
- Analyse the need for counselling and family therapy;
- Develop primary skills of identifying and assessing emotional and behavioural problems in children an adolescents;
- Understand various intervention techniques available for the management of emotional and behavioural problems; and
- Develop intervention skills for managing emotional and behavioural problems of children and adolescents through working with the family.

2.2 EMOTIONAL AND BEHAVIOURAL PROBLEMS

Children spend their time in studies, play activities, interacting with parents, siblings, and peer group and other such activities. If they are emotionally healthy, they get involved in these activities and enjoy them, they remain cheerful and satisfied, they tend to listen to their parents and teachers, they concentrate well in their studies, they are well adjusted, and grow up as well integrated individuals with positive characteristics. There are many factors which contribute to healthy psychosocial development of children such as temperament of the child, quality of parenting, home environment, child's competence, adequate positive experiences, adequate resources, optimal role models within and outside family etc. A psychologically healthy child experiences sense of achievement, affection, and affiliation which promotes further healthy development and adjustment.

Unlike psychologically healthy and well adjusted children, there are children who are emotionally disturbed and have variety of behavioural problems. These children have difficulty in adjusting with both home environment and school environment. Due to their emotional and behavioural problems, these children don't relate well with their family members, siblings, and friends; they don't participate in and enjoy play activities; they experience difficulties with their academics, suffer many aches and pains, failure in school, non-rewarding situations around them, and severe adjustment problems. Emotional and behavioural problems in children are seen related to activity, academic skills, emotions, psychosomatic manifestation, conduct, sexuality, and addiction.

2.3 IDENTIFICATION AND ASSESSMENT

Early identification and proper assessment of psychological disturbances in the child help in effective management and effective family counselling. The counsellor and therapy needs to make specific effort to identify the nature and type of problems, possible determinants of the problems, maintaining factors, effects of the problems, and various positive factors in the child and environment which can further be promoted as part of counselling strategies.

2.3.1 Sources of Emotional and Behavioural Problems in Children and Adolescents

The sources of emotional and behavioural problems in children can be child-related, family-related, school-related and related to other environmental situations. Problems in the child like poor intelligence, sensory defects, mild brain damage, and acquired defects can be the source of problems. A family with parents who are quarrelsome and difficult, are very anxious and ambitious and expect too much from the child, are indifferent to the child, and use excessive punishment is likely to be the source of problems in the child. Besides, sibling rivalry and jealousy, financial problem at home, parental interpersonal problems, and unusual home environment (conflict, extra-marital relationship, and alcoholism) make children emotionally disturbed. School related factors such as academic pressure or stress, punitive and critical teacher, bully classmate or senior etc. contribute significantly in the development of emotional and behavioural problems in children. Similarly, there are factors present in neighborhoods, which may create psychological problems in children, for instance bad company, conflict with neighbourhood, inequality, violence etc.

2.3.2 How to Identify and Assess

Identifying that a child is suffering from emotional and behavioural problems is essential for a counsellor in order to provide his or her services to the child and the family. Some problems can be identified easily but some problems require specific skills and techniques in order to identify them. A counsellor can look for some indicators of emotional and behavioural problems in children; some of them are listed here:

- Frequent absence from school
- Irregularity in homework
- Poor or no participation in play or recreational activities
- Staying alone
- Complaints of various aches and pains during classes
- Complaints from others regarding his/her conduct
- Poor test performances
- Not attentive in the class
- Being irritable, stubborn, and/or aggressive
- Refusal to go out of home
- Frequent crying spells
- Frequent fights with friends and/or siblings
- Poor appetite and/or sleep

Presence of any of these indicates possibility of emotional and behavioural problems. Careful observation of child's behaviour & his academic performances, use of screening tools, parent's interview, and use of psychological/behavioural tests are some of the methods of identifying and assessing problems of children. Children's

Mental Health Screening Questionnaire can be used for identification of psychological problems or mental health problems in children.

CHILDREN'S MENTAL HEALTH SCREENING QUESTIONNAIRE
(Sinha, U. K. & Kapur, M., 2006)

Name: _____ Age: _____ Gender: M / F
Regn No: _____

Instruction:

Here some questions are given regarding the behaviour and feelings of the child. Kindly think of the child's behaviour in last few months or weeks and provide answer either in 'Yes' or in 'No' to all the questions. Remember this will help in the detection of possible emotional and behavioural problems in the child. Thanks for your co-operation.

1. Has there been any problem in his/her behaviour? Yes / No
2. Does he/she remain confused or lost? Yes / No
3. Does he/she appear sad or gloomy? Yes / No
4. Does he/she get angry easily? Yes / No
5. Does he/she have many complaints against other children? Yes / No
6. Does he/she have difficulty in concentrating in studies? Yes / No
7. Is he/she stubborn? Yes / No
8. Does he/she have various aches and pain? Yes / No
9. Does he/she have sleep problem? Yes / No
10. Does he/she have difficulty in sitting still at one place? Yes / No
11. Does he/she become violent or aggressive? Yes / No
12. Does he/she break rules frequently? Yes / No
13. Is he/she excessive fearful?Yes / No
14. Does he/she smoke or chew tobacco? Yes / No
15. Does he/she have difficulty in understanding? Yes / No

Total Score
(No. of Yes)

Examiner's Signature

Once it is identified that the concerned child is likely to have emotional and/or behavioural problems, a systematic effort should be made to explore the sources of these problems through an interview with the child, the parents and other significant persons. You as a counsellor/family therapist must try to establish a convincing explanation about the relationship between the sources of the problems and the emotional and behavioural manifestations of the problems in the child. This explanation must be based on the elicited facts and not on assumptions or any kind of bias. Assessment of children's problems also includes scaling the intensity, frequency, antecedents or triggers, and immediate and long-term consequences of specific behavioural or emotional problems. Use of Visual Analogue Scale can be the simplest method for assessing severity of problems. Psychological tests help in identification and assessment of the natural and the severity of the problem.

Methods of Assessment:

- Observation
- Academic Performance
- Screening Tools
- Interview with Parents
- Use of Psychological Tests

In order to use family based intervention strategy, it is vital to explore some of the important aspects of family structure and functioning including quality of interpersonal relations among the members, interaction and communication pattern, disciplining and controlling mechanisms, problem solving strategy, regulation of emotions, availability of rewarding and non rewarding experiences within the family, presence of aberrant situations like domestic violence, alcoholism, mental illness, chronic and disabling physical problems, ongoing stress etc., as these factors have significant influence on children's emotional and behavioural problems.

Family factors to be explored:

- Communication
- Problem solving
- Interpersonal relations
- Rewarding experiences
- Stressors

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. For each of the following statements, state whether it is 'Correct' or 'Incorrect':

   i) Children with emotional and behavioural problems are well adjusted at home and school. _____

   ii) Early identification and assessment of psychological disturbances in the child can help in its management through effective counselling and family therapy. _____

2.4 MANAGEMENT

2.4.1 Play Therapy

Play therapy is a form of psychodynamic therapy, which provides children an opportunity to deal with their emotional difficulties and develop control over their external problematic behaviour. In play therapy, play is used as an adjunct to communication as well as a vehicle of communication between the child and the therapist. The child is introduced to specific play setting with different play materials with the aim of achieving a therapeutic effect with a cathartic resolution of conflict or tension through the child's play. Play helps the child develop and sustain relationship with the therapist, which has central therapeutic significance. In guided play therapy, the therapist guides the child's play in an effort to help the child achieve psychological integration.

Play therapy as used by Axiline (1947) is considered as most effective play therapy for children. Based on the ideas of Rogerian concept of 'Client-centered therapy' Axiline's play therapy uses play to reflect back to the child his states, wishes, or convictions without attempting interpretations of unconscious motives or conflicts.

2.4.2 Behaviour Therapy

Behaviour therapy refers to a set of related assumptions, principles, and techniques that are rooted in learning theories and used to change human behaviour. Behaviour therapy assumes that most behaviour develops and is maintained according to the principles of learning. Therefore behaviour can be modified with the help of the same learning principles. In behaviour therapy, observable target behaviour is attempted to be changed with the help of different behavioural techniques. Modeling, shaping, exposure, behavioural practice, differential reinforcement techniques, time-out etc. are some of the important behaviour therapy techniques used with children.

2.4.3 Cognitive Therapy

Cognition plays a very important role in the way individuals feel and act, and this is true for children too. Cognitive therapy believes that behavioural and emotional problems are a result of dysfunctional, irrational beliefs and distorted cognition. Identification and exploration of irrational and dysfunctional nature of cognition and intervention to make it functional and rational are the essence of cognitive therapy. Cognition here means the process and manner of interpreting experiences and events around us and assigning meanings to these events.

2.4.4 Supportive Therapy

Many a times individuals are so entrapped in their psychological disturbances that they find it difficult to handle situations on their own; they need encouragement, guidance, and support to sort out their problems and to deal with their difficulties. Supportive therapy helps such individuals come out of their sufferings effectively. In supportive therapy, the therapist focuses on the present situations and sufferings and helps the client by providing opportunity to ventilate, share, and release pent-up feelings; by providing guidance, suggestion, encouragement for positive action, education, clarification, and environmental manipulation.

2.4.5 Parent Training

Parent training empowers parents to deal with emotional and behavioural problems of children through the process of parenting. Parents are trained by the therapist to attend to the positive behaviour of the concerned child, to reward positive behaviour, to ignore some of the unwanted and maladaptive behaviour, and to exercise control and punishment for highly undesirable behaviour. Parents are also trained for using behavioural techniques of positive reinforcement, distraction, punishment, and skills training.

2.4.6 Family Therapy

Structure of family, quality of relationship among the family members, quality of communication, emotional bond, value system, conflict resolution, disciplining pattern, rituals and taboos of the family have significant influence on the mental health and psychological problems of the family members. Family therapy attempts to look at the problems of any member as manifestation of dysfunction in family system including disruption of bond, communication problem, disruption of boundary, pathological handling of conflicts, and other such difficulties within the family. Nature and sources of interpersonal conflicts and their manifestations within the family are identified, explored and measured and relevant interventions are made in family therapy with the participation of each significant unit of the family. Different techniques including behaviour techniques, cognitive and problem solving techniques are used in family therapy.

2.5 FAMILY BASED INTERVENTION

2.5.1 Education to the Family

Acknowledgement of problems and acceptance of responsibility for solution are prerequisite for the family for initiating the process of professional counselling for emotional and behavioural problems of children. Acknowledgement of the fact that the child has problems and needs specific intervention sets appropriate ground for help seeking behaviour of the parents and significant others. It also ensures proper compliance to the process of counselling and therapy. Parents of disturbed children need to be educated by the counsellor so that they can understand the nature of problems the child has and possible remedies for these problems.

Many a time parents have difficulties in accepting that their children have emotional and/or behavioural disturbances and they require counselling/family therapy. Such difficulties may arise due to stigma, ignorance, fear and guilt due to their perceived contribution/role in the development of problems in the child, and some other worries parents have. Counsellorist/family therapist is required to be aware of any such reason for parents' resistance to acceptance.

The counsellor/therapist must explain to the parents the problem of the child, the factors that are contributing to and maintaining the problem, the solution available, their role and responsibility in helping the child to come out of the problems, importance of parenting and family environment in controlling child's problems etc. While educating the family on these aspects, the counsellor:

- Communicate in simple understandable language
- Allow adequate time for information to set in
- Show confidence, acceptance and patience
- Satisfy their queries
- Avoid argument
- Tell them with clarity that it is not their fault
- Wait for their reaction and respect their reactions
- Assure reasonable commitment
- Avoid false promises
- Help them take appropriate decision regarding intervention

2.5.2 Communication Training

Proper and healthy communication between parents, children, and other significant family members play an important role in maintaining sound psychosocial development of children. Faulty communication creates difficulties and spoils relationship and subsequently contributes to emotional and behavioural problems. A large amount of work is required in counselling for emotional and behavioural problems of children and adolescents. A simple, direct, and focused communication is considered better than a difficult, indirect, and vague communication. Adult to adult faulty communication has devastating impact on children. Similarly communication full of critical comments and hostility is considered unhealthy from mental health point of view. Pathogenic communication between parents and other adult family members provide a model for children to emulate. Hostile, critical, vague, and unnecessarily elaborative communication from parents or others to the child, may lead the child to be angry or hostile or confused or stressed. Thus communication training is an important area to work with in counselling of affected family.

In communication skills training you must identify faulty nature of communication being practised in the family. After identifying this, the family has to be clearly explained the link between communication and its consequences indirectly without putting any blame on anybody. Then after appropriate ways of communication are suggested, the family members are encouraged to practise them.

2.5.3 Behavioural Management Training

Adequate behavioural management is the most essential aspect of helping the family with an emotionally and behaviourally disturbed child through counselling and family therapy. The counsellor can help parents/family members learn skills to manage behavioural problems of children by explaining and demonstrating simple procedures to them. The components of behavioural management training include behavioural analysis and assessment, identification and attention to positive behaviour, reward for positive behaviour, weakening or elimination of maladaptive behaviour with the help of appropriate behavioural techniques. ***Behavioural assessment & analysis*** is done to record nature, frequency, severity, origin, and maintenance of behavioural problems in children. Parents may be trained to record all these in a particular manner on the following formats including A-B-C format (Table 2.1) and behaviour record (Table 2.2). This recording and analysis help the parents understand as to where intervention is needed, at A or C level and how one's behaviour is changing over time with intervention.

Table 2.1: A-B-C Record Sheet

Antecedents (A) Situation immediately before problem behaviour has occurred	**Behaviour Problem (B)** Exact description of what is expressed as problem behaviour	**Consequence (C)** Situation after the problem behaviour has occurred

Table 2.2: Behaviour Record Form

Description of Problem Behaviour	Frequency of Occurrence Per Day					
	Day1	Day2	Day3	Day4	Day5	Day6

2.5.4 Parenting Skills Training

Parenting is a process of providing complete care to the child, in order to foster the childs physical, emotional, social, occupational, and interpersonal growth and competencies. In order to provide adequate parenting, parents must ensure that the child gets adequate attention, affection, stimulation, exposure, reward, and encouragement. Principle of 'love, limitation, and let them grow' popularly known as ***Three L's*** is a highly recommended strategy for parents to facilitate sound psychological development of children. Parenting children and adolescents today demands specific interactional skills. A healthy parent-child interaction helps, parents create a conducive context for their children to grow and mature; and children to build enough confidence and self-esteem, to develop competence - life skills, and to expand potentials to their maximum. Needless to say that healthy interaction between parents and children protects against a variety of negative conditions including conflicts, stress, anxiety, addiction, violence, rage, failure and maladjustment.

Specific parenting behaviour and skills have been examined, particularly in relation to the development of aggressive and disruptive behaviour. Parents of aggressive children are characterized as highly punitive and critical to their children and more likely to attribute their children's misbehaviour to more dispositional, intentional and stable causes compared to parents of non-problem children. These attributional processes tend to become more pronounced over time. Child-focussed, responsive, and moderately controlling parenting attitudes have been positively associated with self-esteem, academic achievement, cognitive development and fewer behavioural problems. Parents of children with emotional and behavioural problems need to be encouraged and guided to opt and use such parenting style. Counsellors can use the following as guidelines for interacting with children to suggest to parents of disturbed children.

Suggestions for parents of disturbed children:

- Accept that your child has grown-up to the stage where one's independent identity begins to develop.

- Remember that your child has a strong need to be independent and to have own personal space.
- Teenagers have a lot of inside work to do that does not relate to you; allow them some freedom to complete their work.
- Observe and notice their interests and respect them both in words and in action.
- Be available and emotionally involved with your teenager.
- Tell your teenager that you are always there to support and help whenever there is difficulty.
- Spend time with your teen-aged child discussing and sharing together.
- Convey in clear words to your teenager that he/she is important for you and you care for him/her.
- Remind teenagers that they are studying and working hard for themselves; not for you. Yes, tell them that you feel happy and satisfied seeing them study hard.
- Be flexible in setting guidelines for your teenager by allowing reasonable negotiations but be firm in their enforcement.
- Validate and support emerging mature and autonomous behaviour of your child.
- Help them take their own decisions after providing them with all necessary information.
- Look for and find opportunities to praise, congratulate, reward, and respect your teen-age child.
- Listen to them and ask questions.
- Allow some responsibilities to them and trust their capability.
- Validate and encourage their own capacity to cope.
- Help them learn from their mistakes through self-reflection and discussion.
- Avoid labeling, judging, and devaluing.
- Don’t take interactions personally.
- Help them ask and explore important questions.
- Support their dreams, while helping them to plan, organize, and follow activities to completion.
- Ask if something is wrong when behaviour changes.
- Respect (you don’t have to like) their peer choices.
- Low-key, accepting, calm parents hear more. Kids keep talking to them.
- Permit conflict and guide discussions.
- Help adolescents develop disciplined conformity to society’s necessary rules and expectations.

- Value stimulating conversations with different points of view.
- Encourage them to adopt a personal value system.
- Remember and remind them that adolescence is a process.
- Foster a sense of comfortable continuity.
- Let them set the pace and timing of close and distant interactions

Children are different temperamentally, they have age specific psychological needs, and adolescents often have lots of anxiety related to their own development, career, future, relationships and physical appearance. The parents need to be made aware of the fact that a balanced understanding of all these facts and wise use of interactional style from the list above will help them to interact effectively with the child.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided.

b) Check your answer with those provided at the end of this Unit.

1. What is the significance of play therapy?

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2. Why is it important that counselling and therapy provided in case of emotional and behavioural problems in children and adolescents, be family based?

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2.6 SPECIFIC ISSUES

2.6.1 Cultural Sensitivity

You as a counsellor/therapist must be sensitive to the cultural values of your clients. In the absence of adequate cultural sensitivity, counsellor are likely to be incomplete in their endeavours.

2.6.2 Referral to Specialist

The counsellor should have adequate clarity about her or his professional liabilities and limitations. An objective assessment of the severity and complexity of problems of a particular child is essential and given the possibility of diagnosable psychological

problems, the counsellor must be able to decide and suggest referral to the specialist. If the given child has signs of depression, expresses suicidal wish, harms himself, is hostile and violent, has experienced severe trauma or abuse, is suffering from a long time, has severe behavioural disturbances; the counsellor should prepare the parents of the child and/or other family members for consulting a specialist e.g. Psychiatrist.

2.6.3 Optimization of Expectations

Many a time parents of disturbed children keep and display unrealistic or too much expectations from the counsellor. And many a time counsellors are influenced by the expectations of parents and they also set their expectations high. The counsellor should always try to keep his/her expectation from the counselling at optimal or realistic level. Unrealistic or too much expectation may lead to frustration and a sense of failure. In addition, the counsellor should help parents to keep their expectations realistic by educating them about the nature of problems and what can be achieved through various methods.

2.6.4 Mental Health of the Parents

While identifying problems in children, a careful attempt to recognize mental health problems in parents is highly advisable in the interest of effective management of children's problems. Mental health of parents influences mental health of children by affecting the environment in the family, by providing a particular role model, by shaping quality of parenting process, by affecting parent-child bond in particular manner, and by influencing their involvement in help seeking process. A parent suffering from anxiety may not be able to provide secure attachment with the child; similarly a parent with depressive disorder may not be able to offer adequate parenting, and a parent with alcohol or substance abuse problem will not be able to keep the environment within the family healthy and to provide an ideal role model for the child. Mental illness in parents can be a contributory factor for emotional or behavioural problems in children, can negatively affect intervention process, can trigger non-compliance to counselling/family therapy techniques, and can further complicate the situation of the child. Hence a careful scanning of parental mental health is necessary for the counselling process to attain its goal.

2.6.5 Maintenance of Professional Relationship

A mutually trusting, supporting, warm, and confidential relation between the counsellor and the client is essential for effective counselling. However, it is necessary for the counsellor/therapist to work with the client within professional boundaries. The moment personal elements enter professional relation; it no longer remains a professional relation and loses its professional effect on the client. You as a counsellor must always keep the following points in mind when you practise counselling with your client:

- Work with a specific time frame and have a fixed time for the session
- Always focus on your target in the counselling session
- Allow only relevant aspects of discussion in the session
- End session on time and appreciate client to cooperate
- Never take undue advantage of your client's position

2.7 LET US SUM UP

This Unit sensitizes us to the sources of emotional and behavioural problems in children and adolescents, and provides guidelines regarding how these problems may be identified and assessed. It then highlights the various therapies that are beneficial in the management of these problems. The significance of family based intervention – counselling and family therapy, has been emphasized, and various related specific issues enumerated.

2.8 GLOSSARY

Behaviour therapy : Refers to a set of related assumptions, principles, and techniques that are rooted in learning theories and used to change human behaviour.

Optimization of expectations : Expectations being neither too low nor too high.

2.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. (i) Incorrect

2. (ii) Correct

Check Your Progress Exercise 2

1. Play therapy is a form of psychodynamic therapy which provides children an opportunity, through play, to deal with their emotional difficulties and develop control over their problematic behaviour. The specific play setting provided to the child is aimed at achieving a therapeutic effect with a cathartic resolution of conflict or tension through the child's play. Play also helps in therapeutic rapport formation and communication between the child and therapist.

2. It is important because:

   i) the child's emotional and behavioural problems could well be a manifestation of dysfunction in family system.

   ii) It sets the ground for appropriate involvement of parents and other family members;

   iii) It ensures proper compliance to the process of counselling and therapy.

2.10 UNIT END QUESTIONS

1. What are common sources of emotional and behavioural problems of children? How important it is for the counsellor to identify them in counselling process?
2. What are different methods of assessment a counsellor can try to carryout appropriate assessment in counselling?
3. What are different therapies available for management of emotional and behavioural problems of children and adolescents?
4. What are different aspects of family education in counselling for emotional and behavioural problems of children and adolescents?
5. What measures can a counsellor take to maintain professional relationship with the clients?
6. Why it is important to pay attention to parents' mental health in family counselling and therapy for children's problems?
7. What are important components of behavioural management training?

2.11 FURTHER READINGS AND REFERENCES

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UNIT 3 SCHOOL DIFFICULTIES

Structure

3.1 INTRODUCTION

School adjustment is synonymous to success in one's life and mental health. The process of starting schooling is a stressful time, both for the parents as well as the child. The struggle doesn't end by just getting admission into a school of your choice. This is only the first battle won. The next struggle is a long lasting one, which begins with the anxiety about the child's school adjustment and performance. The present day system places a lot of emphasis on the performance and achievement of the child, whether it concerns the academic or the social realm. Parents burden the child with high expectations, wanting their children to achieve the highest educational degree, with first position everywhere. In such a scenario, if the child fails to live up to their expectations, it creates a large amount of stress not only on the child, but also in the teachers and parents. School difficulties can occur in both 'good' students as well as in not so 'good' students. The causes of school difficulties can be manifold, which could lead to poor school performance. When a child faces difficulty in school, the entire family expresses deep concern. It may lead to frustration, anxiety and depression in the concerned parent, with tremendous implications for the child as well. Thus, one needs to take a systematic approach towards the problem.

Objectives

After studying this Unit, you will be able to:

- Understand prevalence and symptoms of school difficulties in children;
- Identify causes of school difficulties;
- Plan an assessment of child having school difficulties;

- Understand impact of school difficulties on the child and the family; and
- Provide counselling to the family and child.

3.2 PREVALENCE AND SYMPTOMS OF SCHOOL DIFFICULTIES IN CHILDREN

Estimates of the prevalence of school problems in children vary considerably. In India, the estimates of prevalence range from 11-33 %. Wide variation in prevalence rate may also be due to factors such as classification criteria, data collection methods and the individuals who make the judgement regarding dysfunction. Despite the subjectivity involved, many professionals agree that school difficulties interfere seriously with academic and social development of school children. In the Indian context, a study by Kapur (1993) on primary school children from low socio-economic strata in an urban area reported that 41 percent children had school related problems. Shenoy (1992) found nearly one-third children to be scholastically backward of which a majority had specific learning disability. Mehta et. al. (1992) conducted a study on 2055 rural school children near Delhi and found that 11% of the children had school difficulties, 16% had borderline intelligence, 12.8% had Attention Deficit Hyperactivity Disorder and 3.6 had developmental reading disorder. Rozario (1991) conducted a study on a population of 1549 children in the age range of five to eight years from middle socio-economic status, and reported scholastic backwardness in 11 percent of boys and 8 percent girls. Sarkar (1990) in a study of 408 children between the ages of 8 and 12 years from middle socio-economic status found 33 percent children to be scholastically backward, and also found that they had more psychological problems and psycho-social stresses than their counterparts with no scholastic problems. Rozario (1988) in a study of 1374 adolescents, 12-16 years of age, found 32 percent to be scholastically backward. Out of these children 46 percent had psychological disturbances.

Symptoms of School Difficulty

The problem of school difficulty is on the rise. There are either referrals from school authorities or parents on their own seek help. The problem in the area of scholastic performance may manifest through various complaints. Sometimes the presentation is straightforward, but many times the presenting complaint may suggest a psychological disorder, which on detailed assessment comes out as school difficulty.

The following case will help you to understand the presentation of school difficulty:

A 14 year old boy came from a small town with complaints of headache. The boy, named A, could tell very spontaneously about his home, current events and had fair general knowledge. He mentioned that his headache increased whenever he started to study. He had stopped going to school. His family members had taken him to various doctors, he had undergone MRI, CT scan and all other tests. There was no abnormality reported. On psychological assessment he had above average intelligence. He was having specific learning disability – reading and writing. Due to this he did not understand the school course work and could not write properly. Teachers in small town school were not aware of his problem and abused him.

The following complaints indicate school difficulty:

- Poor comprehension
- Poor concentration
- Poor memory
- Inability to reproduce learned material
- Does not get good marks inspite of hard work
- Not interested in studies
- Restlessness and hyperactivity in the class
- Does not want to write
- Does not copy assignment from the black board
- Watches T.V. for many hours
- Afraid of teachers and school
- Headache
- Recurrent abdominal pain
- Excessive anger
- Aggressiveness
- Lying, stealing
- Bunking school
- No friends, loneliness
- Poor self esteem
- Spends lots of time in playing
- School refusal

3.3 CAUSES OF SCHOOL DIFFICULTIES

Academic success is fundamentally important for social development and post school opportunities in life. There is a need to carefully scrutinize the causes that may lead to school difficulties. The causes could be within the family functioning, within the child or due to school environment, which need to be understood in detail by the parents and teachers in order to address the issue in a positive manner. The various causes that could underlie this problem are:

3.3.1 Disability

- ***Physical handicaps***

A child with any kind of physical handicap such as poor vision, speech and hearing impairment, poor motor coordination, weak limb movement, may have problems in performing well in the school. Some children excel in academics in spite of disability whereas others may have difficulty. Some children develop a sense of low self esteem, difficulty in making friends, insecurity which leads to poor concentration and decline in school work, apart from difficulties at the socio-emotional level.

- ***Intellectual ability***

Intellectual ability is highly correlated with school difficulty. Often poor intellectual ability (low IQ) goes unnoticed by parents and teachers. The child is expected to perform as well as other children with higher IQ. Low IQ is cause of poor comprehension, memory, and the child loses interest in studies as he cannot do well despite of hard work. If the child is not able to benefit from school, parents should get intellectual assessment of the child done through a trained clinical psychologist. Nagging and punishment will do more harm to the child than benefit.

- ***Specific learning disability***

Specific learning disability, also known as dyslexia, is a dysfunction in one or more of the processes of learning like attention, perception, processing of information, memory etc. Specific Learning Disability (SLD) affects a specific area of performance, such as reading, writing, spelling and arithmetic, whereas in other areas the child may function optimally. Due to this problem, the child is not able to perform satisfactorily in academics and in social situations. Such children have average to above average intelligence but they need to develop strategies in the deficit areas.

3.3.2 Chronic illness

- ***Physical***

Scholastic difficulties are often seen in children having chronic physical illness like diabetes, epilepsy, thalassemia, cancer or similar problems due to which he has to repeatedly go to hospital and has to miss school. Due to poor physical health, the child may have problem in coping up with the academic load in the classroom. Sometimes, this can also lead to poor self-esteem and difficulty in mixing with other children in the class. Such children should be helped to cope up with their physical illness, learn problem solving skills and take help of other students to complete their class work.

- ***Psychiatric***

Chronic psychiatric illness like autism, childhood schizophrenia, depression, anxiety, ADHD can also lead to school difficulty. Many psychiatric disorders can cause cognitive impairment, due to which the child has difficulty in concentration, memory and comprehension. The cognitive impairment in some disorders is reversible and improves with treatment of the disorder.

3.3.3 Psychological Factors

There are a number of psychological factors which can cause school difficulties. These are as follows:

- ***Environment — Family***

Let us consider an example. Ram belongs to a lower-middle class strata. His parents want him to do well in life, and he is admitted in a good public school with English medium of instruction. Ram is not able to comprehend as in his family nobody can speak English or help him to learn English. In his neighbourhood also he cannot get any help to learn English. They cannot afford a private tutor which is an additional economic constraint. As a result Ram is not able to do well in the school and he refuses to go to school.

This is an example of how family environment can lead to school difficulties. Parent's expectations are one of the leading causes in school difficulty.

Another example of family environment is where parents tell the child that he will be doing family business, so even if he does not score good marks it will not make any difference.

If some family members spend lot of time watching T.V. it can interfere with the child's study. They do not provide proper environment to the child where he can concentrate on his studies.

Alcoholism, conflicts amongst parents, lack of discipline, poor parenting and financial constraints can disturb the child and lead to poor concentration.

- ***Environment — Friends and School***

Children are greatly affected by environmental influences such as peers, friends etc. The peers of the child may have a negative influence on her or him, or may keep her or him occupied in non-academic activities for more than the desired amount of time. The school environment may also be non-conducive to the academic pursuits (such as fear of teachers, not being able to understand the teacher, being bullied by peers or seniors etc.) which may lead to poor school performance.

- ***Lack of motivation***

The child may be lacking in motivation to study and perform. A few children have been found to show complete disinterest in studies, as they do not have any ambition and goals to be achieved. The child may be unaware of the long term benefits of good performance and participation in school activities. This may or may not correlate with the family environment. Very high achieving parents can have unmotivated children. It could be related to child's temperament of being lazy.

- ***Faulty learning style***

The child may have a fautly approach to learning, where he superficially glances through the contents, does rote learning without understanding the subject. Or the child may go in depth of every topic. The good approach to learning is strategic learning where one studies in depth all the topics of high relevance and goes surface learning for unimportant topics. The child with faulty learning strategies may spend too much time on studies or too little, not leading to satisfactory output

in exams. The child can develop a faulty learning style if parents do everything for him, like making notes, making him rehearse through rote learning. Private tutors in elementary class can also harm the child if right learning approach is not used.

- ***Personality***

Some studies have been carried out to see correlation between personality and academic performance. Introvert boys do much better in school whereas extrovert girls perform better in school. An introvert boy is less likely to waste time with friends and will be more focused on studies. An extrovert girl can learn better through group discussions and mutual inspiration.

- ***Anxiety and expectations***

It is a well-known fact that excessive anxiety disrupts performance. This may hold true in case of many children, who may complain of examination phobia, inability to write or recall in the examinations, despite preparing well. Anxiety interferes in performance, leading to results below expectations. Also, parents or teachers may have high expectations from the child, which puts the child under stress and anxiety, leading to poor performance.

- ***Poor attention span***

Some children have been found to have poor attention span, and are easily distracted from their present work. Children who suffer from ADHD may show poor performance because of poor concentration and impulsivity. Such children may also miss out on noting down important information being given in the classroom, or paying attention to the concepts being clarified in the class. With poor focus and inattention, the child may require more time to complete his work.This may result in poor academic performance.

- ***Conduct problems***

Children with conduct problems demonstrate signs of aggression towards others, bullying, abusing, being constantly involved in fights with others, lying, stealing or violation of rules. The child who demonstrates such behaviours may try to gain attention of other children and teachers. They may show poor academic performance as most of the school time is spent in gang work. Such problems in children call for immediate psychological intervention.

- ***Substance abuse***

Conduct problems can be associated with substance abuse. Use of substances like tobacco, *pan masala*, illicit drugs, inhalants, ink removers and alcohol is on the rise in school children. With such habits the child's studies may be neglected or hampered. Long term use of substance can cause cognitive impairment, poor school performance and social withdrawl, in addition to other problems.

- ***Stressful life events***

Children also get affected by stressful life events and daily hassles. Stressful life events in a child's life include transfer of father to another city, death of grandparents/parents, illness in family member, conflicts, separation of parents, academic failure or financial problems. These stresses may pose a serious threat for the child. Change of school is also very stressful for the child as he has to make place for himself in the new environment. The child may show signs of loss of concentration, decrease in interest in activities previously enjoyed, being lonely and sad, decrease in motivation etc. The child's mental and physical energy may

get totally absorbed in coping with these stressful events. These may together contribute towards decline in academic performance.

Check Your Progress Exercise 1

Note: a) Read the following questions carefully and answer in the space provided.

b) Check your answer with those provided at the end of this Unit.

1. Are the symptoms of school difficulties always easily identifiable? Explain your answer.

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2. List any three causes of school difficulties related to the school environment.

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3.4 ASSESSMENT OF SCHOOL DIFFICULTIES

Most of the times, parents may fail to understand and look into the causes of the problem, which may lead to faulty management of the problem. If the performance of the child is consistently deteriorating in the weekly tests, unit tests and terminal exams, then it is a matter of concern. But a lot of times, it is seen that parents may resort to hitting the child or constantly nagging him, which may not solve but further aggravate the problem. It is imperative, therefore, in such a case to find the causes of the problem and then plan for its management.

To understand causes of school difficulty you need to carry out a comprehensive assessment of the child, parent and family environment. The following steps can be helpful in assessment of the child's problems:

- Informal talk with the child about his activities in the school, his friends, likes and dislikes in the school, his attitude towards the teachers and studies.
- Screening for physical fitness should be done periodically. Mild cases of deafness, poor eyesight, anaemia, thalassemia, endocrine disorders go unnoticed but do have an impact on school performance. Chronic disorders can also interfere with school attendance, learning and performance in the school.
- If school tasks are reported to be difficult or there is a problem in memorizing or comprehension then intelligence should be assessed. If the child has below average intelligence then parents should be counselled to lower their expectations for child's academic performance. They should help the child to learn by simplifying the content, breaking it in small parts and memorizing through cognitive maps.
- If intelligence is average then the child can be assessed for other factors like specific learning disability, attention span, conduct disorder, studying habits, motivation, stresses in the family, anxiety and expectations of the child and

of his parents. At times formal psychological tests are required to assess these problems and to quantify them.

- Personality of the child has been correlated with success in the school. Introverted boys and extroverted girls perform better in school. Sometimes environmental manipulations are required to improve the school performance.
- Test anxiety is very common in students. Enquire if the school difficulty increases during examination.
- Family problems like alcoholism, financial problems, conflicts are also source of anxiety for the child and have an adverse effect on school performances. Try to explore if there are any stresses the child is going through.
- Try to see if the child has any time schedules to study. How many hours is he studying? Is he day dreaming while studying? How does he manage his time?
- It also important to know who teaches the child and how the child is disciplined.
- If the private tutor is engaged to teach the child at home, the rapport of the teacher with the child should be explored. Some cases have been reported where private tutors have used physical punishment to improve the child‘s learning. In such cases the child develops hatred for studies and his performance further deteriorates.
- Behaviour in the classroom for day-to-day activities as well as social relationships with other children should be observed. If there is a noticeable change in the child’s behaviour and performance, then it indicates a need for detailed assessment.
- Many times poor school performance could be a manifestation of serious problems that the child could be having. These problems could be beginning of development of a psychiatric illness or domestic abuse/violence/disharmony. These could be due to the complex interactions of the child’s own potential, personality and the environment.
- With early recognition and management, children with school difficulties can be helped to improve their school performance and personal functioning. This can be achieved through a teamwork approach involving parents, teachers, counsellors, pediatricians and others.

Assessment of the child can be carried out through observation and administration of psychological tests and other measures, and information recorded with respect to the following:

- Case history, developmental history
- Intelligence, Attention, Memory
- Specific learning disability
- Studying skills
- Psychopathology
- Family expectations and environment
- Identification of physical disability

3.5 IMPACT OF SCHOOL DIFFICULTIES ON THE CHILD AND FAMILY

Raghu, a 9-year-old boy was brought to a child psychiatry clinic for being aggressive and violent. He was not studying well in spite of going to school regularly. On obtaining detailed history, it was found that the child had no complaints in the school. He would sit in the last row in the class. He had no friends in the school. His teachers never gave or checked any task. After returning from school, the child would throw his school bag, scream, shout and beat his mother. Psychological assessment revealed that the child had an IQ in the range of 80-90 (dull average intelligence) and had poor studying skills, due to which he was not able to comprehend the school subjects, and could not memorize and reproduce during exams. His mother was doing his home work and she would make Raghu memorize the task like a parrot for exams. He was not motivated to study as the learning experience was boring and frustrating for him. Due to poor school performance, teachers and other students rejected him. He became insecure, had poor self esteem. He was submissive in school but back home he vented his anger on mother.

His parents were equally disturbed about his aggressive behaviour and poor performance in school. They would blame each other for Raghu's problems. Their personal and social life was restricted as they did not want relatives and friends to know their child's problems. Their relationship with Raghu was also spoilt. Father stopped talking to Raghu as rejection. Mother was also tense and afraid as she feared that Raghu would beat her. Siblings were also not able to talk to Raghu. So the entire family was disturbed.

As intervention, his mother was counselled; Raghu was taught studying skills and he was involved in open school. His behaviour changed in positive direction.

This case study can help you in understanding the impact of child's scholastic problem on the family and the child himself. School performance is usually the criterion for judging a child in school. You would have noticed that the child securing first rank, is star in the class as well as in his own home. Parents whose children do not perform well in school become nagging, critical and demanding. Parents should understand problems the child faces in school and in studies. Another example of the impact of school difficulties was displayed in the movie *'Taare Zameen Par*'. You can recall how the father rejects the child as incapable. With family counselling, parents' anxiety and distress can be reduced.

The extreme impact of school difficulties is manifested in attempted suicides in the student population. It causes great suffering to both the child and his parents. Besides emotional impact, there are also financial problems in parents with limited financial resources. They have to spend extra on tuitions, taking consultation from doctors and counsellors.

If one child is not studying well it can have a negative impact on the sibling as well. They may also lose interest in studies.

The counsellor can provide help to children and their families.

3.6 SUGGESTIONS TO OVERCOME SCHOOL DIFFICULTIES

For Parents

After identifying causes of school difficulty, parents need to be explained the child's potential and their anxiety has to be reduced to work effectively with the child. Suggestions for parents include the following:

- Accept the child's level of ability
- Don't nag or beat the child
- Encourage and use rewards to motivate the child to study
- Be firm and consistent in disciplining the child
- Create congenial environment at home to facilitate learning
- Provide guidance and support to the child
- Respect your child's opinion or suggestions on improvement
- Involve him in planning his activities and making the time table
- Ask him to write a dairy to improve self expression
- Help him in learning through games
- Try to discuss and reduce effect of stressful life events
- Try to have a healthy and happy family environment

For the Child

- Help to improve attention and concentration by — grain sorting activity, deleting vowels in a paragraph in a newspaper or magazine, working on activity books, scrabble etc.
- Learning strategies to improve specific learning disability
- Learning correct studying skills
- Behaviour therapy to modify conduct problems
- To reduce anxiety give training in relaxation exercises, distraction, changing negative thoughts to positive thoughts
- Systematic desensitization for examination anxiety will be useful
- Use self statement to boost self esteem
- Assertive training to develop social skills and self confidence
- Family counselling and training in coping strategies for the child are useful in these cases
- If the child has depression or any other physical problem, they should be referred to the concerned physician/psychiatrist.

Management of School Difficulties

Management can be structured in form of a few behavioural techniques that can be used such as:

- Making a timetable and activity scheduling to keep the child occupied in constructive activity

- Short study periods with breaks
- Setting reasonable targets
- Rewarding the child for accomplishments and praising him for desirable behaviour
- Ignoring undesirable behaviour
- Helping the child to make friends who can act as a good role model
- Being firm and consistent in disciplining
- Learning through play and through activity books (containing puzzles, mental maths, vocabulary improving techniques etc.)
- Improving memory through graphic organization, linking with already learnt material, writing the learnt material in form of notes, diagrams etc.
- Making a to-do list for tasks to be completed

Check Your Progress Exercise 2

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. Suppose your cousin comes to you for advice regarding how he could help his 10 year old son, who was facing tremendous school difficulties. List four salient suggestions you would give him.

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3.7 LET US SUM UP

School difficulties are common problems faced by children at all levels in the school. These problems can occur in boys and girls both from urban and rural schools. Children with school difficult can manifest the problems through various symptoms which could be physical like headache, abdominal pain, or poor performance in the classroom. They also show behavioural problems. There are various causes of school difficulty; ranging from disability in the child, family environment, school environment or psychological problems in the child. A comprehensive assessment of the child and family should be carried out. The impact of school difficulties can be mild to severe such as child committing suicide and family conflicts,. The problem can be solved by counselling parents and helping the child to develop coping stretegies and learning correct approach to studies.

Any complaint regarding poor performance at school should not be taken only at its face value, but should be looked into in detail. These children need to be assessed in totality for the causative factors, so that the management can be planned in accordance to it. The parents and teachers need to keep their expectations within reasonable limits and try to see the situation from the child's perspective in order to have a better idea of the child's problem. It is also imperative to remember that scholastic performance is only one of the areas of the child's functioning, and therefore, the focus should be on overall personality

development for a well functioning child.

3.8 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. No. While sometimes the presentation is straight forward, many times the presenting complaint may suggest a psychological disorder, which on detailed assessment emerges as school difficulty.
2. Fear of teachers; not being able to understand the teacher; being bullied by peers/seniors.

Check Your Progress Exercise 2

- Accept the child's level ability
- Teach him study skills and help him to learn through game
- Create congenial environment at home to facilitate learning
- Talk with the child, his peer group and teachers, and redress any school environment related issues.

3.9 UNIT END QUESTIONS

1. With the help of examples, discuss the causes of school difficulties due to psychological factors.
2. Outline the important aspects of management of school difficulties.

3.10 FURTHER READINGS AND REFERENCES

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UNIT 4 CHILD/ADOLESCENT WITH DISABILITY

Structure

4.1 INTRODUCTION

This Unit provides some basic knowledge about the various types of disability, and sensitizes you to providing counselling and family therapy support if the diagnosis of disability is confirmed.

Objectives

After studying this Unit, you will be able to:

- Describe different kinds of disability;
- Appreciate what is normal and what is not normal in a child's development;
- Guide the family in reaching appropriate and complete diagnosis and evaluation;
- Counsel and support the family if the diagnosis of disability is confirmed; and
- Support and guide the family in areas where the diagnosis and management needs of the child begin to have an impact on the family.

4.2 EARLY IDENTIFICATION

In Course 1 (MCFT-001) you have already been acquainted with normed human development. You are aware of the milestones of development and also the fact that development is orderly and sequential, and that while the pattern of development is the same in every child the rate varies from one child to another.

While some variation in the rate of development, and the age at which various milestones are reached is normal, a significant delay may be indicative of a diability. For instance, to child if a child is delayed in all areas of development he is likely to have a global developmental delay. This child is likely to be suffering from mental retardation and should be enrolled in an infant stimulation programme. However, if only language development is delayed, the child could require evaluation of hearing. If a child cannot hear, language cannot develop.

These early delays in milestones could be the first indicators of delayed development or future disability. The more severe the problem is likely to be, the earlier it can be detected. Recognition is possible within the first few months of life whereby the infant can be referred for early evaluation and intervention.

4.3 TYPES OF DISBILITY

What is a disability?

A disability refers to personal limitations that are of substantial disadvantage to the individual when attempting to function in society. A disability should be considered within the context of the individual's environmental and personal factors, and the need for individualized supports.

> ***Mind your language***
>
> You may have heard people use words when referring to people with disabilities, which should never be used when talking about disability or handicap.
>
> These terms are stigmatizing and insulting to these affected individuals and reflect more on the user of the term than the person they are being used about. The terms 'moron', 'imbecile' and 'idiot' are not to be used for persons with mental retardation. We should always say, 'a child with mental retardation', and not 'a retarded child.' The person is a child first and then one who suffers from mental retardation. We do not say a measles child; we say a child with measles. Likewise, we should say 'a child with hearing impairment' and should never say 'Deaf and Dumb'. We should speak of 'a child with visual impairment' and not as 'Blind'.

Let us now get familiarised with some common types of disability.

4.3.1 Mental Retardation

Definition

A) Mental retardation is defined as significantly sub average functioning on individually administered intelligence tests with an IQ of 70 or below with a clinical judgment of the same .

B) Concurrent deficits of adaptive functioning — the person has difficulty meeting cultural standards in at least two areas: communication, self care, social skills, academic skills, work, home living, leisure, health, safety, use of community resources and self direction.

C) The onset should be before 18 years.

Prevalence

About 3 % of children in any given population have mental retardation. This figure can be as high as 4% in disadvantaged sections of society.

Clinical Features

Mild Mental Retardation (IQ 50-69)

This is the largest category of children diagnosed to have mental retardation. They look normal and often do not have any abnormalities in appearance. Psychosocial factors like poverty and deprivation are often associated with this type of retardation. They are usually detected when the children start faring poorly in school. They have difficulties with studies and may develop low self esteem and secondary behaviour problems when they are punished for underachievement. Most children are educable and can be integrated into normal schools with a modified curriculum. They can hold jobs as adults but would need help when they have severe stress.

The remaining categories are more often associated with chromosomal and genetic problems. They can be diagnosed at earlier ages – the more severe the mental retardation the earlier the age of recognition as the delay in development is more obvious. These children more often have vision and hearing problems, behavioural problems, cerebral palsy and fits or seizures, in addition to having mental retardation.

Moderate Mental Retardation (IQ 35-49)

These children can achieve minimum academic skills, work in a sheltered environment and need support even for minimum stress.

Severe Mental Retardation (IQ 20-34)

These children have poor language and communication skills. They can achieve self help skills and do simple jobs under supervision .They require regular support.

Profound Mental Retardation (IQ < 20)

These children find it difficult to move. They require nursing care as they cannot manage self help skills.

The causes could be due to factors that are prenatal before birth, perinatal during birth and postnatal after birth.

4.3.2 Cerebral Palsy

Under locomotor disabilities, only cerebral palsy will be dealt within this Unit. Other orthopaedic problems can cause disability but these conditions require more of surgical and medical managements.

Definition

Cerebral palsy is a non progressive neurological disorder cause by factors operating in the developmental period. Problems are experienced in maintaining posture and in movement.

Cerebral palsy may often be caused by birth asphyxia and is associated with low birth weight.

Prevalence

The prevalence is less than 0.4%; however, it is likely that this may go up as more and more children of very low birth weight survive intensive care units.

Clinical Features

Cerebral palsy can be of three basic types:

In the *spastic type* which accounts for more than 85% of children with cerebral palsy, the body is stiff or the tone is increased. The child will not be able to bend or move the affected part. It can involve one side of the body called a hemiplegia, mainly both legs called diplegia, all four limbs called quadriplegia or one limb called monoplegia. If severe, the problem can be observed shortly after birth because movements may be asymmetrical, the baby may not have the usual flexed or rolled up position and there maybe feeding difficulties. The child may keep the fists tightly closed and their may be 'scissoring' or both legs cross over each other when the child is held upright. Milder forms may be noted later with delay in motor milestones. The child may also adopt abnormal postures.

In the *hypotonic type,* the child will also have delayed milestones. The baby will be floppy and the neck and limbs will not have the required tone for sitting or standing.

In the *dystonic type,* there may be tremors and abnormal repetitive movements of the head and limbs when the child attempts a movement.

Traditionally described as "*an intelligent mind caught in a disobedient body*", cerebral palsy is typified by motor dysfunction. However, varying degrees of intellectual impairment or disability may be present.

4.3.3 Autism

Definition

It is a pervasive developmental disorder, with problems in social relatedness, communication and behaviour. It may be associated with normal intelligence or with different levels of mental retardation. The definition requires an onset before three years of age.

Prevalence

Current studies show a rising incidence of children with autism particularly with regressive autism i.e. children develop normally till a certain age and then lose language and social development. This usually happens when the child is 18 months to two years of age. In the US, the approximate figure is or about 6 cases per thousand population.

Clinical features

Social relatedness

A child with autism typically manifests poor eye contact or not looking and appearing to be in his own world. There is no interest in other people.

Communication

Communication is often limited to dragging someone to the object of interest. Echolalia or the parrot like repeating of words or the creation of new words is common.

Behaviour

The child spends time preoccupied with one or more repetitive activities likes spinning objects or lining up objects like kitchen utensils. The child may show interest in non toy objects like shampoo bottles and plastic bags.

4.3.4 Hearing Impairment

Definition

Hearing impairment is a broad term used to describe the loss of hearing in one or both ears.

There are two types of hearing impairment:

- Conductive hearing impairment, which is a problem in the outer or middle ear. This type of hearing problem is often medically or surgically treatable, if there is access to the necessary services; childhood middle ear infection is the most common example;
- Sensorineural hearing impairment, which is usually due to a problem with the inner ear, and occasionally with the hearing nerve going from there to the brain. This type of hearing problem is usually permanent and requires rehabilitation, such as with a hearing aid. Common causes are excessive noise and ageing (WHO 2006).

Table 1: Grades of hearing impairment (WHO, 2006)

Grade of impairment	*Corresponding audiometric ISO value*	*Performance*	*Recommendations*
0 - No impairment	25 dB or better (better ear)	No or very slight hearing problems. Able to hear whispers.	
1 - Slight impairment	26-40 dB (better ear)	Able to hear and repeat words spoken in normal voice at 1 metre.	Counselling. Hearing aids may be needed.
2 - Moderate impairment	41-60 dB (better ear)	Able to hear and repeat words spoken in raised voice at 1 metre.	Hearing aids usually recommended.
3 - Severe impairment	61-80 dB (better ear)	Able to hear some words when shouted into better ear.	Hearing aids needed. If no hearing aids If no hearing aids available, lip-reading and signing should be taught.
4 - Profound impairment	81 dB or greater (better ear)	Unable to hear and understand even a shouted voice.	Hearing aids may help in understanding words. Additional rehabilitation needed. Lip-reading and sometimes signing essential.

Grades 2, 3 and 4 are classified as ***disabling hearing impairment.***

The impact of hearing impairment on a child's speech, language, education and social integration depends on the level and type of hearing impairment, and the age of onset, especially if it begins before the age when speech normally develops.

4.3.5 Visual impairment

Definition

Blindness is the inability to see (WHO).

The terms partially sighted, low vision, legally blind, and totally blind are used for categorizing students for educational and benefit purposes. The relevant definitions are:

- *Partially sighted* indicates some type of visual problem, with a need of person to receive special education in some cases;

- *Low vision* generally refers to a severe visual impairment, not necessarily limited to distance vision. Low vision applies to all individuals with sight who are unable to read the newspaper at a normal viewing distance, even with the aid of eyeglasses or contact lenses. They use a combination of vision and other senses to learn, although they may require adaptations in lighting or the size of print, and, sometimes, Braille;

- *Legally blind* indicates that a person has less than 20/200 vision in the better eye after best correction (contact lenses or glasses), or a field of vision of less than 20 degrees in the better eye; and

- *Totally blind* students learn via Braille or other non-visual media.

(Myopia or short-sight and Hypermetropia or long sight are common and correctable through spectacles).

4.3.6 Multiple Disabilities

This means a combination of two or more disabilities like Deaf-Blind, Cerebral Palsy with Mental Retardation or Mental Retardation with Visual Impairment. Prevalence is difficult to know as most of the children will be classified as those with mental retardation because this is very often present. Rarely the child may have normal or superior intelligence like Helen Keller , who had both visual impairment and hearing impairment. The situation is complicated by the fact that the compensation made by, for example, hearing in the case of visual impairment, will be absent in these children.

> You are aware of the different disabilities and their definitions. Children may not fulfill all the features of a particular disability or they may have more than one disability. All these children will need care depending on the problems perceived by the families. For instance, a child may have an IQ of 78 but have hyperactivity – the parents need guidance.

4.4 MANAGEMENT

It is important that a complete assessment is done when a problem is first suspected as the evaluation done at intake is usually the best one and most complete. *It will often follow the individual for life.*

A thorough assessment will:

- Confirm the diagnosis *or* establish there is no cause for concern
- Identify any treatable cause of developmental delay like rickets or thyroid hormone deficiency
- Establish a referral network for follow up in case the suspicion of delay is confirmed later on

The first step is breaking the news. This must be done carefully, based on a complete evaluation and after getting expert advice as far as possible. Allowance must be made for parental reaction like denial. bargaining, anger and despair. Emotional support should be provided to families.

Let us get oriented to the aspect of management of a disability, by getting familiarized with the basis of management of some of the conditions.

- **Management of Mental Retardation**

Management must commence with assessment which requires:

i) Assessment of the intelligence and the IQ through appropriate tests;

ii) Assessment of the strengths and abilities of the child;

iii) Nature and severity of associated problems of vision, hearing cerebral palsy, behaviour and medical conditions like seizures or fits; and

iv) Early search for medically treatable conditions like hypothyroidism.

Early Intervention

Infant stimulation programmes can be carried out with infants in whom delays have been picked up early. Children should be taught skills in a patient and persistent manner. There should be a link with a referral centre if the child does not respond to the stimulation programme.

Integrated or inclusive education

The tendency all over the world is towards providing education to special children by integration or inclusion into regular school programmes through the provision of additional resource support to regular teachers e.g. Special educators, Speech therapists and physiotherapists and by the provision of aids and appliances which might be required by the children. Behavioural measures and sometimes medication may be needed for the disruptive child.

Pre-Vocational training

Children need to be evaluated through intelligence tests and by rating the child's special skills and strengths. This would help decide the jobs that would best suit the child. Several institutions for special children now provide training in useful employment.

Medical and psychological needs

Children may have medical problems like any other child and require attention. They may also have behaviour problems like hyperactivity, poor impulse control and stereotyped or repetitive behaviour.

i) Medical management of treatable causes: If you have managed to detect a problem in the first few months of life, timely intervention is possible. In hypothyroidism, replacement with thyroid hormone, soon after birth can make the child normal.

ii) Associated problems like seizures, visual and hearing problems and cerebral palsy should be treated. Co-existing behaviour problems can be treated using behaviour modification. Sometimes medication may be needed to treat the behaviour problems.

- Management of Cerebral Palsy

This requires of assessment of the nature and severity of cerebral palsy, intelligence, speech evaluation and feeding and postural problems. Special attention needs to be paid to the following:

i) Physiotherapy

ii) Enrolment in an early intervention programme

iii) Education in an integrated set up

iv) Medical management of fits

v) Surgical correction of contractures or shortening of the muscle tendons

- Management of Autism

The diagnosis is made when the child fulfils the criteria for autism, with symptoms in the three areas mentioned. Evaluation of speech and intelligence are also necessary.

Intervention needs to be intensive with behavioural management, sensory integration and speech therapy. The specialized education needs to be one-on-one; that is, the teacher must spend a great deal of time teaching the child individually. Additional treatments like supervised dietary intervention have been proved to be useful. With early intervention, the prognosis has considerably improved in the past few decades.

4.5 COUNSELLING AND FAMILY THERAPY

4.5.1 Acceptance of Diagnosis and Handling the Grief

Parents have many dreams and hopes for the unborn child. They do not even expect anything less than the perfect child. Depending on their experience of previous older children or the children of relatives, they may suspect some problem when the child does not behave like other children. The more severe the problem, the faster it will be detected. Children with severe retardation or severe visual or hearing problems will show their inability to respond as early as the first ten to twelve weeks of life.

Some conditions like Down's syndrome can be picked up at birth. Very often the diagnosis is given by a busy doctor in a curt and insensitive way. Parents do not even fully understand the impact of what has been said to them. Every family has to complete the grieving for the perfect child they were deprived of before they accept the child with disability. It is only with proper guidance that the family will accept the child and come to terms with the fact that there is no cure for disability but only doing the best possible to bring the child with the problems into the mainstream of society as early as possible. Then only can the family work well with the child to optimize development and mainstreaming.

All parents react with symptoms suggestive of bereavement or death of the child. The first reaction is **denial** – "This cannot happen to me"

Next is **bargaining** – "Will this go away if ..... ?

This is followed by **anger** – "Why did this happen to me?"

This is followed by **depression,** which if unresolved could be life long for the family which is not given enough counselling and support.

Lastly, after this difficult period is overcome, comes **acceptance**.

Some parents remain in a state of "chronic sorrow".

4.5.2 Subsequent day-to-day Issues

A great deal of planning and change in the family's life goals and expectations may have to be made. The family would need help to accept the diagnosis and to clear misconceptions they may have about cause and cure. They need information about access to services, transport and benefits. They need guidance and support. They need help during times of crisis and most of all need help in long term planning.

4.5.3 Impact on Family

The child's disability may preoccupy the family to the detriment of spouse and other healthy children. Siblings may be ashamed of their handicapped brother or sister and resentful because they feel ignored by parents. Sometimes marriages can be strained and these issues need to be discussed with the couple to sort out responsibilities, schedules, time and money spent on the special child and make reasonable adjustment so that the husband or wife or siblings do not suffer emotional neglect and support .

These feelings are natural and need to be explored. Participation in a parent group will help in understanding that the family is not alone and that many people from all walks of life share the same situation.

4.5.4 Individual's Needs

The individual too needs to cope with the demands of family expectations, rejection. self esteem issues and societal attitudes. These become more as the child's understanding improves with awareness of a feeling of difference from others. Integration, though the best option heightens this awareness and should be handled well by the adults in the school. Adolescence brings additional difficulties and so does adulthood with issues of marriage and long term goals. These subjects require sensitive handling and must be dealt with at the individual level by specialists in the field.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. Why is it important for parents of children with disabilities to accetpt their child's condition?

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.....

.....

4.6 REFERRAL

Where to refer is often a crucial question.

It is ideal to refer the child to a multidisciplinary team.

In government set ups services are provided free of cost and necessary certificates issued. Given in the references are the websites of the National Institutes for different disabilities. They would serve as good resources and could guide you regarding the availability of special services in your area.

If required it would be Worthwhile to refer to a major centre for initial evaluation with follow up nearer home.

4.7 EMPOWERING AND ENABLING LEGISLATION

The Persons with Disabilities (Equal Opportunities, Problem of Rights and Full Participation) Act,1995 provides various benefits in terms of scholarships, concessions and job reservations.

The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 provides for guardianship and care of the individual in a responsible manner, by the state, particularly if there is no guardian for the child or dependent adult.

The family and the individual need to be made aware of the empowering and enabling provisions of these Acts.

4.8 LET US SUM UP

A disability refers to personal limitations that are of substantial disadvantage to the individual when attempting to function in society. Some common disabilities include mental retardation, cerebral palsy, autism, hearing impairment, visual impairment and multiple disabilities. It is usually very difficult for the parents and other family members to accept the fact that the child has a disability, and come to terms with it. And yet it is vital, for only then would they be able to provide the child a stimulating and caring environment for optimising her/his development. Counselling and family therapy help in this endeavour.

4.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISE

Check Your Progress Exercise 1

1. The parents of children with disabilities are not able to accept their child's condition. The change in parents attitude and acceptance by the parents of children with disabilities by the parents of children with disabilities is important for subsequent taking care of child in day-to-day issues, and working to optimizing the child's development.

4.10 UNIT END QUESTION

1. Outline the significance of counselling and family therapy in the context of a child/adolescent with disability.

4.11 FURTHER READINGS AND REFERENCES

http://www.disabilityindia.org/insthandi.cfm NIMH

http://www.disabilityindia.org/aliyavar.cfm NIHH

http://www.disabilityindia.org/INSTORTH.cfm NIOH

http://www.disabilityindia.org/instvis.cfm NIVH

http://www.disabilityindia.org/instphys.cfm IPH

http://www.aamr.org/Policies/faq_mental_retardation.shtml

Madhavan T et al (Editors) Mental Retardation A manual for guidance Counsellors 1988 NIMH 2004 Secunderabad500 009

Ministry of Social Justice and Empowerment Government of India No.3-1/1993-DD.III

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Peshawaria R, Menon D.K, Bailey. D, Skinner, D, NIMH FAMILY SUPPORT SCALE 2000, Manovikas Nagar, Secunderabad 500 009

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UNIT 5 PARENT MANAGEMENT TRAINING

5.1 INTRODUCTION

Parenting is a skill that is dynamic in nature and constantly adaptive with the progression of life-cycle stages that a family undergoes. Parenting styles not only determine the parent-child relationship but are also influenced by a multitude of factors like individual parents' characteristics (personalities and temperaments), the couple relationship, family type, socio-cultural make up and also the child's behaviour pattern and personality. Healthy parenting using a democratic style can create a balanced and healthy family whereas, oppressive or autocratic styles can lead to children becoming either suppressed or aggressed.

Objectives

After studying this Unit, you will be able to:

- Describe the different parenting styles;

- Enumerate the kind of behavioural problems that children present with;
- Explain the principles of behaviour modification; and
- Discuss effective parent management skills.

5.1 PARENTING STYLES

Parents use different ways of rearing their children based on an amalgamation of factors including their own personality and temperament, that of the child, gender and culturally accepted norms of rearing amongst others. The style adopted is a cluster of strategies that parents use in bringing up their child, managing the child and contributing to child's growth, maturation and development. According to Baumrind, parenting styles can be classified as follows:

- **Authoritative Parenting**

Authoritative parenting is characterized by a child-centered approach that holds high expectations of maturity from the child. Authoritative parents can understand their children's feelings and teach them how to regulate them. Authoritative parents are not over controlling, and allow a fair degree of freedom to the child to explore, thus having them make their own decisions based upon their own reasoning. When punishing a child, the parents explain the reason for punishment. Their punishments are neither harsh nor arbitrary. Parents set clear standards for their children, monitor limits that they set, and also allow children to develop autonomy. They also expect mature, independent, and age-appropriate behaviour of children. They are attentive to their children's needs and concerns, and will typically forgive and teach instead of punishing if a child falls short. This is supposed to result in children having a higher self esteem and independence because of the democratic give-take nature of the authoritative parenting style. This is the most recommended style of parenting by child-rearing experts.

- **Authoritarian parenting**

Authoritarian parenting is characterized by high expectations of conformity and compliance to parental rules and directions, while allowing little open dialogue between parent and child. Authoritarian parents expect a lot from of their child but generally do not explain the reasoning for the rules or boundaries. Authoritarian parents are less responsive to their children's needs, and are more likely to resort to punitive measures in disciplining the child.

- **Indulgent parenting**

Indulgent parenting is characterized by few behavioural expectations of parents from the child. Parents are very involved with their children but place few demands or controls on them. Parents are nurturing and accepting, and are very responsive to the child's needs and wishes. Indulgent parents do not require children to regulate themselves or behave according to an established code.

- **Neglectful parenting**

Neglectful parenting is also called uninvolved or detached parenting. The parents are low in warmth and control, are generally not involved in their child's life, are disengaged, undemanding, low in responsiveness, and do not set limits. Neglectful parenting can also mean dismissing the children's emotions and opinions. Parents are emotionally unsupportive of their children, but still provide for their basic

needs. Children whose parents are neglectful develop the sense that other aspects of the parents' lives are more important than they are. Parents, and thus their children, often display contradictory behaviour. Children become emotionally withdrawn from social situations. This disturbed attachment also impacts relationships later on in life. In adolescence, they may show patterns of truancy and delinquency.

As we see, there are different styles of parenting which differentially impact the parent-child relationship as well as the psychological and social development of the child. Parent management training is important in understanding the correct way to handle problem areas. Let us understand the areas in which Parent Management Training can be beneficial.

Check Your Progress Exercise 1

Note: a) Read the following question carefully and answer in the space provided.

b) Check your answer with that provided at the end of this Unit.

1. Match the following:

Parenting style	**Definition**
(a) Authoritative parenting	1. Parents meet demands of child and place little restrictions on them
(b) Authoritarian parenting	2. Parents are disengaged, low in responsiveness
(c) Neglectful parenting	3. Parents expect mature, independent and age appropriate behaviour from the child
(d) Indulgent parenting	4. Parents expect conformity to parental rules and expectations

5.3 BEHAVIOURAL PROBLEMS IN CHILDHOOD AND ADOLESCENCE

5.3.1 Symptoms of Problem

Understanding the correct way of rearing children and fostering their development into healthy mature adults can be a daunting task. In addition when there are certain explicit problem areas with the parent, parenting style, child, home/school environment, then parenting can become even more challenging. These problem areas invariably manifest as one or the other symptoms in children. These can be:

- Changes in sleep and appetite
- Irritability and restlessness
- Difficulty in concentrating on a task
- Temper tantrums
- Frequently engaging in arguments with peers/ at home/ at school
- Academic difficulties/ academic decline

- Frequent changes in mood
- Resistance in following instructions

Besides these behavioural problems, Parent Management Training has been used as an adjunct therapy in Autism Spectrum Disorder, Conduct Disorder, Down syndrome, Attention-Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder (ODD).

5.3.2 Parenting Tips

Some parenting tips for dealing with children with behavioural problems can be as follows:

- Set up reasonable, age appropriate rules and limits.
- Be consistent in enforcing rewards and punishments.
- Always bring attention to the positives. Give the child praise and positive reinforcement whenever cooperation or healthy behaviour is shown.
- Engage in consistent parenting between both father and mother.
- Allow and encourage your child to take a time-out to prevent overreacting, aggressiveness, and/or violence. Model the same behaviour.
- Follow a consistent, daily schedule of activity for both self and child.
- Help your child identify the sources of stress and anxiety that make symptoms worse.
- Encourage the child to become involved in tasks and physical activities that provide a healthy outlet for stored up energy and stress.
- Engage in regular family rituals, e.g., eating one meal a day together.
- Spend quality enjoyable time with the child.
- Take out time for your own leisure and relaxation without feeling guilt.

5.4 PARENT MANAGEMENT TRAINING

5.4.1 Meaning

Sometimes typical methods of discipline and parenting don't work in alleviating the complaints as discussed above. Children who are defiant, oppositional, have deficits in behavioural/emotional/social repertoire or have other developmental/ neurological disorder where difficult behaviours, such as anger and aggression persist often need discipline that takes a different approach. ***Parent management training teaches the skills needed to improve a child's behaviour.*** This approach is based on principles of learning theory and behaviour modification.

Dr. Alan Kazdin developed the parent management training (PMT) programme in the 1980s at the Yale Parenting Center and Child Conduct Clinic. PMT focuses on the parents rather than the child, teaching new techniques for managing their child's difficult behaviours. Although we may be tempted to believe that it is purely the child's behaviour that needs modification, PMT approaches the same problem with a different approach. Child's behaviour is not seen as the direct problem but

a reaction to the problem of faulty parenting styles/ techniques. Hence the modification is to be done by the parents/ significant others which will lead to modification of the child's behaviour. PMT focusses on correcting maladaptive parent-child interactions.

5.4.2 Aim and Indications

The aim of PMT is to decrease or eliminate a child's disruptive or inappropriate behaviours at home or school and to replace problematic ways of acting with positive interactions with peers, parents and such authority figures as teachers or other significant others. These targets are dealt with by focussing on enhancing parenting skills. The PMT therapist coaches parents in applying such strategies as rewarding positive behaviour, and responding to negative behaviour by removing rewards or enforcing undesirable consequences (punishments) which are derived from principles of learning theory. PMT however is not a diagnosis centered therapy. It focuses on overt behavioural manifestation of certain problem behaviours in children at home/school/social settings like play. Hence it is commonly used in treating oppositional defiance disorder, conduct disorder, intermittent explosive disorder (age-inappropriate tantrums), and attention deficit disorder with hyperactivity (attention-deficit hyperactivity disorder).

Parents are encouraged to use positive reinforcement, to adopt more effective discipline strategies and learn how to re-negotiate with their children. PMT has been the most extensively researched therapy in this field. It has the potential to produce improvements in child behaviour to within the non-clinical range at home and sometimes at school. Further, these effects can be maintained, together with indirect improvement in other areas such as sibling behaviour, maternal psychopathology, marital satisfaction and family cohesion.

5.4.3 Principle and Rationale

The principle behind parent management training is derived from two schools of thought: role of parent-child interactions and learning principles. These approaches have highlighted the role oswf learning behaviour through observation and receiving of consequences for behaviour. Learning theory, which is the conceptual foundation of PMT, deals with the ways in which organisms learn to respond to their environment and the factors that affect the frequency of a specific behaviour. The core of learning theory is the notion that actions increase or decrease in frequency in response to the consequences that occur immediately after the action. It has been found that in disruptive families, it is the parental response that unintentionally reinforces unwanted behaviour. PMT trains parents to become more careful in their reactions to a child's behaviour. The parents learn to be more discerning: to provide attention, praise and increased affection in reaction to the child behaving in desired ways; and to withdraw attention, to suspend displays of affection, or to withdraw privileges in instances of less desirable behaviour.

The child assumes the parents to be the first role models, and hence learns appropriate conduct not only vicariously through observation but also learns from the manner and pattern which the parents adopt in responding to his/her needs and demands. In PMT, parent-child interactions are modified in ways that are designed to promote prosocial child behaviour and to decrease antisocial or oppositional behaviour.

5.4.4 Description

Treatment sessions include instruction in social learning principles and techniques. The least challenging problems, which have the greatest likelihood of successful change, are tackled first, in hope of giving the family a "success experience". The success experience is a positive reinforcement for the family, increasing the likelihood that they will continue using PMT in efforts to bring about change. In addition, lower-level behavioural problems provide opportunities for parents to become skilled in intervening and to learn consistency in their responses. After the parents have practised using the skills learned in PMT on the less important problems, more severe issues can be tackled. The outline of the treatment module followed can be organized as follows:

Initial Phase:

- Identification of target behaviours, the parenting styles adopted and the overall systemic pattern that is followed in disciplining the child.
- Parents are taught how to define, observe, and record behaviour because once behaviours (e.g. fighting, engaging in tantrums, aggression, defiance, truancy) are defined concretely, reinforcement and punishment techniques can be applied.
- Key findings to be noted are whether parenting has been consistent across both the parents, across various situations and between siblings.
- Parents need to be encouraged to identify strengths, weaknesses and assets of the child.
- The therapist provides a brief overview of underlying concepts of learning behaviour, what governs the initiation, maintenance and exacerbation of adaptive/maladaptive behaviour.
- The therapist models the techniques for the parents and coaches them in implementing the procedures.

Middle Phase

- Procedures and interaction patterns are practised in the sessions via role play between parent-therapist, therapist-child, parent-child in predetermined simulated situations that are jointly understood as difficult areas.
- Transfer of training from the treatment setting to home setting. The techniques are used at home and generalized to possible settings.
- Where possible and needed the school authorities are also involved.
- The PMT therapist details the concepts and procedures derived from positive reinforcement (e.g., contingent delivery of attention, praise, points) and punishment (e.g., time out from reinforcement, loss of privileges, and reprimands). Reinforcement for prosocial and non-deviant behaviour is central to treatment.

End Phase

- Parents are taught how to use reinforcement and punishment techniques contingent on the child's behaviour, to provide consequences consistently, to attend to appropriate behaviours and to ignore inappropriate behaviours, to

apply skills in prompting, shaping, and fading, and to use these techniques to manage future problems.

- There is an extensive amount of practice and shaping of parent behaviour within the sessions to develop skills in carrying out the procedures.
- Feedback of the progress is taken and necessary modifications made.
- Booster sessions are maintained and gradually sessions are tapered off and therapy terminated.

Because the immediate goal of treatment is to develop parenting skills, the therapist begins by having parents apply new skills to relatively simple problems (e.g., compliance, completion of chores, oppositional behaviour). As parents become proficient using the initial techniques, the child's most serious problem behaviours at home and in school are addressed (e.g., fighting, poor school performance, truancy, stealing). Therapist encourages parents to ask questions about the home programmes, prompts compliance with the behaviour-change programmes and reinforces parents' use of the skills, to strengthen the therapeutic alliance.

5.5 BEHAVIOUR MODIFICATION

Behaviour modification is a treatment approach, based on the principles of operant conditioning that replaces undesirable behaviours with more desirable ones through positive or negative reinforcement. As discussed above, sessions begin with a functional behaviour analysis. Once the target behaviours are identified and jointly agreed upon by the parents and the therapist, the existing causal parent-child interactions and patterns of reinforcement are listed. Behaviour modification is the use of empirically demonstrated behaviour change techniques to improve behaviour, such as altering an individual's behaviours and reactions to stimuli through positive and negative reinforcement of adaptive behaviour and/or the reduction of maladaptive behaviour through its extinction, punishment and/or therapy.

Positive reinforcement, the key element of PMT, is given to the child via various techniques such as giving the child increased attention and praise and awarding points for positive behaviour. Punishment for negative behaviour is meted out via methods such as giving time outs, verbal reprimands and loss of privileges such as watching television or playing video games. However, it is advised to include the child in these change strategies by explaining clearly the accepted norm of behaviour expected out of the child and what would be the positive and negative reinforcements that the said behaviour would merit.

Behaviour modification uses positive and negative consequences to change behaviour. The emphasis is on the positive, which means providing rewards for desired behaviours. However, negative consequences are used when necessary. Behaviour management begins by prioritizing the problem behaviours. Working with one behaviour at a time, parents first evaluate the problem before deciding on a plan. The evaluation occurs by maintaining an ABC Chart i.e. observing what happens before the undesired behaviour (Antecedent), the behaviour itself (Behaviour), and its result (Consequnce). This is a critical step, because behaviours serve a purpose and parents can unknowingly reinforce negative behaviour if they don't understand its purpose. The plan states the desired behaviour, defines the smaller steps necessary to reach the goal, and describes the reward system to be used. An example of ABC chart is given as follows:

An example of ABC chart:

Date/Time	*A*	*B*	*C*
31st March, 8.00 p.m.	Permission not given to watch TV	Anger: throws remote, throws books, cries and demands to watch TV	Mother concedes to child's demand
4th April, 4.00 p.m.	Mother refuses to buy toy for the child	Temper tantrum: refuses to leave the market till toy is purchased	Mother concedes to child's demand
10th April 3.00 p.m.	Child asked to study	Defiance: Child disobeys and walks out of the house to play.	Mother reports to father who hits the child upon returning from office.

The most critical element of PMT is offering positive reinforcement for socially appropriate (or at least nondeviant) behaviours. An additional component involves responding to any undesired behaviours by removing rewards or applying punishment. These two types of response to the child must be carried out with great consistency. Consistent responding is important because erratic responses to unwanted behaviour can actually cause the behaviour to increase in frequency. For instance, if a child consistently throws tantrums in stores, hoping to be given something to end the tantrum, inconsistent parent responses can worsen the situation. If a parent is occasionally determined not to give in, but provides a candy bar or a toy to end the tantrum on other occasions, the child learns either to have more tantrums, or to have more dramatic tantrums. The rise in the number or intensity of tantrums occurs because the child is trying to increase the number of opportunities to obtain that infrequent parental reward for the behaviour. Planning responses ahead of time to predefined target behaviours by rewarding desired actions and by withdrawing rewards or applying punishment for undesirable behaviour is a fundamental principle of PMT. Consistent consequences, which are contingent on (in response to) the child's behaviour, result in behaviour change. Parents practise therapeutic ways of responding to their child's behaviour in the PMT sessions with the therapist.

Behaviour modification can then be done at various levels:

- If the antecedents and the consequences appear to be largely constant across different situations, then behaviour modification focuses on these.
- If the antecedent/trigger is usually the same, then alternate stimuli are searched from the environmental repertoire.
- If the maladaptive behaviour serves a particular purpose, for example attracting parental attention, then alternate behaviours serving the same purpose are taught.
- Rewarding appropriate behaviour is more healthy and effective than punishing maladaptive behaviour.

5.5.1 Positive Reinforcement

Parents should provide abundant verbal praise, but children also benefit from a system that shows progress. The system should be age appropriate, but it must

also provide visual reinforcement, such as a chart with a specific number of spaces (representing the number of times the desired behaviour must be achieved) where a sticker can be placed for each success. Once the spaces have been filled, the goal has been reached and a larger reward can be given. Rewards should be provided consistently and immediately. They can range from a favorite meal to going to the park together or more time allowed for playing video games.

5.5.2 Punishment

First, parents learn not to punish every behaviour. When the often long list of difficult behaviours is prioritized, parents can identify those that can temporarily be overlooked so that there can be more emphasis on the positive. In a PMT programme, the type of punishment is defined as part of the plan, so parents have a clear path to follow. Punishment must be consistently implemented without emotion from the parent. The goal is to use punishment that fits the issue and child's age and to enforce it without engaging in arguments or discussion. Punishment in PMT is not necessarily what parents typically refer to as punishment; it most emphatically is *not* the use of physical punishment. A punishment in PMT involves a response to the child's negative behaviour by exposing the child to something he or she regards as unpleasant. Examples of punishments might include having to redo the correct behaviour so many times that it becomes annoying; verbal reproaches.

5.5.3 Behaviour Modification Techniques

Commonly practised behaviour modification techniques are:

1. ***Successive Approximation Principle:***

It is used to teach the child a new behaviour or concept he or she has not learned, by rewarding successive steps to the desired behaviour. For example, we can use this technique in the classroom just by noticing a behaviour that's close to what we want to see and rewarding the child for, "sitting quietly in his seat". Don't wait until the fidgety child begins to squirm to scold him. Instead, look for a close approximation of good behaviour and praise it. Most children seek to please and feel good when the parent or teacher notices. The rewards can be just about anything, depending on the age and cognitive ability of the child. You can use food rewards, but sparingly. A raisin or piece of cereal is a good token for the behaviour you are trying to instill, but with most children, a pat on the head and just the few words, "good job", are enough. As the child gets older and is more motivated, any token will do.

2. ***Continuous Reinforcement Principle:***

It is useful in teaching new behaviours or tasks that a child has not learned. An immediate reward after each correct performance is given to the child. This technique is much the same as the first, but this time you'll be expecting the behaviour to be exact instead of something close to that. After spending time directing the child toward good behaviour, the first technique progresses to this, where you'll not reward until the child complies or behaves appropriately.

3. ***Negative Reinforcement Principle:***

This principle follows providing negative consequence for inappropriate behaviour. The child is given a choice to behave appropriately to receive positive consequence and to avoid negative consequence. By giving the child choices, the child is taught

how to make good decisions by offering a choice of consequences for good and bad behaviour. "I hope you'll choose to sit quietly during story time so that you can have a snack with the rest of the class, but if you choose to get out of your seat during story time, you'll need to stand in time out while the rest of us have a snack". It is important to follow through the stated consequences. Providing stickers or colour cards at the end of a school day is a good way to use this technique. When a child doesn't get his, "happy face," for the day, he'll be more likely to try harder the next day.

4. ***Modelling Principle***

Modelling is based on the principle that learning can happen through observation, and the child does not have to necessarily bear negative or positive consequences first himself/herself and only then learn. When the child observes parents/teachers giving negative consequences to unacceptable behaviour exhibited by another child and positive consequences to acceptable behaviour to another child, the child can learn to choose which behaviour to perform to get desired results.

5. ***Cue Principle:***

To teach a child to remember a learned behaviour, give a cue for the correct performance or behaviour, just before the action is expected. This helps to avoid misbehaviour, especially with the child who is more likely to misbehave without reminding. A teacher can use this technique when lining the children up to go to the lunch room, by saying, "Hands to your side".

6. ***Decreasing Reinforcement:***

This technique is also called "extinguishing". You want the child to behave appropriately, even without a reward, so once the new behaviour has been learned through its rewards, it's time to slowly decrease the rewards to encourage greater expectations. Soon, the child behaves a certain way just because it's now a part of who he is.

Check Your Progress Exercise 2

Note: a) Read the following questions carefully and answer in the space provided.

b) Check your answers with those provided at the end of this Unit.

1. List 3 common behavioural problems in children for which PMT can be used.

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2. What is the parent management training?

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3. What is the principle behind parent management training?

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4. Name 3 methods of behaviour modification.

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5.6 DEVELOPING A PARENT MANAGEMENT TRAINING PROGRAMME

Although the framework of each programme would be approximately the same, beginning with functional behaviour analysis and following key behaviour modification principles and distributing sessions to adequately cover target areas, there are certain considerations which when adopted make the programme more effective.

5.6.1 Effective PMT Programme

A regular PMT programme comprises 5-15 sessions. It is believed, to be effective, PMT programmes should:

- Be structured and have a curriculum based on principles of social learning theory
- Include relationship enhancing strategies
- Offer a sufficient number of sessions
- Enable parents to identify their own parenting objectives
- Incorporate role play during sessions as well as homework between sessions to achieve generalization of newly rehearsed behaviours to the home situation
- Be delivered by appropriately trained and skilled facilitators who are supervised, have access to professional development and are able to engage in a therapeutic alliance with the parents
- Adhere to the programme developer's manual and employ all the necessary aids to ensure consistent implementation

5.6.2 Limitations

Key limitations of PMT include the following:

- High drop out rate of parents due to severe dysfunction within the family

- High rate of marital discordance which percolates as inconsistent parenting
- Presence of multiple significant others which makes firm discipling of the child a difficult task
- Not following through immediate and responsible providing of positive and negative consequences
- Inability of the parents to serve as adequate role models.

5.6.3 Risks

Parent management training focusses on sensitive issues like the relationship between parents and children and specific ways of enhancing the same leading to a more functional and adaptive child. Hence, when this programme is followed only at a superficial level or not continued through, it can result in non satisfactory responses. Also when the parents decide to implement it on their own without the regular supervision and guidance of a trained therapist then the problem can also worsen. The aspects which need to be dealt with care include ensuring that parents stay objective, stay consistent, depict predictable behaviour in response to adaptive and maladaptive behaviour, keep the child informed about the rewards and punishments that would be meted out and choosing appropriate rewards and punishment. Taking these steps can ensure a successful plan and determine productive results.

5.6.4 Normal Results

To estimate the achievement of results over the duration of sessions, the functional analysis comes in handy. The normal results expected at the end of treatment sessions would be reduction in unwanted/ unwarranted behaviour and increase in positive and functional behaviour on the part of the child. At the end of the treatment one would also expect more effective parenting styles to emerge and strengthen the parent-child bond. Furthermore, one would expect the results — improved child behaviour and reduction or elimination of undesirable behaviour — to be sustained over the long term.

5.7 LET US SUM UP

In this Unit, we studied the principles of learning behaviour, the pattern of parent-child interactions and techniques that can be implemented to bring about adequate behaviour modification. Parent management training programme is indicated as an adjunct therapy for children with behavioural problems like ADHD, ODD, and other problems like truancy, temper tantrums etc. Beginning with a functional behaviour analysis of identifying target problems, the therapy progresses to empower parents with skills to differentially respond to adaptive and maladaptive behaviour. Progress in treatment sessions is generalized to real life settings.

5.8 GLOSSARY

Behaviour : Observable action

Behaviour modification : Replacing undesirable behaviour with desirable behaviour based on positive and negative reinforcement principles.

Learning : Relatively permanent change in behaviour

Parenting style : Cluster of strategies used by parents in bringing up and managing their child, and contributing to the child's growth, maturation and development.

Punishment : Introduction of negative stimuli in the environment in response to unacceptable behaviour

Reinforcement : Introduction of or removal of pleasurable stimuli from the environment to modify behaviour

Transfer of training : Process of generalizing in-session developments to real life situations

5.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. 1-3, b-4, c-2, d-1

Check Your Progress Exercise 2

1. Temper tantrums, disobedience/defiance to comply with instructions, hyperactivity.
2. The aim of PMT is to decrease or eliminate a child's disruptive or inappropriate behaviours at home or school and to replace problematic ways of acting with positive interactions with peers, parents and such authority figures as teachers or other significant others.
3. Parent management training is based on learning theory; how children learn through parent-child interactions and reinforcement principles.
4. Successive approximation, modeling, cue principle.

5.10 UNIT END QUESTIONS

1. A school has asked you to talk to the group of parents reparding the parerting style which should be adopted. What would you advise the parents?
2. What is the meaning and significance of parent management training? State the rationale underllying this approach.

5.11 FURTHER READINGS AND REFERENCES

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