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Indira Gandhi National Open University
National Centre for Disability Studies

MCFTE-005
Child and Adolescent Counselling and Family Therapy

MANUAL FOR SUPERVISED PRACTICUM

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Dear Learner,

The optional course Child and Adolescent Counselling and Family Therapy has 2 credits of theory (MCFTE-002) and 4 Credits of Supervised Practicum (MCFTE-005). The 4 Credits of Supervised Practicum are divided into five Practicals that have been described in this Manual, which you should complete along with your theory Course in the specific period of time. This Supervised Practicum (MCFTE-005) helps you to understand better the theoretical concepts which you have studied. This would help you to apply these concepts later in work.

These practicals emerge out of the theory syllabus. The practical activities will help you to get hands-on experience of working with childen, adolescents and their families in different settings.

Here, we would like you to understand that in Supervised Practicum, you have to work under the overall supervision of the Academic Counsellor, generally called Counsellor or Supervisor in this Block. Further, before starting the practical activities, it is very important for you to read this Manual for Supervised Practicum carefully. Go through this Manual in order to understand what has to be done.

With best wishes,

Programme Coordinators
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INTRODUCTION AND GUIDELINES

The optional course Child and Adolescent Counselling and Family Therapy has 2 credits of theory (MCFTE-002) and 4 Credits of Supervised Practicum (MCFTE-005). The focus of this Supervised Practicum (MCFTE-005) is on understanding the applications and interventions related to child and adolescent counselling and family therapy. As a counsellor and family therapist, we provide you different areas to specialise in. This supervised Practicum is intended to be the demonstration of learning and experience in the area of promoting well-being of children and adolescents.

In this Supervised Practicum Manual, you are provided with two basic units (Basic Units 1 and 2) on identification of common behavioural disorders and specific learning disabilities in children and a case illustration (Basic Unit 3) exemplifying case history taking, assessment and therapy for childhood and adolescent problems. Basic Unit 4 acquaints you with the fundamentals of doing and recording case work, which you need to refer to for doing the counselling and family therapy case works in Practicals 3 and 4. Various practicals have been prescribed in this Manual to facilitate learning by doing.

You are required to carry out the Supervised Practicum under the guidance and supervision of an approved Academic Counsellor/Supervisor, to whom you are assigned for the purpose by your PSC/SC. You will read more about this apect a little later in this Section.

Suggested Schedule

It is advised that you should start the Supervised Practicum as soon as you go through the theory component of this course. Before starting the practical activities, therefore, you should devote your time to:

i) Reading and understanding the related Units.

ii) Attending the theory counselling sessions which will be organised by the respective Programme Study Centre/Study Centre, you are attached with.

It is advisable to complete the practical activities as per the scheduled time. You are suggested to do the practicals in a series, that is, to complete one Practicum first and then move to the next one.

Duration of Supervised Practicum MCFTE-005

The Supervised Practicum comprises five practicals, the details of which are given in this Manual. You have to complete these practicum in a total of 30 working days which include 30 compulsory contact classes (sessions) with the Counsellor, each of 1 hour duration. As stated earlier, you must spend the remaining 3 hours of each of the 30 working sessions for carrying out field work pertaining to the 5 practicals prescribed in this Manual. Some extra working sessions have been kept to allow for the fact that you may need some extra time and working sessions in some of the practicals. The tasks pertaining to the practicals, including conducting/participating in counselling/family therapy sessions, organizing an awareness generation compaign, report writing etc. are included in this time assigned for field work.

If the Supervised Practicum takes more time than this scheduled duration, then you can rearrange your work accordingly, but only after discussing it with the Supervisor/Academic Counsellor you are attached with at the Programme Study Centre/Study Centre.

You have to complete all the practicals for submitting the Practicum File. Please do not copy the illustrated examples as you will be asked to resubmit the Practicum File and this will lead to delay in award of the Degree. Also, do not copy from your peers/friends, as both would repeat the whole practicum again.

Role of the Academic Counsellor in Supervised Practicum

The Supervised Practicum has to be esentially done under the guidance and supervision of the Academic Counsellor/Supervisor. The Academic Counsellor is a qualified professional in the field, allotted by the Programme Study Centre/Study Centre to which you are attached. The Counsellor will supervise and guide for the Practicum Activities, during the academic year. The Supervisor can also be identified by you.

For doing the Supervised Practicum, you may identify an Academic Counsellor who is working as a counsellor/family therapist in an organisation working in related area of your specialisation such as university, college, hospital, child guidance centre, juvenile home, adoption centre, day care centre, counselling centre in a school, etc., as well as NGOs or governmental or private organisations working in the area of child and adolescent counselling and family therapy.

The essential qualification of the Academic Counsellor is as follows: Master's degree in any of these disciplines – Human Development and Family Studies/ Child Development / Human Development / Psychiatry / Mental Health and Social Psychology / Psychiatric Social Work/Clinical Psychology / allied disciplines, with at least five years of relevant experience.

It is essential that the Academic Counsellor/Supervisor be approved by the Programme Coordinators at IGNOU headquarters. Mere possession of degrees and experience does not mean the 'Counsellor' would be approved. The detailed biodata of the proposed counsellor has to be submitted for approval by the Programme Incharge at the PSC/SC to the Programme Coordinators at IGNOU Headquarters keeping the Regional Centre in the loop. The student may obtain the biodata form may to be used for the purpose from the Programme Incharge at the Programme Study Centre or the Study Centre Coordinator.

You have to spend 1 hour of each of your 30 working sessions with the Supervisor/Counsellor, in which she or he will guide you on the method in which the Practicum Activity has to be performed, as well as the analysis of the same. Besides this, you can seek the help of the Counsellor at any time during the sessions. Each working session is deemed to be of 4 hours duration.

The Counsellor may or may not be associated with the individuals or families you identify for the practicum activity, but she or he can help you in identifying the same.

To conduct practicum activities, you have to meet the Counsellor first, discuss the practical you are going to conduct as well as the method that you are going to use for the purpose, take her or his advice and then visit your respondent(s). Here, in this programme of study, respondent is also called 'participant' and at times 'subject' or 'client'. It is advisable to report to your Counsellor after you complete each

session, and discuss what had transpired in the course of the session, along with planning the next session.

After completing each practical, you need to write each and every detail in your report. If you have any problem or query regarding report writing, then contact your Academic Counsellor/Supervisor for the same.

Apart from guiding and supervising, the Counsellor will also evaluate your work. Thus, the Counsellor will evaluate and mark each Practical. The evaluation sheet to be used is given at the end of this Manual.

Important Guidelines for Working with Individuals and Families in Different Settings

Identify the individual/family needing counselling/family therapy for each counselling and family therapy case record – from intial phase to termination phase.

Inform the Counsellor about the selected individual/family and the counselling/family therapy approach to be used with them.

Seek the consent from the family/participant before conducting the practicum activity. The consent form is enclosed at the end of this Manual.

The time schedule for conducting the practicum activity should be planned according to the convenience of the family or the individual with whom the practical activity is to be carried out.

Be punctual for your appointment; and if there is any change in time or day inform the concerned family or individual.

Before conducting any practicum, you should have thorough knowledge of its theoretical component and complete understanding of the procedure of performing the practicum activity.

Before starting any practical, spend some time with the respondent(s) to establish rapport and create an environment comfortable for conversation or activity; this is generally termed as rapport building.

Use the case history taking formats, mental status examination forms, and family interview schedule as given in the first year Supervised Practicum course material, as per the requirement of the case.

Respect the views of respondents and do not interrupt or show your own attitude, opinion or prejudice regarding what they are saying or doing. The process should not be biased by your view points. Keep the information confidential, sharing it only with the Supervisor. Do not discuss it with any other person including your friend, spouse, parents and other family members.

In case the family or the individual does not cooperate with you, or you feel that you are not making any headway in counselling/family therapy, or there is unplanned termination, you would need to admit the same. Report this in your file. Also, find another respondent – individual/family to carry out your case work for the required number of sessions.

The awareness generation campaign should be well planned and well organised at the community level, creating awareness under the overall guidance of the counsellor/supervisor.

Important Points for Writing a Report

1. Basic Information

Please mention all relevant details of your student status (enrolment number, study centre etc.) clearly on each Practicum Report, as well as on the cover of the Supervised Practicum File. The File should be presentable and legibly written. Attach all other materials in the File (audio tapes/CDs and transcripts or sheets of paper on which you had taken notes during the sessions etc.) and list each one of them as '*enclosures*' in the File along with the number of such items.

2. Content

In most of the practicals, one has to give details of the activity or session conducted. As you would realise, others (especially your evaluators!) would not have access to this information unless you provide the same in the report of the Practicum. So do remember to provide all relevant information. At the same time, be true to yourself as you are learning important concepts from the practicum activity. Do not falsify the report or modify the record of the practicum activity to make it look 'good'. Don't worry if everything in the family does not fit a given, stereotypical norm of a family or a relationship. The idea here is to move away from being judgemental and learn to create a view that is unbiased, encompassing and sensitive to plurality. Your evaluations are going to be based on an objective and unbiased treatment of the same in analysis. Please use the concepts you have learnt in the Course in order to meet this end.

You need to have at least 7 sessions of counselling, and at least 12 sessions of family therapy in the respective case records. Conducting an awareness campaign in the community would require at least 4-5 sessions. Acclimatisation would require at least 4-5 sessions.

The content of your file will also be evaluated on how comprehensively and objectively you have dealt with the issues at hand. Your personal beliefs and preconceived notions should not hinder the understanding of the content.

3. Presentation

Your report for each practical should be comprehensive and analytical. Be organised and help the evaluator know that you have understood the concepts. Use pseudonyms rather than the actual names for the subjects and family members. But rest of the information should be truthful.

4. Length

Give all relevant details of each case/practicum. Be careful not to beat about the bush! The richness of content and organisation of your report carry more weight than how many pages it consists of or how long it is!

Supervised Practicum File

The Supervised Practicum File will be prepared by compiling the written records of all the practicals. You have to submit the complete Practicum

File duly evaluated by your Practicum Supervisor at your Programme Study Centre/Study Centre, before the mentioned due date. The File would contain sheets on which you have written the report of each practical (along with the requisite enclosures to support the same), duly evaluated by the Academic Counsellor, and the filled-in evaluation sheet given at 'Annexure A' at the end of this Manual.

The Counsellor will record the marks that you have obtained for the Practicum at the end of each practical in your Supervised Practicum File, and in Section 1 of the mark sheet provided at the end of this Manual at Annexure A. Sections 2 & 3 of Annexure A have to be left blank, as these are to be filled-in by the External Evaluator.

This Annexure A, with duly filled in Section 1 and blank Sections 2 & 3, must be included in the Supervised Practicum File that you submit.

In addition, the Counsellor will certify the Form given at Annexure B at the end of this Supervised Practicum Manual which declares that every practical was conducted by you under her or his supervision. You must also include this duly filled-in Annexure B in the File you submit.

Evaluation of Supervised Practicum File

The evaluation of Supervised Practicum is done at two levels. These are:

- Evaluation Level 1 : Internal Evaluation
- Evaluation Level 2 : External Evaluation

Evaluation Level 1: At the Programme Study Centre / Study Centre by the Academic Counsellor/Supervisor

Every practical will be evaluated by the Academic Counsellor/Supervisor with whom you have been attached by the Programme Study Centre/Study Centre for this Supervised Practicum Course. For the purpose of evaluation, for each practical, the Academic Counsellor will judge your performance during interactive sessions and the counselling/family therapy sessions, as well as evaluate the written records which have been submitted by you in the Supervised Practicum File. This is called *Internal Evaluation.*

The marking scheme is as follows:

Maximum Marks for each of the Practicals 1 to 5:

- Maximum marks (MM) for review of organisation = 50
- Maximum marks (MM) for acclimatisation sessions = 100
- Maximum marks (MM) for counselling case record = 200
- Maximum marks (MM) for family therapy case record = 300
- Maximum marks (MM) for conducting awareness generation campaign = 150

Hence, total MM for the internal evaluation component of the Supervised Practicum (all the practicals) is 800.

Evaluation Level 2: External Evaluation (Evaluation of Practicum File at IGNOU Headquarters)

An expert from the panel, nominated by IGNOU, will evaluate the Supervised Practicum File. This is called *External Evaluation.* The External Evaluator

will record the marks in Sections 2 and 3 of Annexure A of this Supervised Practicum Manual, that you would have enclosed in the File.

External evaluation will therefore be done on the basis of the Supervised Practicum File submitted by the learner.

Maximum marks for each of the Practicals 1 to 5:

- Maximum marks (MM) for review of organisation = 50
- Maximum marks (MM) for acclimatisation sessions = 100
- Maximum marks (MM) for counselling case record = 200
- Maximum marks (MM) for family therapy case record = 300
- Maximum marks (MM) for conducting awareness generation campaign = 150

The External Evaluator shall evaluate the Practicals as above. Thus, the total marks for the external evaluation component shall be 800.

Weightage of Two Levels of Evaluation

The two levels of evaluation carry equal weightage towards final marks:

- The marks given by the Supervisor at Level 1, known as *'Internal Assessment',* will be calculated as 50% weightage; and
- The marks given by the Expert at Level 2, known as *'External Assessment',* will also be calculated as 50% weightage.

You have to secure 40% as pass marks in both the assessments, internal as well as external. If you are not able to secure 40% marks in either assessment, you have to repeat the complete Supervised Practicum MCFTE-005. It means you have to re-do all the Practicum activities, make a new Practicum File and submit it.

Note: *The panel of experts nominated by IGNOU, who are going to evaluate your Practicum File have the right to moderate the Internal Assessment marks awarded through the Programme Study Centre / Study Centre in any component of the Practicum.*

If the evaluator finds the practicum work NOT up to the standard desired, the evaluator may suggest minor/major changes and/or corrections, ask for clarifications and also can reject the manuscript. All instructions and advice to the student for subsequent modifications are made through the programme incharge. The practicum supervisor will have the responsibility to have the student make the suggested changes for the final copy and resubmit the report for re-evaluation.

In case of failed students, a pro-rata fee of Rs. 1500/- by way of a demand draft in favour of IGNOU and payable at the city where the Regional Centre is located should be remitted along with the resubmission of the Supervised Practicum File.

If the student is unsuccessful in the Supervised Practicum File for optional paper, she or he has to re-do the whole cycle, right from requesting the Programme Incharge for a Supervisor and re-submitting the File.

Submission of Supervised Practicum File

The complete Practicum File may be sent to the following address:

Student Evaluation Division
Indira Gandhi National Open University
Maidan Garhi, New Delhi – 110068

Note: *Before mailing the Practicum File, you must keep a photocopy of the File with yourself, so that in case of loss in transit or misplacement, you would be able to submit the copy of that file.*

Maximum Duration of the Practicum

For this 4 credit Supervised Practicum Course, you have to spent 30 sessions of which one hour is with your Counsellor or Supervisor and 3 hours are to be devoted to the field work. The maximum time you can take to complete the practicum is five months from the date of commencement of the Supervised Practicum for this Course.

At any given time, an Academic Counsellor shall have a maximum of only 6 learners attached to him/her. Once the Supervisor has been allotted, the Supervisor would be committed to the learner for supervised practicum for a maximum period of five months.

If for any reason a student is not able to complete the work in a maximum duration of 5 months, the student has to start afresh, and would be treated as a new student to the Supervisor.

Student is NOT permitted to hop between different Supervisors/Counsellors.

If the student has to change the Supervisor, then it should be done in the beginning itself; once the work assigned starts no changes are permissible.

Date for submission of the Supervised Practicum File

- If you wish the marks of the Supervised Practicum to be included in the June Term-end Examination marksheet then your Supervised Practicum File must reach SED, IGNOU, Maidan Garhi, New Delhi latest by 30th April. The File should be duly verified and evaluated by your Supervisor before submission for external evaluation.
- In case the File is submitted after 30th April, and before 31st October, marks would be included in December term-end examination marksheet.

  Thus, if your Supervised Practicum File reaches IGNOU between 1st November and 30th April it will be accounted for in the marksheet for the June examination, and if the Supervised Practicum File reaches IGNOU between 1st May and 31st October it will be accounted for in the marksheet for the December examination.
- In the first year of your registration, the first time you can appear in the term-end examination is in June. Subsequently you can appear for both June & December term-end examination.
- The file submitted will not be returned to you.
- Do remember to keep a photocopy of the File.

Checklist of Enclosures:

When submitting your Supervised Practicum File please ensure that you have included the following:

1) The cover page should clearly state the title ‘‘Supervised Practicum File for the Course MCFTE-005’’. Your name and enrolment number must also be mentioned on the cover page.

2) The first page or the face sheet must also have your name, enrolment number, full address, name, designation and address of your Supervisor; as well as name and address of your PSC/SC. The format for the face sheet of the Practicum File is given on the next page.

3) Written record of the Practicals and corresponding enclosures like audio tape/CDs and transcripts, as well as other materials used.

   In Annexures or enclosures, you must include the written record of each interview as it took place. Also enclose the audio tape/CD, if used and the transcripts or the sheets on which you noted the answers of the respondents during the interview. The materials that you prepared/used for conducting the awareness programme in the community must also be enclosed.

4) Annexure A (Sections 1, 2 & 3) and Annexure B.

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SUPERVISED PRACTICUM FILE

M.Sc. (CFT) — Second Year
(Optional Paper)

MCFTE-005

Name of the Student :

Enrolment No. :

Address :

Phone No. :

Study Centre/
Programme Study Centre :

Regional Centre :

Name & Address of
Supervised Practicum
Supervisor :

Phone No./Mobile No./
e-mail address of Supervisor :

Signature of the Student

Date :

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PART I

UNDERSTANDING THE BASICS

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BASIC UNIT 1 : UNDERSTANDING COMMON EMOTIONAL AND BEHAVIOURAL PROBLEMS DURING CHILDHOOD

INTRODUCTION

Sahil was a highly sensitive six-year-old boy who suffered from numerous fears, nightmares and chronic anxiety. He was terrified of being separated from his mother, even for a brief period. When his mother tried to enroll him in Nursery, he became so upset when she left the room that the Principal arranged for her to remain in the classroom. After two weeks, however, this arrangement had to be discontinued, and Sahil had to be withdrawn from Nursery because he would not let his mother leave even for a few minutes. Later, when his mother attempted to enroll him in the first grade, Sahil showed the same intense anxiety and unwillingness to be separated from her. At the suggestion of the school counsellor, Sahil's mother brought him to a Child Development Centre for assistance with the problem. The therapist who initially saw Sahil and his mother was wearing a white clinic coat, which led to a severe panic reaction on Sahil's part. His mother had to hold him to keep him from running away, and he did not settle down until the therapist removed his coat. Sahil's mother explained that "he is terrified of doctors, and it is almost impossible to get him to a doctor even when he is sick".

Master C, 11 years of age, in class V, has been suspended from the school thrice for hitting children of his class badly. It was also reported that in this academic year, he has not been attending school very frequently. He was made to repeat class III since he had not been able to gather the concepts of class III. The mother agreed to the decision of the school. He always had difficulty sitting in the class. However, when he was young he would still attend a few classes. Since the past two years, his bullying behaviour and aggressive tendencies have increased. He has also been missing school frequently. When he attends school, then incidents of him disrupting the class and hitting others have been reported. His teachers find it difficult to control him. He doesn't have friends in his class. He has been promoted to subsequent classes due to the no-fail policy till class VIII. Interactions with the teacher indicate that he has very basic academic skills and they are not age-appropriate. His family background indicates that he is living with his mother in a peri-urban area near the school. His father has not been living with them since the last three years. His father has visited them very rarely in the last three years. His father has had a history of alcoholism and also been involved in a number of small time offences. On certain occasions, C's father has also hit C's mother under the influence of alcohol to which C has been a witness. According to his mother, C's milestones were age-appropriate. He didn't have any developmental problem. Since C's father had not been working, C's mother had been

working since C was one year old. Due to this, during the day time, C would stay at the Balwadi (govt. crèche) throughout the day and in the evening, C would stay with the neighbour till the time mother would be back from work. According to the mother he had been a naughty child, and was also frequently hit by the mother since he was 3-4 years old. There used to be regular complaints from neighbours who were taking care of the child in the absence of the mother that he doesn't listen to them, hits others and gets angry very frequently. She thought that sending C to school would help in improving his behaviour but it didn't help. An assessment was undertaken by a psychologist. It was reported that it was not easy for the psychologist to undertake the assessment since he would not listen. It has been reported that he has normal intelligence but academically there are gaps. Also, he had severe difficulties in visual-spatial skills. It was diagnosed that he has conduct disorder.

Rahul, an 6 year old boy in a private school was taken by a very harassed teacher to the principal's office. She complained that he hits other children, keeps throwing things down, is always moving in the class and has to be told repeatedly to complete his work. She was totally fed up of him and felt that she had to run after him constantly. She was unable to concentrate on teaching the rest of the class. In spite of his hyperactive behaviour and poor academic performance, he was an intelligent boy.

Devansh, an 8 year old boy, had already established himself as a social out caste by the time he entered the 3rd class. He had been expelled from his previous school because of unmanageable behaviour. Within the first week of the new school, his quarrelsome and defiant behaviour became impossible for the teacher to handle. Other children saw his bullying behaviour and at the slightest movement of his they would tell the teacher that he was disturbing them. He would abuse and hit other children and give explanation about how other children were making false complaints. The fights grew worse in the school bus and playground, where there was low supervision of the teacher. On one occasion, he was even found to be carrying a knife in his bag.

Tarun was brought by his parents with the complaint that since he has entered class 6, he has been very worried about his studies. He repeatedly says that he won't be able to cope up with the syllabus. At times he avoids going to school as he feels that it is of no use. He remains irritable, and cries at the small things too. He complaints of frequent headaches, stomach ache, and has dizziness too. In spite of all this, he spends hours trying to study and finish his homework, but is never satisfied with his performance. His parents have been noticing this change since about last 3 months, and initially dealt with him in a strict manner, but that only led to an increase in the problems. They also reported that they have been strict about his academic achievement since beginning and placed a high degree of emphasis on his good grades. Tarun is reported to be an above average performer in studies.

Every child is unique. Individual differences among children are due to genetic, environmental and socio-cultural factors. While growing up, children may also experience disturbance in emotions, behaviours and relationships which may impair their functioning. However, it is important to distinguish between the causes of emotional and behavioural disturbances in children. Emotional and behavioural difficulties can be either due to developmental causes or due to certain disorders in children.

a) Some of the disturbances in emotions and behaviours are developmental in nature. That is, normal growing up process is characterized by physical, behavioural and emotional changes. These changes not only lead to growth but they may also cause the child to feel confused, irritated and upset about these changes. Since the child exists in a system, the impact may be felt not only on the child but also on the family, also peers for some time. To illustrate, a 11 year old child who otherwise was happy and sociable, suddenly begins to stay indoors, talks less and exhibits irritating behaviour. This is quite normal since the child is entering adolescence phase in which the changes in the hormones and the body cause changes in mood. However, the same behaviour can be a cause of worry if it persists for a longer period of time. Then the child may require help from adults to deal with these changes. Most of the disturbances subside with age and support from the environment. It is important to note that the children who experience the developmental disturbances may require support from environment, such as parents, siblings, teachers and friends.

b) On the other hand, some of the disturbances in emotion and behaviour could be due to disorders, such as Attention Deficit Hyperactive Disorder, Learning Disability. These disorders have an impact on the child, family and others.

It is important to distinguish whether disturbances in the child are due to normal growing up process or whether the child has a disorder. For this it is crucial to be aware of the various developmental milestones and symptoms associated with the disorders.

FACTORS AFFECTING EMOTIONAL AND BEHAVIOURAL PROBLEMS DURING CHILDHOOD

Before we discuss the emotional and behavioural problems, let's look briefly at the broad factors which may lead to the development of emotional or behavioural problems in children. It is important to note that there is no one factor which causes these problems. There are often multiple reasons which include:

Genetic factors: There have been evidences that behavioural and emotional problems are caused due to genetic, neurological or biochemical factors. The difficulties may be caused by one of these factors or a combination of these factors.

Environmental factors: Along with the genetic factors, environment also has been known to cause emotional and behavioural difficulties. For example, it is known that environment also plays a major role in

contributing towards conduct disorder. Factors such as adverse child rearing environment, rejection by peers also contribute to the conduct disorder.

Pre-natal and post-natal factors: Conditions such as maternal diseases, psychological stress to the mother during the pregnancy period and pre-term delivery increases the chances of a child developing emotional or behavioural disorder.

It is a combination of these factors that may predispose a child to develop emotional or behavioural disorders. Factors like child's temperament, parental health, family relationships and parenting styles contribute to the manifestation of these problems.

CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Children with Attention Deficit Hyperactive Disorder (ADHD) exhibit difficulty in sustaining attention on simple tasks or play activities. Three characteristics viz., hyperactivity, inattention and impulsivity are the key features of this disorder. They exhibit persistent patterns of hyperactivity. By hyperactivity it is meant that the child finds it very difficult to stay at one place, is often on the move. Inattention causes the child to often not follow instructions, follow schedules, or finish work on time. Impulsivity often makes it difficult for the child to wait for turn; he/she tends to interrupt others and so forth. These features interfere with the children's social, academic and personal life. For a diagnosis of ADHD to be made, the presence of symptoms is seen for a period of six months and the degree is of these more than is observed in other children of the same age. Making a diagnosis of ADHD involves comprehensive assessment. This involves detailed case history taking, getting inputs about the behaviour of the child across at least two settings (such as home and school), observation of the child etc.

Though the exact causes of ADHD are unknown, some suggested factors include, minimal and subtle brain damage during foetal development and early infancy caused by infection. Premature birth also has been known to cause ADHD. Some studies have also noted that prolonged emotional deprivation, stressful life events, may initiate or perpetuate ADHD.

Diagnosing Children with ADHD

As has already been mentioned, making a diagnosis involves intensive assessment. Either the criteria given in DSM-IV or ICD-10 are followed to make a diagnosis. For the correct diagnosis to be made, it is important to note the intensity of the symptoms, that is, the behaviours should be excessive, persistent and have presence of at least 6 months.

For a diagnosis to be made according to DSM-IV TR, some symptoms must be present before the age of 7 years. Information about the following needs to be gathered while taking casehistory: prenatal history, natal and postnatal factors. These help to indicate if there had been any impact on the central nervous system. Other important aspects such as rates of development, deviations in development also indicate whether the symptoms were present while the child was developing. At the same time, it is very crucial to bring

out the impact of environmental influences on the behaviour of the child. For this parental reactions on the child's stressful behaviour need to be ascertained. This will indicate the extent to which parents have contributed or reacted towards the child's inefficiencies. Additionally, school history and teachers' observations are also important for evaluation of the causes of child's difficulties. It is important to delineate whether the child's difficulties are due to child's attitudinal or maturational problems or due to poor self-image.

Children with significant levels of attention deficits and hyperactivity not only are bothersome to adults and noxious to peers, they also tend to display:

- Aggression and antisocial behaviour (30-50%)
- Learning disabilities and underachievement (10-30%)
- Anxiety and depressive disorders
- Family disharmony
- Difficulty getting along with others
- School underachievement
- Poor self esteem
- Other behavioural disorders
- School underachievement underachievement (10-30%)

It is to be remembered that ADHD effects life at school, in the classroom, within the family, with peers and also within the person. Child can have a loss of confidence and negative perceptions about himself based on past and repeated frustration, struggle or failure.

Managing Children with ADHD

Life can be difficult for children with ADHD. The predisposing biological factors lead the children to engage in behaviour which creates trouble for them at school, lose friends, develop low self esteem. The comprehensive treatment plan for children with ADHD involves a bio-psycho-social approach. Medication has been shown to have an impact on reducing the hyperactivity of the children. But there are certain aspects of their behaviour which cannot be managed by medication. Through various techniques, parents and children are trained to manage the patterns of behaviour.

Before we give an overview of certain techniques, there are certain salient aspects which should be understood about a child with ADHD:

- ❑ Adults should remember that a child with ADHD does not misbehave intentionally. It is primarily due to biological factors that the child is pre-disposed to act in inappropriate ways.
- ❑ For children with ADHD, it is not easy to cope with the frustrations due to their inability to adjust in schools; always getting pointed out for misbehaviour and difficulty in having peer relations.

- As adults we can provide the child with ADHD a safe/conducive environment to act. Also, we need to lower down our expectations from a child with ADHD, since there will always be a gap between child's actual performance and his or her ability.

Following are some of the useful tips which can be helpful in creating a safe and a positive environment for a child with ADHD at home /school:

- Providing the child with ADHD social skills training, and cognitive behaviour therapy. These will help the child to manage certain aspects of his or her behaviour. Through cognitive behaviour therapy the child can be trained in anger management techniques.
- In addition to these trainings at individual level, parent skills training is very important. Through this training, parents are coached with certain behavioural strategies which can be used to manage the child with ADHD and create a positive environment at home. The sessions also focus on teaching parents how to give commands, labelled praise, engaging in playful activities with children with ADHD in a specific manner.
- Another important guideline for creating a positive environment for children with ADHD, is the technique of giving instructions to the child with ADHD. The following should be kept in mind:
  - Maintain eye contact during verbal instruction.
  - Simplify complex directions. Avoid multiple commands at one time.
  - Make ***directions clear and concise***. Be consistent with daily instructions.
  - Make sure child comprehend the instructions before beginning the task, thus ask the child to repeat what needs to be done.
  - Repeat instructions in a calm, positive manner, if needed.
- As mentioned earlier, there will always be a gap in the child's potential and performance. It is important that the child is praised for the tasks that they can accomplish. "Labeled praise" is more effective for a child with ADHD. An example of labelled praise would be when the child has completed the work on time, instead of just saying 'good' say 'Well done! You have completed work on time'.
- Ensure fellow students are sensitized to the condition of the child and do not ridicule him or her.
- Strategies such as token economy can be followed to reinforce desirable behaviours.
- In school, it is recommended that students with ADHD are seated near the teacher's desk, while including them as part of the regular class room seating. This will ensure that they will have their front to the teacher with their back to the rest of the class and other students will be out of the view. Thus, there will be less distraction for them. Also, try not to place students with ADHD near air conditioners, sounds of high traffic areas, heaters, or doors or windows.
- Students with ADHD should be surrounded with good role models, preferably students whom they view as significant others. Encourage ***peer tutoring and cooperative/collaborative learning***.

- Children with ADHD do not handle change well, so ***avoid transitions***, physical relocation (monitor them closely on field trips), changes in schedule, and disruptions.
- When giving assignments, break them in smaller parts. For instance, the child can accomplish some part of the task in 15 minutes and then take a break in which he or she moves out of the class to get some notebooks and finish the remaining half of the assignment later.
- Be tolerant of the child's condition. Accept the child's needs. Thus, if a child wants a new activity after 30 minutes or so, give him tasks of responsibility such as getting chalk from other room and so forth.
- Determine specific strengths and weaknesses of this student. Develop an ***individualized education programme*** which may be at a different pace than the rest of the class.
- Remember the focus is on making the child learn. Thus, according to the needs of the child, they can be modified. For instance, fill in the blanks, multiple choice questions can be prepared for the child.
- Give extra time for certain tasks. Students with ADHD may work slowly. Do not penalize them for needed extra time.
- Keep in mind that children with ADHD are easily frustrated. Stress, pressure, and fatigue can break down their self control and lead to poor behaviour.

Following are some of the tips for parents with a child with ADHD:

- ❑ Parents need to be advised that it is important to remember that they need to maintain their sense of calm, humour while managing the behaviour of child with ADHD. It is important for parents to have a time for relaxation for themselves such that they are able to rejuvenate their energies.
- ❑ An ADHD child works best in boundaries. A schedule of their activities should be set.
- ❑ Parents should let their child know that it is their behaviour that they don't like, not the child.
- ❑ It is important for parents to stay calm while dealing with a child with ADHD and not yell at them.
- ❑ should be reminded to have special fun times with their child.
- ❑ Ways can be explored to develop child's self esteem such as a sport, activity etc.
- ❑ It is recommended that tasks should be broken into small achievable parts to let the child experience a sense of achievement.
- ❑ Try to ignore some of their non harmful behaviour.
- ❑ Make effective use of punishment along with rewarding appropriate behaviour. Avoid those punishments which have the potential to harm the self esteem of the child.
- ❑ Prepare star charts to reinforce some of the behaviour.
- ❑ Give frequent, small and immediate rewards for actual accomplishments rather than obedience.

- Give attention to the child not only when the child breaks a rule but also when they accomplish a task even though the task may be small.
- Consistent and relatively predictable behaviour to be exhibited by the parents.
- At home, there should be planned ***periods of exercise***.
- The child should be prepared, before there is a transition in the regular activities.
- Promote selfcontrol in child through methods like self talk. The child is taught to talk to him/herself in order to guide his/her own behaviour. Rather than moving purposelessly, he is taught to tell him/herself (first aloud and then silently) what to do ("I want to finish this. So I'll pay attention and play later.").
- Parents should be told that it is neither a wishful misbehaviour on the child's part nor due to their mismanagement. The parents must be reassured about the favourable outcomes as excessive activity ceases during adolescence.
- The parents should keep the valuables, breakable or dangerous objects out of reach of the children, as they are more prone to accidents.
- If properly treated, most children with ADHD can live productive lives and can cope reasonably well with their symptoms.
- Remember that these strategies work best if they are followed consistently at home and school.

It is now understood that ADHD is a life span disability. One does not outgrow ADHD, nevertheless the individual can learn to master strategies to function effectively.

The course of ADHD is highly variable. Some of the symptoms may persist into adolescence and adult life. Children may show reduced hyperactivity but attention span and impulse control problems may persist. However, application of behavioural strategies under the guidance of a professional at home/school has a positive impact on the management of the behaviour.

OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER (DISRUPTIVE BEHAVIOUR DISORDERS)

Oppositional Defiant Disorder (ODD):

A certain amount of aggression is present in all children. Up to the age of 5 years, aggression is usually physical. Around 2½ to 3 years it is at its peak. Slowly children learn to harness their anger as cooperative play starts developing. Oppositional defiant disorder is characterized by the child's repeated temper outbursts, active refusal to comply with rules, disobedience and hostile behaviour of over a period of 6 months. The onset age appears to be around 6 years, when most children have surpassed earlier normative oppositional behaviours. However, there is absence of severe violations of social norms or rights of others.

Conduct Disorder (CD)

A conduct disturbed child is repeatedly aggressive and his/her behaviour violates the rights of others. They show excessive levels of fighting, hostility, verbal

abuse, defiance, cruelty to animals, destruction of property, lying, stealing and truancy. Conduct disorder is the most common reason for referral of children for behavioural evaluation and treatment. It appears to be more prevalent in urban than rural settings. It is about 3 times more common in boys than in girls. The prevalence rates for boys under the age of 18 are 6-16%; for girls, rates range from 2-9%.

Other behaviours associated with conduct disorder are stealing, truancy, setting fire, deliberate destruction of another's property, cruelty towards animals, and initiating physical fights.

Understanding the Causes of Disruptive Disorders

Since disruptive disorders are not characterized by a single attribute but rather by a combination of behaviours, there is no single cause of disruptive behaviours. Research has indicated that there many factors which increase the ***risk for onset and development of disruptive behaviours.***

- Family studies indicate transmission of aggressive traits.
- Socio-cultural factors, such as low socioeconomic status and living in areas with easy access to antisocial or deviant peer groups.
- Parental factors such as:
  - Low maternal affection;
  - Father's deviance (alcoholism or criminality);
  - Substance use disorders in parents;
  - Parental aggression or violence and/or physical or sexual abuse of children;
  - Parental mental illness
  - Lack of consistent parental emotional investment, support, and affection.
- Family conflict between parents, and between parents and other siblings
- Poor parenting practices:
  - Families do not adequately monitor the child's behaviours.
  - Mothers are often rejecting and fathers tend to be excessive or inconsistent in discipline practices.
  - Discipline is often excessive, lacking, inconsistent or inappropriate.
  - Inability of the parents to provide adequate supervision, structure, and limit.
- Child with difficult temperament may also contribute to disturbed family relationships and this may be a risk factor for ODD.
- Violence in the neighbourhood and fear for personal safety.
- Inability to cope with the physical and emotional changes of adolescence.

- Peer pressure to rebel against school/antisocial role models.
- Feelings of alienation and isolation.
- Unmet special learning needs.
- Poor academic performance. This may be a risk factor as well a consequence of ODD/CD. Poor academic performance may cause a child to feel frustrated and react in an antisocial manner.
- Bullying and intimidation either within the school or outside.
- Being ridiculed in class.
- Adolescent treated to harsh discipline, physical or sexual abuse increases the risk for developing anti social behaviour.
- Being different (accent, culture, religion) and then ridiculed or isolated at school.
- Death of a close family member or divorce of parents.

Managing children with disruptive disorders

A multi-modal treatment programme is considered to be effective for managing children with disruptive behaviours. Since there is an entire spectrum of behaviours which consists of disruptive behaviour, therefore, variety of treatments are helpful in managing behaviour and promoting prosocial behaviour.

Medication has been shown to be effective in managing aggressive tendencies of children with conduct disorder. However, for controlling other aspects of behaviour, behavioural strategies are used with children with disruptive behaviours.

For children with disruptive disorders, a structured environment with consistent rules and expected consequences needs to be set. The structured environment can be set at home through training the parents in behaviour techniques. Even in the school setting, behavioural techniques can be applied with the child to promote prosocial behaviour.

Let's look at some of the tips which can be given to the teachers/parents to manage the behaviour of the child in school and home settings:

- Establishing rapport with the ODD/CD child is very crucial to ensure that the child listens to the teacher. Also research has indicated that most children with ODD/CD respond best to the behavioural therapy when they themselves feel distressed because of their own behaviour and want to change.
- Teacher/parents can be trained to develop a behaviour management plan by a counsellor.
- Teacher/parents can be told to ignore certain behaviours and take up a few important behaviours for modification in the behaviour management plan.
- Maintain consistency, structure and clear consequences for the child's behaviour.

- Set an adequate example before the child in how they manage their anger, solve frustrating situations or show respect for authority figures. Gradually relaxation exercises, counting backwards when the child feels angry can be taught to the child.

- The rule should be clear and specific and ensure it has been understood by the child. Establish the rules which are non-negotiable.

- Praise all the good efforts even if the end result (behaviour) is unsuccessful. Use labelled praise with the child.

- Children with disruptive disorders like to provoke reactions in adults and thus they are successful in creating power struggles. Try not to show any emotion such as getting irritated when dealing with their difficult behaviours. This will pass a message to them that their behaviour is having no effect on the adult. Gradually, this may reduce their disruptive behaviours.

- It is important to address the concerns of the child with ODD privately. This will help to minimize power struggles as an audience won't be present.

- Avoid debating or arguing with a student with OD/CDD. In situations, where the child debates on why he or she is being asked to undertake a project, simply repeat the instructions. Do not raise voice with the child since getting your voice to be raised may be the main motive of the child.

- Remember that the techniques that seem to be less effective with the child with CD/ODD include constant overcorrection and verbal reprimands, the use of physical reprimands and seating or segregating the student away from others.

SEPARATION ANXIETY DISORDER (SAD) OF CHILDHOOD

For children, the experience of fear is an essential part of normal development. However, for some children and adolescents, excessive and intense fears and anxiety can occur, resulting in disruption of the child's daily activities and quality of life. It is normal for toddlers and preschool children to show a degree of anxiety over real or threatened separation from people to whom they are attached. Separation anxiety disorder (SAD) should be diagnosed only when fear over separation constitutes the focus of the anxiety and when such anxiety arises during the early years. It is differentiated from normal separation anxiety when it is of such severity that is unusual.

Children with SAD may show evidence of crying and distress in anticipation of or at the occasion of separation. These children often fear that some untoward event will occur to cause the separation (e.g., fear of being kidnapped or getting lost). Children with SAD are reluctant to be alone and often try to sleep with their parents or refuse to leave the house. In extreme cases, children with SAD will "shadow" their parents and refuse to be alone at any time.

Following is a case sample:

Sneha is a five year old girl who refuses to part with her mother. She visits the school along with the mother, goes about her daily routine activities with

her and sleeps with her only. This behaviour has become more prominent ever since she joined school. Earlier, she used to play comfortably if the mother was in the other room, however now she stays close by to her mother all the time. Due to this behaviour, she is not able to pick up concepts in school and it is interfering with her overall functioning.

AUTISM

Autism is the developmental disability in which there is significant impairment in social relatedness, communication and the quality, variety, and frequency of various activities and behaviours. The onset of autism is before 3 years of age and impairment persists throughout the lifespan. Autism may occur across a range of functioning and is often associated with mental retardation.

The prevalence of autism in the general population is approximately 4-5 per 10,000 live births. Autism occurs more often in boys than in girls. The gender ratio is approximately 4:1 males to females.

Description of the condition

A child is diagnosed with autism when combinations of these symptoms are exhibited by the child.

a) **Impairment in communication:** Impairment in communication may be manifested by one or more of the following:

   a. Either there is a delay in language development or no speech at all
   b. Lack of language development
   c. Lack of use of gesture for communication
   d. May exhibit repetitive use of language - for example they may repeat the word which they have just heard
   e. Find it difficult to understand jokes, sarcasm.

b) **Impairment in social interaction:** Impairment in social interaction may be manifested by one or more of the following:

   a. Prefer to be alone, appear unaware of other people's existence
   b. May not respond to name and may on occasion appear to be deaf
   c. Poor eye contact, avoid gaze
   d. May not smile in response to parents
   e. Prefer solitary play, may not interact with other children
   f. When playing with other children exhibit difficulty in interacting and mixing with them
   g. Lack the ability to indulge in making believe/pretend play
   h. Do not imitate adults actions
   i. Not seek comfort at times of distress.

c) **Restricted, repetitive stereotyped patterns of behaviours, interests and activities:**

   a. May exhibit repeated movements such as hand or finger flapping etc.
   b. Strong attachment to particular objects

c. Develop repetitive interests in an activity

d. Have difficulty tolerating change and variations in routine. This may be a cause of significant distress to the child.

d) Associated features

a. Same autistic children may exhibit special skills or highly developed skills in specific areas.

b. They may also exhibit over sensitivity to light, sound and touch

c. They may indicate preference for certain kinds of food

d. May exhibit abnormal sleeping patterns

e. IQ may fall within range of mental retardation.

Each of the main and the related symptoms of autism vary in severity making this disorder quite different from one individual to the next.

PHOBIC ANXIETY DISORDER OF CHILDHOOD

Children, like adults, can develop fear that is focused on a wide range of objects or situations. Some of these fears (or phobias), for example agoraphobia, are not a normal part of psychosocial development. However, some fears show marked developmental phase specificity and arise (in some degree) in a majority of children; this would be true, for example, of fear of animals in the preschool period.

Specific phobias, in contrast to normal fears of childhood, reflect fears that are excessive, lead to avoidance of the feared object, are persistent and maladaptive, and are perceived as being uncontrollable by the child. Common phobias in childhood may include excessive fears of animals, storms, darkness, needles, and high places. Phobias are evident in children and adolescents of all ages, can begin at early ages of childhood, and are not necessarily tied to traumatic precipitating events. Prospective empirical research regarding the course of childhood phobias is lacking, and thus many conclusions in this area are based on retrospective studies with adults. Nevertheless, both prospective and retrospective studies suggest that some phobias may resolve without specific intervention. Improvement is more rapid in children compared to adults; however, for a considerable portion of children and adolescents, phobias can persist over time and continue to interfere with daily functioning.

SIBLING RIVALRY DISORDER

A high proportion, or even a majority, of young children show some degree of emotional disturbance following the birth of a younger (usually immediately younger) sibling. In most cases the disturbance is mild, but the rivalry or jealousy set up during the period after the birth may be present.

Sibling rivalry/jealousy may be shown by competition with siblings for the attention and affection of parents; for this to be regarded as abnormal, it should be associated with an unusual degree of negative feelings. In severe cases this may be accompanied by overt hostility, physical trauma and/or maliciousness towards, and undermining of, the sibling. In lesser cases, it may be shown by a strong reluctance to share, a lack of positive regard, and a paucity of friendly interactions. The emotional disturbance may take any of several forms, often including some regression with loss of previously acquired skills (such as bowel or bladder control) and a tendency to babyish behaviour. Frequently, too, the child wants to copy the baby in activities that provide for

parental attention, such as feeding. There is usually an increase in confrontational or oppositional behaviour with the parents, temper tantrums, of anxiety, misery, or social withdrawal. Sleep may become disturbed and there is frequently increased pressure for parental attention, such as at bedtime.

Case study:

Anjali is a 9 years old girl studying in class V of a reputed public school. She has a brother, who was born as a premature child and is two years younger to her. She often exhibits childish behaviour and cries over little things. She often gets punished at home for teasing and hitting her younger brother. Her class work is generally incomplete and she often hits her classmates. The more the complaints from the school, the more punitive the parents become. Over time, she has begun to argue and revolt over almost everything she is asked or told to do. She has a few close friends at school and with them she tends to share her feelings. She actively participates in co-curricular activities and has even received some prizes for the same. Standard efforts of disciplining her at school and home met with no results. On being scolded earlier she would cry and would apologize for her behaviour but now she is usually seen standing mum and would not respond to anything that is asked for.

ELECTIVE MUTISM

The condition is characterized by an emotionally determined selectivity in speaking, such that the child demonstrates his or her language competence in some situations but fails to speak in other (definable) situations. Most frequently, the disorder manifests in early childhood. Other behavioural characteristics include social anxiety, withdrawal, sensitivity, or resistance. Typically, the child speaks at home or with close friends and is mute at school or with strangers, but other patterns (including the converse) can occur.

Following is a case sample:

Sandhya, a 6 year old girl, was brought with the chief concerns regarding her not speaking with anyone except her immediate family members. When guests arrive at her house, she retreats to her playroom and plays quietly. Even with children of her age, she does not talk or play; however she likes to watch them play from a distance. She speaks in whispers to her class teacher and remains quiet in school. Her written performance in school is satisfactory, however she scores low in oral activities.

BASIC UNIT 2: IDENTIFICATION AND SCREENING OF SPECIFIC LEARNING DISABILITIES

INTRODUCTION

Ridhima is a 10 year old girl, studying in Grade V. She faces significant difficulties in reading and writing. Her listening skills are weak and vocabulary is limited. She is unable to retrieve words. She hesitates to try reading new words. While writing, substitutions and omissions are present. Letter reversal is evident too. She is unable to generalize and apply facts. She is unable to comprehend the text. In Mathematics, she faces difficulty in performing calculations. She makes errors in addition, subtraction and multiplication. She places the numbers inappropriately.

Shreya is a student of class 4th in a public school. She is nine years old. She was referred to the school counsellor by her class teacher with the chief complaints of poor hand writing, frequent spelling mistakes, and a tendency to avoid reading. She has a difficulty in copying from the board, her class work and home work is also incomplete most of the times. She tries to escape from studies, and when forced to complete her work or write, she starts to cry. According to the parents, there has been a decrease in her level of social interaction during the last two years. She also tended to evade any situation in which she could have been judged. Birth history revealed pre-term delivery by one month through cesarean section along with her twin brother. The water bag had ruptured. The twins had neonatal jaundice at the time of birth. No developmental delays were reported. Temperamentally she is reported to be a highly sensitive child who gets highly disturbed when criticized for her behaviour or performance.

Raghav is a 13 year old boy, studying in Grade 8. He is seen alone during reccess or is a non participating member in a group of children. He maintains silence when he can not do a task. He appears distressed by failures. He seems to have certain anxieties and fear about failures, which makes him stubborn and he avoids doing work. He rarely self corrects his work. His flexibility in thinking is also restricted. He has poor ability to retain auditory information. His ability to formulate ideas and recall and relate experiences is poor. He finds it difficult to express his feelings. His reading of words is very slow and hesitant and is usually marked by being able to read the initial syllable and generalizing it to read as a more familiar word. He transposes letters within the words. He has self engrossed behaviour and impaired social interaction. He faces difficulty in organization, sorting out, differentiation, remembering and integrating. Raghav's short attention span and limited language and social skills impact his abilities to participate.

People with learning disabilities have trouble with taking in, organizing, and/or acting on information their brains receive through the senses. That information

can be nonverbal, but more commonly, the difficulty has to do with understanding or using written or spoken language. The problems are based on brain structure and function: a case of poor wiring in one or more areas of the brain.

Information about specific learning disabilities occurring in Indian children is scanty. The incidence of dyslexia in primary school children in India has been reported to be 2-18%, of dysgraphia 14%, and of dyscalculia 5.5%. However, awareness that learning disability is an important cause of academic underachievement has recently increased.

Learning disabilities are not the same as low intelligence; when given IQ tests, people with learning disabilities generally show average or above-average intelligence. But there's typically a big gap between how smart they are and what they're able to achieve, because the brain sets up roadblocks that keep them from processing and reproducing information. Consequently, a hallmark of learning disabilities is that people who have them consistently learn and work below their intellectual capabilities. Learning disabilities should not be confused with other disabilities such as mental retardation, or autism, hard of hearing, visual handicap or behavioural disorders. None of these are learning disabilities. In addition they should not be confused with lack of educational opportunities like frequent changes or attendance problems.

Three important factors which highlight significant dimensions of the disability are:

1. The learning-disabled child shows a discrepancy between achievement and intelligence.
2. Handicaps such as mental retardation, visual and hearing impairment and emotional/behavioural disorders must be ruled out.
3. A learning disability is a psychological processing disorder and presumes a central nervous system dysfunction.

Learning disabilities fall within the class of neurological issues called developmental disabilities, in that they are chronic, they limit success in one or more major life areas, and they cannot be reversed by medication. This classification includes mental retardation, but most developmental disabilities, such as cerebral palsy and autism, don't by definition encompass low intellectual function. One of the most painful aspects of having a learning disability is to have your brain's inability to process information in certain ways mistaken for low intelligence.

DIAGNOSING SPECIFIC LEARNING DISABILTIES

According to the DSM-IV

Learning Disorders are diagnosed when the individual's achievement on individually administered, standardized tests in reading, mathematics, or written expression is substantially below that expected for age, schooling, and level of intelligence. The learning problems significantly interfere with academic achievement or activities of daily living that require reading, mathematical, or writing skills. A variety of statistical approaches can be used to establish that a discrepancy is significant. **Substantially below** is usually defined as a discrepancy of more than 2 standard deviations between achievement and IQ.

A smaller discrepancy between achievement and IQ (i.e., between 1 and 2 standard deviations) is sometimes used, especially in cases where an individual's performance on an IQ test may have been compromised by an associated disorder in cognitive processing, a comorbid mental disorder or a general medical condition, or the individual's ethnic or cultural background. If a sensory deficit is present, the learning difficulties must be in excess of those usually associated with the deficit. Learning Disorders may persist into adulthood.

DIFFERENTIAL DIAGNOSIS

According to DSM-IV-TR:

- Learning disorders must be differentiated from normal variations in academic attainments, and from scholastic difficulties due to lack of opportunity, poor teaching, or cultural factors.
- Impaired vision or hearing may affect learning ability and should be investigated through audiometric or visual screening tests.
- In mental retardation, learning difficulties are commensurate with general impairment in intellectual functioning.
- An additional learning disorder diagnosis should be made in the context of pervasive developmental disorder only when academic impairment is significantly below expected levels given the individual's intellectual functioning and schooling.
- In individuals with communication disorders, intellectual functioning may have to be assessed using standardized measures of nonverbal intellectual capacity. In cases in which academic achievement is significantly below this measured capacity, the appropriate learning disorder should be diagnosed.
- Mathematics disorder and disorder of written expression most commonly occur in combination with reading disorder. When criteria are met for more than one learning disorder, all should be diagnosed.

According to ICD-10

It is clinically important to differentiate between specific developmental disorders of scholastic skills (SDDSS) that arise in the absence of any diagnosable neurological disorder and those that are secondary to some neurological condition such as cerebral palsy. In practice, this differentiation is often difficult to make (because of the uncertain significance of multiple "soft" neurological signs), and research findings do not show any clear-cut differentiation in either the pattern or course of SDDSS according to the presence or absence of overt neurological dysfunction. Accordingly, although this does not form part of the diagnostic criteria, it is necessary that any associated disorder be separately coded in the appropriate neurological section of the classification.

TYPES OF LEARNING DISABILITIES

Dyslexia or *specific language difficulties* is a term used to describe those individuals who have a difficulty in reading and blending of words.

Characteristics:

1. Severe difficulty in remembering printed words or symbols.
2. Illegible handwriting.
3. Poor spelling skills and frequent spelling errors.
4. Reversal of letters or improper letter sequences (for example b for d).
5. Poorly written composition.
6. Difficulty reading aloud.
7. Often skips lines while reading.
8. Difficulty copying from the board in a classroom.
9. Unable to count backwards from 100 down to 0.
10. Confusion with directions (for example playing on a team).
11. A poor, slow, fatiguing reading ability prone to compensatory head tilting, near-far focusing, and finger pointing.
12. Letter and word blurring, doubling, movement, scrambling, omission, insertion, size change, etc.
13. Poor concentration, distractibility, light sensitivity (photophobia), tunnel vision, delayed visual and phonetic processing, etc.

Some characterize dyslexia as a reading problem, when in fact dyslexics have problems with other skills as well such as:

- Spelling, Math, Memory, and Grammar – Memory instability for spelling, grammar, math, names, dates, and lists, or sequences such as the alphabet, the days of the week and months of the year, and directions.
- Speech – Speech disorders such as slurring, stuttering, minor articulation errors, poor word recall, auditory-input and motor-output speech lags.
- Direction – Right/left and related directional uncertainty.
- Time – Delay in learning to tell time.

Following is a case sample of Dyslexia:

Neha is a student of class II. Her teacher and mother report that they have a major difficulty making her read. In spite of being able to copy test from blackboard and other mediums, she has major difficulties in reading. Sometimes she even confuses similar looking words. When asked to write the English alphabet, she was found to make many mistakes as she jumbled the sequence and missed out many letters.

Dysgraphia is a *learning disability that affects writing abilities*. Most common difficulties are those of spelling, poor handwriting and trouble putting thoughts together on paper. It is a processing disorder.

Characteristics:

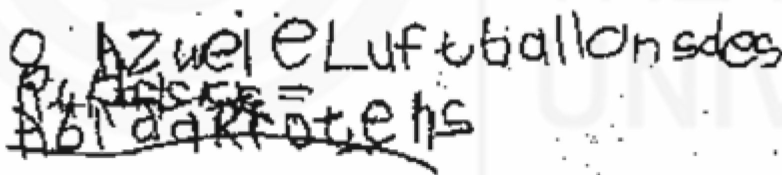
1. Tight awkward pencil grip and body position.
2. Illegible handwriting.

3. Tiring quickly while writing.
4. High levels of resistance and frustrations while writing.
5. Saying words out loud while writing.
6. Unfinished or omitted words in sentences.
7. Difficulty with sentence structure and grammar.
8. Large gap between written ideas and understanding demonstrated through speech.

Following is a case sample of Dysgraphia:

Aryan, 7 year old attending class III was brought by his parents with the complaint that he just cannot write. He reverses letters, and sometimes word, for example, writes "god" as "dog". He mixes capital letters with lower case letter while writing. He can barely copy a line from the blackboard while the class finishes the copying, and that too with mistakes. He often complaints that the teacher rubs off the board before he can copy. Further, he never seems to write within the lines, and his words are huge. The word formation remains illegible, and its very difficult for teachers and parents alike to read what he writes. His notebooks are full of remarks like "redo", "untidy work", and frequent red marks. His mother reports that he does not tell her what home work assignments he gets, and even says that nothing was done in the class. She has to take notebooks from the school and then help him complete the work. Of late he has also started to tear pages from his notebooks, and sometimes loses them altogether.

A handwriting sample of a child with dysgraphia is given below:



***Dyscalculia** is a learning disability with mathematics.*

Characteristics:

1. Shows difficulty understanding concepts or place value, quantity, number lines, positive and negative value, and carrying and borrowing.
2. Difficulty understanding and completing word problems.
3. Difficulty with adding, subtracting, multiplying, or dividing.
4. Exhibits difficulty using steps involved in math operations.
5. Challenged making change or handling money.

Following is a case sample of Dyscalculia:

Ananya has severe difficulties with numbers. Studying in 5th standard, and now 9 years old, she can never get the concept of simple addition and subtraction till now without help. Her retention of tables is also very poor, and

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she needs help again and again with them too. She confuses between the signs of +, - often and multiplication concepts she has not been able to grasp yet. She has started to avoid mathematics classes, however in all other areas her performance is reported to be adequate.

ASSESSMENT FOR LEARNING DISABILITIES

In order to answer questions regarding non-performance or underperformance, assessment needs to focus on various areas. Psychological tests need to be used, and the test performance needs to be seen against the background of information provided by the case history, interview, and the observation of the behaviour of the child. The clinician derives answers only by integrating information from these different sources:

1) developmental, medical, behavioural, academic and family history
2) general intellectual functioning
3) information on cognitive processing (language, memory, auditory processing, visual processing, visual motor integration, reasoning abilities, and executive functioning)
4) tests of specific oral language skills
5) educational tests; reading, spelling, written language, and math-testing
6) classroom observation

Developmental, medical, behavioural, academic and family history

Details about pre, peri, and post-natal history, inquiry about delays in developmental milestones either of global, or of specific nature are obtained. Sensory-motor handicaps, central nervous system damages which are present at birth or acquired later also need to be considered.

Socio-economic and educational factors, presence of psychosocial stressors, and the child's temperament are also worthy of exploration.

The IQ-Achievement Descrepancy

Resulting information collected from history, psychological tests, behavioural observations; school reports are used to determine whether child's academic performance is commensurate with cognitive ability. In order to diagnose learning disability, there needs to be a significant discrepancy between cognitive ability and academic achievement. The academic achievement is not in keeping with the child's intellectual ability, age, and schooling.

Significant discrepancy between cognitive ability and academic achievement is usually defined as a discrepancy of more than 2 standard deviations between achievement and IQ, which is difference of two grades between IQ and achievement. For example, a child who is 10 years old, and has a mental age of 10 years as well, can be diagnosed to have a learning disability only if his/her academic achievement age is 8 years or below. In case the child is found to have an achievement age of 5 years, he/she cannot be diagnosed to have a learning disability.

BASIC UNIT 3: CASE ILLUSTRATION OF CHILDHOOD PROBLEMS

INTRODUCTION

Case history taking, assessment and therapy constitute a vital component for formulating a case among childhood and adolescent problems. Case history taking followed by mental status examination and psychological assessment help to elicit important information about the child or adolescent's thoughts, feelings and behaviour as well as familial and social factors which aid case conceptualization. This further helps to plan therapy sessions with child or adolescent and family. This Unit highlights the case history, assessment and therapy processes through a case vignette.

CASE HISTORY TAKING

This involves interviewing the child or adolescent and the informants, who may be parents or caregivers regarding the problems or distress experienced by the child or adolescent. This includes information regarding the history of the problems experienced and the developmental, personal, familial and social factors which may contribute to the development and maintenance of the distress. A skillful case history interview may aid in obtaining better information, more accurate diagnosis, better rapport and ensuring treatment compliance (Ahuja, 2001).

The important points of consideration while conducting a case history interview include:

- A *consistent scheme* should be used to record the interview. The case history interview should not be fixed or rigid but should rather have flexibility that varies as per the clinical circumstances.
- Whenever possible the child or adolescent should be seen first. In case the accounts of the child or adolescent and the caregiver differ, then they should be recorded separately.
- The child or adolescent should be put at ease and a warm, *empathic relationship* should be established with him or her.
- The child or adolescent's and caregiver's responses should be recorded as *verbatim* in the person's own language whenever possible.
- The questions should be *open-ended* and non-directive rather than direct. Example: "How are you feeling?" instead of "do you feel sad or depressed?"
- During the interview, it is important to *listen* and show that you are interested in listening to and attending to the patient.
- *Confidentiality* should always be maintained except in cases where there is suicidal/homicidal risk and child abuse.
- *Signs* refer to the problems or distress experienced as inferred by the mental health professional whereas *symptoms* constitute the problems or distress as communicated by the child or adolescent and informant.

The case history taking for children and adolescents is discussed under the following heads and illustrated through a case vignette.

Identification Data

This includes identification data such as Name (including any aliases), Age, Sex, Education, Religion, Socio-economic status of the child or adolescent. An illustration of identification data with case vignette is as follows:

Name: Ms. X

Age: 12 years

Sex: Female

Education: Class 7th

School: Government School

Religion: Hindu

Socio-economic Status: Lower socio-economic status

Informants

At times the history provided by the child or adolescent may not be complete due to factors such as a young age, absent insight or uncooperativeness. It is important to substantiate the history from the child or adolescent's parents or caregivers who are informants. Their identification data should be recorded along with their relationship to the patient, whether they stay with the child or adolescent or not, as well as the duration of stay together. Additionally, the reliability and adequacy of the information provided by the informants should be noted. These can be assessed on the following parameters:

- Relationship with the child or adolescent
- Intellectual and observational ability
- Familiarity with the child or adolescent and the length of stay with the child or adolescent
- Degree of concern regarding the child or adolescent

The source of referral may also provide information regarding the child or adolescent's condition. An example of case vignette is as follows:

Name: Mrs. Y

Age: 30 years

Sex: Female

Religion: Hindu

Education: Graduation

Occupation: Housewife

Socio-economic Status: Lower socio-economic status

Relationship with patient: Mother

Information elicited was reliable and adequate.

Presenting Chief Complaints

These include the reasons for which children or adolescents and their caregivers seek mental health consultation. Both the child or adolescent and the informant's versions should be recorded separately. If the child or adolescent says that he or she doesn't have any complaints, it should be recorded. The complaints should be recorded in the child or adolescent's own words and a note of the duration of each complaint should be recorded. Certain additional points that are noted include:

- Onset of the presenting complaints
- Duration of the present illness
- Course
- Precipitating factors (including stressors, if any)
- Aggravating, maintaining, and/or relieving factors, if any

This can be illustrated by the case vignette as follows:

Ms. X (adolescent): "…sarr mein bahut dard rehta hai…" ("…I have a lot of pain in my head…"

(since past 6 months)

Mrs. Y (informant): "…poora din sarr pakad ke baithi rehti hai…" ("…She keeps on sitting the whole day holding her head…")

"…padhai theek se nahi karti hai…" ("…doesn't study properly…")

(since past 6-8 months)

- *Onset of the presenting complaints: insidious*
- *Duration of the present illness: 6-8 months*
- *Course: continuous*
- *Precipitating factors (including stressors, if any): failure in class test*
- *Aggravating, maintaining, and/or relieving factors, if any: academic difficulty (aggravating and maintaining factors), head massage by mother (relieving factors)*

History of Presenting Illness

This includes information about how the present illness developed. The last time when the child or adolescent was well should be noted and the time of onset should be established. The symptoms of the illness from the earliest time at which a change was noticed until the present time should be noted chronologically, in a coherent manner. The presenting chief complaints are expanded and in particular, any disturbance in physiological functions like sleep and appetite should be elicited. Presence of any suicidal ideation should be inquired and important negative history should be noted. A life chart can be included to provide a valuable display of the course of illness and episodic sequence, polarity, frequency and relationship to stressors and response to treatment.

Example illustrated with case vignette is as follows:

The child was apparently well 8 months back. She failed in a class test, following which her teacher scolded her in front of the whole class. She started having headaches in the frontal region of her head every day. She reported having constant pain in her head throughout the day, especially in the morning when she had to go to school. The pain was relieved if she was allowed to stay home and not go to school by her mother or when her mother massaged her head. She started performing poorly at school and would score poorly on her examinations. Her parents would repeatedly scold and coax her to study and this would increase the pain. No visual aura, nausea, projectile vomiting was present. Her sleep and appetite were normal. Her eyesight was 6/6 as checked by a doctor 6 months back.

There was no history suggestive of seizures, loss of consciousness and head injury, depressive symptoms, conduct problems, attention and hyperkinetic symptoms, mental sub normality and pervasive developmental disorders.

Past Psychiatric and Medical History

This includes information about any psychiatric and medical history of the child or adolescent. In case of adolescents, it may be important to explore any history of alcohol or any other substance use as well as hospitalization due to psychiatric issues. Past medical history of any serious medical, neurological or surgical illness, operations and hospitalization should be obtained. The nature of treatment given should be noted. History of head injury, convulsions, unconsciousness, or diabetes should be specifically asked.

An example to illustrate the past psychiatric and medical history through the case vignette is:

There was no history of any medical and psychiatric illness.

Treatment History

The details of treatment given for the present illness or any previous illness should be asked and the response/compliance should be noted. This can be illustrated through the case vignette as follows:

The child was shown to the local physician for complaint of headaches and he had prescribed her Paracetamol 500mg SOS. She did not receive any other treatment. Her mother would give her the medicine sometimes but not every day for the headache.

Family History

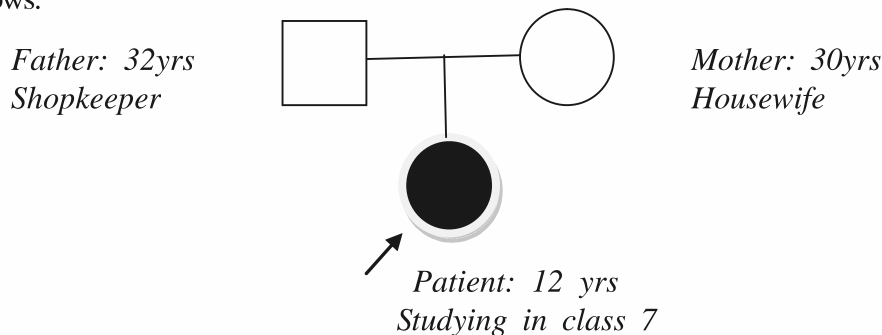
This includes information about the family of origin (i.e., parents, siblings, etc). The family history is recorded under the following heads:

- Family Structure: This includes drawing a ‘family tree’ (pedigree chart). The type of family, i.e., joint or nuclear, etc. should be noted along with the age and cause of death (if any) of family members.
- Family history of similar or other psychiatric illnesses, major medical illnesses, alcohol or drug dependence and suicide (and suicidal attempts) should be recorded.

- Current social situation: Home circumstances, per capita income, socio-economic status, leader of the family (nominal and functional) and current attitude of the family members towards the child or adolescent's illness should be noted.

Additionally, the communication patterns in the family, range of affectivity, cultural and religious values and social support system should be enquired about wherever relevant.

The family history with the aid of the case vignette can be illustrated as follows:



There is no history of any psychiatric or medical illness in the family. The adolescent belongs to a lower socio-economic nuclear family. There are cordial relationships among family members. The father is the head of the family and takes all decisions for the family. Both parents are extremely concerned about the patient's illness. They are very religious.

Personal History

This includes history about the child or adolescent's development, education and play as well as his or her temperament. The personal history is covered under the following heads:

Perinatal History

This includes history of any febrile illness, medications, drugs and/or alcohol abuse, trauma to the abdomen and any physical or psychiatric illness during pregnancy (particularly in the first trimester, that is, first three months of gestation). Other information includes whether the child or adolescent was a wanted or an unwanted child, date of birth, whether normal or abnormal delivery, any instrumentation, where was the child born, any complications (e.g., jaundice, convulsions), birth cry, any birth defects or premature delivery.

This can be illustrated through the case vignette as follows:

There was no history of any illness or complications during pregnancy. She was a wanted child, born on 29.08.1997. Her mother had a full term normal delivery at home with the assistance of a local nurse (dai) and birth cry was present.

Childhood History

This section includes information regarding whether the child or adolescent was brought up by the mother or someone else, breast feeding, weaning and any history suggestive of maternal deprivation. The age of achieving important milestones should be noted. Additionally, the presence of neurotic traits such as stuttering, stammering, tics, enuresis, encopresis, night terrors, thumb sucking,

nail biting, head banging, body rocking, morbid fears or phobias, somnambulism, temper tantrums and food fads should be noted.

This can be illustrated with the case vignette as follows:

The child was brought up by her mother and breast fed till 1 year. Her mother could not recall the exact age of achieving the developmental milestones but reported that in comparison to other children, the motor, speech and adaptive milestones were attained normally. The child would throw temper tantrums if her demands were not met with and would often bite her nails.

Educational History

This includes the age of beginning education, academic achievements and relationships with peers and teachers. Any school phobias, non-attendance, truancy, any learning difficulties and reasons for termination of studies (if it occurs prematurely) should be noted.

This can be illustrated with the case vignette as follows:

The child was enrolled into school at 4 years of age. She has been an average performer at school, obtaining 60-70% marks in examinations. She has cordial relationships with her peers at school. However, is fearful of teachers, particularly of an English teacher, who had scolded her 8 months back for failing in a class test in front of the class. She reported taking frequent leaves from school after that incident.

Play History

This section includes information regarding which games were played at what stage, with whom and where. The relationships with peers, particularly opposite sex should additionally be recorded here.

This can be illustrated with the case vignette as below:

The child would prefer to play on her own. She would play ghar ghar (house house) at home alone and sometimes with her mother. Presently she goes to the park with her mother to play badminton. She is shy and doesn't make friends easily. She has 2 close friends, who are her classmates. She is very shy in talking to opposite sex peers.

Puberty and Menstrual History

This includes the age at menarche and reaction to menarche, age at appearance of secondary sexual characteristics, masturbation and any anxiety related to puberty changes. The regularity and duration of menses as well as any abnormalities during the menstrual period are also noted.

This can be illustrated through the case vignette as follows:

The patient attained menarche at the age of 11 years. She was very anxious and cried a lot on attaining menarche. Her secondary sexual characteristics started to develop at the age of 11 years. Her menses lasted for 4 days and were regular. However she reported having abdominal cramps during menstruation.

Temperament

This section includes details regarding the child or adolescent's temperament. It is helpful to note the details of the following heads:

- Interpersonal relationship – This explores the relationships with family members and friends, introverted/extraverted nature as well as ease of making and keeping social relations.
- Use of leisure time – This includes hobbies, interests, etc.
- Predominant mood – optimistic or pessimistic, stable or prone to anxiety, cheerful or despondent, as well as reaction to stressful life events.
- Attitude towards self and others – level of self confidence, self criticism, selfish or thoughtful of others, self appraisal of abilities, achievements and failures.
- Attitude towards studies and responsibilities – decision making, acceptance of responsibility, etc.
- Habits – food fads or use of substances by adolescents.

This section can be illustrated through the case vignette as follows:

The patient was slow to warm up to people but was very emotionally attached to her mother. She had few close friends and was shy to make friends. During her leisure time she would watch TV or play with her mother. Her predominant mood was anxious and she had low levels of self confidence. She would take responsibility at home and would help her mother with home chores. She would however not take responsibility at school and would not be regular in doing her homework.

Mental Status Examination

This includes a detailed description of the child or adolescent's current mental functioning, which is obtained through observation and specific questioning (Saddock & Saddock, 2007). The mental status can be assessed under the following subheads:

- **Physical Appearance** – The interviewer reports the child's size, grooming, nutritional state, bruising, head circumference, physical signs of anxiety, facial expression and mannerisms. Example from case vignette: *the patient was a 12 year old adolescent girl, average height and build and well groomed and kempt. She was fidgeting with her dupatta and did not make eye to eye contact. She did not greet the interviewer and took the chair on offering. Rapport was established with difficulty.*
- **Parent-child Interaction** – The interaction between the child and parent can be observed during the waiting before the interview and in the family session. The manner in which the parent and child interact may reveal important clues to the emotional overtones. Example from case vignette is: *the patient was sitting very close to her mother and at times would want to sit in her lap during the interview. At times, she would whisper in her mother's ear to respond on her behalf when asked questions during the interview.*

- **Separation and Reunion** – The interviewer should note the manner in which the child or adolescent responds to separation from the parent for individual interview and reunion. Lack of any affect on separation from parent or severe distress on separation may indicate problems in the parent child relationship or any other psychiatric disturbance. Example from case vignette is: *the patient was not comfortable and started crying when she was asked to be interviewed separately.*

- **Orientation to Time, Place and Person –** The age of the child should be kept in mind when assessing orientation as a very young child may not know the date or may falter with chronological information. Impairment in orientation may be suggestive of a thought disorder or organicity. An example with the case vignette can be: *the patient was oriented to time, place and person.*

- **Speech and Language** – The rate, rhythm, spontaneity, latency to answer, intonation and articulation should be noted. Example: *the patient's speech was slow and not spontaneous. She could articulate clearly and would answer after a pause.*

- **Mood –** The child's predominant mood such as sadness, anxiety, anger etc. Example of case vignette: *the child's mood was anxious.*

- **Affect –** The range of emotional expressivity, appropriateness of affect, sudden emotional shifts should be noted. Example of case vignette: *affect (objective): anxious, affect (subjective): "theek hu" (I'm fine).*

- **Thought Process and Content** – The content of thought and form such as obsessions, suicidal ideation, delusions should be explored. Example of case vignette: *there was no abnormality in thought process and content.*

- **Social Relatedness –** The responses to the interviewer, social skills, eye contact, degree of familiarity or withdrawal in the interview process. Example: *the child did not greet the interviewer and she was shy and withdrawn during the interview and would at times ask her mother to respond to the questions. Eye to eye contact was made but not sustained. Her social skills were poor.*

- **Motor Behaviour –** This includes examining the level of activity and ability to pay attention. Signs of involuntary movements, hyperactivity etc. should be noted. Example: *the psychomotor activity of the patient was increased. She was constantly fidgeting with her dupatta.*

- **Cognition –** This includes assessment of the child or adolescent's intellectual and problem solving abilities as well as his or her level of comprehension. Example: *the patient was able to tell the differences between chair and table and adequately responded to the questions pertaining to if there is a fire in the house, what should be done. Her attention was aroused but not sustained. Her cognitive abilities were inferred to be average.*

- **Memory –** School age children should be able to name 3 objects in 5 minutes and repeat 5 digits forward and 3 digits backwards. Anxiety may interfere with the child or adolescent's performance and should be

kept in mind when assessing memory. Example: *the patient's immediate, remote and recent memory were found to be intact.*

- **Judgement and Insight** – The child or adolescent's view of the problems, reactions to them may give an estimate of judgment and insight. Example: *the patient attributed her headaches to some illness and wanted to become a dancer when she grew up. The judgement and insight was partial.*

Diagnostic Formulation

This section involves a conceptualization of the case to arrive at a diagnosis. It includes both positive and negative history and significant findings on the mental status examination. This can be illustrated through the case vignette as follows:

A 12 year old adolescent girl, studying in class 7, belonging to lower socio-economic status with no family history of psychiatric illness, presented with repeated headaches in the frontal region, anxiety and academic problems after being scolded by her teacher on failing on a class test. The mental status examination revealed anxious mood and affect, poor attention span, increased psychomotor activity and partial judgement and insight. However, her cognitive abilities, orientation and memory were intact.

Provisional Diagnosis: Somatoform Pain Disorder

ASSESSMENT

This is an important part of case conceptualization. It includes intelligence or cognitive testing as well as personality testing. The goals of assessment include: firstly, to establish whether possibility of any physical disease has been ruled out. Secondly, to engage the patient in a therapeutic process. Thirdly, to gain information regarding case formulation of the presenting complaints. Lastly, to understand the medical and psychological conditions that the person is suffering from. The assessment strategies can be discussed as below:

- *Interview*

This involves interviewing the child/adolescent and informant regarding the symptoms, history of development of symptoms, personality/temperament of the child (easy going, difficult), any associated medical conditions, history of psychiatric illness in family and developmental history. This can also be supplemented with a mental status examination

- *ABC Chart, Diary*

The child/adolescent is asked to maintain an ABC chart to record the situations, beliefs and consequences to help identify maladaptive thought, feeling and behavioural patterns. A daily record of dysfunctional thoughts can be maintained in which the situation, thoughts, feelings and behaviour can be recorded. The symptoms, severity and frequency can also be monitored through a symptom diary. The caregiver may be asked to maintain the symptom diary so as to be a co-therapist in the therapeutic process. Examples of an ABC chart, Daily record of dysfunctional thoughts are illustrated in the Figures 1 and 2.

A (Antecedent/ Situation)	B (Beliefs/ Thoughts)	C (Consequences)
While doing homework	"I cannot understand anything"	Feels irritated and starts crying
Mother scolds the child for not behaving properly	"Nobody loves me"	Gets angry and throws a temper tantrum

Figure 1. **Example of an ABC Chart**

Situation	Thoughts	Feelings (0 – no distress, 100 – extreme distress)	Behaviour/ Symptom (0 – no distress, 100 – extremely severe)
Doing homework	"I can't do anything properly"	Irritation (80)	Headache (90)

Figure 2. **Example of Daily Record of Dysfunctional Thoughts**

- *Self Report Measures and Projective Techniques*

Certain paper-pencil tests or questionnaires as well as certain projective techniques can be employed to elicit maladaptive patterns of thinking, feeling and behaving.

- *Observation*

The child/adolescent's maladaptive patterns of emoting and behaving can be observed and recorded while he/she is at home or school (teacher and parent reports), while waiting for the therapy session and during the therapy sessions. These can be useful in helping the child learn adaptive coping patterns and for social skills training.

THERAPY

The steps or techniques involved in the management of psychiatric disorders in childhood and adolescence as illustrated with case vignette can be elucidated as below:

- **Initial Phase**

The first session is focused on forming a working therapeutic alliance with the patient and psycho-educating the patient regarding the nature and course of chronic headaches as well as the role of stress and other psychological factors in precipitating and maintaining the illness.

Example:

The patient and her mother were informed that the problems or distress experienced by the patient was not due to a medical condition but due to anxiety and psychological problems. The mother was separately educated that paying attention to the symptoms will lead them to persist. She was

made aware that her massaging the patient's head was reinforcing the pain behaviour.

Goal setting

The treatment goals identified prior to therapy include objective and realistic goals. A contract regarding number of sessions can be negotiated at this stage with the patient as per the goals delineated. Example:

The goals identified for Ms. X were to reduce anxiety and pain behaviour and develop study skills.

- **Interventions**

Certain behavioural interventions can be used in management of psychiatric disorders (Beck, 1995). These can be illustrated through excerpts from case vignette as follows:

- *Relaxation exercises* – These include abdominal breathing, tensing and relaxing muscle groups progressively. *Example: Ms. X was asked to do breathing exercises by focusing 15 times on the stomach, chest and nose respectively. She was asked to do them twice a day with half an hour interval before and after doing the relaxation exercises.*
- *Imagery* – The child/adolescent is asked to imagine a pleasurable scene, *for example, a garden, beach etc. and focus attention on the details of the scene like the colours, smells etc. to have a calming effect.*
- *Distraction techniques* – These techniques involve taking one's attention away from the symptoms and refocusing the attention to other neutral or pleasurable stimuli. *Example, since the patient is experiencing pain, she may be asked to divert her attention away from the pain by dancing or playing games with her mother.*
- *Study Skills* – These involve using methods like reading aloud and making notes instead of silently reading and taking small breaks (10 min.) which involve drinking water but not activities like TV.
- *Contingency Management* – This is a behavioural strategy, which involves reinforcing positive behaviours. This can be done through token economy (e.g., giving child a token for every positive behaviour and then the child can exchange a number of tokens for something tangible he/she likes), star charting (providing stars for positive activity and then if the child has stars every day for the week, he/she can be rewarded). An illustration of the star chart for the patient to do homework and play with other friends is provided in Figure 3.

Activity	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Doing homework	☆	☆	☆	☆			
Playing with other friends	☆		☆	☆	☆		

***Figure 3:* An Example of a Star Chart**

- **Terminating Therapy**

The patient was encouraged to take more responsibility while ending therapy. The therapist discussed the possibility of minor setbacks involved when terminating therapy. The goals of therapy as well as the process of therapy were reviewed with the patient and practising the techniques which have proved to be effective for the patient was reinforced by the therapist. This is followed by booster sessions. Example:

The patient was asked to follow through with the techniques taught and the mother was reminded not to reinforce pain behaviours. She was asked to come for follow up sessions.

GLOSSARY

Case History Interview : It involves interviewing the child or adolescent and the informants, who may be parents or caregivers regarding the problems or distress experienced by the child or adolescent. This includes information regarding the history of the problems experienced and the developmental, personal, familial and social factors which may contribute to the development and maintenance of the distress.

Contingency Management : This is a behavioural strategy, which involves reinforcing positive behaviours.

Distraction Techniques : These techniques involve taking one's attention away from the symptoms and refocusing the attention to other neutral or pleasurable stimuli.

Imagery : The child/adolescent is asked to imagine a pleasurable scene e.g., a garden, beach etc. and focus attention on the details of the scene like the colours, smells etc. to have a calming effect.

Mental Status Examination : Includes a detailed description of the child or adolescent's current mental functioning, which is obtained through observation and specific questioning.

Observations : Recording behaviour in various situations by observing the actions of the child or adolescent.

Relaxation exercises : These include abdominal breathing, tensing and relaxing muscle groups progressively.

FURTHER READINGS AND REFERENCES

Ahuja, N. (2001). *A Short Textbook of Psychiatry.* New Delhi: Jaypee.

Saddock, and Saddock, (2007). *Kaplan and Saddock's Synopsis of Psychiatry – Behavioral Sciences/Clinical Psychiatry.* New Delhi: Lippincott Williams and Wilkins.

BASIC UNIT 4 : FUNDAMENTALS OF DOING AND RECORDING CASE WORK

INTRODUCTION

Important guidelines for working with cases

For working with a case you have to first identify the case — an individual or a family, who is willing to take counselling/family therapy sessions with you to resolve their problems. Confidentiality, trust buiding, rapport formation, sensitivity and neutrality are among the key points which need to be remembered while handling a case.

- Seek the consent from the case — individual/family before conducting counselling/family therapy. For each case, separate consent needs to be taken. The consent form is enclosed at the end of this Manual.

- The time schedule for conducting the counselling/family therapy sessions should be planned according to the convenience of the family or the individual with whom the sessions have to be carried out.

- Be punctual for your appointment; and if there is any change in time or day inform the concerned family or individual and also expect the same from them.

- Before conducting any session, you should have thorough knowledge of the theoretical components as well as thorough understanding of the procedures.

- Respect the views of the individual(s) involved, and do not interrupt or show your own attitude, opinion or prejudice regarding what they are saying or doing. The process should not be biased by your view points. Keep the information confidential, and do not discuss it with any other person including your friend, spouse, parents and other family members. You have to discuss the case with you Supervisor though.

- In a case where the family or the individual refuses to cooperate with you, or you feel that therapy/counselling is not successful or making a desired impact, or if the individual/family stops coming for counselling/family therapy and you are forced towards unplanned termination, you would have to accept the case work as incomplete, and a learning exercise rather than a case you may submit for evaluation in your Supervised Practicum. You would then need to identify another case to carry out your work.

- Your Supervised Practicum File must have two case works, one involving individual counselling (minimum 7 sessions) and one involving family therapy (minimum 12 sessions).

Important points to keep in mind while carrying out the case work:

Intake of the client(s) should be recorded. If it was through any referral, their comments/suggestions should also be recorded.

Give due emphasis to rapport formation, senstivity, objectivity and neutrality.

Your report for each case work should include the case history and mental status examination of your respondents.

Make an assessment through genogram and family line. Carry out genogram analysis and find out whether the problem occurred in any previous generation(s). At least 2-3 stage genogram analysis has to be done. Identification of repeat of any problem seen in the client with the family members from past generations should be probed further and noted.

Family history taking interview should begin from the client's present family life cycle stage and proceed backwards.

Understand power, hierarchy, subsystems in the family from therapeutic viewpoint.

Identify of stressors in your client. Help your client in coping with stress.

Understand manifestations of the problem in the family.

Note down hypothesization formulated by you in each case.

Understand handling resistance to change in the client.

Note: The tools for case history taking, mental status examination and semi-structured family interview schedule were given in the first year supervised practicum courses. Use the ones relevant for the individual whom you have identified for the specific case. For children/adolescents you would use Case History Taking of Child/Adolescent and Mental Status Examination Inventory. From the Family Interview Schedule, use the areas/topics relevant for the individual/family, whom you have identified for the specific case work. In the first year practicum courses, you have also learnt about assessment through genogram.

Listing of what has to be done with the client(s):

List all the characters in the case record including your client.

List all the worries, problems, ailments, feelings or disorders which your client has reported.

List all the worries, problems, ailments, feelings or disorders which you feel are likely to exist and the client is unaware of.

Give reasons as to why do you think the client must be experiencing both — something in particular which client(s) is unaware of and something which client(s) is aware of.

Find out your client's purpose in coming to you.

Summarise and interpret what the client has reported to you.

Transform the problem statements made by your client into goal statements.

Set realistic goals mutually with your client and describe the same.

Explore the possibilities to reach the goal(s) and list them. Plan both long term and short term goals. Long term goal is the outcome expected after completion of the counselling/therapy. Short term goal is for one or two/ three therapy/counselling session(s).

Develop a plan to reach the goal together with the client and explain the same.

Evaluate your own progress at the end of each session as well as after completion of the process of counselling/family therapy.

Use circular questioning with your client(s).

Observe neutrality in your sessions.

Involve all family members who are willing to participate in your session.

Try to involve the important (who influence the client) family members in the family sessions.

Assign home work assignments and ask about the follow-up in the next session.

Clearly hypothesize the reasons for the problem.

Discuss which therapeutic approach has to be used with the client(s) with your Supervisor. Substantiate your choice of therapy with reasons.

Evaluate the success or failure of your therapy and critically analyse the reasons for the same.

Inform the client 2-3 sessions early about the termination of family therapy/ counselling.

Tips for Counselling/Family Therapy Sessions

Note whether the client was on time, late, or much before time for the meeting. This should be noted especially for the first appointment, and also for all other subsequent meetings.

Explanation of the meaning of the term family therapy and counselling to the client(s) needs to be done.

Note down the number of family members to be involved in the therapeutic sessions; and the number and relations of family members who can participate in the sessions.

Write a brief description of the problem diagnosed in the patient/family/ or the index patient in the family. Here Index Patient would be the person or family member who is thought by the family members to have a problem and is the basic reason for the family to seek intervention or family therapy.

Make an assessment of the environment or climate as seen at the time of each therapeutic meeting/session and note it down; for instance: whether the emotional atmosphere was warm, the rapport between the client(s) and the therapist and the rapport among the family members. The following terms are commonly used:

Noisy – The client(s) were fighting with each other or one person was cutting the other person's thoughts.

Cool – The client(s) pretended not to be affected by the problems so displayed a cool behaviour.

Anger – At a particular family member.

Loud – The client(s) were shouting.

Calm – The client(s) calmly participated in the session.

Warm – The client(s) displayed warmth towards each other.

For each therapeutic session this has to be noted. At times the atmosphere may change from beginning to the end; it should also be noted.

You and the client should agree to a contract containing long term goals of therapy.

Short term goals of therapy need to be outlined with the client(s).

Intake is to be a small session of 20-30 minutes. The therapist needs to understand the presenting complaint in systemic perspective.

During your student/trainee period when studying this course, you are NOT permitted to charge your patients i.e. take money/gifts. But, later on as a professional in actual practice, before and during your intake session you should tell about fees of a session and approximately how many sessions you would have, the frequency of the sessions and timings of the same to the client in the first meeting. At times you may take 2-3 sessions to decide upon the problem and number of sessions required.

Now, after understanding the client(s)' problem you have to decide upon the specific theory(ies) and therapy(ies) you would use. You have to give reasons for the choice of theory and therapy after understanding the client(s)' problem.

In most of the cases, you would have to psychoeducate the index patient's family regarding the problem/mental disorder the patient is suffering from.

Here, we would like you to give a description of what psychoeducation you provided and how did you go about it.

In dealing with especially children, adolescents and at times young adults with poor social mental functioning you may need to do social skills training and provide life skills education.

Here, we would like you to give a description of what and how you provided social skills training and/or life skills education.

In your family interview of the client(s) you have to note down the family life cycle stage of that person. Note down the roles and responsibilities, tasks carried out by the family, disciplinary techniques used by the family, understand the individual life span development of the individual, and so on. You have to find this by asking various relevant questions.

In your understanding of the client(s) understand the deviations from the norms as specified by the culture to which one belongs. These understandings have to be from both life span and family life cycle perspectives.

Identify the stressors, hierarchy, power arrangements, alignments,

triangulations, etc. in the family.

While doing individual counselling/therapy you have to note down the perceptions of the individual regarding the family members and their impact on the individual.

Please remember that it is the perception that one has about others' thoughts and feelings that has influence on us and our therapy.

Note down how did you as a counsellor/family therapist manage your personal issues, stress and anxiety.

Were you able to maintain the confidentiality issues? Now, please remember that as a trainee your have to discuss all the issues and concerns of the client with your Guide/Supervisor. You are not breaching confidentiality issues!

Note down if the client(s) had sought help before, when, what was the reason for seeking help and was the 'help' successful in resolving the client(s)' problem.

Note down client(s)' expectations from therapy. In family therapy sessions, each family member's expectations from therapy need to be ascertained. Then a common therapy goal among the family members needs to be found out.

Note the instances that describe your understanding of the following:

– What did the facial expressions of the client(s) indicate?
– Was there maintenance of eye contact?
– Was there failure at times in maintaining eye contact?
– What was the body position of you and your client(s)?
– How much space was there between you and your client(s)?
– Did you fall in the common therapist's traps in your therapeutic sessions?
– How did you get out of the trap?
– What was 'your role'/your self's role in therapy?
– What kind of therapist/counsellor and client relationship get formed?
– What professional and ethical issues did you take special care of?
– In what kind of therapeutic sessions were you an effective active listener?
– Did you preach too much on moralistic grounds?
– Did you allow your client to speak?
– Did you allow your client to speak on non-relevant issues?
– Were you able to bring the client to speak on the relevant issues?
– How did you stop the client from diverting from the main issue or speaking on not-relevant issues of that particular session — were you blunt or polite, how did you handle it?

- Was your relationship with your client affected by the client's and therapist's age, gender, disability, socio-economic status, etc.? Please elaborate.
- How was the attitude of the index patient towards counselling/family therapy?
- What was the attitude of the other family members called for therapy towards counselling/family therapy?
- Who decided who all would attend the family therapy sessions?
- Describe the client's and his/her family's motivation for change.
- How did you use reflection with your case?
- Explain use of transference and counter-transference in your client-counsellor/therapist relationship.
- What kind of resistance did you face during therapy?
- How did you handle resistance to therapy?
- Explain one situation that required your coping skills during counselling and family therapy sessions.
- How did you deal with this situation?
- When and how did you discuss these situations with your Supervisor?
- What was the role of your Supervisor in these situations?

To bring the client back to the point you may say, "All right, what issue you are discussing is important, but at present we need to focus on .... we will come to this issue later".

Never adopt a high-handed attitude in a session.

Note down the home work tasks assigned to the client. Remember to take feedback regarding the home work assignment from your client in the next sessions.

If you will not take feedback, then they would think it is not important to follow the home work tasks.

You have to ask your client regarding their anxieties, fears and expectations.

Note down the kind of the environment that was present during each therapy/counselling session.

Note down, if any specific therapeutic technique was used, why did you use it and details related to it. Obtain your Supervisor's permission to use that technique.

Do proper record keeping.

One counselling/family therapy session is equal to one hour approximately.

Note down the number of sessions, duration of a session, as well as details of each session.

In your file, submit as appendices and enclosures the audio/video cassette/ CD and transcripts, record sheets used at the time of interviewing/observing/ counselling/family therapy, etc.

In actual practice, gap between sessions should be neither too less nor too much. However, for your Course you need keep the sessions with less gap.

Preparation of Case Records

In your Supervised Practicum File as described in this Manual, you are required to submit two case records; one pertaining to individual counselling and one pertaining to family therapy, from the stipulated area. The minimum number of sessions, each of about 1 hour duration is 7 for a counselling case work and 12 for family therapy case work. You may, of course, conduct more sessions in a case, if required.

For the pupose of the File, your case record (that would be evaluated by an external expert) would need to be a summative, critical account of all the sessions put together, with relevant excerpts and examples interwoven as required. Details of individual sessions (including details of each session; transcript of each session; and records pertaining to case history, mental status examination, genogram analysis, family interview, etc. and audio/video cassette/CD and transcript sheets) are to be provided as appendices/enclosures in the Report/File, for the external expert to refer to.

FRAMEWORK OF CASE RECORDS

Referral & Intake

Assessment of the individual/family in terms of:

- Knowledge about illness
- Physical/Emotional/Financial/Household routine burden
- Basic needs
- Social support available
- Reaction of family members
- Impact of illness

Intervention Adopted

- What was the specific counselling/family therapy technique adopted with the client(s).
- Why was this technique chosen? Give clear reasons, with examples from your patient's case.
- How was the counselling/therapy implemented? Give details of the sessions.

Psychoeducation

- Whether needed
- Was it done
- How

Difficult situations encountered

- List down all the situations with your client which you found difficult to handle. Explain in detail.
- How did you handle these situations.

Reflections

- Note down your reflections for the case.
- Were you always right in your reflections? Give examples of when your reflections were right and when wrong.

Barriers in Communication and Handling Emotional Outbursts

- Were you able to handle the communication with the client effectively in all the sessions?
- List examples when you were not able to manage proper communication.
- What measures were undertaken by you to handle communication.
- How did you handle emotional outbursts.

Termination and Follow up

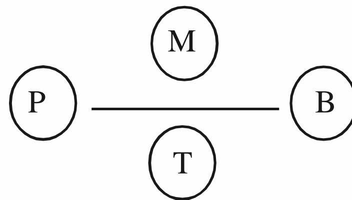
- Did you terminate at the appropriate time or abruptly? Was the termination planned or unplanned? Give details.
- Did the client stop coming without information?
- Were some tasks given at termination to be assessed in the follow up sessions? Write details.
- Did you follow up the case?
- Was therapy showing any positive/negative/no impact in the life of the client(s) after termination of the therapy? Elaborate with examples.

For each session, following points have to be recorded:

- ☞ Number of participants
- ☞ Details of participants
- ☞ Aim of the session (Intake/which phase of therapy)
- ☞ Emotional atmosphere (how was the emotional atmosphere during the session)
- ☞ Duration of the session
- ☞ Date
- ☞ Main themes in each session

- Details of any psychological assessment/tool if used or carried out
- Sitting arrangement (Shows how clients and toherapist were sitting, who was proximally closer to the therapist, etc.)

Examples:-

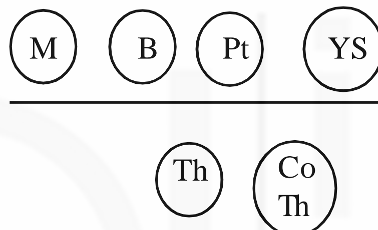


Here, P - Patient

M - Mother

B - Brother

T - Therapist



Here, M - Mother

B - Brother

Pt - Patient

YS - Younger Sister

Th - Therapist

Co Th - Co-Therapist

Please Note

- You have to submit 2 case works complete with intake, initial phase, middle phase and termination.
- One of the case works should involve counselling, and one should involve family therapy, from the specified area.
- Each counselling case record should include at least 7 sessions, while a family therapy case record should include at least 12 sessions. While you may take more sessions if required in a case, taking lesser number of sessions than stipulated is not permitted. Such a case would be rejected, and the Supervised Practicum deemed incomplete.
- Remember each session is of about 1 hour.

REPORT WRITING AND EVALUATION OF CASE RECORD

PARAMETERS FOR CASE EVALUATION

The report you prepare should be so designed and presented that it showcases your knowledge, skills acquired and competencies achieved for practice in counselling and family therapy profession. These are points which have to be noted by the Supervisor also.

Each counselling/family therapy case record would be evaluated on the following tasks performed by you:-

- Intake
- Initial phase
- Middle phase
- Termination
- Follow up
- Your understanding of the case
- Planning a therapeutic (counselling/family therapy) session
- Handling of ethical issues
- Sensitivity and skills applied with the case
- Adequacy and effectiveness of counselling/therapy
- Suggestions for improvement
- Honest reflections
- Regularity

Submission of original transcriptions of the sessions, along with CDs/audio tapes is compulsory.

You have to submit ***two complete case records.***

One case record has to be from counselling perspective and one case record has to be from family therapy perspective.

PART II

PRACTICALS TO BE DONE

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PRACTICAL 1: REVIEW OF AN ORGANISATION WORKING IN THE FIELD

You have to review one organisation or centre working in the area of child and adolescent counselling and family therapy. Visit the organisation/centre, discuss with the functionaries and service providers, and also meet the beneficiaries and others to obtain the desired information.

You have to review the organisation/centre with respect to administration, therapeutic services provided, research and training, aim and mission of the organisation/centre etc. The organisation/centre identified by you for review should be one that is working in the area of child and adolescent well-being. It could be a child guidance centre or a counselling unit in a school, day care centre, juvenile home or remand home etc., or it may be any governmental, private or non-governmental organisation/centre/institution etc., involved in providing child and adolescent counselling and family therapy.

In your Report on the organisation/centre, include information pertaining to the following heads:

Name and address of the Organisation/Centre.

Organisational and administrative set up of the institution/organisation including board or governing bodies of the centre. History of the organisation.

Aim and mission of the centre/organisation.

Whether the organisation/institution is registered.

Professional support and services available at the centre/organisation. Focus on the domain of child and adolescent counselling and family therapy.

The kind of benficiaries that approach the organisation/centre for help and the nature of problems/issues they seek help for.

Target group of beneficiaries, and how the services are envisaged to reach the target beneficiaries.

Funding sources of the organisation/centre.

Infrastructural facilities present.

Relationship with other governmental, non-governmental and private agencies, and type of association with them.

Relationship with local bodies like panchayats, community based organisations, etc.

Job description of employees.

Community recognition and awards received.

Future plans of the centre.

Your reflections about the centre (It should include your impression about the centre, its functioning, its strengths, its weaknesses, etc.; what insight you got from being at the centre; what you learnt in terms of knowledge, skills and attitudes; how could the centre be more productive according to you; and so on. Write the honest impression you had).

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PRACTICAL 2: ACCLIMATISATION SESSIONS

Before conducting the counselling/family therapy sessions yourself, it would be a good idea for you to observe how your Guide/Supervisor engages in child and adolescent counselling and family therapy, as well as carry out some mock sessions or role play in the presence of the Supervisor.

At least 4-5 such sessions would be very useful. Include a detailed report on these acclimatisation sessions in your Supervised Practicum File.

Thus, for this practical, you have to report in the File in detail how these sessions were carried out, and in what ways did these sessions help you.

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PRACTICAL 3: COUNSELLING CASE WORK

In this supervised practicum, you are required to prepare a case record comprising 7-10 counselling sessions. Thus, you need to be involved in counselling a child or adolescent, from the initial phase onwards, and prepare a record of the same. The case work must involve at least 7 counselling sessions; though you may take more counselling sessions with the client if required.

Steps to be followed:

- Identify a case (child/adolescent) requiring counselling.
- Your counselling case work should start from the initial phase, and progress till termination.
- In this practical, you have to apply therapeutic interventions from counselling perspective under the guidance and supervision of your Supervisor.
- **Refer to Basic Unit 4 in this Manual to learn about how you need to do the case work and record the same.**
- Prepare a record of the sessions and draw inference of each session in the end.
- At the summative level of the case record, give a summary about the client, the presenting problem, intervention strategy used, achievement or progress of each session, changes seen etc.

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PRACTICAL 4: FAMILY THERAPY CASE WORK

In this supervised practicum, you are required to prepare a case record comprising 12-15 family therapy sessions. Thus, you need to be involved in family therapy of a child/adolescent (involving the family members), from the initial phase till middle phase or termination (as the case may be), and prepare a record of the same. The case work must involve at least 12 family therapy sessions; though you may take more sessions if required.

Steps to be followed:

- Identify a case (child/adolescent) needing family therapy interventions.
- The family therapy interventions should include not just the Index Patient, but also his/her family members.
- Your family therapy case work should start from intake/initial phase upto middle/termination phase, as the case may be.
- In this practical you have to apply therapeutic interventions from family therapy perspective under the guidance and supervision of your Supervisor.
- **Refer to Basic Unit 4 in this Manual to learn about how you need to do the case work and record the same.**
- Prepare a record of the sessions and analyse each session in the end.
- At the summative level of the case record, give a summary about the client, the presenting problem, intervention strategy used, achievement or progress of each session, changes seen, etc.

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PRACTICAL 5 : CONDUCTING AN AWARENESS GENERATION CAMPAIGN IN THE COMMUNITY

You are required to conduct an awareness generation campaign in the community, regarding aspects and issues pertaining to child and adolescent well-being.

You are expected to devote 4-5 working sessions for doing this activity.

Steps to be followed:

Decide on a topic / aspect / theme / issue related to child and adolescent well-being, after discussing it with your Supervisor, that would be the focus of your awareness generation campaign.

In discussion with your Supervisor, plan the campaign. You would need to:

Decide on the methods and modalities of how you would conduct the awareness generation campaign in the community.

Consolidate the information, and the specific messages, that you would like to communicate to the community in the course of the awareness generation campaign.

Develop/prepare the materials to be used in the campaign.

Conduct the awareness generation campaign in the community, as per your plan and materials prepared. A multi-method approach is desirable.

Report of this practical must include details of:

- The rationale for the theme/issue selected by you for the awareness generation campaign. Give reasons for your choice of the particular topic.
- The planning of the awareness generation campaign. Provide detailed information on the above aspects.
- How you conducted the awareness generation campaign in the community. Provide detailed information on the modalities and methods adopted to disseminate the message or information on the theme selected, for awareness generation among community members. Enclose in the File, copies of materials you prepared and used in the campaign.
- The reaction and response of the people/community members.
- Impact of the awareness generation campaign, and how you assessed the same.
- Your accomplishments while conducting the campaign. Comment on how many people you were able to reach out to.
- Your limitations while conducting the campaign. What improvements would you bring about, if you were to conduct a similar campaign in future?
- Scope for future work in this direction.
- Your reflections on your attempt.

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ANNEXURE A

EVALUATION SHEET

Remember to attach this Annexure A (Completed Section 1, and Blank Sections 2 & 3) with the Supervised Practicum File when you submit the File for external evaluation at IGNOU. *Keep a copy with yourself.*

SECTION 1: Internal Evaluation by the Academic Counsellor at the Programme Study Centre/Study Centre

The following is the format in which the Academic Counsellor/Supervisor is required to consolidate the marks for the 5 Practicals done by the student. These marks should also be stated on each written Practical submission in the Supervised Practicum File.

Practical No.	Name of the Practical	Maximum Marks	Marks Obtained
Practical 1	Review of an Organization Working in the Field	50	
Practical 2	Record of Acclimatisation Sessions	100	
Practical 3	Record of Counselling Case Work	200	
Practical 4	Record of Family Therapy Case Work	300	
Practical 5	Record of Conducting an Awareness Generation Campaign in the Community	150	
	Grand Total	**800**	**Grand Total (*x*)**

- **Weightage of marks for Internal Evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained by learner } (x)}{800} \times 50 = \text{'N'}$$

Note : The pass percentage for Internal Evaluation is 40%. Therefore, if the learner gets **less than 20 marks** after calculating 50% weightage of total marks obtained, then the student has to **repeat the supervised practicum**. In other words, 'N' obtained should be at least 20 for the learner to pass.

The Counsellor is required to use the given formula to calculate the final marks out of 50, obtained by the learner in internal evaluation and to write this final score in figures and in words.

$$\frac{(x)}{800} \times 50 = \text{..........}$$

(Marks obtained out of 50 in internal evaluation to be written in both figures and words)

....

Academic Counsellor's/Supervisor's overall comments about the learner (use additional sheets, if needed).

....

....

....

....

....

Date:

Place: **(Signature of the Academic Counsellor/ Supervisor)**

Name & Designation of Academic Counsellor/Supervisor : ....

....

Address of Academic Counsellor/Supervisor : ....

....

E-mail Address of Academic Counsellor/Supervisor : ....

Phone/Mobile No. of Academic Counsellor/Supervisor : ....

Date:

Place: **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**

Name of Programme Incharge of PSC / Coordinator of SC : ....

....

Address of Programme Incharge/Coordinator : ....

....

E-mail Address of Programme Incharge/Coordinator : ....

Phone/Mobile No. of Programme Incharge/Coordinator : ....

SECTION 2 : To be Used for External Evaluation at IGNOU

The following sheet will be used by the Expert Examiner identified by IGNOU headquarters to evaluate the Supervised Practicum File submitted by the Learner.

Practical No.	Name of the Practical	Maximum Marks	Marks Obtained
Practical 1	Record of Review of an Organization Working in the Field	**50**	
Practical 2	Record of Acclimatisation Sessions	**100**	
Practical 3	Record of Counselling Case Work	**200**	
Practical 4	Record of Family Therapy Case Work	**300**	
Practical 5	Record of Conducting an Awareness Generation Campaign in the Community	**150**	
	Grand Total	**800**	**Grand Total (*y*)**

- **Weightage of marks for external evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained by learner } (y)}{800} \times 50 = \mathbf{S}$$

Note: The pass percentage for external evaluation is 40%. Therefore if the learner gets less than 20 marks after calculating 50% weightage, then the student has to repeat the Supervised Practicum. In other words, 'S' obtained by the student should be at least 20 to pass.

The external evaluator is required to use the above formula to calculate the final marks, out of 50, obtained by the learner in external evaluation and to write this score in figures and in words.

$$\frac{(y)}{800} \times 50 = \text{.............}$$

(Marks obtained out of 50 in external evaluation to be written in both figures and words)

....

Date: **(Signature of External Examiner of IGNOU Panel)**

Place:

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SECTION 3 : Grand Total of Marks for Inclusion in the Learner's Final Marksheet

Marks Obtained by the Learner in Sections 1 and 2 i.e. in both internal and external evaluation of Supervised Practicum are to be consolidated below by the External Expert (who did evaluation in Section 2)

Supervised Practicum (MCFTE-005)

Internal Assessment *(External Expert to write marks as stated by the Learner's Supervisor as 'N' at the end of Section 1 of Annexure A)* ***(Marks out of 50)***	**External Assessment** *(External evaluator to write marks here given by her/him as 'S' at the end of Section 2 of Annexure A)* ***(Marks out of 50)***	**Total marks obtained (T)** *(Expert to add marks 'N' and 'S' and write the total here) (N+S=T)* ***(Marks out of 100)***

GRAND TOTAL OF MARKS OBTAINED BY THE LEARNER (T) : ....

(To be written in both figures and words)

....

Date: **(Signature of External Examiner of IGNOU Panel)**

Place:

Name of External Examiner : ....

Address of External Examiner : ....

....

E-mail Addess of External Examiner : ....

Phone/Mobile No. of External Examiner : ....

ANNEXURE B

Certificate of Completion of Supervised Practicum MCFTE-005

Remember to enclose this Annexure in your Practicum File. Keep a copy with yourself.

(To be certified by the Academic Counsellor/Supervisor and the Programme Incharge of the Programme Study Centre or Study Centre Coordinator)

We certify that the student Mr. / Ms. / Dr. ....with enrolment number ....has carried out the stipulated 5 practicals of the Supervised Practicum of the course 'Child and Adolescent Counselling and Family Therapy' under our guidance and supervision. The Supervised Practicum File submitted herewith is the result of bonafide work done by the student for the supervised practicum MCFTE-005 from .... (start date) to .... (end date).

Date:

Place: **(Signature of the Academic Counsellor/ Supervisor)**

Name & Designation of Academic Counsellor/Supervisor : ....

....

Address of Academic Counsellor/Supervisor : ....

....

E-mail Address of Academic Counsellor/Supervisor : ....

Phone/Mobile No. of Academic Counsellor/Supervisor : ....

Date:

Place: **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**

Name of Programme Incharge of PSC / Coordinator of SC : ....

....

Address of Programme Incharge/Coordinator : ....

....

E-mail Address of Programme Incharge/Coordinator : ....

Phone/Mobile No. of Programme Incharge/Coordinator : ....

Dear Learner,

Photocopy this page, and place the duly filled-in copy at the end of each in your Supervised Practicum File.

Practical No. : ....

TO BE FILLED IN BY THE SUPERVISOR/COUNSELLOR

Counsellor's Comments:

....

....

....

....

....

....

MM for the Practical:..................

Maximum marks (MM) for review of organisation = 50

Maximum marks (MM) for acclimatisation sessions = 100

Maximum marks (MM) for counselling case record = 200

Maximum marks (MM) for family therapy case record = 300

Maximum marks (MM) for conducting awareness campaign = 150

Marks obtained by the learner :................

(The marks obtained by the learner in the Practical are to be written in both figures and words)

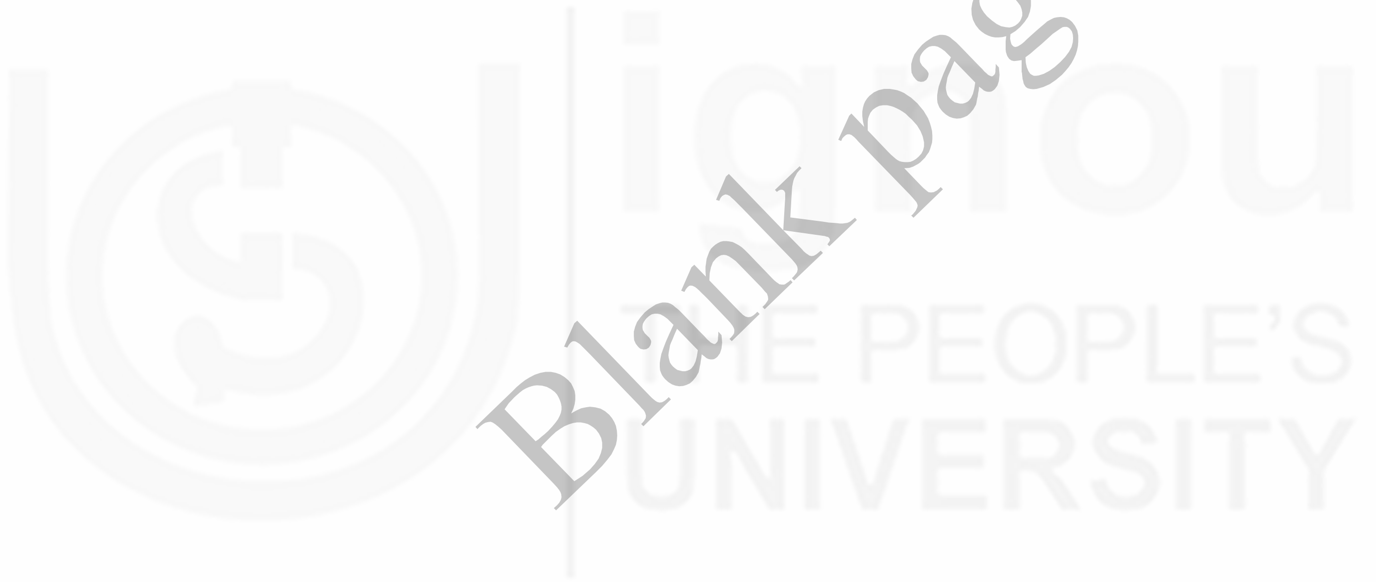
....

....

(Counsellor's Signature and Date)

....

(Counsellor's Name)



Sample of Permission Letter

I, ... (name of the student) am pursuing M.Sc. (CFT)/PGDCFT programme from IGNOU. I am attached to .... Regional Centre at Study Centre / Programme Study Centre...

....

(Name, Address and PSC/SC No.). I am doing Supervised Practicum of the Course 'Child and Adolescent Counselling and Family Therapy' — MCFTE-005 under the guidance of my Academic Counsellor/Supervisor .... (name of the Academic Counsellor/Supervisor). For the completion of my course work, I need you to grant me permission to interview you for about 1½ -2 hours as per your convenience. Please grant me permission and oblige.

(Student's Signature & Name)

(Academic Counsellor's Signature & Name)

(Name & Signature of the Persons to be Interviewed)