PSY 318
Child Psychopathology

PROPERTY OF DISTANCE LEARNING CENTRE, UNIVERSITY OF IBADAN

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Ibadan Distance Learning Centre Series

PSY 318
Child Psychopathology

PROPERTY OF DISTANCE LEARNING CENTRE, UNIVERSITY OF IBADAN

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Vice-Chancellor's Message

I congratulate you on being part of the historic evolution of our Centre for External Studies into a Distance Learning Centre. The reinvigorated Centre, is building on a solid tradition of nearly twenty years of service to the Nigerian community in providing higher education to those who had hitherto been unable to benefit from it.

Distance Learning requires an environment in which learners themselves actively participate in constructing their own knowledge. They need to be able to access and interpret existing knowledge and in the process, become autonomous learners.

Consequently, our major goal is to provide full multi media mode of teaching/learning in which you will use not only print but also video, audio and electronic learning materials.

To this end, we have run two intensive workshops to produce a fresh batch of course materials in order to increase substantially the number of texts available to you. The authors made great efforts to include the latest information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly. It is our hope that you will put them to the best use.

Professor Olufemi A. Bamiro, FNSE
Vice-Chancellor

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Foreword

The University of Ibadan Distance Learning Programme has a vision of providing lifelong education for Nigerian citizens who for a variety of reasons have opted for the Distance Learning mode. In this way, it aims at democratizing education by ensuring access and equity.

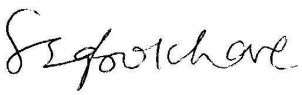
The U.I. experience in Distance Learning dates back to 1988 when the Centre for External Studies was established to cater mainly for upgrading the knowledge and skills of NCE teachers to a Bachelors degree in Education. Since then, it has gathered considerable experience in preparing and producing course materials for its programmes. The recent expansion of the programme to cover Agriculture and the need to review the existing materials have necessitated an accelerated process of course materials production. To this end, one major workshop was held in December 2006 which have resulted in a substantial increase in the number of course materials. The writing of the courses by a team of experts and rigorous peer review have ensured the maintenance of the University's high standards. The approach is not only to emphasize cognitive knowledge but also skills and humane values which are at the core of education, even in an ICT age.

The materials have had the input of experienced editors and illustrators who have ensured that they are accurate, current and learner friendly. They are specially written with distance learners in mind, since such people can often feel isolated from the community of learners. Adequate supplementary reading materials as well as other information sources are suggested in the course materials.

The Distance Learning Centre also envisages that regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks will find these books very useful. We are therefore delighted to present these new titles to both our Distance Learning students and the University's regular students. We are confident that the books will be an invaluable resource to them.

We would like to thank all our authors, reviewers and production staff for the high quality of work**.**

Best wishes.



Professor Francis O. Egbokhare

Director

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General Introduction

This is a course in abnormal child psychology which is better described as child psychopathology. The term “psychopathology” refers to the symptoms, causes and outcomes of a mental disorder usually described so that treatment can alleviate symptoms. Child psychopathology is not the immature form of the study of adult psychopathology. The study of child psychopathology is the study of disorders that arise in childhood and the study of childhood origins in the development of risk for psychopathology at any age (this latter areas is the domain of the new and exciting field of “developmental psychopathology). Many child psychopathologists also recognize that adolescent disorder needs particular attention due to its unique (and often drastic) developmental features. Many adult disorders occur in children, and many disorders arising in childhood occur in adulthood.

This course is an overview of child psychopathology, and it examines reviewing childhood disorders, the diagnosis of these difficulties and strategies for intervention. It is taught from the perspective of developmental psychopathology. It emphasizes the use of empirical research and evidence-based intervention. The field encompasses an enormous number of disorders and concerns, ranging from mild and transient disorders to serious developmental disorders to serious developmental disorders requiring lifetime care. This study is an introductory course sufficient for practice in the entire field. It serves well as a foundation from which students should pursue specialty areas of interest. Most practitioners and researchers in the field are specialists.

This book contains 10 lectures, covering five domains of childhood disorders: behavioural (e.g., conduct and oppositional defiant disorder), emotional and social (e.g., depression, anxiety), developmental and learning (e.g., autism, schizophrenia), health (e.g., anorexia), and children at risk (e.g., child maltreatment).

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Course Objectives

As an advanced course, student participation and discussion are encouraged and expected. Students will be expected to collect resource materials on disorders and make presentations on the current state of knowledge of these disorders. The course will include discussions of case studies.

The main discussions will include reviews that help students prepare for these exams. Class attendance is very important but may not be a factor in evaluations and grading. Evaluations and grades will be based on the students' performance in the examinations and presentations. Students should complete all assignments on time. At the end of the semester, students will know that child psychology is an exciting and interesting area of work and study.

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LECTURE ONE

Classification and Diagnosis of Childhood Disorders

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Introduction

This lecture introduces you to the general classification and diagnosis of childhood disorders. Highlights include the classification and diagnosis of childhood disorders listed in DSM – IV. Also included are discussions on the diagnosis of childhood disorders, which centre mostly on the importance of maturational change and experience. Childhood disorders as contained in DSM-IV are presented graphically to facilitate better understanding on the part of the students.

Objectives

At the end of this lecture, you should be able to:

1. classify childhood disorders;
2. identify various types of childhood disorders; and
3. mention the factors responsible for abnormal child development (childhood disorders).

Pre-Test

1. Classify childhood disorders
2. Mention the four areas of childhood disorders.
3. Mention the factors responsible for childhood disorders.

CONTENT

All the childhood disorders listed in DSM-IV involve behaviours in which a child deviates from what is expected of her at a particular age and cultural setting. In addition, these behaviours are persistent and severe and they interfere with the child's development and day-to-day functioning. Thus, in order for a behavioural or psychological problem to be considered a 'disorder', the child must either be suffering or the child's behaviour must be making others to suffer. What distinguishes a childhood disorder from normal variation in development is often only a matter of degree. In other words, there is a quantitative rather than a qualitative difference between abnormal and normal behaviours Minor versions of these problem behaviours can be found in well-adjusted children. For example, the occasional temper tantrums that occur in many pre-scholars would hardly be labelled psychological disorder. But frequent tantrums that occur in peculiar circumstances or for a long period of time might be considered abnormal. The child's developmental stage is also important.

Some of the most severe mental disorders such as bipolar disorder, major depressive disorder and schizophrenia do not appear in the table 8-1. It is uncommon for children to show signs of these disorders, but when they do, the adult diagnostic criteria are used.

Many children meet criteria for more than one of the diagnoses listed in Table 1. This is referred to as co-morbidity, meaning multiple diagnoses. It is especially common for depression to co-occur with other disorders in children particularly with conduct disorder and anxiety disorder. Researchers do not know why syndromes tend to occur together. One possible explanation is that there is a causal relationship. In other words, having a disorder like depression may cause the child to seek attention by violating rules.

On the whole, children's problems can be divided into four areas: emotional disorders, developmental disorders, eating and habit disorders and disruptive behaviour disorders.

A discussion of the diagnosis of childhood disorders centres mostly on the importance of maturational change and experience. The normal course of human development involves constant change, and the child's behavioural capacities and propensities are always evolving memory, and concentration. Impulse control improves dramatically throughout

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childhood and during the teenage years, abstract reasoning abilities begin to approach adult levels.

Abnormal child development, like normal child development is the result of many factors. Vulnerability to some disorders is present at birth and may be the consequence of genetic factors or prenatal complications. One example of disorder that is influenced by genetic factors and prenatal complications is schizophrenia, a mental illness that involves abnormalities in clarity of thought and communication. Usually the early signs of childhood disorders are recognised by parents, primary care physicians and/or the child's teacher.

The outset of a mental disorder is tragic at any age, but it is especially so when it occurs in childhood. People often think of childhood as a carefree and happy time; yet it can also be frightening and upsetting. Children of all cultures typically experience at least some emotional and behavioural problems as they encounter new people and situations. When the cause of development is interrupted by psychological problems, the child is often deprived of experiences that are important for psychological growth.

When diagnosing children, a psychologist must differentiate normal variability in rates of development from psychological problems that indicate a need for treatment. A unique aspect of childhood problems is that normal psychological development proceeds at different rates for different children. As a result it can be difficult to distinguish a genuine psychological problem, one that requires professional attention, from a problem that simply reflects the child's current developmental stage. A second unique aspect of childhood psychological problem is that they are less predictable than adult disorders. Children often change dramatically over a relatively short period of time so that it is difficult to predict which children are vulnerable to persistent problems.

Thirdly, children cannot communicate their problems as easily as adults do. Sometimes, a child's distress may manifest indirectly through disruptive behaviour. Other times, adults mislabel a child's behaviour as a 'psychological problem' when it is merely a normal developmental phase.

At other times, adults will ignore children problem behaviours, believing that the child will grow out of them when in fact the child really does need professional help. There are also differences among adults in how they perceive children's behaviour.

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Finally, children's problems are often quite specific to particular situations or contexts. For example, a child might be physically aggressive at home but not at school. Similarly, over-activity which is a common complaint of teachers depends on the circumstances.

TABLE 1
MAJOR CLUSTERS OF CHILDHOOD DISORDERS

DIAGNOSTIC CLASS	DISORDER	TYPICAL AGE OF ONSET
Emotional disorders	Reactive attachment disorder	Birth – 5yrs
	Separation Anxiety	Preschool – 18 yrs
	Phobias	Varies according to type
	Childhood depression	Birth – 17yrs
Developmental disorders	Artistic disorder	0-3yrs
	Rett's disorder	0 – 4 yrs
	Childhood disintegrative disorder	3 – 4 yrs
	Asperger's disorder	Pre-school period
	Mental retardate learning disorders	Varies among sub types
Eating and habit	Bulimia nervosa	Late adolescence
	Anorexia nervosa	- 17 yrs
	Elimination disorders e.g. enuresis	- 5 yrs
	Speech disorders e.g. stuttering	2 – 7 yrs
	Tourette's disorder	2 – 18 yrs
Disruptive behaviour disorders	Conduct oppositional defiant disorder	5 – 16 yrs 0 – 8yrs
	Attention deficit hyperactivity disorder (ADHD)	Elementary school age

Source: Based on data from DSM – IV

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Summary

In this lecture, we have learnt that all of the childhood disorders listed in DSM - IV involve behaviours in which a child deviates from what is expected of her at a particular age and cultural setting. These behaviours are persistent and severe. They interfere with the child's development and day-to-day functioning. There is a quantitative rather than a qualitative difference between normal and abnormal behaviours. Co-morbidity means multiple diagnoses. Children's disorders can be divided into four: emotional disorders, developmental disorders, eating and habit disorders and disruptive behaviour disorders.

Assignment

Classify childhood disorders according to DSM – IV category.

Post-Test

1. Childhood disorders interfere with the child's _____ and _____
2. Co-morbidity means _____
3. Frequent tantrums that occur in peculiar circumstances might be considered_____ Abnormal/Normal. (tick the right response)
4. On the whole, children's problems can be divided into _____areas. (a) Five (b) Two (c) Three (d) Six.

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LECTURE TWO

Conceptual Models of Abnormality

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Introduction

In science, the perspectives used to explain phenomena are known as models, or paradigms. Each model spells out the scientists' basic assumptions, gives order to the field under study and sets guidelines for its investigation. Each model gives what the investigators observe as well as the questions they ask, the information they seek and how they interprete this information. In the contemporary world, several models are used to explain and treat abnormal functioning. The biological model sees physical processes as the key to human behaviour, while the socio-cultural model examines the effects of society and culture on individual behaviour. In between, are four models that focus on more psychological and personal aspects of human functioning. They are psychodynamic model; which looks at people's unconscious internal processes and conflicts; the behavioural model emphasizes behaviour and the ways, in which it is learned, the cognitive model concentrates on the thinking that underlies behaviour and the humanistic – existential model stresses the role of values and choices in human functioning. None of the models are complete in themselves each focuses mainly on one aspect of human functioning, and none can explain all aspects of abnormality.

Objectives

At the end of this lecture, you should be able to:

1. list the models of abnormality; and
2. explain the models of abnormality so listed.

Pre-Test

1. What are theories of abnormality?
2. Explain the determinants of abnormality as conceptualised by the biological perspective.
3. List the other *models* of abnormality.

CONTENT

The Biological Model

The biological theorists adopt a medical perspective. They view abnormal behaviour as an illness brought about by malfunctioning parts of the organism. Typically, they point to a malfunctioning brain as the cause of abnormal behaviour focusing particularly on problems in brain anatomy or brain chemistry. Biological researchers have learnt that psychological disorders can be related to problems in the transmission of messages from neuron to neuron. Studies indicate that abnormal activity by certain neurotransmitters can lead to specific mental disorders. Certain anxiety disorders, for example, have been linked to low activity of the neurotransmitter gamma-aminobutyric acid. (GABA) Schizophrenia has been linked to excessive activity of the neurotransmitter, serotonin and norepinephrine. Mental disorders have also been found to be related to abnormal chemical activity in the body's endocrine system. Endocrine glands, located throughout the body work along with neurons to control such vital activities as growth, reproduction, sexual activity, heart rate, body temperature, energy and responses to stress. The glands release chemicals called hormones into the bloodstream and these chemicals then propel body organs into action. During stress, for example, the adrenal glands located on top of the kidneys secret the hormone cortisol. Abnormal secretions of this chemical have been tied to anxiety and mood disorders.

A change of other factors can contribute to biological dysfunction from head injuries to poor nutrition to vascular diseases (which may affect the flow of blood to the brain). Three sources of biological abnormalities have been identified: they are genetics, evolution and rural infections.

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Genetics

Abnormalities in brain anatomy of chemistry are sometimes the result of genetic inheritance. Studies suggest that inheritance plays an important role in mood disorders, schizophrenia and mental retardation.

Evolution

Many of the genes that contribute to abnormal functioning are actually the result of normal evolutionary principles. Evolutionary theorists argue that we can best understand why people behave the way they do, why certain genes are inherited, by examining their evolutionary history, the millions of years during which the human specials evolved from DNA sludge to upright primate. The theorists believe that various human reactions and the genes responsible for them have survived over the course of time because they have helped individuals to thrive and adapt. For example, people who were particularly sensitive to danger, those with greater fear responses were more likely to survive catastrophes.

These three parts of the personality are often in some degree of conflict. If the Id, ego and superego are in excessive conflict the person's behaviour may show signs of dysfunction. A healthy personality is one in which an effective working relationship, an acceptable compromise, has formed among the three forces.

The Behaviour Model

Behaviourists concentrate on behaviours and propose that they develop in accordance with the principles of learning. These theorists hold that three types of conditioning; classical conditioning, operant conditioning and modeling conditioning account for all behaviour, whether normal or dysfunctional. The goal of behavioural therapies is to identify and replace them with more appropriate ones, using techniques based on one or more of the principles of learning. The classical conditioning approach of systematic desensitisation, for example, has been effective in treating phobias.

Behaviourists believe that many learned behaviours help people to cope with daily challenges and to lead happy productive lives. However, abnormal behaviours can be learnt. In operant conditioning, for example, humans and animals learn to behave in certain ways as a result of receiving rewards, which is any satisfying consequences, whenever they

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do so. In modelling, individuals learn responses simply by observing other individuals and repeating their behaviours. In a third form of conditioning, classical conditioning learning occurs by temporal association when two events repeatedly occur close together in time. They become fused in a person's mind and before long. The person responds in the same way to both events.

Viral Infections and Abnormal Behaviour

This is another possible source of abnormal brain structure or biochemical dysfunctioning. Schizophrenia may be related to exposure to certain viruses in utero, before birth. Researchers have linked viruses to anxiety mood disorders and psychotic disorders.

The Psychodynamic Model

The Psychodynamic theorists believe that a person's behaviour, whether normal or abnormal, is determined by underlying psychological forces of which he or she is not consciously aware. These internal forces are described as dynamic, that is, they interact with one another and their interaction gives rise to behaviour thoughts and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces.

The psychodynamic model was first formulated by Viennese neurologist, Sigmund Freud (1856-1939), at the turn of the twentieth century. Freud developed the theory of psychoanalysis to explain both normal and abnormal functioning. Freud believed that three central forces shape the personality; instinctual needs, rational thinking and moral standards. All these forces operate at the unconscious level, unavailable to immediate awareness and he believed them to be dynamic or interactive. Freud called the forces the Id, the ego and the super-ego.

The Id

The Id denotes instinctual needs, drives and impulses. The Id operates in accordance with the pleasure principle, that is, it always seeks gratification. Freud believed that children's instincts tend to be sexual. From the very earliest stages of life, a child's pleasure is obtained from nursing, defecating, masturbating or engaging in other activities that he

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considered having sexual overtones. Also a person's libido or sexual energy fuels the Id.

The Ego

A part of the Id separates off and becomes the ego. Like the Id, the ego unconsciously seeks gratification but it does so in accordance with reality principle, the knowledge we acquire through experience that it can be unacceptable to express our Id impulses outright. The ego, employing reason, guides us to know when we can or cannot express those impulses. The ego develops basic strategies called ego defense mechanisms to control unacceptable Id impulses and avoid or reduce the anxiety they arouse. The defense mechanisms include Repression, Denial, Fantasy, projection, Rationalisation, Reaction formation, Displacement, Intellectualization, Undoing, Regression, Overcompensation, Sublimation.

The Super-ego

The super-ego grows from the ego. As we learn from our parents that many of our Id impulses are unacceptable, we unconsciously adopt or introjet our parent's values. We identify with our parents and judge ourselves by their standards. We develop a conscience. When we uphold their values we feel good; and we feel guilty, when we go against them.

Developmental stages

Freud proposed that at each stage of development from infancy to maturity, new events and pressures challenge individuals and require adjustments in their Id, the ego and the superego. If the adjustments are successful, they lead to personal growth. If not, the person may became fixated or entrapped at an early stage of development. Then all subsequent development suffers, and the individual may be headed for abnormal functioning in the future because parents are the key environmental figure during the early years of life. They are often seen as the cause of improper development. The first 18 months of life is referred to as **the oral stage,** 18 months to 3 yrs of age is the **anal stage**, 3-5 yrs is the **phallic stage**, while 12 yrs to adulthood is the **genital stage**. Children whose mothers consistently fail to gratify their oral needs may become fixated at the oral stage and display a character marked by extreme dependence or extreme mistrust. Such persons are particularly prone to develop depression.

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The Cognitive Model

According to the cognitive model, we must understand human thought in order to understand human behaviour. When people display abnormal patterns of functioning, cognitive theorists point to cognitive problems, such as maladaptive assumptions and illogical thinking processes. Cognitive therapists try to help people recognise and change their faulty ideas and thinking processes.

The Humanistic – Existential Model

The humanistic – existential model focuses on the human need to successful confront philosophical issues, such as self-awareness values, meaning and choice in order to be satisfied in life. Humanists believe that people are driven to self-actualise. When this drive is interfered with, abnormal behaviour may result. One group of humanistic therapists, the client – centered therapist tries to create a very supportive therapy climate in which people can look at themselves honestly and acceptingly, thus opening the door to self-actualisation. Another group, the gestalt therapists uses more active techniques to help people recognize and accept their needs.

According to existentialists abnormal behaviour results from hiding from life's responsibilities. Existential therapists encourage people to accept responsibility for their lives, to recognize their freedom to choose a different course and to choose to live with greater meaning.

The Socio-Cultural Model

The socio cultural model looks outwards to the social forces that affect members of a society. Some socio-cultural theorists emphasize the family system believing that a family's structure or communication pattern may force members to behave in abnormal ways. Still others look at cultural background, social networks and support or societal conditions to see what special issues they may pose. Finally some theorist focus on societal labels and roles; they hold that society calls certain people "mentally ill" and that the label itself may influence how a person behaves and is responded to.

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Post-Test

1. The perspectives used to explain phenomena are known as ----------
2. Cognitive-behavioral approaches Includes ---------- and----------
3. ----------focuses on the biological and physiological conditions that initiate childhood disorders.

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LECTURE THREE

Emotional and Social Disorders

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Introduction

This lecture introduces you to the emotional and social disorders. This includes specifically reactive attachment disorder, separation anxiety disorder, phobias and childhood depression. The symptoms, causes and treatments for these disorders are also mentioned for better understanding of the part of the students.

Objectives

At the end of this lecture, you should be able to:

1. identify the emotional and social disorders in children;
2. discuss separation anxiety, Reactive attachment disorder and phobias in children; and
3. mention the factors that trigger childhood depression.

Pre-Test

1. What are emotional and social disorders in children?
2. What are the factors that trigger childhood depression?
3. What do you understand by depression?
4. Mention the types of school phobias that we have.

CONTENT

Reactive Attachment Disorder

Reactive attachment disorder is characterised by a marked disturbance in the child's ability to relate to other people. The disturbance begins before the age of five years. Children with this disorder fail to show social attachments that are appropriate for their age. There are two sub-types: The inhibited and the disinherited sub-type.

The inhibited sub-type: entails a persistent failure to initiate or respond to interpersonal situations. The child tends to be highly inhibited, constantly observing the behaviour of others, and resists physical contact or comforting.

The disinherited sub-type: shows an opposite pattern of behaviour: these children are indiscriminate in their social responses. They respond to strangers and familiar people in the same way, with lots of physical contact and expressed need for comforting.

The diagnostic criteria for reactive attachment disorder include the child's early experiences, as well as symptoms. In order to receive this diagnosis, the child must have been exposed to serous neglect or outright abuse during some period before the symptoms began. It is assumed that inadequate care causes the syndrome.

Because reactive attachment disorder is a new diagnostic category in DSM – IV, there has been relatively little research on its prevalence, specific causes or treatments some practitioners advocated certain forms of therapy that they believe are effective in the treatment of Reactive attachment disorder while other clinicians have expressed their doubts about the appropriateness of these therapy treatment.

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Separation Anxiety

Fear and anxiety that children experience when separated from their parents or primary caregivers, psychologists consider separation anxiety a normal part of a child's development. It usually begins when a child is 8 or 9 months old, peaks at about 14 months, and then gradually subsides. The onset of separation anxiety coincides with the child's development of object romance, the ability to understand that people and objects still exists when they disappear from view. Infants with separation anxiety cry or become irritable and distressed when separated from their parents.

When separation anxiety continues well into childhood or reappears later in childhood or adolescence, the diagnosis may be separation anxiety disorder. Children with this disorder worry excessively about the safety of their parents. They may fear that their parents will die or become ill. They may worry that some danger, such as a kidnapping or car accident, will lead to separation from their parents. They are often scared of being alone and may refuse to go to school because of fears of separation. Children with this disorder often act in demanding or intrusive ways and seek constant attention. At bedtime they may insist that someone stay with them until they fall asleep. Some children experience physical symptoms, such as headache and nausea, when they anticipate separation from their parents.

Sometimes, separation anxiety disorder continues into adulthood. Adults with separation anxiety may refuse to move from their parents' home or feel unable to live independently. In addition, they may experience anxiety when separated from their spouse or children.

Researchers are unsure what causes separation anxiety disorder. Often the symptoms begin after the children experience some loss, such as the death of a family member or a pet. Treatment involves gradually exposing the child to separation experiences, such as attending school and teaching the child how to overcome his or her anxiety and irrational thinking. In addition, the therapist often works with the parents to ensure that they do not inadvertently aggravate their child's separation anxiety through over protective parents.

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Phobias

At some point, many children experience unjustified fear so extreme that he or she is immobilised. Childhood fears are a universal phenomenon, although there are cultural differences in their content and intensity. The nature of fear also varies with age. Fears become phobias when they are out of proportion to the reality of danger that an object presents. The following case demonstrates the transition of fear to phobia.

School phobia is one of the most common and problematic childhood phobias. It creates great distress in both children and their parents. Many children with school phobia do well in school and express desire to attend but they experience intense anxiety when they get ready to go to school, for example, they may go to the toilet frequently, feel sick, or sweat

profusely when the topic of school is brought up. Unlike the truants whose parents are often unaware that their child is not at school, these children stay at home during their prolonged absences, and their parents know exactly where they are. Some specific and effective behavioural treatments for phobias include de-sensitization which involves gradual exposure to the feared object and therapy that involves some work with the parents. It is important that parents be involved in the process so that they can monitor the child's behaviour. The therapist also helps the parents to identify any behaviour on their part that might be subtly encouraging and maintaining the child's phobia.

Many cases of school phobias have causes other than separation fears such as social or academic fears, depression and fears of specific objects or persons at school.

Case study

SARA was referred for treatment of her phobias when she was thirteen. She acknowledged that beyond airplanes and bees, she was also afraid of elevators but nothing more. Yet, after she came to know and trust her therapist, it emerged that there was a fear that underlay and linked all the others that was a fear of anesthesia. A number of years early Sara had to have a tooth extracted. The doctor used a general anesthetic. As she 'went under', everything went black but Sara could still hear voices and rushing voices. She was not prepared for these sedating, they terrified her. Ever since she has diligently avoided putting herself in a situation where she might be injured and therefore be rushed to the hospital. Airplanes crush, so do elevators, Bees sting. Any of these might land her in the hospital. The therapist later treated Sara in relaxation techniques that could be used in situations of high anxiety. Within 3 months Sara had reported no more difficulties.

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Childhood Depression

Childhood depression is an emotional disorder that has the highest lifetime prevalence. Prior to the 1970's, many clinicians assumed that pre-adolescent were unlikely to develop depression. In recent years, researchers have found that pre-adolescents children can and do develop the symptoms that make up the syndrome of depression. Children like

adults may develop depression. Between 2 and 4 percent of children under 17 years of age experience major depressive disorders. The symptoms in young sufferers are likely to include physical discomfort, irritability, and social withdrawal (APA, 2000). Explanations of childhood depression are similar to those of adult depression. Factors such as loss, learned helplessness, negative cognitions and low serotonin or epinephrine activity are indicators. Also like adults many cases of childhood depression seem to be triggered by a negative life event, major change, rejection or ongoing abuse. Like depressed adults, children with depression are at high risk for suicide. Like depression among adults, childhood depression often is helped by cognitive therapy or interpersonal approaches, such as social skills training. In addition, family therapy can be effective. Anti-depressant medications also seem to help some depressed adolescents.

Depression is a mental illness in which a person experiences deep unshakeable sadness and diminished interest in nearly all activities. Severe depression also called “major depression” can dramatically impair a person’s ability to function in social situations and at work. People with major depression often have feelings of despair, hopelessness, and worthlessness as well as thoughts of committing suicide. Depression can take other forms. In the case of Bipolar disorder sometimes called “manic depressive illness”, a person’s mood swings back and forth between depression and mania. In younger children, depression may include physical complaints, such as stomach-aches, headaches as well as irritability, moping around, social withdrawal and changes in eating habits. They may feel unexcited about school and other activities.

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Summary

Reactive attachment disorder is characterised by a marked disturbance in the child's ability to relate to other people. There are two subtypes of reactive attachment disorder; The inhibited and the disinherited subtype. Separation anxiety is the fear and anxiety that children experience when separated from their parents or primary caregivers.

When separation anxiety continues well into childhood or appears later in childhood or re-appears later in childhood or adolescence, the diagnosis may be separation anxiety disorder. Some children experience physical symptoms such as headache and nausea when they anticipate separation from their parents. Adults with separation anxiety may refuse to move from their parent's home or feel unable to live independently.

Fears become phobias when they are out of proportion to the reality of danger that an object presents. Many children with school phobia do well in school and express desire to attend but they experience intense anxiety when they get ready to go to school. Some specific and effective behavioral treatments for phobias include de-sensitisation. Researchers have found that in recent years, pre-adolescent children can and do develop the symptoms that make up the syndrome of depression.

Between 2 and 4 percent of children under 17 years of age experience major depressive disorders. The symptoms in young sufferers are likely to include physical discomfort, irritability and social withdrawal.

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Post-Test

1. Reactive attachment disorder is characterized by _____ in the child's _____.
2. There are two subtypes of reactive attachment disorder namely (a)_____ (b) _____
3. The reactive attachment disorder begins before the age of _____ years.
4. The diagnostic criteria for reactive attachment disorder include _____ and _____
5. Some forms of _____ are effective in the treatment of reactive attachment disorder.

6. Separation anxiety disorder begins when a child is _____ months old.
7. Infants with separation anxiety _____ or become _____ and _____ when separated from their parents
8. Children with separation anxiety disorder _____ about the safely of their parents.
9. Treatments of separation anxiety disorder involves _____
10. Causes of school phobias may be caused by academic and _____ (mention one fear).
11. Children like adults may develop depression

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LECTURE FOUR

Developmental Disorders

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Introduction

The Essential feature of developmental disorders is in the acquisition of cognitive language, motor or social skills. The course of developmental disorders tends to be chronic when signs of the disorder persist into adult life. However, in many mild cases, adaptation or full recovery may occur (DSM-IV).

A general category of developmental disorders called **"pervasive developmental disorders"** includes Autism, Rett's disorder, Childhood disintegrative disorder and Asperger's disorder as listed in DSM – IV. These disorders involve noticeable abnormalities in the child's social adjustment. In contrast, other developmental disorders such as mental retardation and learning and communication disorders, impair the child's cognitive functioning but these disorders do not necessarily affect social adjustment of all the childhood disorders listed in DSM-IV, the pervasive developmental disorders are the most devastating and the most perplexing. These disorders involve problems in many domains of functioning: language attention, social responsiveness, perception and motor development. The term 'pervasive' is used because early developmental processes are often so seriously impaired that the child usually requires a special educational setting.

Objectives

At the end of this lecture, you should be able to;

1. learn about developmental disorders;
2. discuss pervasive developmental disorders;

3. learn how developmental disorders affects children; and
4. identify the various types of developmental disorders.

Pre-Test

1. Mention the essential feature of developmental disorders.
2. Mention why term 'pervasive' is used.
3. List the *pervasive developmental disorders.*
4. List the other developmental disorders.
5. When is course of developmental disorder termed to be chronic?

CONTENT

Autism: Autism is a pervasive developmental disorder whose symptoms are first observed very early in life – usually in infancy. Autistic disorder is also called Autism. The pattern was first identified by the American psychiatrist named Leo Kanner in 1943. Children with this disorder are extremely unresponsive to others, uncommunicative, repetitive and rigid. Their symptoms appear early in life before 3 yrs of age. Autism affects 5 of every 10,000 children (Phares 2003, APA 2000) about 80 per cent of children with autism are boys. As many as 90 percent of children autism remain severely disabled into adulthood and are unable to lead independent lives (APA 2000). The highest functioning adults with autism typically have problems in social interacting and communication and have restricted activities and interests. (APA, 2000, 1994).

Several other disorders are similar to autism but differ to some degree in symptoms or time of onset. These different disorders are categorised as pervasive developmental disorders, but most clinicians refer to them in general as autism. The individual's lack of responsiveness including extreme aloofness and lack of interest in other people has long been considered the central feature of autism. Sufferers sometimes have language or communication problem in the forms of echolalia, delayed echolalia and pronominal reversal. Autism is also marked by limited imaginative play and very repetitive and rigid behaviour. Affected children may be unable to play in a varied, spontaneous way or to include others in their play. The motor movements of people with this disorder may also be unusual.

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Characteristics: One main feature of autism is that the child's ability to respond to others does not develop normally within the first three years of life. They lack interest in people and do not respond to them. They fail to develop normal attachments to the adults who care for them. In infancy, these tendencies are reflected in their failure to cuddle, lack of eye contact, or even a version to physical affection. These children may fail to develop language, and if language is acquired it is usually abnormal. It might be characterised by echolalia, the tendency to repeat or echo precisely what one has just heard and echopraxia, the tendency to repeat the action of others. These children respond negatively to change in their routines or in their environments.

Causes of Autism

A variety of explanations has been offered for autism. Recent work in the psychological and biological spheres has persuaded clinical theories that cognitive limitations and abnormalities are the primary causes of autism. Leo Kanner (1943), a child psychiatrist was the first to recognise this disorder as a distinct syndrome. A significant proportion of children with autism have IQS in the range of mental retardation. Psychodynamic and behavioural theorists came up with possible psychological causes of autism by examining parental traits. The parents of children with autism seemed to be introverted, distant, intellectual and meticulous. (Betel-heim, 1967). They were described as creating an environment of emotional refrigeration, and many clinicians referred to the "refrigerator mothers" of these children. It is assumed that the parents' behavioural tendencies were reflected in their offspring, increase in attention has also been directed to the biological origins of the disorder (Rapin and Katzinen, 1988). A biological basis to autism is that the children with the disorder tend to have seizures. Another biological cause is neuro-transmission. When the neuro-transmitter activity is abnormal, the brain is unable to pass messages efficiently from one neuron to another. This could produce the behavioural and cognitive abnormalities observed in children with autism.

Treatment: behavioural techniques may treat specific disorders caused by autism. A variety of medications are used in the treatment of autism. They are prescribed for limited periods of time to treat specific symptoms rather than the entire syndrome. Treatment can help people with autism adapt

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better to their environment, although no treatment yet known totally reverses the autistic pattern. Behavioural therapies, communication training, parent training and community integration are being used in treatment of autism.

Mental Retardation

Mental retardation refers to substantial limitations in present functioning. (AAMR – American association on mental retardation) It is characterized by significantly sub-average intellectual functioning existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before the age of eighteen. This definition has been incorporated into DSM – IV as criteria for diagnosing mental retardation. It is often present in children with Autism and Schizophrenia. According to the DSM-IV, mental retardation has a 1 percent prevalence rate. Despite its prevalence, it is however a controversial disorder and it is often difficult to diagnose. In part the difficulty arises from the stereotypes that people have about mental retardation. But in a larger measure, the difficulty occurs because the notion of intelligence is at the heart of mental retardation and intelligence is very difficult to define (Gould 1981; Kamin, 1974). What has been clearly established however is that there are more males than females suffering from the disorder.

In recent years, the less stigmatising term “developmental disability” has became synonymous with mental retardation in many clinical settings (Phares, 2003) Approximately, one of every 100 persons receives this diagnosis (APA, 2000). Around three-fifths of them are male and the vast majorities are considered mildly retarded. According to DSM-IV, people should receive a diagnosis of mental retardation when they display general intellectual functioning that is well below average in combination with poor adaptive behaviour (APA, 2000, 1994). That is in addition to having a low IQ (a score of 70 or below) a person with mental retardant may have great difficulty in areas such as communication, home, living self direction or safety (APA, 2000 1994). The Symptoms must also appear before the age of 18.

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Characteristics of Mental Retardation

The most consistent sign of mental retardation is that the person learns very slowly. Other areas of difficult are attention, short-term memory planning and language. These who are institutionalized with mental retardation are particularly likely to have these limitations. DSM-IV describes four levels of mental Retardation; mild (IQ 50-70) moderate (IQ 35-49) severe (IQ 20-34) and Profound (IQ below 20).

Mild Retardation: About 85 of all the people with mental retardation fall into the category of mild retardant (IQ 50 – 70) (APA 2000). They are sometimes called educable retarded because they can benefit from schooling and can support themselves as adults. Still, they typically need assistance when they are under stress. Their jobs tend to be skilled or semi-skilled. Mild mental retardation is not usually recognised until a child enters school and is assessed there. The intellectual performance of individuals in this category often seems to improve with age, some even seem to leave the label behind when they leave school and they go on to function well in the community.

Research has linked mild mental retardation mainly to socio-cultural and psychological causes particularly poor and dull environments, inadequate parent child interactions and insufficient learning experiences during a child's early years. Some biological factors also may be causative. Studies suggest, for example, that a mother's moderate drinking, drug use or malnourishment during pregnancy may lower a child's intellectual potential; similarly, malnourishment during a child's early years may hurt his or her intellectual development, although this effect can be reversed at least partly if a child's diet is improved before too much time goes by (Bareff & Olley, 1999).

Moderate Retardation: Approximately, 10 percent of persons with mental retardation function at a level of moderate retardation. They can learn to care for themselves and can benefit from vocational training and many can work in unskilled or semi-skilled jobs usually under supervision. Most persons with moderate retardation also function well in the community if they have supervision (APA 2000, 1994).

Approximately, 10 percent of children in this category make up those with mental retardation. Like other children, they are able to learn to talk

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and communicate during the pre-school period. But, unlike other children, those with moderate mental retardation have difficulty learning social conventions. During the school-age period they can profit from training in social and occupational skills, but they are unlikely to go beyond the second grade levels in academic subjects. Physically, they may be clumsy and occasionally they may suffer from poor motor co-ordination.

Severe Mental Retardation

Before they are five, those with severe mental retardation show poor motor development and they develop little or no communicative speech. At special schools, they may learn to talk and can be trained in elementary hygiene. Generally they are unable to profit from vocational training, though as adults they may be able to perform simple, unskilled job tasks under supervision.

Profound Mental Retardation

Children in this category are severely handicapped in adaptive behaviours and they are unable to master the simplest motor tasks during the pre-school years. During the school years, some development in motor skills may occur, and the child may respond in a limited way to training in self-care. Severe physical deformity, central nervous system difficulties, and retarded growth are not uncommon. Health and resistance to disease are poor and life expectancy is shorter than normal. These children require custodial care.

Causes of mental Retardation

Mental Retardation is a symptom and not a specific disease, and there are a multitude of causes. Mental retardation may result from chromosomal disorders, prenatal exposure to certain drugs, infections, complications during labour and delivery, post natal physical trauma to the brain, metabolism or nutrition problems, brain disease and psychosocial disadvantages including deprivation, abuse and neglect. Genetic causes include single-gene defects such as fragile X syndrome and chromosomal disorders, such as Down syndrome. Metabolic disorders such as in PICU (Phenyketonuria fragile & syndrome is caused when the tip of the X chromosome breaks off. The syndrome is characterised by severe to profound mental retardation, autistic behaviour and speech defects. In

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addition, males with fragile x syndrome have large ears, long faces and enlarged testes.

Down syndrome sometimes referred to as 'Trisomy 21' involves an abnormal number of chromosomes or changes in the structure of a chromosome. The most common form of Down syndrome is not inherited. It occurs at conception and immediately affects the development of the fetus. It arises because there are forty-seven chromosomes rather than the usual forty six in the cell is of the children born with the disorder. There is an "extra" chromosome 21. Down syndrome children have a characteristic facial appearance that usually includes wide-set, slanted eyes, physical anomalies, especially heart malformations.

It is possible to detect chromosomal problems through amniocentesis, a test that is administered to the mother after the thirteenth week of pregnancy. In this procedure, a small amount of amniotic fluid (the fluid that surrounds the fetus) is drawn off and examined for the presence of abnormal chromosomes.

Environment appears to play an important role in the development of intelligence. The prenatal environment to which the fetus is exposed can have a profound effect on intellectual development, high blood pressure or diabetes in the mother can interfere with fetal brain development. Similarly, infectious disease, and drugs the mother takes can affect fetal development. Low birth weight, premature births accidental falls or physical abuse can also cause brain damage and mental retardation.

The treatment of mentally retarded children has greatly changed in modern times. In the past, many children with mental retardation were placed in institutional aged settings. Today, in the western world, young children with severe retardation are now educated in regional facilities that offer a broad range of educational programs to prepare them for independent living. Early intervention programme can provide specialised teaching and other services for infants, toddlers, and pre-school children some individuals diagnosed with mild mental retardation as children may gradually develop new skills through early intervention and educational services. Children with mental retardation also benefit from help with acquiring social skills that enable them to interact more easily with people in school and community settings.

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Rett's Disorder

Rett's disorder is distinguished from autism because the disorder shows a different developmental course and patterns of symptom. Rett's disorder typically has its onset between five and forty-eight months of age, although the age of onset may range from birth to four years of age as described by DSM-IV. It is a rare disorder with a prevalence estimate of 1 in 10,000. Unlike the other pervasive developmental disorders, Rett's disorder only occurs in females.

At first, the child's physical emotional development is normal. When the disorder does begin to manifest itself, the child shows a slowing down in head growth and a decline in motor and communication skills. She then begins to withdraw from social interaction and rigidly adheres to non-functional routines or rituals. She also starts manifesting stereotypic and repetitive hand or finger movements or whole body movements. Most children with Rett's disorder suffer from mental retardation. Unfortunately, Rett's disorder is usually persistent and progressive. Studies have discovered that Rett's syndrome is caused by mutations in a specific gene on the X chromosome.

Childhood Disintegrative Disorders

In this type of disorder, development is within the normal range at least until the child reaches two years. The child begins by showing a loss of skills in at least two of three areas; language, social and motor. The symptoms are very similar to those shown by autistic children. This disorder occurs more often in males than in females. The cause of the disorder is unknown but researchers believe it probably involves some abnormality in the early development of the nervous system. The treatment is the same as those for autism which are intensive behaviour therapy, educational programme, and in some cases medication.

Asperger's Disorder

Asperger's Disorder has the latest onset. Usually, it is not detected until the pre-school period or later. The estimated prevalence for Asperger disorder is 1 to 26 percent of the population. It is associated with less severe deficits. The primary symptom is impairment in social interaction.

It is often accompanied by repetitive patterns of behaviour and limited interests. When interacting with others, most individuals with Asperger's

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disorder fail to make eye contact and their facial expressions rarely change. Their body posture and gestures seem almost mechanised. They have few friends and express little interest in recreational activities and humour. Like autism, it is more common in males than females. Surprisingly, some children who suffer from Asperger disorder are unusually gifted in certain areas.

Case study

> *Samuel was diagnosed as having Asperger syndrome when he was ten years old. He was viewed as very unusual by adults and peers. Sam went on to complete his high school education with the help of a tutor. He then got a job packing groceries at a local supermarket. He has now worked there for over ten years. He is the most reliable employee at the store. Nonetheless, Sam has very obvious signs of Asperger's disorder. He never makes eye contact, and he greets everyone with the same phrase in the same high pitched tone of voice. As patrons enter the store, he says "welcome today and I hope you are doing fine". He turns his head towards the person but averts his gaze to the right and shows no facial expression of emotion. He packs the groceries in a very precise manner and occasionally initiates a brief conversation while doing so. As the customer leaves the store, Sam says, "Good-bye and I hope you come back real soon". Sometimes, he repeats this several times, usually in the same high pitch and with the same pattern of intonation.*

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Learning Disorders

Learning disorders are more common than mental retardation. Learning disorders are difficulties that reflect developmental delays mainly in the areas of language and mathematical skills. Children with learning disorder are considered to be learning disabled. There are three main types of learning disorders and they are reading disorder mathematics disorder and disorders of written expressions.

Individuals with learning disorders are delayed in specific cognitive skills not in all areas of mental functioning. They do not have the severe social problems that characterize those with pervasive developmental disorders. Learning disorders also occur frequently in combination with other difficulties. Children progress in their education at different speeds.

A certain amount of logging behind is to be expected of many children some of the time. But when a child is significantly below the expected level, as indexed by the child's schooling, age and IQ, then the matter is viewed as psychological. A significant problem exists if the child is more than two years behind his or her age level.

Reading Difficulties

Reading disorder has also been referred to as "dyslexia". It is the most common of all the learning disorders. It affects about 2 percent of school-aged children.

As group poor readers are late in acquiring language, they are poor spellers and are more likely to have a history of reading difficulty in their families. Children with severe reading difficulties at age ten are at increased risk of other psychological disorders particularly behaviour disorders. Boys and girls suffer serious reading difficulties.

Theories of the causes of reading disorder focus on various aspects of brain development. On dominant view is that dyslexia is caused by a delay in the development of the brain. Another perspective is that there is actually an abnormality in the structure of the brain.

In the treatment of dyslexia, a combination of training in reading skills and behaviour therapy designed to maintain a child's interest in learning has proven effective for many children with learning disabilities. Many programme for enhancing reading skills are available for use on home computers.

There are social implications of serious reading problems: poor readers who are of average intelligence rarely read books or newspapers. Some fail to graduate from high school. Many children with reading disabilities emerge from the school system handicapped educationally socially and economically and their employment opportunities may be limited. Their self-esteem often suffers. Nevertheless, most of the children with learning disabilities grow up to be highly successful adults.

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Summary

The essential feature of developmental disorders is in the acquisition of cognitive, language, motor or social skills. The course of developmental disorders tends to be chronic when signs of the disorder persist into adult life. However in mild cases, adaptation or full recovery may occur. A general category called "pervasive developmental disorders include autism, Rett's disorder, childhood disintegrative disorder and Asperger's disorder as listed in DSM-IV.

Other developmental disorders include mental retardation and learning and communication disorders. The symptoms of autism are first observed very early in life – usually in infancy.

Leo Kanner (1943) a child psychiatrist was the first to recognize this disorder as a distinct syndrome. Mental retardation refers to substantial limitations in present functioning (AAMR - American association on mental retardation.

Approximately 1 out of every 100 people receives this diagnosis (APA 2000). In Rett's disorder, at first, the child's physical and emotional development is normal. When the disorder does begin to manifest itself, the child shows a slowing down in head growth and a decline in motor and communication skills. The typical onset of childhood disintegrative disorder is between three and four years. The primary symptom of Asperger's syndrome is impairment in social interaction. There are three main types of learning disorders and they are reading disorders, mathematics disorder and disorders of written expressions.

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Post-Test

1. _____ _____ _____ are the essential features of developmental disorders
2. Pervasive developmental disorders includes _____ _____ _____ _____
3. Other development disorders include _____ _____ _____
4. The symptoms of autism are first observed _____
5. Autistic disorder was first identified by _____ in 1943.

6. Mental Retardation refers to _____
7. There are _____ levels of mental retardation.
8. The age of onset of Rett's disorder may range from _____ to _____ years.
9. Asperger's disorder is not detracted until the _____ period.
10. Learning disorders are difficulties that reflect developmental delays in the areas of _____ and _____ skills.

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LECTURE FIVE

Disruptive Behaviour Disorders

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Introduction

Children often break rules or misbehave. If they consistently display extreme hostility and defiance, however, they may qualify for a diagnosis of oppositional defiant disorder or conduct disorder.

Disruptive behaviour disorders are characterized by deficits in self control and involve behaviour tendencies like hyperactivity, inattention, aggressiveness, destructiveness, and defiance of authority. The symptoms tend to emerge in the preschool and elementary school years. There are three types of disruptive behaviour disorders namely conduct disorders, oppositional defiant disorder and attention deficit/hyperactivity disorder.

Objectives

At the end of this lecture, you should be able to:

1. identify oppositional defiant disorders;
2. identify conduct disorders; and
3. identify Attention deficit/hyperactivity disorders.

Pre-Test

1. What are the characteristics of Disruptive behaviour disorders
2. Name the three types of disruptive behaviour disorders.
3. Mention the diagnostic criteria for children with conduct disorder.
4. Mention the three subtypes of attention–deficit/hyperactivity disorder.

5. Mention the distinction between oppositional defiant disorder and conduct disorder

CONTENT

Oppositional Defiant Disorder

Children with oppositional defiant disorder argue repeatedly with adults, lose their temper, and feel great anger and resentment. They often ignore adult rules and requests, try to annoy other people and blame others for their own mistakes and problems. Between 2 and 16 percent of children display this pattern (APA, 2000). The disorder is more common in boys than in girls before puberty, built equal in both sexes after puberty probably because many boys with this disorder actually worsen during adolescence and develop a more extensive and severe antisocial pattern, called conduct disorder.

Children who meet diagnostic criteria for oppositional defiant disorder (ODD) are negativistic, hostile, temperamental and defiant towards authority figures over at least six months. Although, the non compliant behaviours of children with ODD are usually manifested toward adults, these children are also prone to be negativistic towards peers. Many steal from, threaten or harm their victims, committing such crimes as shop lifting, forgery, breaking into buildings or cars, assault and armed robbery. As they get older, their acts of physical violence many include rape or in rare cases, homicide (APA 2000, 1994). Conduct disorders usually begins between 7 and 15 years of age (APA, 2000). Children with a mild conduct disorder may improve overtime but severe cases frequently continue into adulthood and may develop into anti-social personality disorder or other psychological problems (Phares, 2003).

The distinction between ODD and conduct disorder is based on the presence of violating of the law or basic social mores. Children with ODD do not engage in repeated physical aggression, property destruction, theft or deceit. Both disorders tend to occur in sequence and are associated with problems in understanding and solving interpersonal problems. Both disorders are also associated with increased risk for anti-social behaviour in adulthood.

Conduct disorders are characterised by persistent behaviours that seriously violate the rights of others and basic societal norms. Children with conduct disorders often get in trouble with the law, and some become

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career criminals. Children who meet diagnostic criteria for conduct disorder repeatedly violate very basic norms for interpersonal behaviour. They are often physically aggressive and cruel to others. They may habitually lie and cheat.

Society factors might play a role in the most serious cases of conduct disorder. There is also a biological basis of vulnerability to conduct disorder a constitutional vulnerability to conduct disorder. Heredity is one source. Genetic factors play a role in determining which children have conduct problems and which do not. Cases of conduct disorders have been linked to genetic and biological factors, drug abuse, poverty, traumatic events and exposure to violent peers or community violence.

Treatments for conduct disorder are generally most effective with children younger than 13. Given the importance of family factors in this disorder, therapists often use family interventions. Socio cultural approaches such as residential treatment in the community, programme at school and group therapy have also helped some children improve (Phares, 2003). Individual approaches are sometimes effective as well. Drug therapy has also been tried to help control aggressive outburst in children institutionalisation in juvenile training centres has not met with much success.

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Attention Deficit Hyperactivity Disorder (ADHD)

This is the most frequently diagnosed disruptive disorder of childhood. DSM-IV distinguishes three sub-types of this disorder: attention deficit hyperactivity disorder – combined type; attention deficit hyperactivity disorder – predominantly inattentive type: and attention deficit hyperactivity disorder – predominantly hyper active – impulsive type. These distinctions are made because children may show only one aspect of the syndrome, attention problems or excessive activity level. In majority of cases however, they show problems with both attention and activity level. In order to be diagnosed with ADHD, a child must show developmentally inappropriate attention problems, impulsiveness and motor hyperactivity. In the classroom, the attention difficulties are often manifested in an ability to stick with a specific task. Children with ADHD have difficulty organising and completing work. They often give the impression that they are not listening or that they have not heard what they have been told. Just sitting still seems to be a major challenge for them.

When they interact with pears, children with ADHD are sometimes awkward and disorganised. Similarly, at home they are described as failing to follow through on parental requests and failing to sustain activities including play for periods of time that are appropriate for their age. A good example of a child with attention deficit hyperactivity disorder is provided in the following case.

"Victor was four years old when he was first admitted to a children's psychiatric ward as a day patient. As soon as he could crawl, he got into everything. He had no ideas of danger. He slept very little at night and was difficult to pacify when upset. It was only because he was their only child and they could devote all of their time to him that his parents managed to maintain him at home.

His problems were noticed by others just as soon as Victor began pre-school at age three. He made no friends among the other children. Every interaction ended in trouble. He rushed around all day, and could not even sit still at story time. His flitting from one activity to another completely exhausted her teachers. After some eighteen months of trying, his teachers suggested that he be referred to the hospital for assessment and treatment.

On examination, no gross physical damage can be found in his control nervous system. Psychological examinations revealed that Victor had a nearly average intelligence. In the hospital, he was just as hyperactive as he had been in school and at home. He climbed dangerously to the top of the outdoor swings. He ran from one play thing to another and showed no consideration for other children who were using them. Left to his own devices, he was constantly on the move, tearing up paper, messing with toys all in a non constructive manner.

Victor was placed in a highly structured classroom with two teachers and five other children. There, his behavior was gradually brought under control. He was given small tasks that were well within his ability, and he was carefully shown how to perform them. His successes were met with lavish praises. Moreover, patience and reward gradually increased the length of time he would spend seated at the table.

Victor had an especially severe form of ADHD. He was hyperactive, always on the go, with apparently boundless energy. He was impulsive; doing whatever came to mind, often without regard to physical danger. And he had problems focusing his attention on any one task without a

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great deal of support from teachers. Eventually, Victor was placed in a small structured, residential school. By age sixteen, he had settled down a great deal. He was no longer physically overactive, but his conversation still flitted from one subject to another. He had no friends among his peers, although he could relate reasonably well to adults. Victor showed little initiative in matters concerning his own life and his prospect for gaining employment was not good".

Children who display ADHD have great difficulty attending to tasks or behave over actively and impulsively, or both. The disorder often appears before the child starts school. The symptoms of ADHD often feed into one another. Children, who have trouble focusing attention, may keep turning from task to task until they end up trying to run in several directions at once. About half of the children with ADHD also have learning or communication problems, many perform poorly in school, a number have difficulty interacting with other children and about 80 percent misbehave, often quite seriously it is also common for the children to have mood or anxiety problems. The disorder usually persists throughout childhood (APA 2000, 1994) many children show a marked lessening of symptoms as they move into mid-adolescence but at least half continue to have problems (Phares, 2003).

ADHD have been considered to have several interacting causes, including biological causes, high levels of stress and family dysfunction (Barkley, 2002).

DSM-IV cites prevalence rates in pre-adolescence ranging from 3-5 percent. The proportion of children who meet the diagnostic criteria for ADHD varies as a function of (1) how information about the child's behaviour is obtained from parents, teachers or clinical observers. (2) The nature of the setting classroom, playground or home and (3) the child's family background. Teachers are often the first to recognize ADHD in a child. This is especially true of children from lower-income families. Many children "grow out" of the symptoms of ADHD as they get older. Genetic factors are involved in some cases of ADHD. (Vulnerability to ADHD is also increased by environmental factors that interfere with brain function). The child's social environment may also be a factor in the symptoms of ADHD.

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Treatment

The two main treatment approaches to ADHD are medication and behavior therapy.

1. Either of the following groups:

   A. At least six of the following symptoms of inattention, persisting for at least six months to a degree that is maladaptive and inconsistent with development level:

      a) Frequent failure to give attention to details or making careless mistakes.

      b) Frequent difficulty in sustaining attention.

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c) Frequent failure to listen when spoken to directly.
d) Frequent failure to follow through an instructions and failure to finish work.
e) Difficulty in organising tasks and activities.
f) Avoidance of dislike of, and reluctance to, engage in tasks that require sustained mental effort.
g) Frequent loss of items necessary for tasks or activities.
h) Easy distraction by irrelevant stimuli.
i) Forgetfulness in daily activities.

B. At least six of the following symptoms of hyperactivity – impulsivity, persisting for at least six months to a degree that is maladaptive and inconsistent with developmental level:

a) Fidgeting with hands or feet, or squirming in seat.
b) Frequent wandering from seat in classroom or similar situation.
c) Frequent running about or climbing excessively in situations in which it is appropriate.
d) Frequent difficulty in playing or engaging in leisure activities quickly.
e) Frequently "on the go" activity or acting as if "driven by a motor".
f) Frequent excessive talking.
g) Frequent blurting out of answers before questions has been completed.
h) Frequent difficulty in awaiting his turn.
i) Frequent interrupting of or intruding on others.

1. The presence of some symptoms before the age of 7
2. Impairment from the symptoms in at least two settings.
3. Significant impairment

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Summary

Children with oppositional defiant disorder argue repeatedly with adults, lose their temper and feel great anger and resentment. Between 2 and 16 percent of children display this pattern (APA, 2000). The distinction between ODD and conduct disorder is based on the presence of violations of the law or basic social mares. Children with conduct disorders often get in trouble with the law and some become career criminals. Conduct disorders usually begin between 7 and 15 years of age (APA, 2000). The three subtypes of attention deficit hyperactivity disorders are (1) Attention deficit hyperactivity disorder – combined type (2) attention deficit hyperactivity disorder – predominantly inattentive type and attention deficit hyperactivity disorder – predominantly hyperactive impulsive type. When they interact with peers, children with ADHD are sometimes awkward and disorganised. ADHD is the most frequently diagnosed disruptive disorder of children (DSM-IV). In order to be diagnosed with ADHD. A child must show development mentally inappropriate attention problems. At home, child with PDHD are described as failing to follow through on parental requests.

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Post-Test

1. Disruptive behaviour disorders involve behaviour tendencies like _____ _____ _____ _____
2. _____ _____ _____ are the types of Disruptive behaviour disorders.
3. Between _____ and 16 percent of children display ODD pattern.
4. Children with_____ engage in repeated physical aggression.
5. Conduct disorders begins from between 7 and _____ years of age.
6. Conduct disorders are characterised by persistent behaviours that _____.
7. Children with _____ conduct disorder improve overtime.
8. _____ is the most frequently diagnosed disruptive disorder of childhood.

9. In order to be diagnosed with ADHD, a child must show _____.
10. The causes of ADHD are _____ and _____.

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LECTURE SIX

Eating and Habit Disorder

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Introduction

Disorders whose primary symptoms involve a disruption in the individual's patterns of eating, elimination, movement or communication will be discussed in this lecture. The eating disorders can occur at either extreme; excessive consumption of food or dramatic reductions in food intake. Both can have life-threatening consequences. The habit disorders of elimination movement and communication. Acquiring socially appropriate habits with respect to this behaviour is of critical importance for healthy development. Problems with elimination, referred to as enuresis and encopresis can have significant psychological causes and consequences. Similarly, the ability to communicate clearly and maintain conscious control over movement is central to the child's functioning in society. In this lecture, we will also discuss stuttering and tic disorders.

Objectives

At the end of the lecture, you should be able to:

1. identify the eating and Habit disorders;
2. list the eating and Habit disorders; and
3. mention or list the symptoms of the eating and Habit disorders.

Pre-Test

1. List the two major categories of eating and habit disorders.
2. Mention the symptoms of Anorexia and Bulimia
3. Mention the prevalence of Anorexia and Bulimia.

CONTENT

Eating Disorders: Anorexia and Bulimia

The two major categories of eating disorders that we have are anorexia nervosa and bulimia. These two disorders have distinct features but they also share some common symptoms and common etiologies. They show a similar developmental course. They tend to begin in adolescence but do not extend past early adulthood.

Anorexia Nervosa: People suffering from anorexia nervosa have an intense fear of gaining weight despite being much underweight. Even when they are emaciated, people with anorexia often feel fat. There are two sub-types of those with anorexia: Restrictors and Purgers. Restrictors are thin primarily because they refuse to eat. Purgers also refuse to eat much of the time, but when they do eat, they use vomiting and laxatives to purge what they have eaten. The consequences of anorexia can be severe, such as having low blood pressure and low body temperature, the occurrence of life – threatening cardiac rhythm as, retarded bone growth and anemia. Moreover, the low level of serum potassium caused by starvation can lead to irregularities in the heart rate that may cause death. Amenorrhea the absence of menstrual periods is common among girls or women with anorexia.

About 95 percent of those with anorexia are female. The prevalence of this disorder appears to be rising such that about 1 in 100 females suffer from it. Anorexia is considered a disorder of childhood because its onset is usually in early to late adolescence, although it can begin at any age. Psychosocial theories of anorexia suggest that it arises from a deep need for autonomy, which comes from being in over controlling family.

Anorexia can be a difficult disorder to treat. Clinicians and researchers explore the use of psychotherapy in treatments. While more recent approaches rely heavily on behavioural and cognitive therapy techniques to help the families reduce the symptoms.

Bulimia: Bingeing on food is not uncommon but people with bulimia are excessively critical about their binges and more generally about their physical appearance. As a result, they attempt to purge after a binge by self-induced vomiting by misusing laxatives, diuretics, or other medications by fasting or by excessive exercising. Often the binge/purge

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episodes take hours out of each deny and become habitual. Many sufferers of bulimia also suffer from severe depression. Many sufferers of bulimia also suffer from severe depression. Majority of people who suffer from bulimia are women. The women also experience menstrual problems frequent vomiting and other types of purging can lead to severe loss of body fluids and an imbalance in electrolytes, which regulate the heart. Such an imbalance can result in heart failure.

Some researchers believe that both anorexia and bulimia are variants of a mood disorder. In recent years, there is an increase in the prevalence of both anorexia and bulimia, and they are more common in developed countries than in underdeveloped countries. Cultural norms play a role in the etiology of these disorders. Thinness is considered a virtue in some societies, especially for females. The ideal shape for women as indicated by television stars, fashion models and winners of beauty pageants has been that of a thin frame. Some women succumb to this pressure by going on extremely restrictive diets. Many women who develop bulimia have a history of going on extremely restrictive diets, which are chronically stressful and frustrating. Other times, purging is a way of reducing the distress that the binge has caused.

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Summary

The two major categories of eating disorders that we have are anorexia nervosa and bulimia. People suffering from anorexia nervosa have an intense fear of ____ The two subtypes of anorexia nervosa are restricters and purgers. About 95 percent of those with anorexia are female. People with Bulimia are excessively critical about their binges and more generally about their physical appearance. Many sufferers of Bulimia also suffer from severe depression.

The term *enuresis* is defined as involuntary urination at least twice a month for those who are older. Stuttering is a marked disorder in speech rhythm. The signs are first apparent by the time the child is 3 years old. A tic is a repetitive involuntary movement or vocalisation that has a very sudden onset.

Post-Test

1. Mention the two major categories of eating disorders.
2. People suffering from anorexia nervosa have an intense fear of ____
3. The two subtypes of anorexia nervosa are ___ and ___
4. ____ is common among girls or women with anorexia.
5. ____ Percent of those with anorexia are women.
6. People with Bulimia shows ____ about their binges and _____
7. Many sufferers of Bulimia also suffer from severe.
8. Another term for enuresis is ____
9. Primary Enuresis occurs when ____
10. _____ Factors play a role in stuttering.

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LECTURE SEVEN

Substance Abuse Disorders

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Introduction

In this lecture, substance use disorders are discussed with emphasis on the maladaptive patterns of substance use. The categories of substances people often misuse are also listed according to the DSM-IV. Many people use drugs to change their level of awareness, mood and feelings. Sometimes, the drugs are not prescribed by a qualified medical practitioner i.e. they are self-medicated and self administered. This is what is referred to as drug abuse, which could lead to maladaptive behaviour, drug dependence and addiction.

Objectives

At the end of this lecture, you should be able to:

1. distinguish between substance use and substance use disorders,
2. describe the maladaptive of behaviour due to substance misuse; and
3. differentiate the categories of substances people often misuse.

Pre-Test

1. Distinguish between substance use and substance use disorders.
2. Describe the maladaptive patterns of substance misuse.
3. Differentiate the categories of substances people often misuse.

CONTENT

Drug use is not a new problem. Humans have used drugs for thousands of years to cure illness, alleviate pain, and relieve mental suffering. A drug is defined as any substance other than food that affects our bodies and minds. It need not be a medicine or be illegal. The term "substance" is now frequently used in place of "drug" in part because many people fail to see that such substances as alcohol, tobacco and caffeine are drugs too. When a person ingests a substance whether it is alcohol, cocaine, marijuana or some form of medication, trillions of powerful molecules surge through the blood stream and into the brain. Once there, the molecules set off a series of biochemical events that disturb the normal operation of the brain and body. The substance mis-use may lead to various kinds of abnormal functioning. Some substances can also lead to long-term problems. People who regularly ingest them may develop maladaptive patterns of behavior and changes in their body's physical responses. The maladaptive patterns may include:

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Substance Abuse: This is a maladaptive pattern of substance use leading to clinically significant impairment or distress. People may excessively rely on the drug and in doing so damage their family and social relationships, function poorly at work or put themselves and others in danger. This is indicated by one or more of the following occurring within one year.

1. Recurrent substance use, resulting in failure to fulfill major obligations at work, school or home.
2. Recurrent substance use in situations in which it is physically hazardous ,
3. Recurrent substance-related legal problems ; and
4. Substance use that continues despite its causing or increasing persistent social or interpersonal problems.

Substance Dependence: This is a more advanced maladaptive pattern of substance use leading to significant impairment or distress. Substance dependence is also known as addiction. In this pattern, people not only abuse the drug but also centre their lives on it and perhaps acquire a physical dependence on it, marked by a tolerance for it, withdrawal

symptoms or both. Substance dependence is manifested by at least three of the following within one year period:

1. Tolerance
2. Withdrawal
3. Substance often taken in larger amounts over a longer period than was intended.
4. Persistent desire for substance or unsuccessful efforts to control substance use.
5. Considerable time spent trying to obtain, use or recover from the substance
6. Substance use in place of important activities
7. Substance use that continues despite its causing or increasing persistent physical or psychological problems.

Withdrawal: symptoms consist of unpleasant and even dangerous symptoms – cramps, anxiety attacks, sweating, and nausea that occur when individuals suddenly stop taking or can't cut back on the drug.

Categories

The substances people misuse fall into several categories. They are examined below:

1. Depressants

Depressants slow the activity of the central nervous system. It includes alcohol, sedative – hypnotic drugs and opiods.

2. Alcohol: is any beverage that contains ethyl alcohol including beer, wine and liquor.

3. Sedative-hypnotic drug: A drug used in low doses to reduce anxiety and in higher doses to help people sleep. It is also called anxiolytic drug. The sedative-hypnotic drug includes Barbiturates and benzodiazepines.

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3. Opiods: This is a highly addictive substance made from the sop of opium poppy. The drugs derived from it are heroin, morphine and endorphins.

Stimulants

These are substances that increase the activity of the control Nervous system resulting in increased blood pressure and heart rate, greater alertness and speeded up behaviour and thinking. This includes cocaine, amphetamines, caffeine and nicotine.

Cocaine: An addictive stimulant obtained from the coca plant. It is the most powerful stimulant known. Its potent form is crack, which is extremely addictive. Chronic use can cause psychosis and paranoia. Cocaine use is associated with many medical problems.

Amphetamine: Is a stimulant drug that is manufactured in the laboratory.

Caffeine: The world's most widely used stimulant, most often consumed in coffee. The rest is consumed in tea (from the tea leaf) cola (from Kola nut) chocolate (from Cocoa Bean) and numerous prescriptions and over-the-counter medications, such as Excedrin.

Hallucinogens

This is a substance that causes powerful changes primarily in sensory perception including strengthening perceptions and producing illusions and hallucinations. This includes LSD (Lysergic acid diethylamide) developed by Albert Hoffman in 1938. Lysergic Acid Diethylamide (LCD) is a hallucinogenic drug derived from ergot Alkaloids.

Cannabis Drugs

These are drugs produced from the varieties of the hemp plant cannabis sativa. They cause a mixture of hallucinogenic, depressant and stimulant effects. The most powerful of them... is hashish, the weaker ones include Marijuana.

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Marijuana: One of the cannabis drugs derived from the buds, crushed leaves and flowering tops of hemp plant, Cannabis sativa. It is a commonly used illicit drug and cause mild perceptual changes and feelings of well-being.

Polysubstance-related Disorder:

A long-term pattern of maladaptive behaviour centred on abuse of or dependence on a combination of drugs. Poly substance related disorders are becoming as common as individual substances related disorders. Multiple drug use has led to the death of thousands of people, especially, American celebrities. Elvis Presley delicate balancing act of stimulants and depressants eventually killed him. This is the same for many others.

Psychological, social and biological factors contribute to the development of substance use disorders (see lecture 2). A diagnosis of anti-social personality disorder is a risk factor drug and alcohol addiction. Genetic factor may also influence vulnerability to addiction.

Many approaches have been used to treat substance-related disorders, including psychodynamic, behavioral cognitive-behavioural, biological and socio cultural therapies. Today, the treatments are typically used in combinations on both out- patient and in-patient basis. Moreover, some people recover without any intervention at all while others recover and then relapse and still others fail to improve. Adejumo (2007) suggested the following in the treatment of drug abuse:

1. Re-assure the patient that it is possible to stop abusing substances/drugs.
2. Link the patient up with alcohol/narcotic among many groups.
3. It may be necessary to enter a patient treatment center.
4. Encourage patient de-toxification for about two weeks.
5. Identify and deal with psychosocial problems emerging from drug use.

Substance abuse shows a high rate of co morbidity with personality disorders depression, anxiety and schizophrenia. There is often a developmental progression with children who have a conduct disorder beginning experimentation with drugs, then progressing with children who have a conduct disorder beginning experimentation with drugs, then progressing to anti social personality disorder and drug addiction.

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Although this developmental pattern is more common among males, it can also occur in females. The following case history of many illustrates the childhood origins of substance abuse.

Substance Abuse in children: case study

Mary was the second of three children born into a middle class family. Her father was a sales representative for a furniture company and her mother worked part-time as a hair stylist. Mary was a happy energetic child who did well in school and had a broad cycle of friends. At the age of nine, she won a state award for her skills in jazz dance. Her family and friends attended her performance and celebrated her award. When Mary was twelve, she travelled with a group of friends to participate in a dance competition in another state. Her group came in second place. At a party following the competition, many met pre-teens from many areas of the country. After she returned home, Mary began to correspond with a boy name Larry, whom she had met at the party. Mary's parents had some apprehension about her new friend, primarily because he was fourteen years old. But they decided not to express their reservations. One year later, when Mary was thirteen, Larry came to visit friends in her home town. He phoned Mary and invited her to his home town. He phoned Mary and invited her to a party. Her parents said she should not go, and Mary became furious. She sneaked out of the house that evening to attend the party, and didn't return until 2.00am.

That evening marked the beginning of a series of behaviour problems. At fourteen, Mary began to wear make-up and clothes that made her look much older than she was. She repeatedly violated her curfew and her grades began to drop. One night, she came home at 12:00am with alcohol on her breath. Her parents grounded her and limited her privileges but nothing seemed to affect Mary's behaviour. When she was fifteen, Mary stole money from her parents and she began smoking Marijuana.

Mary's first experience with an illegal drug, Marijuana, was preceded by the use of a legal drug, alcohol. During this transitional period, there was an increase in her noncompliance. This is a very typical developmental pattern. However, for most youngsters, the behaviour problems begin to subside in late adolescence, and there is no progression to adult substance

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abuse. It is only a minority of teens who progress to drug addiction.

Summary

The term "substance" is now frequently used in place of "drug" Substance misuse many lead to various kinds of abnormal functioning. The maladaptive patterns of substance misuse many include substance Abuse and substance dependence. Substance abuse shows a high rate of co morbidity with personality disorders. There is often a developmental progression with children who have a conduct disorder beginning experimentation with drugs, the progressing to antisocial personality disorder and drug addiction. The substances people misuse falls into several categories such as depressants stimulants, Hallucinogens and cannabis drugs. Depressants include alcohol, Sedative-hypnotic drugs and opiods. Stimulants include cocaine, amphetamines caffeine and Nicotine. Hallucinogens include cocaine, amphetamines caffeine and Nicotine.

Cannabis drugs include hashish and marijuana. Poly-substance related disorder is a long term pattern of maladaptive behaviour centered on abuse of or dependence on a combination of drugs.

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Post-Test

1. The maladaptive patterns of substance misuse may include _____
2. Substance abuse shows a high rate of co-morbidity with _____
3. Depressants includes _____ _____ and _____
4. Stimulants includes _____ _____ _____ and _____
5. LSD is derived from _____
6. Hashish and marijuana are derived from _____
7. Poly-substance related disorder is centered on _____
8. Withdrawal symptoms includes _____ (mention 3) _____ and ____
9. Alcohol is any beverage that contains _____

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LECTURE EIGHT

Child Abuse & Neglect

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Introduction

Child abuse is a problem that affects many children and has an enormous impact on their psychological development. This lecture will make you to understand the early detection of child abuse, prevalence of child abuse, the forms of child abuse and the treatments which helps parents to deal with child abuse.

Objectives

At the end of the lecture, you should be able to:

1. explain child abuse;
2. describe the forms of child abuse; and
3. describe the treatments of child abuse.

Pre-Test

1. Explain what is meant by child abuse
2. describe the forms of child abuse
3. describe the treatments of child abuse

CONTENT

Case study

> *What I remember most about my mother was that she was always beating me. She'd beat me with her high-heeled shoes, with my father's belt, with a potato masher. When I was eight, she black and blued my legs so badly, and I told her I'd go to the*

police. She said, "Go, they'll first put you into the darkest prison". So I stayed. When my breast started growing at 13, she beat me across the chest until I fainted. Then she'd hug me and for ask forgiveness… most kids have nightmares about being taken away from their parents. I would sit on our front porch crooning softly of going far, far away to find another mother". (TIME, SEPTEMBER 5, 1983, p. 20)

The above represents physical or psychological force by an adult on a child, often with the intention of hurting or destroying the child. 5/26 percent of children in the United States are physically abused each year. Surveys suggest that one of every 10 children is the victim of severe violence, such as being kicked, bitten, hit, beaten, or threatened with a knife or a gun. Some observers believe that physical abuse and neglect are the leading causes of death among young children.

Boys and girls are physically abused at approximately the same rate. Child abuse occurs in all socio-economic groups, and it is more common among the poor. Abusers are usually the parents. There are two forms of child abuse; psychological abuse and sexual abuse.

Psychological abuse: This may include severe regeration, excessive discipline, scapegoating and ridicule, isolation and refusal to provide help for a child with psychological problems. It probably accompanies all forms of physical abuse and neglect and often occurs by itself.

Child sexual Abuse: This is the use of a child for gratification of adult sexual desires. This may occur outside the home or within the home. Child sexual abuse appears to be equally common across all socio-economic classes, races, and ethnic groups' surveys suggest that at least 13 percent of women were forced into sexual contact with an adult male during their childhood, many of them with their father or stepfather. At least 4 percent of men were also sexually abused during childhood. Therapies which help parents to develop insights into their behaviour provide training on alternatives to abuse and also teach parenting skills have been used in the treatment of child abuse. Other treatments help parents deal more effectively with the stresses that often trigger the abuse, such as unemployment, marital conflict and feelings of depression.

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Summary

Child abuse is a non-accidental use of excessive physical or psychological force by an adult on a child often with the intention of hurting or destroying the child. Surveys suggest that one of every 10 children is the victim of severe violence such as being kicked, bitten, hit, beaten or threatened with a knife or a gun. Some observers believe that physical abuse and neglect are the leading causes of death among young children. Boys and girls are physically abused at approximately the same rate. Abusers are usually the parents. There are two forms of child abuse psychological abuse and sexual abuse. Psychological abuse may include sever rejection, excessive discipline scopegoating and ridicule, isolation and refusal to provide help for a child with psychological problems. Child sexual abuse: is the use of a child for gratification of adult sexual desires. Therapies are useful in the treatment of child abuse.

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Post –Test

1. Child abuse is a problem that affects money _____
2. What is child abuse?
3. Child abuse can lead to ____ of a child
4. Child abuse occurs in_____ groups.
5. The abusers are usually _____
6. The two forms of child abuse are _____ and _____.
7. What is child sexual abuse?
8. Child sexual abuse may occur
9. ____ is useful in the treatment of child abuse.
10. Other treatments help the parents to _____.

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LECTURE NINE

Childhood Indicators of Schizophrenia

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Introduction

Schizophrenia is a profound psychological disorder that affects thought, perception and mood. In this lecture you will learn about the definition, symptoms, diagnosis, prevalence and treatment of schizophrenia in order to better understand the childhood indicators of schizophrenia.

Objectives

At the end of this lecture, you should be able to.

1. define schizophrenias;
2. Identify the symptoms of schizophrenia; and
3. Explain the childhood indicators of schizophrenias.

Pre-Test

1. Define schizophrenia.
2. Identify the symptoms of schizophrenia
3. Explain the childhood indicators of schizophrenia.

CONTENT

The term “schizophrenia” was coined by combining Greek words that mean” split mind” by the Swiss psychiatrist Eugen Bleuler (1857-1939). Although the definition of schizophrenia is controversial, Comer (2004) defined schizophrenia as a psychotic disorder in which personal, social and occupational functioning deteriorate as a result of strange perceptions disturbed thought processes, unusual emotions and motor abnormalities.

People with schizophrenia experience psychosis, a loss of contact with reality. Their ability to perceive and respond to the environment becomes so disturbed that they may not be able to function at home, with friends in school or at work. They may have hallucinations (false sensory perceptions) or delusions (false sensory perceptions) or delusions (false beliefs), or they may withdraw into a private world.

Another definition was offered in 1994 in DSM – IV. In order to be diagnosed with schizophrenia, the symptoms must last for at least 6 months and there must be marked deterioration from the individual's previous level of functioning at work, in social relations and in self care. The five symptoms according to DSM IV category are examined below:

Delusions

Many people with schizophrenia develop delusions, ideas that they believe whole-heartedly but that have no basis in fact. There are five kinds of delusions: delusions of grandeur, delusions of control, delusions of persecution, delusions of reference, and somatic delusions. The deluded person may consider the ideas enlightening or may feel confused by them.

Hallucination

This is the experiencing of sights, sounds or other perceptions in the absence of external stimuli. Hallucinations are the perceptual signs of psychosis. They involve false sensory perceptions that have a compelling sense of reality even in the absence of external stimuli that ordinarily provoke such perceptions. In a schizophrenic, hallucinations are usually auditory, but they can also be usual or involve other sense organs, such as taste and smell.

Occasionally, children are diagnosed with schizophrenia, but this is very rare. For children under the age of twelve, the prevalence is about 2 cases per 100,000 children. In late adolescence and early adulthood, there is a marked increase, so that the prevalence approaches the lifetime rate of 1 in 100. The risk for the onset of schizophrenia is strongly linked with developmental changes. Numerous studies show that parents state that long before the onset of clinical symptoms, they noticed the same unusual behavioural characteristics in their pre-schizophrenic child such as motor delays, emotional instability and academic problems. Some parents report that they noticed subtle temperamental abnormalities in infancy.

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In most cases, clinical symptoms of schizophrenia are not apparent until the person reaches early adulthood. Researchers suggest that the vulnerability must be “silent” or unexpressed during the person’s formative years. Pre-schizophrenic children differ from their healthy siblings. They show more delays and abnormalities in motor development during the first two years of life. Among the abnormalities observed were weakness and unusual positioning of the left arm and leg. The early signs of schizophrenia falls into several domains of behaviours such as motor, interpersonal and cognitive. Secondly, many pre-schizophrenic children show the most pronounced adjustment problems when they enter adolescence. Thirdly, the more severe the childhood problems, the earlier the onset and the more severe the illness vulnerability to the disorder can be inherited. Events that occur during pregnancy and delivery such as obstetrical complications can increase the child’s risk for schizophrenia in adult life. The leading psychological explanations for schizophrenia come from the psycho-dynamic, behavioural and cognitive models. There are also socio-cultural and the diathesis – stress explanations.

For several years in the past, efforts to treat schizophrenia brought only frustration. The disorder is still difficult to treat however; therapies in the contemporary world are more successful, than those of the past. In the past, the main treatment for schizophrenia was institutionalisation and custodial care through overcrowd public institutions, such a state hospitals etc. Nowadays the discovery of anti-psychotic drugs in the 1950s revolutionised the treatment of schizophrenia. Psychotherapy has also been employed successfully in combination with antipsychotic drug. A community approach to the treatment of schizophrenia also began in the 1960’s.

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Summary

The term schizophrenia was carried by combining Greek words that mean "split mind. In order to be diagnosed with schizophrenia, the symptoms must last for at least 6 months. The definition of schizophrenia is controversial. Comer (2004) defined schizophrenia as a psychotic disorder in which personal, social and occupational functioning deteriorate as a result of strange perceptions, disturbed thought processes, unusual emotions and motor abnormalities. Delusions are ideas that people with schizophrenia behave whole heartedly but that have no basis in fact. There are five kinds of delusions of grandeur, delusions of control, delusions of references, delusions of persecution and somatic delusions. Hallucinations are the perceptual signs of psychosis. Children are diagnosed with schizophrenia but this is very rare. The risk for onset of schizophrenia is strongly linked with developmental changes. Antipsychotic drugs and psychotherapy are used in the treatment of schizophrenia.

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Post-Test

1. _____ coined the term for schizophrenia in 1857-1939.
2. A psychotic disorder in which personal, social and occupational functioning deteriorates is called _____.
3. Psychosis is a _____ with reality.
4. According to DSM – IV, 1994, in order to be diagnosed with schizophrenia, the symptoms must last for at least _____ month.
5. Delusions are _____
6. The experiencing of sights, swords or other perceptions in the absence of external stimuli is called _____
7. Unusual behavioural characteristics in pre-schizophrenic children includes (a) _____ (b) _____ and (c) _____
8. In the past, the main treatment for schizophrenia was _____
9. Recent treatments for schizophrenia includes (a) _____ and (b) _____

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LECTURE TEN

Suicide in Children

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Introduction

Most people faced with difficult situation never try to kill themselves. In an effort to understand why some people are more prone to suicide than other, theorists have proposed explanations for self destructive actions. Recently, researchers have paid particularly attention to self-destructive behaviour in children party because suicide at their young age contradicts perception that childhood is an enjoyable period. This lecture gives a definition of suicide and what triggers it, the prevalence of suicide in children, causes of suicide in children, causes of suicide in children, the behavioural patterns that precedes suicide attempts in children and finally treatment of suicide.

Suicide is the most disastrous consequence of depression. It is frequent among young people, and it is the second most common cause of death among college students. There are two fundamental motivations for suicide. Surcease or desire to end it all, and manipulation: or desire to charge the world or other individuals by a suicide attempt

Objectives

At the end of the lecture, you should be able to:

1. describe “suicide”;
2. discuss suicide in children; and
3. Explain treatment and suicide.

Pre-Test

1. Distinguish between suicide and natural death.
2. discuss in detents suicide in children
3. explain treatment and suicide

CONTENT

Edwin Schneidman (2001) defines suicide as intentioned death in which one makes an intentional, direct and conscious effort to end one's life. Suicidal acts may be triggered by stressful events, mood and thought changes, alcohol, other drug use, mental disorder and modelling. Most people faced with difficult situation never try to kill themselves. In an effort to understand why some people are more prone to suicide than others, theorists have proposed explanations for self destructive action. The leading theories come from the psychodynamic, socio-cultural and biological perspectives. These hypotheses have received limited research support and fail to address the full range of suicidal acts. The likelihood of suicide varies with age.

Although suicide in children is infrequent, it has been increasing over the past several decades. Approximately, 500 children under 14 years of age in the United States now commit suicide each year. Boys out number girls by as much as 5 to 1. It has been estimated that one of every 100 children tries to harm himself or herself and many thousands of children are hospitalised each year for deliberately self destructive acts such as stabbing, cutting, burning overdosing or jumping from high places. One study of suicide attempts by children revealed that the majority had taken an overdose of drugs at home, half were living with only one parent and a quarter had attempted suicide before. Recent studies further suggest that the use of guns is increasing among children who attempt suicide (Cytrn and Mcknew, 1996)

The suicide attempts by the very young are commonly preceded by such behavioural patterns as running away from home, accident proneness, acting out temper tantrums, self depreciation, social withdrawal and loneliness, extreme sensitivity to criticism, low tolerance of frustration, dark fantasies and clay dreams, marked personality change and overwhelming interest in death and suicide.

Children suicide has also been limited to the recent or anticipated loss of a loved one family stress etc. Furthermore, conditions of poverty,

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unemployment, etc could lead to depression that would eventually cause suicide attempts. Most people find it hard to believe that children fully comprehend the meaning of a suicide act. They agree that because a child's thinking is so limited, children who attempt suicide fall into Schneidman category of "death ignorer "*like a boy named Billy who sought to join his mother in heaven."*

Many child suicides, however, appear to be based on a clear understanding of death and a wish to die. Clinical interviews with school children revealed that between 6 and 33 percent have thought about suicide. (Culp, Cylman & Culp, 1995).

Treatment and suicide: the treatment of suicidal people falls into two major categories: treatment after suicide has been attempted and suicide prevention. Treatment may also be beneficial to relatives and friends. After a fatal suicide attempt, most victims need medical care. Some are left with several injuries, brain damage, and either an inpatient or outpatient basics.

Suicide prevention: the first suicide prevention programme in the United States was founded in Los Angeles in 1955 while the first in England called the Samaritans was started in 1953. There are numerous suicide prevention centres in the United States and in England. In addition, many of today's mental health centre hospital emergency rooms, pastoral counselling centre include suicide prevention programmes among their services. Suicide prevention programmes offer crisis intervention; they try to help suicidal people see their situations more accurately, make better decisions act more constructively, and overcome their crises. Furthermore, crises intervention in the lives of suicidal people also need long term therapy. Thus, another way to help prevent suicide may be to reduce the public access to common means of suicide. Measures such as gun control, safer medications and car emmission may eradicate this negative phenomenon. Several theorists have called for effective public education about suicide as the ultimate form of prevention. As a result, some suicide education programmes have begun to emerge.

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Case study 1

Tommy (age 7) and his younger brother were playing together, and a quarrel arose that was settled by the mother, who then left the room. The mother recalled nothing to distinguish this incident from previous innumerable similar ones. Several minutes after she left, she considered Tommy strangely quiet and returned to find him crimson face and struggling for air, having knotted a jumping rope around his neck and jerked it tight. (French Berlin, 1979, p 144)

Case study 2 Dear Mum & dad

I love you. Please tell my teacher that I cannot take it anymore. I quit. Please don't take me to school anymore. Please help me, l will run away so don't stop me. I will kill myself. So, don't look for me because I will be dead. I love you. I will always love you. Remember me. Help me

Love Justin (age 10) (Pfeiffer, 1986, p. 273)

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Summary

Edwin Schneidman (2001) defines suicide as _____Suicidal acts may be triggered by stressful life events, mood and thought changes. Suicide is the most disastrous consequence of depression. There are two fundamental motivations for suicide, surcease, or desire to end it all, and manipulation or desire to change the world or other individuals by a suicidal attempt. Although suicide in children in children in infrequent, it has been increasing over the past several decades. Recent studies suggest that the use of guns is increasing among children who now attempt suicide. Suicide attempts by the very young are preceded by behavioral patterns such as running away from home, accident proneness, acting out, temper tantrums self-depreciation, social withdrawal and loneliness, extreme sensitivity to criticism low tolerance of frustration, dark fantasies and day dreams, marked personality change and overwhelming interest in death and suicide.

Children who attempt suicide fall into Schneidman's category of 'death ignorers". Although crisis intervention seems to be sufficient treatment of suicide, most suicidal people also need long-term therapy. The treatment of suicidal people falls into two major categories "treatment after suicide has been attempted and suicide prevention.

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Post-Test

1. Edwin Scheidman (2001) defines suicide as _____
2. Suicidal acts may be triggered by (a) _____ (b) _____ (c) _____ changes, alcohol and other drug use mental disorders and modeling.
3. Suicide is the most disastrous consequence of _____.
4. There are two fundamental motivations for suicide: (a) _____ (b) _____
5. Approximately 500 children under ____ years of age in the United States how commit suicide each year.
6. Children with suicidal tendencies commit self-destructive acts such as (a) _____ (b) _____ and (c) _____

7. The suicide attempts by the very young are commonly preceded by such behavioural patterns as (a) _____ (b) _____ (c) _____ (d) _____
8. Child suicides have been linked to _____
9. Children who attempt suicide fall into Schneidman's category of _____
10. The two major categories of suicide treatments are (a) _____ (b) _____

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