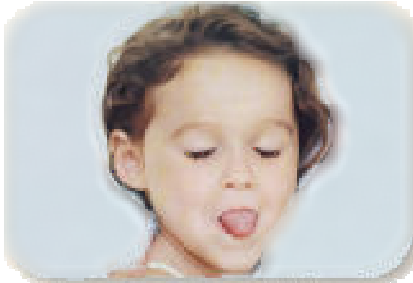


DEVELOPMENTAL AND BEHAVIOURAL PROBLEMS



This Section contains information on the following topics-

An Overview

Selected Developmental and Behavioural Problems Usually First Diagnosed in Infancy, Childhood or Adolescence-Identification and Management

- **Pervasive Developmental Disorders**
 - Autism Spectrum Disorders
 - Autism
 - Asperger's Syndrome
 - Rett's Disorder
 - Pervasive Developmental Disorder (NOS)
- **Attention-Deficit and Disruptive Behaviour Disorder**
 - Attention-Deficit/Hyperactivity Disorder (Subtypes)
 - Conduct Disorder
 - Oppositional Defiant Disorder
 - Disruptive Behaviour Disorder (NOS)

Reclassification of Some Developmental and Behavioural Problems in the DSM-5

- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder

Selected Emotional Disorders in Children and Adolescence-Identification and Management

- **Anxiety**
 - Generalised Anxiety Disorder
 - Separation Anxiety Disorder
 - Phobias
 - Obsessive Compulsive Disorder
 - Post-Traumatic Stress Disorder

- **Depression**

Reclassification of Anxiety and Depression in the DSM-5

Stress and Anxiety in Adults-Identification and Management

- Defining Stress
- Maslow's Hierarchy of Needs
- Management of Stress
- Defining Anxiety
- Management of Anxiety

Resources

References

AN OVERVIEW

This Section explores issues central to the identification and management of developmental and behavioural disorders found in children and adolescents. Some attention is also given to adults suffering with stress, anxiety and depression.

Classification of Disorders

To assist psychologists and other professionals recognise and manage children and adolescents with developmental and behavioural/emotional problems, the classificatory systems of the Diagnostic and Statistical Manual of Mental Disorders-(DSM-1V TR-2005), the International Statistical Classification of Diseases and Related Health Problems (ICD-10-2007), Managing Mental Disorders, WHO (2004), and the DSM-5 (2013), provide excellent direction and guidance. Other sources include the DEECD classification and selected texts.

From these and other sources, details are provided on the following topics-

- Categories of Disorders
- Definition of Disorders
- Treatment and Management of Disorders

The main classificatory systems, while basically identifying similar disorders, vary slightly in terminology and definitions. From the total list of disorders, those considered more common and hence most likely to come to the attention of psychologists and teachers will be studied.

The DSM-5 has introduced the new term, **Neurodevelopmental Disorders** which encompasses the following categories-

Intellectual Disabilities*

Intellectual Disability (Intellectual Developmental Disorder)

Autism Spectrum Disorder

Autism Spectrum Disorder

Specific Learning Disorder*

Specific Learning Disorder

Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder

Other Specified Attention-Deficit/Hyperactivity Disorder

Unspecified Attention-Deficit/Hyperactivity Disorder

Communication Disorders

Language Disorder

Speech Sound Disorder (Previously Phonological Disorder)

Childhood-Onset Fluency Disorder (Stuttering)

Social (Pragmatic) Communication Disorder

Unspecified Communication Disorder

Motor Disorders

Developmental Coordination Disorder

Stereotypic Movement Disorder

Tourette's Disorder

* Information on these two Disorders is provided in detail in the Section-**Exceptionality**.

Detailed information on the following disorders is provided below-

- Autism Spectrum Disorder
- Attention- Deficit/Hyperactivity Disorder

In addition, information on **Disruptive Mood Dysregulation Disorder**, a new addition to the Depressive Disorders, has been included. This has been added as a disorder to diagnose children who exhibit persistent irritability and frequent episodes of behaviour outbursts three or more times a week for more than a year. The diagnosis is intended to address concerns about potential over-diagnosis and overtreatment of bipolar disorder in children.

This new disorder will be discussed in detail below under Depression.

Psychological Treatment of Disorders

Nathan and Gorman (2002, 2007) provide a helpful classification of treatments. The main types of psychological interventions that have been used with children and adolescents with developmental and behavioural disorders include the following-

- Cognitive-Behavioural Therapy (CBT)
- Behavioural Interventions
- Exposure Techniques
- Activity Scheduling
- Psychoeducation
- Social Skills Training
- Parent Management Training
- Relaxation Techniques

Cognitive-Behavioural Therapy (CBT)

CBT is well established as an effective treatment for a range of disorders. This approach utilises a combination of cognitive and behavioural techniques to target an individual's symptoms. The focus is on teaching a person how to control their symptoms, correct faulty thinking patterns and manage their own disorder. Ideally, at the end of treatment a client should be able to use the strategies they have been taught to deal with any future problems and possible return of symptoms.

Cognitive Interventions

These treatments are predicated on the proposition that the way a person interprets or appraises a situation is based on their past experiences and that this focus influences how they think and subsequently feel. This approach contends that modifying the way a person thinks will change the way they interpret a situation which should then lead to a subsequent change in behaviour. For example, a person with depression will often have a number of negative thoughts which are a classic "cognitive symptom". Although treating some of the symptoms of depression using behavioural techniques (e.g., activity scheduling) will be affective, it is also important to focus directly on this cognitive symptom.

The A-B-C model developed by Ellis (1975) is often used to explain the influence on the way we think, on the way we feel and behave.

Activating Event (A) Belief or Reaction to Event (B) Emotional Consequences (C)

It is commonly assumed that (A) leads directly to (C). However, in most cases, it is a person's reaction or thoughts in response to an event (B) that influences how they feel.

Beliefs and what we say to ourselves (i.e., "self-talk") have a very strong influence on how we feel. Thus, the aim of cognitive therapy is to teach a client how to modify their beliefs (B) about an event in order to change their emotional reaction (C). The next step, often referred to as (D) in this model, is when the client learns to challenge their negative thoughts and substitute these with more rational beliefs. The end result is (E), a new emotional effect or consequence.

Care needs to be taken when using these approaches with children and adolescents as their effectiveness is very dependent on their ability to think and reason. Hence, factors such as the level of intellectual, language and communication skills must be taken into consideration.

Behavioural Interventions

These techniques are used to decrease dysfunctional or problem behaviour or to increase or learn desirable or functional behaviour. It is particularly effective in treating externalising disorders and for developing prosocial and basic living skills in children and adolescents.

Behaviour modification commences with a thorough behavioural analysis which involves specifying and measuring the behaviours to be altered and identifying the antecedents and consequences controlling these behaviours. This analysis is followed by a systematic program which may include altering the stimulus triggering the unwanted behaviour, shaping up new adaptive (competing) behaviour and contingency management (using reinforcers for increasing desirable and consequences to decrease the unwanted/dysfunctional behaviour).

After changing particular behaviours, techniques for generalisation and maintenance are discussed along with relapse prevention.

Exposure Techniques

Exposure techniques are used for all the anxiety disorders, particularly the phobias. Essentially, exposure involves confronting the feared situation/event/ activity so that the fear decreases or ideally is extinguished.

Graded exposure is the most commonly used technique. It involves identifying a client's fears and constructing a hierarchy of the least to the most feared situations. A graded approach is necessary because of the fear it provokes and few individuals would be willing to confront this immediately and directly when commencing treatment.

Hence the individual enters the anxiety provoking situations in graded steps so that anxiety is evoked but not overwhelmingly so. The person is then instructed to remain in the situation until their anxiety decreases. By staying in the situation until the fear subsides, the person learns that their fear is groundless.

Systematic desensitisation is similar in that it involves exposure to a hierarchy of feared objects or situations (often in imagination) while using slow breathing and/ or relaxation techniques and cognitive coping self-statements to cope with the anxiety experienced.

Activity Scheduling

This technique is mainly used to assist clients with depression. Activity scheduling is a useful strategy for clients who have lost interest in doing things that they enjoy and who find it difficult to undertake basic daily tasks. It is particularly important to increase pleasurable activities when people feel depressed, as they feel less inclined to engage in activities that are a source of pleasure and satisfaction. Similarly, when people are not involving themselves in activities that they consider pleasant, this can make them feel depressed. This creates a vicious cycle and in order to break this pattern of inactivity clients need to learn how to keep active when they feel down. Activity scheduling is a behavioural technique designed to mobilise the client and to increase the range and frequency of pleasant activities in which they are engaged. The overall aim is to teach clients how to increase their activities in a structured and organised manner, thereby improving their mood. Activity is the key and mastery of tasks, pleasant activities or exercise, should be reinforced.

Psychoeducation

This approach involves explaining the disorder to the client and answering the client's questions about the disorder. Typically, the information is provided at the appropriate level and this includes education about how common is their disorder, what symptoms they have, any complications or other problems, what causes it, what will happen in the long term, what treatments work and what are the potential positive and negative consequences of those treatments. It is also useful to supplement this discussion with a handout that the client can read and refer to as needed. While helpful with some children and adolescents, care must be taken in determining how much information they can meaningfully assimilate and understand. With young people, their parents are usually actively involved in their management and treatment programs and hence an understanding of their youngster's condition is vitally important.

Social Skills Training (SST)

SST uses the principles of behaviour therapy to teach social skills, communication skills and independent living skills. Skills are broken down into several discrete steps. After reviewing the steps of the skill, the therapist usually models the skill by demonstrating a role-play. The client then does a role-play to learn and practise the skill. The therapist provides constructive feedback after each role-play and the client is given the opportunity to practise the skill several times. Repeated practice and "over-learning" of skills are important aspects of SST. Duration, frequency and exact content of SST interventions depend on the needs of the client.

The rationale for SST is based on the belief that people with certain disorders including Autism Spectrum Disorder, Conduct Disorder, Oppositional Defiant Disorder are deficient in social and/or communication skills and that these need immediate attention if their condition is to improve.

Parent Management Training

The work of Alfred Adler has been used to inspire the development and use of parenting programs for many years. The STEP (Systematic Training for Effective Parenting) program and the numerous "derivations" have been extremely popular with both parents and teachers. While these programs focus on the management of the behaviour of children and adolescents generally, they also are extremely helpful in managing behavioural and developmental disorders in young people. Details of such programs are provided in the **Parenting Section**.

Relaxation Techniques

Such techniques often supplement the main thrust of treatment. For further details see below on pages 61-66.

Other **Sections** also contain material relevant to the identification and treatment of developmental and behavioural disorders in children and adolescents. These include-

- **Exceptionality**
- **Parenting**
- **FAQs**

Selected Disorders from the Categories-Pervasive Developmental Disorders and Attention-Deficit and Disruptive Behaviour Disorders as well as some prominent Emotional Disorders, will be discussed below.

SELECTED DEVELOPMENTAL AND BEHAVIOURAL PROBLEMS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE- IDENTIFICATION AND MANAGEMENT

Pervasive Developmental Disorders

Autism Spectrum Disorders

- Autism
- Asperger's Disorder
- Rett's Disorder
- Pervasive Developmental Disorder (NOS)

Autism Spectrum Disorders

These disorders are characterised by severe deficits and pervasive impairment in multiple areas of development. These include impairment in reciprocal social interaction, impairment in communication and the presence of stereotyped behaviour, interests and activities. The conditions are difficult to treat and require ongoing intensive work to achieve even small gains.

Autism

Is characterised by qualitative impairment in the development of reciprocal social interaction, in the development of verbal and non-verbal communication and in imaginary activity. (DSM-1V-TR, 2005).

Characteristics

- abnormalities in the development of cognitive skills
- abnormalities of posture and motor behaviour, such as stereotypes (arm-flapping, jumping, grimacing) in response to excitement. Walking on tiptoe, odd hand and body postures and poor motor coordination
- odd responses to sensory input
- abnormalities in eating, drinking and sleeping
- abnormalities of mood
- self-injurious behaviour
- degree of severity

Asperger's Syndrome

A severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behaviour, interests, and activities. The disturbance must cause clinically significant impairment in social, occupational or other important areas of functioning. There are no clinically significant delays in language and cognitive development, although this does not imply that there are no problems with communication. (DSM-1V-TR, 2005).

Characteristics

- impairment in social interaction-e.g.,
 - marked impairment in multiple nonverbal behaviours such as eye-to-eye gaze, facial expression, body postures and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - lack of spontaneous seeking to share enjoyment, interests or achievements with other people
 - lack of social or emotional reciprocity

- restricted, repetitive and stereotyped patterns of behaviour, interests and activities-e.g.,
 - preoccupation with one or more stereotyped and restricted patterns of interests that is abnormal either in intensity or focus
 - inflexibility adherence to specific, non-functional routines or rituals
 - stereotyped and repetitive motor mannerism (hand and finger flapping or twisting, complex whole-body movements)
 - persistent preoccupation with parts of objects

- disturbance causes clinically significant impairment in social, occupational or other important areas of functioning
- while no clinically significant delay in language, communication problems are common
- no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behaviour (other than social interaction), and curiosity about the environment in childhood
- degree of severity

Because the DSM-1V-TR (2005) indicated the need to consider very recent developments in regard to Asperger's Syndrome, substantial details are provided above and additional information is summarised below.

In the revision, specific examples of typical manifestations of the impairment in reciprocal social interactions and in restricted, repetitive behaviour and interests are provided in order to better differentiate those individuals from those with Autism Disorder. In addition, the text has been extended to clarify the point that the requirement for no clinically significant delays in language does not imply that individuals with Asperger's Syndrome have no problem with communication.

I have been asked by parents, teachers and psychologists to develop an easy to use preliminary screening checklist that can be helpful in identifying common characteristics frequently observed in children and adolescents with Asperger's Syndrome. If several, positive signs are noted in more than two of the four domains, the student should be referred to a team of specialists including a paediatrician, a psychologist and a speech pathologist for comprehensive diagnostic assessments.

The following screening checklist draws on the valuable contributions of the following-

- DSM-1V-TR
- ICD-10
- Gillberg and Gillberg (1989)
- Szatmari, et al., (1989)
- Childhood Autism Rating Scales –CARS2 (Schopler et al., 2010)

In addition, the author's several decades of clinical observations are also used to identify defining characteristics.

The following is a checklist of the characteristics that I use and share with parents and teachers to tentatively identify children with possible Asperger's Syndrome and to decide whether or not to conduct a formal diagnosis.

This checklist can be used to identify the presence (Yes) or absence (No) of relevant characteristics.

The presence of Age Appropriate or Positive Attributes in cognitive, language and often academic areas, are important requirements while a range of Developmental Delays or Negative Attributes are defining characteristics.

The common symptoms of Asperger's Syndrome are arranged in four domains-

- Social Impairment
- Language and Communication Problems
- Motor Clumsiness
- Restrictive and Intense Interests

ASPERGER'S SYNDROME CHECKLIST

CHARACTERISTICS

Age Appropriate or Positive Attributes-	Yes	No
	√	X
<ul style="list-style-type: none"> No clinically significant general delay in spoken or receptive language or cognitive development 		
<ul style="list-style-type: none"> Satisfactory or better academic progress 		
Developmental Delays or Negative Attributes-		
Social Impairment		
<u>Solitary Activities</u>		
<ul style="list-style-type: none"> No or few close friends 		
<ul style="list-style-type: none"> Avoids others, no or little interest in making friends 		
<ul style="list-style-type: none"> Great difficulty keeping friends 		
<ul style="list-style-type: none"> A loner 		
<u>Impaired Social Interaction</u>		
<ul style="list-style-type: none"> Failure to develop age appropriate peer relationships that involve a mutual sharing of interests, activities and emotions 		
<ul style="list-style-type: none"> Impaired or deviant response to other person's emotions 		
<ul style="list-style-type: none"> Lack of spontaneous seeking to share enjoyment, interests or achievements 		
Language and Communication Problems		
Verbal		
<u>Speech</u>		
<ul style="list-style-type: none"> Abnormalities in inflection, prosody, voice characteristics 		
<ul style="list-style-type: none"> Repetitive pattern of speech 		
<ul style="list-style-type: none"> Superficially pompous, perfect or pedantic speech 		
<u>Language</u>		
<ul style="list-style-type: none"> Failure or weak use of eye-to-eye gaze 		
<ul style="list-style-type: none"> Talks to, not with, a person- engages in a monologue rather than a dialogue 		
<ul style="list-style-type: none"> Idiosyncratic use of word 		

Non-verbal		
Failure to use the following to regulate social interaction		
• Facial expressions		
• Body posture		
• Gestures		
• Social distance, social space		
Motor Clumsiness		
• Underdeveloped fine-motor skills and co-ordination-handwriting problems common		
• Clumsy gross-motor skills		
• Awkward gait		
Restrictive and Intense Interests		
• Preoccupation with stereotyped and restricted pattern of interests		
• Compulsive adherence to specific, non-functional routines or rituals		
• Stereotyped and repetitive motor mannerisms that involve hand or finger flapping or twisting or complete whole-body movements, pacing		
• Preoccupation with part-objects or non-functional elements of play material (such as colour, smell, feel or noise)		

If several impairments are registered in more than two of the four domains-

- **Social Impairment**
- **Language and Communication Problems**
- **Motor Clumsiness**
- **Restrictive and Intense Interests**

then further investigation is recommended.

It must be stressed that children with Asperger's Syndrome are not a homogeneous group and do not display the same clinical profile. Each individual will reveal a unique pattern of characteristics. However, within the unique profile there will be a set of common characteristics that indicate a positive diagnosis.

Adapted by Stewart Sykes (2011)

This checklist is also presented in Section FAQs where the topic of Asperger's Syndrome is discussed further.

Rett's Syndrome

A condition of unknown cause, to date reported only in girls, which has been differentiated on the basis of a characteristic onset, course, and pattern of symptoms. Typically apparently normal or near normal early development is followed by partial or complete loss of acquired hand skills, together with deceleration in head growth, usually with an onset between 7 and 24 months of age. Hand-wringing, loss of purposive hand movements and hyperventilation are particularly characteristic. Problems develop in the coordination of gait and trunk movements. Social and play development are arrested in the first 2 or 3 years, but social interest tends to be maintained. The condition is typically associated with severe or profound intellectual disability and severe impairment in receptive and expressive language development.

Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

Severe and pervasive developmental disorder that differs from autism in terms either of age of onset or of failure to fulfil all three sets of diagnostic criteria. Thus abnormal and/or impaired development becomes manifest for the first time only after age of 3 years and/or there are insufficient demonstrable abnormalities in one or two of the three areas of psychopathology required for the diagnosis of autism (namely, reciprocal social interactions, communication and restrictive, stereotyped, repetitive behaviour) in spite of characteristic abnormalities in the other area(s). Atypical autism arises most often in profoundly retarded individuals whose very low level of functioning provides little scope for exhibition of the specific deviant behaviours required for the diagnosis of autism; it also occurs in individuals with severe specific developmental disorder of receptive language.

DSM-5 and Autism Spectrum Disorder

The descriptors recently used to diagnose Autism have been in place since 2000 (DSM-1V-TR) and include behaviours across the well known 'Triad of Impairments': social interaction, communication and restricted interests/repetitive behaviours.

For a diagnosis of Autism individuals needed to display at least 6 of the described behaviours across the areas, with at least 2 behaviours in the social domain and at least 1 from each of communication and restrictive interests/repetitive behaviours.

A diagnosis of Asperger's Syndrome required at least 2 of the social interaction criteria and 1 criterion from the repetitive and restricted behaviours domain along with no language delay and average or above intellectual functioning.

A diagnosis of Pervasive Developmental Disorder (Not Otherwise Specified) is less prescriptive, requiring severe social impairment with neither communication difficulties or restrictive/repetitive behaviours.

The Fifth edition of the Manual, DSM-5 sees wide ranging changes throughout the manual. Autism is one of the conditions which looks quite different under the DSM-5 and there is significant consequences for the diagnosis of Autism and the way Autism Spectrum Disorders are described and understood.

The Changes in Brief

The only diagnostic category is Autism Spectrum Disorder, which replaces the previous categories of Autistic Disorder (Autism), Asperger's Disorder and Pervasive Developmental Disorder not Otherwise Specified.

The three domains currently used to make a diagnosis-Social Interaction, Communication and Repetitive Behaviours/Restricted Interests) are now reduced to two domains-Social Communication and Restricted and Repetitive Patterns of Behaviour, Interests and Activities.

Individuals must display all 3 criteria in the Social Communication domain and at least 2 of the 4 criteria in the Restricted and Repetitive Behaviours domain, a total of 5 out of 7 criteria.

The new version provides greater scope across age ranges with descriptors that cover the range of presentations across the spectrum.

DSM-5 also requires that a severity rating be applied for each individual diagnosed with an Autism Spectrum Disorder. There is a severity rating applied for each individual diagnosed with an Autism Spectrum Disorder. There is a severity rating for both domains of impairment ranging from

Level 1-requiring support to Level 3-requiring very substantial support.

In addition, clinicians will be able to add specifiers (with or without Intellectual Disability) and co-morbidities (such as ADHD, Anxiety Disorder, Specific Language Disorder) to allow for a more comprehensive description of an individual's presentation.

DSM-5 states that "Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life)". (p.50)

There is a greater acknowledgement of the role of social demands.

Sensory behaviours are recognised under the Restricted and Repetitive Patterns of Behaviour Interests and Activities domain.

AUTISM SPECTRUM DISORDER: DIAGNOSTIC CRITERIA

A. Persistent deficits in social communication and social interaction across contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity; ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviours used for social interaction; ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging from, for example, from difficulties adjusting behaviour to suit various social contexts; to difficulties sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on the social communication impairments and restricted, repetitive patterns of behaviour.

B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus; (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movements).

Specify current severity:

Severity is based on the social communication impairments and restricted, repetitive patterns of behaviour.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are no better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disorder, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-1V diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

A new addition to DSM-5 is a Table of severity descriptors for both the Social Communication domain and the Restrictive Interests and Repetitive Behaviours domain.

Severity Level for ASD

Level 3

Requiring Very Substantial Support

Social Communication

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.

Restricted Interests and Repetitive Behaviours

Inflexibility of behaviour, extreme difficulty coping with change, or other restricted/repetitive behaviour markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Level 2

Requiring Substantial Support

Social Communication

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal response to social overtures from others.

Restricted Interests and Repetitive Behaviours

Inflexibility of behaviour, difficulty coping with change, or other restricted/repetitive behaviours appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1

Requiring Support

Social Communication

Without supports in place, deficits in social communication cause noticeable impairments. Difficulties initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.

Restricted Interests and Repetitive Behaviours

Inflexibility of behaviour causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

I have decided to develop a new checklist with information obtained from DSM-5. The heading will be Autism Spectrum Disorder. See below.

AUTISM SPECTRUM DISORDER CHECKLIST

CHARACTERISTICS

Developmental Delays or Deficits	Yes	No
	√	X
A. Social Communication and Social Interaction		
<u>1. Deficits in Social-Emotional Reciprocity</u>		
• Abnormal social approach		
• Failure of normal back and forth conversation		
• Reduced sharing of emotions		
• Reduced sharing of interests		
• Failure to initiate or respond to social interactions		
<u>2. Deficits in Nonverbal Communication</u>		
• Poor use of verbal and nonverbal communication		
• Abnormal eye contact		
• Abnormal body language		
• Deficits in understanding and using gestures		
• Restricted use of facial expressions		
<u>3. Deficits in Developing, Maintaining and Understanding Relationships</u>		
• Failure to develop age appropriate peer relationships that involve a mutual sharing of interests, activities and emotions		
• Difficulties sharing imaginative play		
• Difficulties making friends		
• Limited interest in peers		

B. Restricted, Repetitive Patterns of Behaviour, Interests or Activities		
<u>1.Stereotyped/ repetitive motor movements, use of objects or speech</u>		
• Simple motor stereotypes-lining up toys, flipping/spinning objects		
• Echolalia-repeating another person's words, sentences		
• Idiosyncratic phrases		
<u>2.Insistence on sameness</u>		
• Inflexible adherence to routines		
• Extreme distress with small changes in routine		
• Difficulties with transitions		
• Rigid thinking patterns		
• Rigid greeting rituals		
• Rigid eating habits		
<u>3.Highly restricted, fixed interests</u>		
• Strong attachment to unusual objects		
• Excessively restricted interests		
<u>4.Over or under reaction to sensory input</u>		
• Indifference to pain/temperature		
• Adverse reactions to specific sounds or textures		
• Excessive touching of objects		
• Excessive smelling of objects		
• Visual fascination with lights or movement		

If impairments are registered in the following two domains-

- **In ALL THREE of the Social Communication/ Social Interaction Areas**
- **In at LEAST TWO of the FOUR Restrictive/ Repetitive Areas**

then further investigation is recommended.

It must be stressed that children with Autism Spectrum Disorder are not a homogeneous group and do not display the same clinical profile. Each individual will reveal a unique pattern of characteristics. However, within the unique profile there will be a set of common characteristics that indicate a positive diagnosis.

Adapted from DSM-5 by Stewart Sykes (2013)

Management of Children with Autism Spectrum Disorders

Children with ASD share common behavioural and cognitive characteristics, however, there are important differences in terms of severity and pervasiveness of characteristics.

Children with Autism are defined as having more extreme and extensive disorders than children with Asperger's Syndrome. For instance, many Autistic children have below average intellectual abilities while most children with Asperger's Syndrome have intellectual abilities within at least the average range with some possessing superior cognitive abilities. Most children with Asperger's Syndrome attend regular schools with many successfully completing their secondary education. However, most Autistic children attend special schools and settings where their needs can receive intensive multidisciplinary care.

Programs usually have four main components. The aims are to increase appropriate behaviour and reduce inappropriate behaviour. Hence, activities focus on developing skills that will address disorders in-

- Social interaction and play
- Communication
- Behaviour (restricted and repetitive)

In addition, attention is given to developing basic functional academic skills such as reading, writing and social mathematics.

Typically interventions are based on behavioural strategies. Learning techniques are used to demonstrate and increase desirable behaviours and to decrease undesirable behaviours. Interventions also concentrate on improving a child's social and emotional coping skills.

The overall emphasis is on increasing basic social and behavioural skills and communication competencies to enable the child to participate in family life and also in society.

The management of autistic children usually requires the co-ordinated efforts of a team of professions including, special education teachers, psychologists, speech therapists, occupational therapists and physiotherapists. Parents and cares have a central role in the management plan.

Children with Asperger's Syndrome also require programs that focus on their areas of need which include the same components as mentioned above. However, while special support from psychologists, speech therapists, occupational therapist and others is very important, essentially their needs are well met in regular schools. Usually the same curriculum is undertaken with modifications where necessary- often in areas such as language and communication skills and handwriting. For most children with Asperger's Syndrome, their social and emotional needs require constant attention.

Some common situations and management suggestions-

Children with Autism Spectrum Disorders often present as being stubborn and wanting to follow their own agenda regardless of pressures to conform. The issue that they have with rules of social interaction is that they are unwritten, subtle and constantly changing in everyday life. These children tend to be very logical and willingly follow rules that are clearly explained. Clear and careful explanation and demonstration of appropriate behaviour are the best teaching strategies.

These children find the social world unpredictable and confusing. They often fail to see patterns in the daily events of every day life so they need a framework to identify the order of regularly occurring events. They require a structured, organised program to give them a feeling of safety, security and confidence. They have considerable problems anticipating future events. They live almost entirely in the present and have less ability to learn from past events and have great difficulty anticipating the future. They sometimes rely on routines and obsessions to provide structure to an ever changing and variable world. These children need to be provided with as much information about upcoming events as possible. A visual wall chart with stickers, drawings, etc, can assist in anticipating imminent events.

Repetitive visual activities such as DVDs, computer games, board games, drawing, model building, visual exploration tasks such as Where's Wally?, using a magnifying glass, a microscope, etc, are often successful in developing concentration, provide a calming and relaxing environment and help reduce anxiety.

These youngsters need time to complete tasks as they usually have a slower output tempo and frequently have handwriting difficulties. It is advisable to use tangible rewards for compliance or tasks well done such as stickers or stamps. They often derive little intrinsic reward from verbal compliments like "good job" or "well done" or from a friendly pat on the back.

Identifying strengths and interests provide ways to increase motivation for learning. Often these children possess intense interests in certain objects/topics-planes, trains, cars, trucks, toys, cards, animals, cartoon characters, etc. These can be used to personalise learning and hence increase task commitment, motivation and enjoyment.

These children are rarely deliberately rude, naughty or unkind. Their socially inappropriate or unacceptable behaviour often arises from their lack of understanding of other people and social situations. Limited understanding of non-verbal communication is also a major problem and can result in significant confusion. A firm but gentle and calm response is the most appropriate way to handle the situation. Try to avoid angry responses as they simply confuse them.

Attention-Deficit and Disruptive Behaviour Disorders

- Attention-Deficit/Hyperactivity Disorders (Subtypes)
- Oppositional Defiant Disorder
- Conduct Disorder
- Disruptive Behaviour Disorder (NOS)

Attention-Deficit Disorders

The DSM-1V-TR (2005) provides a very detailed account of this disorder and the three subtypes.

The central feature of ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development. There must be clear evidence of interference with developmentally appropriate social, academic or occupational functioning.

Inattention may be manifest in academic, occupational or social situations. Individuals with this disorder may fail to give close attention to details or may make careless mistakes with schoolwork or other tasks. Work is often messy and performed carelessly and without considered thought. Individuals often have difficulty sustaining attention to tasks or play activities and find it hard to persist with tasks until completion. They often appear as if their mind is elsewhere or as if they are not listening or did not hear what has just been said. They often do not follow through on requests or instructions and fail to complete schoolwork, chores or other duties.

Hyperactivity may be manifested by fidgeting or squirming in one's seat, by not remaining seated when expected to do so, by excessive running or climbing in situations where it is inappropriate, by having difficulty playing or engaging quietly in leisure activities, by appearing to be often "on the go" or as if "driven by a motor" or by talking excessively.

Impulsivity manifests itself as impatience, difficulty in delaying responses, blurting out answers before questions have been completed, difficulty awaiting one's turn and frequently interrupting or intruding on others to the point of causing difficulties in social, academic or occupational settings. Individuals with this disorder typically make comments out of turn, fail to listen to directions, initiate conversations at inappropriate times, interrupt others excessively, intrude on others, grab objects from others, touch things they are not supposed to touch and clown around. Impulsivity may lead to accidents and to engage in potentially dangerous activities without consideration of possible consequences. Behavioural manifestations usually appear in multiple contexts, including home, school and social situations.

In 2005, earlier estimates of prevalence rates (3-5%) were revised upward reflecting increased prevalence due to the inclusion of the predominantly Hyperactive-Impulsive and Predominantly Inattentive Types.

Although many individuals present with symptoms of both inattention and hyperactivity-impulsivity, there are individuals in whom one or the other pattern is predominant. The appropriate subtypes should be indicated-

- AD/HD, Combined
- AD/HD, Predominantly Inattentive Type
- AD/HD, Predominantly Hyperactive-Impulsive Type

AD/HD, Combined and AD/HD Predominantly Hyperactive-Impulsive Type

Children with these conditions display significant and developmentally inappropriate inattention, impulsivity and overactivity from an early age (before 7 years).

Also difficulty concentrating, are restless, squirm and fidget, easily distracted, loud and noisy. Comorbidity with conduct problems and learning difficulties is common.

These behaviours are typically present across situations (home, school, clinic) and produce substantial impairment in functioning. Children with this problem are typically rejected by their peers and show a variety of difficulties with social relationships.

AD/HD, Predominantly Inattentive Type

Children with this condition have significant difficulties focussing and sustaining attention. They are easily distracted and find concentrating on tasks extremely difficult.

Such children do not display hyperactivity or impulsivity which characterises the other subtypes.

As mentioned in the Section-**Exceptionality**, the DSM-5 has updated information on ADHD. The new details are provided below

Diagnostic Criteria

- A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development as characterised by (1) and/or (2):
1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that it is inconsistent with developmental level and that the negatively impacts directly on social and academic/occupational activities:
Note: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
 - a. Often fails to give close attention to details or making careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
 - b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focussed during lectures, conversations, or lengthy reading).
 - c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of and obvious distraction).
 - d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
 - e. Often has difficulty organising work; has poor time management; fails to meet deadlines).
 - f. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
 - g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile-phones).
 - h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
 - i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
 2. **Hyperactivity and Impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/ occupational activities:
Note: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
 - a. Often fidgets with or taps hands or feet or squirms in seat.

- b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace or in other situations that require remaining in place).
- c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents and adults may be limited to feeling restless).
- d. Often unable to play or engage in leisure activities quietly.
- e. Is often "on the go", acting as if "driven by a motor" (e.g., is unable to be uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- f. Often talks incessantly.
- g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for a turn in conversation).
- h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games or activities; for adolescents and adults, may intrude into or take over what others are doing).

- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- C. Several inattentive or hyperactive-impulsive symptoms were present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are no better explained by mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:

314.00 (F90.2) Combined presentation: If both Criterion A1 (Inattention) and Criterion A2 (Hyperactivity) are met for the past 6 months.

314.00 (F90.0) Predominantly Inattentive presentation: If Criterion A1 (Inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (F90.1) Predominantly Hyperactive/Impulsivity presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

Specify if:

In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

Mild: Few, if any, symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between “mild” and “severe” are present.

Severe: Many symptoms in excess of those required to make the diagnosis or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

Management of Attention-Deficit Disorders

A multidisciplinary approach is essential in the management of these disorders. Medication on its own is considered not to be a sufficient treatment and psychological treatments such as behaviour therapy, family therapy and classroom management are recommended in all instances.

Psychological treatment is extremely important. The role of parents and teachers is central as they are primarily responsible for implementing the treatment program.

The main aims of psychological management are:

- To help parents and teachers understand the child's difficulties and have realistic expectations of the child
- To avoid reinforcing the child's disruptive behaviour
- To provide encouragement and positive reinforcement for appropriate behaviour
- To help the child gradually increase the ability to concentrate through specially designed activities-often in-seat activities, e.g., completing a puzzle for a set period of time-say 10 minutes
- To prevent the development of persistent conduct disorders
- Psychological interventions derive primarily from cognitive-behavioural principles. The child's behaviour in all settings must be targeted.

In the home, parents need to-

- Understand that the child's behaviour is due to a disorder and not to wilful misconduct
- Reduce critical comments about the child-praise compliance and appropriate behaviour
- Reward desirable behaviours as soon as possible after they have occurred, as these children have little ability to delay gratification
- Create a routine (e.g., eating, going to bed, getting ready for school, homework)
- Reduce unnecessary stimulation (e.g., have a quiet area, allow one friend at a time to visit, limit time on computers, internet)
- Keep the child busy and encourage sports and other constructive activities
- Reward and praise small achievements and goal directed behaviour
- Reward and praise effort not only the result
- Where possible try to ignore disruptive behaviour

At school, teachers are advised to expect problems with attention, concentration, distractibility and therefore set short tasks that the child can handle.

- Try to reward on-task behaviour immediately
- Avoid critical, negative, sarcastic remarks
- Provide time-out opportunities when frustrations occur
- Create a predictable routine
- Reduce stimulation by doing work with the child on a one-to- one basis for short periods, in small groups or alone in a quiet area
- Expect learning problems-attentional problems invariably result in academic underachievement
- Organise the child's breaks and playground activities; have a Buddy to play with and provide general supervision.

Parents and teachers should find the information on child management in the **Parenting Section** helpful.

Oppositional Defiant Disorder

This type of Conduct Disorder is usually seen in children below the age of 9 or 10 years. It is defined by the presence of markedly defiant, disobedient, provocative behaviour and by the absence of more severe dissocial or aggressive acts that violate the law or the rights of others. Severely mischievous or naughty behaviour is not, in itself, sufficient for a diagnosis. Many authorities consider that oppositional defiant patterns of behaviour represent a less severe type of Conduct Disorder, rather than a qualitatively distinct type. Research evidence is lacking on whether the distinction is qualitative or quantitative.

Caution should be taken in using this category, especially in the case of older children. Clinically significant conduct disorders in older children are usually accompanied by dissocial or aggressive behaviour that goes beyond defiance, disobedience or disruptiveness, although not infrequently they are preceded by an Oppositional Defiant Disorder at an earlier age.

The essential feature of this disorder is a pattern of persistently negativistic, hostile, defiant, provocative and disruptive behaviour, which is clearly outside the normal range of behaviour for a child of the same age and which does not include the more serious violations of the right of others.

Children with this disorder frequently and actively defy adult requests or rules and deliberately annoy other people. Usually they tend to be angry, resentful and easily annoyed by other people whom they blame for their own mistakes or difficulties. They generally have a low frustration tolerance and readily lose their temper. Typically, their defiance has a provocative quality, so that they initiate confrontations and generally exhibit excessive levels of rudeness, uncooperativeness and resistance to authority. Frequently this behaviour is most evident in interactions with adults or peers whom the child knows well. Signs of the disorder may not be evident during a clinical interview.

In the DSM-5, there is a separate Chapter on Disruptive, Impulsive-Control and Conduct Disorders. Disorders relevant to this Section include-

- Oppositional Defiant Disorder
- Conduct Disorder
 - Childhood-onset Type
 - Adolescent-onset Type

Disruptive, impulse-control and conduct disorders include conditions involving problems in self-control of emotions and behaviours. Problems are manifested in behaviours that violate the rights of others (e.g., aggression, destruction of property) and/or that brings the individual into significant conflict with social norms or authority figures. The underlying causes of the problems in the self-control of emotions and behaviours can vary greatly across the disorders in this chapter and among individuals within a given diagnostic category.

Management of Opposition-Defiant Disorders

The suggestions provided in the **Section-Parenting** are appropriate.

Conduct Disorder

Young people with Conduct Disorder display a pattern of behaviour characterised by breaking rules, deceit and lack of respect for the rights of others. These children and adolescents are constantly in conflict with parents, teachers, peers and society as a whole.

Conduct Disorder is characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant conduct. Such behaviour should amount to major violations of age-appropriate social expectations; it should therefore be more severe than ordinary childish mischief or adolescent rebelliousness and should imply an enduring pattern of behaviour (six months or longer). Features of Conduct Disorder can also be symptomatic of other psychiatric conditions, in which case the underlying diagnosis should be preferred. Examples of the behaviours on which the diagnosis is based include excessive levels of fighting or bullying, cruelty to other people or animals, severe destructiveness to property, fire-setting, stealing, repeated lying, truancy from school and running away from home, unusually frequent and severe temper tantrums and disobedience. Any one of these behaviours, if marked, is sufficient for a diagnosis, but isolated dissocial acts are not.

The DSM-5 adds a descriptive features specifier to the diagnosis of Conduct Disorder for individuals who meet the full criteria for the disorder and who also present with limited prosocial emotions, such as limited empathy and guilt. The specifier applies to those individuals with a more serious pattern of behaviour characterised by a "callous and unemotional" interpersonal style across multiple settings and relationships. Individuals with conduct disorder who meet the criteria for the specifier have a relatively more severe form of the disorder and a different treatment response.

Management of Conduct Disorder

Many treatments produce short-term relief of symptoms but improvements usually are short-lived.

Individual counselling is difficult and ineffective in most cases because these young people lack remorse and typically believe they have done nothing wrong. Once established the behaviours are very resistance to change.

The more promising treatments are problem solving skills training, parenting skills training, functional family therapy and multisystemic therapy.

A close ongoing working relationship between the family and the therapist offers the best chances of success. Unfortunately for many of these children, if they have a family at all, it is often disorganised, neglectful or abusive.

Placement in a residential setting may be required.

It is clear that prevention is the best way of dealing with Conduct Disorders. Parents and teachers should be assisted to identify the early signs of such behaviour during early childhood and the first years of school and to seek and persist with treatment to address such behaviours. The most useful early intervention at that stage is parenting skills training.

Disruptive Behaviour Disorder (NOS)

This category is for disorders characterised by conduct or oppositional defiant behaviours that do not meet the criteria for Conduct Disorder or Oppositional Defiant Disorder. For example, it includes clinical presentations that do not meet full criteria for these disorders but in which there is clinically significant impairment.

SELECTED EMOTIONAL DISORDERS IN CHILDREN AND ADOLESCENTS- IDENTIFICATION AND MANAGEMENT

Anxiety

Some of the major disorders classified in the DSM-1V TM

- Generalised Anxiety Disorder
- Separation Anxiety Disorder
- Obsessive Compulsive Disorder
- Phobias
- Post-Traumatic Stress Disorder

Some DSM-5 changes

Depression

Some DSM-5 changes

Selected Emotional Disorders

Children with emotional disorders may appear unhappy, sad, frightened or worried. In pre-pubertal children, the prevalence of emotional disorders is approximately equal amongst boys and girls: after puberty, emotional disorders become more common in females. Young people with emotional disorders represent about half of those seen in child and adolescent mental health services.

Anxiety Disorders

Apprehensions and fears are normal and more common during childhood and adolescence. Infants are frightened by loud noises, falling and strangers. Children aged one to two years are scared when separated from their parents. Later on, children are fearful of the dark, animals, storms, strange imaginary beasts and monsters. From the age of 7 or 8 years, children begin to worry about their academic performance and their interpersonal relationships-especially girls. Adolescents are concerned about being accepted, disliked, rejected or criticised by their peers.

The type of fears experienced at each stage of development is largely a reflection of the intellectual and emotional growth of the child at that point in time. An anxiety disorder is likely if fears become intense or pervasive and cause significant impairment in functioning.

Anxiety disorders are frequent in young people. Their onset is often during childhood or adolescence and they can follow a chronic, fluctuating course. All the anxiety disorders occurring in children, adolescence and adults have similar, although not, identical symptoms, with the exception of separation anxiety which is peculiar to children and adolescents. Anxiety disorders are not easily recognised in young people because they know that their fears are often groundless and so try to conceal them.

Traditionally, a differentiation has been made between emotional disorders specific to childhood and adolescence and adult-type neurotic disorders. The majority of children with emotional disorders go on to become normal adults: only a minority show neurotic disorders in adult life. Many emotional disorders in childhood seem to constitute exaggerations of normal developmental trends rather than phenomena that are qualitatively abnormal in themselves. The emotional disorders of childhood are less clearly demarcated into supposedly specific entities such as phobic disorders or obsessional disorders.

Generalised Anxiety Disorder

In line with DSM-1V-TR classification of Anxiety Disorders, the category of Generalised Anxiety Disorder includes Overanxious Disorder in Childhood.

The essential feature is anxiety, which is generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstance (i.e., it is "free-floating"). As in other anxiety disorders, the dominant symptoms are highly variable but complaints of continuous feelings of nervousness, trembling, muscular tension, sweating, light-headedness, palpitations, dizziness are common. Fears that the sufferer will become ill or a parent or relative will shortly become ill or have an accident are often expressed, together with a variety of other worries and forebodings. Its course is variable but tends to be fluctuating and chronic.

The sufferer must have primary symptoms of anxiety most days for at least several weeks at a time, and usually for several months. These symptoms should usually involve elements of:

Apprehensiveness (worries about future misfortunes, feeling "on edge", difficulty in concentrating, etc.)

Motor tension (restless fidgeting, tension headaches, trembling, inability to relax)

Automatic over-activity (light-headedness, sweating, epigastric discomfort, dizziness, dry mouth etc.)

The intensity, duration or frequency of the anxiety and worry is well out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping worrying.

In children and adolescents with Generalised Anxiety Disorder, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events even when their performance is not being evaluated by others. There may be excessive concerns about punctuality. They may also worry about catastrophic events such as earthquakes or cyclones etc. Children may be overly conforming, perfectionistic and unsure of themselves and tend to redo tasks because of excessive dissatisfaction with less-than-perfect performance. They are typically overzealous in seeking approval and require excessive reassurance about their performance and their other worries. Recurrent somatic complaints may be prominent.

DSM-5 Changes

The DSM-5 has a separate Chapter on "Anxiety Disorders". These include disorders that share features of excessive fears and anxiety and related behaviour disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously these two states overlap but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger and escape behaviour and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviours includes-

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder (Agoraphobia)
- Generalised Anxiety Disorder

It is important to note that Obsessive Compulsive Disorder is not included in the Anxiety Disorders but in a separate Chapter. See below.

Managing Anxiety in Children and Adolescents

The recommendations are taken from the following guides-

Rapee, R.M., Spencer, S.H., Cobham, V., & Wignall, A.M. (2000). Helping Your Anxious Child: A Step-by-Step Guide for Parents. Oakland, CA: New Harbinger.

Spencer, E.D., DuPont, R.L., & DuPont, C.M. (2004). The Anxiety Cure for Kids: A Guide for Parents. New York: Wiley.

Three techniques are mentioned-

1. Progressive Muscle Relaxation (PMR)

This is a technique where a person progressively tenses the muscle groups in the body and then relaxes them. This teaches the difference between feeling tense and feeling relaxed. **(Extensive notes on Learning to Relax are available in this Section under Adults with Anxiety-Management).**

2. Breathing and Imagery

A person learns how to breathe in an even, gentle manner while picturing a relaxing scene or event to help reduce feelings of anxiety.

(Notes on Slow Breathing exercises are provided in this Section under Adults with Anxiety-Management).

3. The Detective Technique

When a person becomes anxious it is important that they learn ways of coping rather than relying on others to constantly re-assure them. This technique helps to problem-solve the situation which is causing anxiety. The anxiety can be understood by asking the following questions-

What am I worried about?

Someone breaking into the house when I am asleep.

What is the evidence?

I have slept through the nights lots of times and no one has ever broken in. Nothing like this has happened before.

What is my calm thought?

I am safe in my house, nothing bad is likely to happen.

Some General Strategies

Praise, compliment and reward courageous, confident, non-anxious behaviour.

Try to minimise giving attention to the anxious behaviour and direct the child into a more productive activity giving praise for the activity without acknowledging the anxiety.

Gentle, positive, encouragement for the child to confront anxiety-inducing situations.

Role-playing and relaxation techniques have proven useful.

Try to deal with the child's anxious behaviour in a calm, compassionate, empathetic manner.

Demonstrate and model non-anxious behaviour so that the child can learn how to respond appropriately to anxiety inducing situations.

Remember. Often family factors can have an association with the development and maintenance of childhood anxiety. These factors include parental anxiety and depression, family conflict, marital discord and parental reinforcement of avoidance coping strategies, negative feedback and parental restrictions. Young people can learn both effective and ineffective ways of coping with anxiety by observing family members managing their own anxiety.

Separation Anxiety Disorder

It is normal for toddlers and preschool children to show some anxiety over real or threatened separation from people to whom they are attached. Separation Anxiety Disorder should be diagnosed only when fear over separation constitutes the focus of the anxiety and when such anxiety arises during the early years. It is differentiated from normal separation anxiety when it is associated with significant problems in social functioning. In addition, the diagnosis requires that there should be no generalized disturbance of personality development or functioning.

The key diagnostic feature is a focussed excessive anxiety concerning separation from people to whom the child is attached- usually parents or other family members.

The anxiety may take the form of:

An unrealistic, consuming worry about possible harm happening to parents or a fear that they will leave and never return.

An unrealistic, preoccupying worry that some untoward event, such as the child being lost, admitted to hospital or killed, will separate them from parents.

Persistent reluctance or refusal to go to school because of a fear about separation (rather than for other reasons such as fear about events or experiences at school). Becoming physically ill or complaining about some illness in the morning when they are due to leave for school (e.g., headaches, stomach pains, vomiting). Monday mornings and the period immediately following school holidays are usually the worst times for these happenings or complaints.

Excessive difficulty coping with parents going out. If their parents do go out, they may require considerable reassurance and need to know every single detail about the outing.

Persistent reluctance or fear of going to sleep without being near or next to a parent. Difficulty going off to sleep or needing the company and comfort of a parent when going to bed. Some older children and adolescents with separation anxiety still share a bed with their parents.

Reluctance to sleep over at friends' places or attend school camps.

Persistent, inappropriate fear of being alone.

Excessive, recurrent distress in anticipation of, during, or immediately following separation from a parent.

Separation Anxiety is different from school refusal or school phobia. With school refusal the major problems arise from issues at school-e.g., social stresses such as restricted peer relationships, interpersonal problems, bullying, poor academic achievement, learning problems and low self-esteem as a learner.

Management of Separation Anxiety Disorder

The onset of separation anxiety is often triggered by a worrying or traumatic incident such as an illness or death in the family, a separation or divorce, a change of school or a minor illness that keeps young people at home for a few days. The disorder can also emerge out of the blue. There may be a family history of anxiety problems. It is common for at least one parent of a child with separation anxiety disorder to be highly anxious.

It is important for parents to realise that facing fear or uncertainty, while initially distressing, reduces anxiety, whereas avoidance increases it. Intense anxiety is mainly confined to the time immediately before the parent-child separation- parents going out for the evening, the child going to school, etc.

It helps to have a set routine and to be firm about the separation. Excessive reassurances also need to be avoided as they can reinforce the child's belief that their concerns for their parents' welfare are legitimate.

I find Maslow's Need Hierarchy helpful in explaining the importance of a child feeling safe and secure. The model on pages 52-56 outlines the positive and negative consequences when the need for safety is satisfied and not satisfied. The negative consequences include- instability, insecurity, uncertainty, distress, worry, anxiety, fear, obsession, compulsion.

Phobias

Specific Phobia

The essential feature of Specific Phobia is marked and persistent fear of clearly discernable, circumscribed objects or situations. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response. This response may take the form of a situationally bound or situationally predisposed Panic Attack. Although adolescents and adults with this disorder recognise that their fear is excessive or unreasonable this may not be the case with children. Most often the phobic stimulus is avoided, although it is sometimes endured with dread. The diagnosis is appropriate only if the avoidance, fear or anxious anticipation of encountering the phobic stimulus interferes significantly with the person's daily routine, occupational functioning or social life. Or if the person is markedly distressed about having the phobia.

Anxiety is almost invariably felt immediately on confronting the phobic stimulus.

In children, the anxiety may be expressed by crying, tantrums, freezing or clinging. Children often do not recognise that the fears are excessive or unreasonable and rarely report distress about having the phobias. Fears of animals, strangers, clowns, storms and other objects in the natural environment are particularly common and are usually transitory in childhood. A diagnosis of Specific Phobia is not warranted unless the fears lead to clinical impairment (e.g., unwillingness to go to school if dark clouds are about and a storm is imminent).

Social Phobia

The essential feature is a marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to the social or performance situation almost invariably provokes an immediate anxiety response. Although adolescents and adults with this disorder recognise that their fear is excessive or unreasonable, this may not be the case with children.

In children crying, tantrums, freezing, clinging or staying close to a familiar person and inhibited interactions to the point of mutism may be present. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults. Unlike adults, children with Social Phobia, usually do not have the option of avoiding feared situations altogether and may be unable to identify the nature of their anxiety. There may be a decline in classroom performance, school refusal or avoiding age-appropriate social activities and dating. To make the diagnosis in children there must be evidence of a capacity for social relationships with familiar people and the social anxiety must occur in peer settings, not only in interactions with adults. Social Phobia typically has an onset in the mid-teens, sometimes emerging out of a childhood history of social inhibition or shyness.

Obsessional Compulsive Disorder

According to the DSM-1V-TR, OCD is characterised by recurrent obsessions and/or compulsions that interfere considerably with daily functioning. Obsessions are persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and cause marked anxiety or distress. The most common obsessions are repeated thoughts about contamination, repeated doubts, a need to have things in a particular order, aggressive or horrific impulses and sexual imagery.

Compulsions are repetitive behaviours or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. The most common compulsions involve washing and cleaning, counting, checking, requesting or demanding assurances, repeating actions and ordering.

Onset is usually in childhood or early adult life.

Presentations of OCD in children are generally similar to those in adulthood. Washing, checking and ordering rituals are particularly common in children. Children generally do not request help; the problem is usually identified by parents. Gradual declines in schoolwork secondary to impaired ability to concentrate have been reported. Like adults, children are more prone to engage in rituals at home than in front of peers, teachers or strangers.

DSM-5 Changes

The DSM-5 includes a new Chapter on Obsessive-Compulsive and Related Disorders. Disorders grouped in this Chapter have features in common such as an obsessive preoccupation and repetitive behaviours. The disorders in this new Chapter include obsessive-compulsive disorder, body dysmorphic disorder and trichotillomania (hair-pulling disorder), as well as two new disorders: hoarding disorder and excoriation (skin picking) disorder.

Obsessive-Compulsive and Related Disorders include several disorders, the most relevant for my DVD being Obsessive -Compulsive Disorder (OCD). OCD is characterised by the presence of obsessions and/or compulsion. Obsessions are recurrent and persistent thoughts, urges or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviours or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

Post-Traumatic Stress Disorder

The essential feature is the development of characteristic symptoms following exposure to an extremely traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury or threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness or horror or in children, the response must involve disorganised or agitated behaviour. The disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

In younger children, distressing dreams of the event may, within several weeks, change into generalised nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather the reliving of the trauma may occur through repetitive play. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

Depression

Depression is a mood state that is characterised by significantly lowered mood and loss of interest or pleasure in activities that are normally enjoyable. Such depressed mood is a common and normal experience. However, a major depressive episode can be distinguished from this "normal" depression by its severity, persistence, duration and the presence of characteristic symptoms (e.g., sleep disturbance). The most common emotional, behavioural and physical symptoms of a major depressive episode are listed below-

- Marked depressive mood
- Loss of interest or enjoyment
- Reduced self-esteem and self-confidence
- Feelings of guilt or worthlessness
- Bleak and pessimistic views of the future
- Ideas or acts of self-harm or suicide
- Disturbed sleep
- Disturbed appetite
- Decreased libido
- Reduced energy leading to fatigue and diminished activity
- Reduced concentration and memory

The overall depressed mood is relatively constant from one day to the next, although the mood may vary somewhat during the course of the day. A pattern is often present in which mood becomes better as the day progresses.

According to ICD-10, a major depression can be coded according to severity and the presence of psychotic features or somatic (melancholic) features. The severity of the disorder can be classified as mild, moderate or severe depending on the level of functional impairment-everyday activities, occupational or social functioning.

DSM-1V-TR considers that the core symptoms of a Major Depressive Episode (lasting at least two weeks) are the same for children and adolescents, although it is suggested that the prominence of characteristic symptoms may change with age. Certain symptoms such as somatic complaints, irritability and social withdrawal are particularly common in children, whereas psycho-motor retardation, hypersomnia and delusions are less common in prepuberty than adolescence and adulthood. In prepubertal children, Major Depressive episodes occur more frequently in conjunction with other mental disorders (especially Disruptive Behaviour Disorders, Attention-Deficit Disorders and Anxiety Disorders) than in isolation. In adolescence, Major Depressive Episodes are frequently associated with Disruptive Behaviour Disorders, Attention-Deficit Disorders, Anxiety Disorders, Substance Abuse Disorders and Eating Disorders.

DSM-5 Changes

The DSM-5 Chapter on Depressive Disorders includes Disruptive Mood Dysregulation Disorder (DMDD), major depressive disorder (including major depressive episode) persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication induced depression, depressive disorder due to another medical condition, other specified depressive disorder and unspecified disorder. Unlike in DSM-1V, this Chapter "Depressive Disorders", has been separated from the previous Chapter, "Bipolar and Related Disorders". The common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive change that significantly affect the individual's capacity to function. What differs among them are issues of duration, timing or presumed etiology.

As indicated above, the DSM-5 has included Disruptive Mood Dysregulation Disorder as a Depressive Disorder. The core feature of disruptive mood dysregulation disorder is chronic, severe persistent irritability. The severe irritability has two prominent clinical features, the first of which is frequent temper outbursts. These outbursts typically occur in response to frustration and can be verbal or behavioural (the latter in the form of aggression against property, self or others). They must occur frequently (i.e., on average, three or more times per week).

DIAGNOSTIC CRITERIA

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviourally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.
- C. The temper outbursts occur, on average, three or more times per week.
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
- E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting three or more consecutive months without all of the symptoms in Criteria A-D.
- F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
- H. By history of observation, the age at onset of Criteria A-E is before 10 years.
- I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for manic or hypomanic episode have been met.

Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

- J. The behaviours do not occur exclusively during an episode of major depressive disorder are no better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder-dysthymia). **Note:** This disorder cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance abuse disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.
- K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Comment: As mentioned elsewhere, the DSM-5 has been attacked for expanding the range of mental health issues that are classified as disorders. For example, considerable controversy has surrounded the inclusion of Disruptive Mood Dysregulation Disorder, which it is claimed essentially makes children's temper tantrums a mental illness.

STRESS AND ANXIETY IN ADULTS: IDENTIFICATION AND MANAGEMENT

Defining Stress

Maslow's Hierarchy of Needs

A Model of Stress

Management of Stress

Defining Anxiety

Management of Anxiety

Defining Stress

Stress is a part of everyone's life and a source of difficulty for many.

Basically, STRESS refers to the application of some force or pressure to something. Some force is needed to get moving, whether it is a basic need such as hunger or thirst or a more complex human need or desire such as belonging, self-esteem or understanding or creating.

A useful paradigm to understand human needs and the consequences of unfulfilment and stress is provided in Maslow's Hierarchy of Needs. (See details below).

There is a relationship between the level of drive, need or arousal, ranging from low to high and performance and wellbeing, ranging from high to low. At very low levels of need or arousal, an individual is under-stimulated and undermotivated. More stimulation may be needed. Both quality of performance and wellbeing are low. Examples of this are people in boring, monotonous, unfulfilled, repetitive jobs, with little or no control over what they do or how they do it.

People in these situations will show all of the usual signs of too much stress and often try to cope by avoiding work, or smoking, eating, drinking excessively.

At very high levels of need or arousal, a person can become over-stimulated and typically subjected to conflicting motivations and demands. An excess of stimulation usually results in a declension in both performance and wellbeing. Examples of this situation are people who have high-performance occupations which make too many, often competing demands on them but who have little control over what they do or how they do it.

This is typically the case of many professions. Often it occurs as a result of ever-commitment, resulting from a basic inability to refuse unreasonable requests. People in this state of over-arousal show the usual signs of too much stress:

- Fatigue
- Anxiety
- Tension
- Worry
- Physical symptoms

They may try to cope with it through health threatening or reducing behaviours. Smoking, eating or drinking too much and excessive use of other drugs, prescribed or not. These are the indirect attacks of stress on physical health.

Effective stress management is aimed at helping a person control or at least minimising their stress, as much as it is possible and using the stress positively to perform and feel at their best. Obviously, stress can not be eliminated from life; at best it can be minimised.

To maximise wellbeing, satisfaction and enjoyment, a middle position between too much and too little stress is considered appropriate. Achieving the right balance between beneficial, helpful and positive arousal and unpleasant, harmful, negative arousal is the challenge.

FIVE COMPONENTS OF THE STRESS PROCESS

THOUGHTS

BEHAVIOUR

STRESSORS

PHYSIOLOGICAL SIGNS

FEELINGS

This conceptual paradigm identifies five components of STRESS: the stressors and the four symptoms of stress.

Stressors

These are the sources of the stress that place demands on an individual's coping skills. They can stem from an increase or decrease in demands, events and situations, e.g.,

Real

- requests
- insults
- assaults
- frustrations
- uncertainty
- lack of control
- criticism
- discouragement
- failures
- boredom
- monotony
- fears

Imagined

- past unpleasant experiences or failures
- possible future failures, forebodings
- fears

Thoughts

An event or situation only becomes a stressor because of our thoughts. While some thoughts are realistic or rational, some thoughts are unrealistic or irrational. Unrealistic, exaggerated and distorted thinking plays a major role in stress. Thoughts will determine whether the situation becomes "good" stress or "bad" stress. The constructive power of positive thoughts is challenged by the destructive power of negative thoughts.

Physiological Responses

Our body reacts to a stressor with basically a constant set of physiological changes called the General Adaptation Syndrome (GAS). These are the body's attempts to adapt to the increased load of coping with the stressor and include changes in-

- Blood flow and pressure
- Heart rate
- Breathing
- Muscle tension
- Perspiration

Basically, our body is preparing itself to either "fight" or "flee" the stressor.

Feelings

Emotional response to the stressor can be either good or bad.

“Good” stress or positive feelings include-

- Happiness
- Satisfaction
- Enjoyment
- Pleasure
- Excitement
- Exhilaration

“Bad” stress or negative feelings include-

- Unhappiness
- Dissatisfaction
- Frustration
- Misery
- Hopelessness
- Discouragement
- Anxiety
- Depression
- Fear
- Anger

Because most people believe that there is something wrong with feeling “bad”, these feelings themselves can act as stressors. When people get upset with themselves for feeling upset, their stress is increased. Many people attempt to eliminate their bad feelings by smoking, over-drinking, taking drugs, over-eating or by denying that they feel bad. This accounts for much stress related illness.

Behaviour

When discussing stress, behaviour can be classified in terms of “fight” or “flight”.

Fight behaviours include positive and constructive attempts to cope with a stressor and to solve any resulting problems. They can also include aggressive verbal or physical responses. Aggression can be passive, too, like sulking, ignoring people or refusing reasonable requests.

Flight or Flee behaviours can literally mean escaping from the situation, by walking out; or by deliberately avoiding a situation. Both escape and avoidance can reduce stress in the short-term and may sometimes be appropriate choices. But sometimes they result in such major restrictions that they cause even greater stress in the long-term.

Some people try to escape from their stress biochemically by taking their favourite “drug”. Unfortunately, these health-threatening substances are sometimes openly marketed as being stress-reducing.

Stress is an Interaction

The five components of the stress process interact with and influence each other. For instance-

If you are already in a bad mood, you are more likely to see an event as a stressor.

If you are run down physically, you are less likely to expect to cope with a new demand.

If you see yourself handling a situation well, you are more likely to expect to cope.

If you react aggressively to a stressful situation, you may influence others in the situation to be aggressive towards you, increasing the demands on you.

If you know that you have habitually avoided a particular situation in the past, you are unlikely to expect to cope with it next time.

Maslow's Hierarchy of Needs

I have found the work of Maslow (1962, 1968) extremely helpful in explaining some of the behavioural/emotional challenges and problems experienced by children, adolescents and adults.

Maslow (1962) proposed a theory of motivation based on a hierarchy of needs. He argued that the individual progresses through a series of stages/levels. Only when needs are gratified at a particular level is the individual motivated to move on to the next higher level. The progression begins with basic needs and moves towards the higher needs.

The needs are as follows-

- the basic physiological needs (food, water, air, sleep)
- the safety needs (security, freedom from danger, stability)
- the love needs (intimacy, belonging, accepted by others)
- the self-esteem needs (knowledge, mastery, achievement, self-confidence)
- the self-actualisation needs (on-going realisation of potential, creative living, peak experiences)

Some people are so focussed trying to satisfy the basic needs of, say safety and love, that they have hardly any energy or motivation to reach the higher level needs such as self-esteem and self-actualisation.

What are we doing in our schools and homes to make the attainment of higher- level needs a reality?

For instance, today many children and adolescents do not feel safe and secure in their environment and hence are likely to experience the negative consequences as outlined below. Likewise, for some the social/love needs are not satisfied resulting in the negative consequences of rejection, worthlessness, loneliness and isolation.

Before such children can progress to the important higher self-esteem needs, satisfied through schooling, learning and achievement, the fulfilment of the basic needs must be addressed.

The first table below provides an overview of Maslow's theory. The second table, while mainly focussing on social/ emotional needs, also identifies our higher-order needs and shows the positive and negative consequences when needs are fulfilled or unfulfilled. It is contended that unfulfilled needs can result in STRESS and ANXIETY and other negative consequences.

MASLOW'S THEORY OF HUMAN MOTIVATION: A HIERARCHY OF NEEDS

BASIC NEEDS

PHYSIOLOGICAL NEEDS

- OXYGEN
- FOOD
- WATER
- WARMTH
- SLEEP/REST

SAFETY NEEDS

- SHELTER
- SECURITY
- STABILITY

LOVE NEEDS

- ATTENTION
- AFFECTION
- BELONGING

HIGHER NEEDS

SELF-ESTEEM NEEDS

- **KNOWLEDGE-UNDERSTANDING**
- **LEARNING-ACHIEVEMENT**
- **CAPABLE**
- **USEFUL**
- **SELF-WORTH**
- **SELF-RESPECT**
- **SELF-CONFIDENCE**

SELF-ACTUALISATION NEEDS

- **SELF-FULFILMENT**
- **BECOMING SELF**
- **FULLY FUNCTIONING**

AN OVERVIEW OF CHILD/ADOLESCENT BEHAVIOUR

UNDERSTANDING BASIC SOCIAL/EMOTIONAL NEEDS

DOMAINS	NEEDS	CONSEQUENCES		
		POSITIVES	NEGATIVES	
SOCIAL / EMOTIONAL	SAFETY	STABILITY	INSTABILITY	
		SECURITY	INSECURITY	
		POISE	STRESS	
		COMFORT	FEAR	
		CALM	OBSESSION	
		PREDICTABILITY	COMPULSION	
		SOCIAL	IDENTITY	ISOLATION
			AFFILIATION	LONELINESS
			BELONGING	ANXIETY
	LOVE	AFFECTION	ANXIETY	
		ATTENTION	DEPRESSION	
		INTIMACY	OUTSIDER	

REJECTION

AGGRESSION

CONDUCT/

DISORDERS

WITHDRAWAL

EMPTINESS

HIGHER NEEDS

SELF-ESTEEM

KNOWLEDGE

UNDERSTANDING

LEARNING

ACHIEVEMENT

MASTERY

COMPETENT

FAILURE

CAPABLE

INFERIORITY

USEFUL

DISCOURAGEMENT

ENCOURAGED

USELESS

SELF-WORTH

INCOMPETENT

**SELF-
ACTUALISATION**

CURIOSITY

MASTERY

CREATIVE

FULFILMENT

SELF-RESPECT

LEARNED/

CONFIDENT

HELPLESSNESS

**REALISING
POTENTIAL**

ALIENATION

**PEAK
EXPERIENCES**

CREATIVE LIVING

Management of Stress

Stress can be managed or minimised in various ways.

Changing Your Stressors

Work

- Changing jobs
- Quitting jobs
- Improving jobs

Relationships

- Friendships
- Partnerships

Life Style

Developing new interests, activities, hobbies or skills.

Changing Thoughts

The challenge is the identification of irrational thoughts and the adoption of rational thoughts.

Some common, irrational thoughts

I must be loved or at least liked and approved by every significant person I meet.

I must be completely competent, make no mistakes and achieve in every possible way, if I am to be worthwhile.

Some people are bad, wicked or evil and they should be blamed and punished.

It is absolutely dreadful when things aren't how I would like them to be.

Human happiness, including mine, is caused by factors outside my control, so little can be done about it.

If something might be dangerous, unpleasant or frightening, I should worry about it excessively.

It is easier to put off something difficult or unpleasant than it is to face up to it.

I need someone stronger than myself to depend on.

My problem(s) were caused by event(s) in my past and that is why I have my problem(s) now.

I should be very concerned and upset by other people's problems and difficulties.

Some common, rational thoughts

I want to be liked or loved by some of the people in my life, and I know I may feel disappointed or lonely when that doesn't happen, but I can cope with those feelings and I can take constructive steps to make and keep better relationships.

I want to do some things well most of the time but, like everybody else, I will occasionally fail or make mistakes. Then I may feel bad but I can handle that and I can take constructive steps to do better next time.

It is sad that most of us do some bad things from time to time and some people do many bad things, but making myself upset won't change things.

It is disappointing, sometimes very disappointing, when things aren't how I would like them to be, but I can't, it doesn't help to exaggerate my disappointment.

My problem(s) may be influenced by factors outside my control, but my thoughts and actions also influence my problem(s) are they ARE under my control.

Worrying about something that may go wrong won't stop it from happening: it just makes me unhappy now. I can take constructive steps to prepare for possible problems and that's as much as anyone can do. So I won't dwell on the future now.

Facing difficult situations may make me feel bad at the time, but I can cope with that. Putting off problems doesn't make them any easier-it just gives me longer to worry about them.

It is good to get support and assistance from others when I want it, but the only person I really need to rely on is me.

My problem(s) may have started in some past event(s) but what keeps them going now are my thoughts and actions and they are under my control.

It is sad to see other people in trouble but I won't help them by making myself miserable; sometimes I can take constructive steps to help others.

Irrational thoughts play a major role in creating stress. Watch out for "silly" thinking and start "clever" thinking.

Changing Physiological Responses

Learn to engage in relaxing activities. See comments below on relaxation techniques.

Increase your physical wellbeing and endurance capacity by regular exercise, healthy eating and good sleeping habits.

Changing Feelings

The aim is to understand your feelings. Use introspection (what is going on?) and positive self-talk. Challenge your irrational belief(s).

Changing Behaviour

Develop new and more appropriate behaviours through such programs as assertiveness training and social skills training.

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Anxiety

Understanding and Managing Anxiety in Adults

The DSM-1V-TR includes a wide range of disorders under the rubric "Anxiety". The focus will be on Generalised Anxiety Disorder.

The essential feature is anxiety, which is generalised and persistent but not restricted to, or even strongly predominating in, any particular environmental circumstance (i.e., it is "free-floating"). As in other anxiety disorders, the dominant symptoms are highly variable but complaints of continuous feelings of nervousness, trembling, muscular tension, sweating, light-headedness, palpitations, dizziness are common. Fears that the sufferer will become ill or a parent or relative will shortly become ill or have an accident are often expressed, together with a variety of other worries and forebodings. Its course is variable but tends to be fluctuating and chronic.

The sufferer must have primary symptoms of anxiety most days for at least several weeks at a time, and usually for several months. These symptoms should usually involve elements of:

Apprehensiveness (worries about future misfortunes, feeling "on edge", difficulty in concentrating, etc.)

Motor tension (restless fidgeting, tension headaches, trembling, inability to relax)

Automatic overactivity (light-headedness, sweating, epigastric discomfort, dizziness, dry mouth, etc.)

The intensity, duration or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping worrying.

Management of Anxiety

Some general recommendations include the following-

Activities mentioned above under the heading STRESS are obviously relevant in this section. Stress and worry have both physical and mental effects. Learning skills to reduce the effect of stress and control the worry, will provide the most effective relief.

Some practical steps to take in dealing with anxiety-

Daily relaxation methods greatly help to reduce the physical symptoms or tension.

Plan short-term activities that are relaxing, distracting or pleasant.

Resume enjoyable activities that have been helpful in the past.

Identifying and challenging exaggerated worries can reduce anxiety symptoms.

Identify exaggerated worries or pessimistic thoughts. What are your thoughts when you are anxious? Try to identify specific thought distortions. In cognitive therapy, anxiety is recognised as the result of biases in thinking-

These include

- Fortune-telling-Something bad will happen if.....
- Mind-reading-She thinks that I am a loser.
- Catastrophic-thinking-It would be just terrible if.....
- Personalising-He's yawning because I'm boring.

Some Specific Management Strategies

Relaxation Training

Components of Relaxation Training

In order to be more in control of stress, anxiety, emotions and general physical wellbeing, it is important to learn to relax. To do this the individual will need to learn to:

1. Recognise tension.
2. Learn how to relax.

Recognising Tension

The following questions will be useful for examining an individual's tension level in greater detail:

1. Where do you feel tension?

- Do you notice tension in your face and jaw?
- Do you clench your fists?
- What other parts of your body do you feel tense?
- Are there other parts of your body where tension goes unnoticed until you feel pain?

2. What are the characteristics of the tension?

- Do your muscles feel stretched and sore?
- Do your muscles feel hard and contracted?
- Do your muscles feel fatigue?

3. Which events within yourself lead to an increase in tension?

- Anger or frustration?
- Thinking about difficulties?
- Loneliness?
- Boredom?
- Impatience?
- Changes in breathing or heart rate?
- Other?

4. Do certain people make you feel tense?

- Family members?
- Friends?
- Work people?
- School teachers?
- School peers?
- Others?

5. Which external events lead to an increase in tension?

- Home events?
- School events?
- Sporting events?
- Religious events?
- Social events?
- Other events?

Learning to Relax

Relaxation is useful in reducing physical and mental tension and stress. Relaxation helps people to reduce worry and anxiety, improve sleep and relieve physical symptoms caused by stress (e.g., headaches, stomach pains, diarrhoea or constipation).

Progressive muscle relaxation involves relaxing the muscles in a progressive or step-by-step manner. This form of relaxation is a practical skill which is best learned through instruction from a skilled teacher. In addition, many music stores sell relaxation tapes which guide the individual through the progressive relaxation exercises. Although these tapes are useful, they are recommended as training aids rather than as a substitute for training itself.

How to relax

The two main principles of physical relaxation are to:

1. Purposely tense the muscles so as to recognise the feeling of tension
2. Relax the muscles letting the tension flow out of the body

A full session of progressive relaxation takes about 20 minutes. The individual will need to sit in a supportive, straight-back chair, with feet flat on the floor, hands resting in the lap, and eyes closed. Lying down is discouraged so as to reduce the likelihood of falling asleep. The room needs to be quiet, dim and free from interruptions.

If you follow the specified steps you will be well on your way to learning how to relax. This exercise should take about 15-20 minutes. However, if you only have 5 minutes to spare, 5 minutes is certainly better than nothing!

1. Find a quiet and relaxing place.

Choose a comfortable chair in a place which is free from noise and interruptions. You may need to explain to your family what you are doing so that they will not disturb you. Telling your family may also reduce any embarrassment you may feel.

2. Clear your mind.

Try to clear your mind of all worries or disturbing thoughts. If these worries or thoughts drift back into your mind while you are relaxing, do not worry, just let them float gently out of your mind without reacting to them. Let your mind be clear and calm.

3. Practise the slow breathing method for one minute.

Breathe in for 3 seconds and breathe out for 3 seconds, thinking the word **relax** every time you breathe out. Let your breathing flow smoothly. Imagine the tension flowing gently out of your body each time you breathe out.

4. Relax your muscles.

For each of the muscle groups in your body, tense the muscles for 7-10 seconds, then relax for about 10 seconds. Only tense your muscles moderately (not to the point of inducing pain). Tense and relax your muscles in the following order:

Hands-curl your hands in to fists, then **relax**.

Lower arms-bend your hand down at the wrist, as though you were trying to touch the underside of your arm, then **relax**.

Upper arms-tighten your biceps by bending your arm at the elbow, then **relax**.

Shoulders-lift your shoulders up as if trying to touch your ears with them, then **relax**.

Neck-turn your neck gently to the left (touching your left shoulder), then bend it forward, then gently to the right (touching your right shoulder) then to the back in a slow rolling motion, then **relax**.

Forehead and scalp-raise your eyebrows, then **relax**.

Eyes-screw up your eyes, then **relax**.

Jaw-clench your teeth (just to tighten your muscles), then **relax**.

Tongue-press your tongue against the roof of your mouth, then **relax**.

Chest-breathe in deeply to inflate your lungs, then **relax**.

Stomach-push your tummy out to tighten the muscles, then **relax**.

Upper back-pull your shoulders forward with your arms at your side, then **relax**.

Lower back-while sitting, lean your head and upper back forward, rolling your back into a smooth arc tensing the lower back, then **relax**.

Buttocks-tighten your buttocks, then **relax**.

Thighs-while sitting, push your feet firmly into the floor, then **relax**.

Calves-lift your toes off the ground towards your shins, then **relax**.

Feet-gently curl your toes so that they are pressing into the floor, then **relax**.

5. Enjoy the feeling of relaxation

Sit still for a few minutes enjoying the feeling of total body relaxation.

Normal activities are then resumed in a calm and peaceful manner, thus bringing the feeling of relaxation into the daily routine.

Practise once or twice every day for at least 8 weeks.

During the day, try relaxing specific muscles whenever you notice that they are tense.

Remember, achieving deep levels of relaxation requires patience and practice. However, the effort is worth it as many of my patients have discovered. The more often you practise, the deeper and longer lasting the relation will be and the more quickly anxiety can be reduced.

Once progressive muscle relation is sufficiently mastered, you will be able to use this relation technique in most places at most times as the need arises. Whenever an increase in muscle tension is recognised, the relevant muscle group can be targeted for a quick, on the spot relation exercise. By keeping muscle tension levels in check throughout the day, you will be able to maintain more continuous feelings of relation.

Other Relaxation Methods

Although progressive muscle relaxation is the most recognised and documented method of relaxation, there are other methods that can achieve similar results. It is preferable for individuals to regularly use an effective method that they feel comfortable with and which has been successful in the past, rather than use "no method" at all. Other methods include-

- meditation
- aerobic exercise
- yoga
- pilates
- tai chi
- music therapy
- "activity" therapy-
 - sport
 - walking/jogging/running
 - swimming
 - hobbies
 - gardening
 - sewing/knitting
 - drawing/painting

Any of these "methods" can be useful if they reduce tension and are used daily/regularly.

Slow Breathing

When you become anxious your rate of breathing increases. This over-breathing is often referred to as "hyperventilation". When you over-breathe you breathe out too much carbon dioxide which leads to a decrease in the level of carbon dioxide in the blood. The decrease level of carbon dioxide causes or worsens a number of symptoms such as breathlessness or light-headedness. You may experience these symptoms if you have panic attacks.

To get rid of these symptoms, the level of carbon dioxide in the blood must be steadied. One way of achieving increased levels of carbon dioxide in the blood is to breathe into a paper bag. A large proportion of the air that you breathe out is carbon dioxide, therefore, by re-breathing your old air you are taking higher amounts of carbon dioxide into your lungs.

Although breathing into a paper bag is simple and effective, it may not always be convenient or socially appropriate to pull out your paper bag in public! Additionally, although breathing into a paper bag is effective *during* a panic attack, this method cannot *prevent* hyperventilation in the future. An alternative method which is less obvious to other people and more effective in the long run is slow breathing exercise. This method will help you to control your hyperventilation. Also, by learning slow and regular breathing habits you will help to prevent future episode of hyperventilation and other symptoms of panic.

The following exercise is to be practised four times every day for at least five minutes each time **AND** at the first signs of panic or anxiety. Combining slow breathing with relaxation is particularly helpful.

A Slow Breathing Exercise

(To be practised regularly and at the first signs of anxiety or panic).

1. Hold your breath and count to 5 (do not take a deep breath).
2. When you get to 5, breathe out and say the word **relax** to yourself in a calm, soothing manner.
3. Breathe in and out slowly through your nose in a 6 second cycle. Breathe in for 3 seconds and out for 3 seconds. This will produce a breathing rate of 10 breaths per minute. Say the word **relax** to yourself every time you breathe out.
4. At the end of each minute (after breaths) hold your breath again for 5 seconds and then continue breathing using the 6 second cycle.
5. Continue breathing in this way until all the symptoms of overbreathing have gone.

It is very important for you to practise the above so that it becomes easy to use any time you feel anxious. It is helpful to time the exercise using the second hand of your watch or nearby clock.

Source: Management of Mental Disorders. Volume 1. (2004) Treatment Protocol. World Health Organization Collaborating Centre. Sydney. (Fourth Edition).

The major sources for the above information are as follows-

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A Literature Review. (3rd Edition). 2010.

Tip Sheets

- Anger: Managing your Anger.
- Anxiety: Understanding and Managing Anxiety
- Depression: Understanding and Managing Depression
- ADHD: Understanding and Managing Attention Deficit Hyperactive Disorder (ADHD) in Children
- Autism: Understanding and Managing Autism Spectrum Disorder

Other General Publications

Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. (DSM-IVTR). (2005)

Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition. (DSM-5). (2013)

International Statistical Classification of Diseases and Related Health Problems. 10th Revision. (ICD-10). (2007)

Management of Mental Disorders. Volumes 1 and 2. (Fourth Edition). (2004). Treatment Protocol Project. World Health Collaborating Centre. Sydney.

Nathan, P. & Gorman, J. (Eds.) (2002). Evidence-based Psychosocial Treatment of Children and Adolescents.

Nathan, P. & Gorman, J. (Eds.) 3rd Edition (2007). A Guide to Treatments that Work.

RESOURCES

KidsMatter Resources

- Children's development: understanding emotions
- Social and emotional learning: how it works
- Children with depression

Websites

- Australian Psychological Society www.psychology.org.au
- <http://gpcare.org/>
- My website www.docsykes.com
- <http://autism.ahpa.com.au>
- www.kidsmatter.edu.au

Some valuable general resources on managing children from ACER (www.acerpress.com.au)

- 1-2-3 Magic-Effective Discipline for Children 2-12
- 1-2-3 Magic for Teachers-Effective Discipline for Children 2-12
- Anger Management-A Practical Guide
- Coat of Many Pockets-Managing Classroom Interactions
- Challenging Behaviours in Early Childhood Settings
- Kids Behaving Badly
- Stop-Think-Do-Social Skills Training. Early Years of Schooling Ages 4-8
- Stop and Think Friendship
- Not you Again!
- What Else can I do with You?

Some relevant general parenting websites

- Parenting Australia www.parentingaustralia.com.au
- The Australian Parenting Website www.raisingchildren.net.au
- Parenting Ideas-Michael Grose www.parentingideas.com.au
- Triple P-Positive Parenting Program www.triplep.net
- Aha! Parenting-Dr. L. Markham www.ahaparenting.com
- Prevent-Teach-Reinforce <http://www.challengingbehavior.org>

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Additional information is contained in the **Section-Exceptionality**. While the emphasis in that Section is on students with special educational needs, relevant information is provided on the definition, identification and diagnosis of certain pervasive developmental and behavioural problems and types of anxiety. Hence, readers are advised to consult that **Section**.

Information on basic management skills recommended for children and adolescents is also available in the **Section-Parenting**.

This resource has been prepared by Dr. Stewart C. Sykes - Psychologist. MAPS.
Former Associate Professor of Psychology and Special Education and Director of the
Krongold Centre for Exceptional Children.
Monash University, Australia.

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