BLOCK 3
Problem Behaviour in Children and Adolescents

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UNIT 4 CHILDREN WITH SPECIAL NEEDS*

Structure

4.0 LEARNING OBJECTIVES

After going through this Unit, you will be able to:

- Differentiate between the concepts of impairment, disability and handicap;
- Discuss the direction of growth in field of special education from segregated education to inclusive education;
- Gain awareness into the concept of 'specific learning disabilities' and identify the types;
- Discuss the problems related to assessment of specific learning disabilities;
- Define the construct of 'intelligence' and relate with its cultural perspective;
- Identify the levels of intellectual disability and the assessment tools used;
- Gain knowledge on the gifted and exceptional children;
- Appreciate the efforts made by Indian Government for the identification and mentoring of the gifted children; and
- Elucidate the role of a school psychologist in the field of special education.

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4.1 INTRODUCTION

Educating children with special needs or disabilities and including them into regular schools, has been a constant challenge. While developed countries have been able to legally and formally ensure inclusive education in its educational system, India struggles to ensure the fundamental right of education for its children. Efforts need to be targeted on how to develop a system where children with special needs get accepted into regular schools. Private (unaided) schools in India vary considerably on how they provide inclusion education, with some establishing separate special units within the school premises and others hiring special educators to provide for the needs of children with special needs. There are many problems when we consider the early identification procedures and assessment methods for various disabilities. Given that India is a multicultural and multilingual country, there are limits in the use of standardised tools and assessment procedures. Lack of awareness of teachers and parents of children with disabilities further, aggravates the existing conditions of education for the children with special needs in India. Thus, children with special needs like, children with disabilities, exceptional and gifted children as well as the role of school psychologist in special education, will be the highlight of this Unit.

4.2 CHILDREN WITH DISABILITY IN INDIA

Defining 'disability' with a single, inarguable definition is not possible. Definitions of disability have varied across countries, within the country, and in various national surveys. As a result of this, finding the correct estimate of children 'with disability' in India is indeed a difficult and an almost impossible task. In addition, the situation gets more complicated with issues pertaining to lack of awareness, untrained field investigators and social stigma attached with people with disability. In India, disability data can be made available from large scale surveys like National Sample Survey, the Annual Health Survey, World Health Survey, and District-Level Household Survey. The recent Census data on disability (Census, 2011) estimated that 2.2% of the Indian population is with disability. In other words, out of the 121 crore Indian population, around 2.68 crore persons are with disability. As a developing country, India is driven towards the fulfilment of Sustainable Developmental Goals and to create a proper measuring criterion for the right estimation of the percent of people with disability in the country. This is considered of utmost importance since the correct figures can enable appropriate measures to be taken by the Government for the welfare of persons with disability and also have implications on the implementation of National Policies driven in this direction.

Box 4.1: Know the Difference!

- Impairment – refers to a loss (or a form of abnormality) in physiological, psychological or anatomical structure or function. Impairment can be corrected with the help of aids and/or appliances and does not always lead to a disability or handicap.
- Disability – results from impairment, and refers to a lack of ability to perform functions that fall within the normal range of activities carried out by people of a specific age group.
- Handicap – results from impairment or disability, refers to the disadvantage faced by an individual that causes an inability to perform normal roles as per his/her age, gender, and educational status. Handicap occurs as

a result of social, cultural and physical barriers that prevent individuals with disability or impairment to function within the regular systems of the society.

4.2.1 Education of the Children with Special Needs

The journey of education of children with special needs has been constantly evolving and driven more towards the betterment of these children. At the outset, initiatives were taken to create separate institutes that cater to the educational needs of these children. One of such premier institutes was the School for the Deaf (1883) established in Mumbai, and since then, more than 3,000 such schools catering to the needs of children with various other forms of disabilities have been established. There were a number of problems which surfaced with the segregated education. The most significant problem was the seclusion of these children from the rest of the society which made acceptance of these children difficult for their age peers and the rest of the community. Issues such as these resulted in the establishment of integrated education. This did not imply that the special schools close down, but rather be more beneficial for the children who had severe disability. The Ministry of Education (India) in collaboration with UNICEF introduced the Integrated Education for Disabled Children (IEDC) in 1987. The mainstreaming of the 'eligible' child with disability was made possible in existing 'regular' schools with provisions of teacher training programmes, removal of architectural barriers and the like. The concept of inclusive education is gradually emerging and getting incorporated into the regular school structure. Inclusive education strongly asserts that all children have the right to learn together in any form of educational setting, be it preschool, school or colleges.

The inability of a child to study in a particular educational institute is not because of the child's disability but because of the inability of that educational institute to fulfil the needs of that child. Provisions for inclusive education include (though not limited to) having aids and appliances, modifying the teaching practices, having educational resources available for all within the school setting, and most importantly, preparing and implementing an inclusive curriculum.

4.2.2 Classification of Disabilities

The Right of Persons with Disabilities Act, 2016 (RPWD, 2016) has increased the number of disability conditions from 7 to 21. The updated list of disabilities includes three blood disorders and acid attack survivors also. Following is the list of 21 disabilities, recognised under the RPWD Act 2016:

1. Blindness	12. Chronic Neurological conditions
2. Low-vision	13. Specific Learning Disabilities
3. Leprosy Cured persons	14. Multiple Sclerosis
4. Hearing Impairment (deaf and hard of hearing)	15. Speech and Language disability
5. Locomotor Disability	16. Thalassemia
6. Dwarfism	17. Hemophilia
7. Intellectual Disability	18. Sickle Cell disease
8. Mental Illness	19. Multiple Disabilities including deaf-blindness
9. Autism Spectrum Disorder	20. Acid Attack victim
10. Cerebral Palsy	21. Parkinson's disease
11. Muscular Dystrophy	

In the present Unit, we will look into two disability conditions, viz. i) Specific Learning Disabilities, and ii) Intellectual Disabilities.

Box 4.2: They say, "What's in a name?"

Special Education has evolved and expanded since the last few decades and as a result, the special education literature has witnessed significant changes in terminologies used in this field. One of the challenges that is faced in this field is that of attitudinal approaches. A particular mind set is created when an individual with disability is addressed. It is therefore, important to note that significant changes have come about as a result of years of work by NGOs and healthcare workers to improve the existing state of mind for persons with disability and give them their rightful place in the society. More often than not, an individual is blamed for a disabled condition, when in the real situation, it is the society that has failed to accommodate the needs of those who are 'differently abled'. Recently, the 'person first' movement has also been initiated where emphasis is laid on the 'person first' and not on the 'disability'. For example, instead of 'disabled person', 'person with disability' is asserted.

Earlier terms	Current terminology
Disabled people	People with disability
Blind people	People with visual impairment
Mental retardation	Intellectual disability
Deaf	Hearing impairment
Crippled	Physical impairment

Check Your Progress 1

1) Which of the following is true for the concept of disability?

a) Disability as a concept is difficult to define.	b) Disability results from handicap.
c) The developing or developed status of the country determines to a large extent, that country's management of children with special needs.	d) The national surveys in India have the correct estimate of people with disability.

Codes:

i) Only (a) is correct	i) (a) and (c) are correct
ii) (b) and (d) are correct	ii) (c) and (d) are correct

2) Match the following:

1) Segregated Education	a) Establishment of special schools
2) Integrated Education	b) Modification of teaching practices and school curriculum
3) Inclusive Education	c) Mainstreaming of the 'eligible' disabled children

Codes:

i) 1(a), 2(b), 3(c)	ii) 1(b), 2(c), 3(a)
iii) 1(c), 2(a), 3(b)	iv) 1(a), 2(c), 3(b)

4.3 SPECIFIC LEARNING DISABILITIES

Although school as a 'socialising agent' is considered crucial in the overall development of the child, the focus invariably remains on the academic progress of the child. Children display differences in their approaches to learning, with some learning in one go, some requiring personal attention, and yet others, failing to comprehend the concepts and require repeated efforts on part of the educators and parents. Children with learning disability (LD) experience an inability to receive and process information in the brain. Often average or above average in intelligence, these children fail to meet academic standards as their counterparts and are termed as slow learners. The Diagnostic and Statistical Manual for Mental Disorders-5 (DSM-5) classifies Specific Learning Disability (SLD) as a type of neurodevelopmental disorder that manifests in the inability to engage in specific academic skills like reading, writing or math. DSM-5 is an internationally referred manual for medical practitioners and hence use the term 'disorder' and not disability. Disability as a term is used more commonly by psychologists. SLD is hence a clinical diagnosis and should not be used synonymously with LD. LD is a broad term identified by the education system for children displaying learning difficulties which do not necessarily meet the criteria for clinical diagnosis of SLD. India follows the Federal Definition provided by the U.S. Government of Public Law 94-142 of Learning Disabilities –

"Specific Learning Disabilities means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, speak, read, spell or to do mathematical calculations".

4.3.1 Types of Specific Learning Disabilities

The following table displays a classification of specific learning disabilities, with the primary area of difficulty and instances of few symptoms.

Types	Prominent feature(s)	Few characteristic symptoms
Dyslexia	Difficulty in reading	• Inability to distinguish rhyming words from nursery rhymes • Letters and/or reversing of words while reading (d/b, p/q, saw/was) • Difficulty with spellings, inability to copy correctly, and often shows phonic versions in spellings like phone- fon
Dysgraphia	Difficulty in writing	• Experience unpleasantness in drawing, showing difficulty in colouring within boundaries • Displays handwriting difficulty in terms of spacing, alignment of alphabets, mirror images of words and letters • Difficulty in written expressions like absence of punctuation marks, inability to follow grammatical rules (comes becomes comed), limited vocabulary
Dyscalculia	Difficulty with mathematics	• Displaying inability in pre math concepts like comparison (big-small, high-low), counting, sorting etc. • Confusion with rules and steps for addition, subtraction, multiplication and division. • Difficulty in telling time, understanding money and measurement concepts.

Dyspraxia	Inability in planning and completing fine motor skills	• Poor sense of direction • Difficulty in walking, hopping, throwing and catching ball, etc. • Higher sensitivity to touch (experiencing unpleasantness in nail cutting, hair combing, tooth brushing)
Nonverbal learning disability	Inability to recognize and translate nonverbal cues	• Poor coordination (acts clumsily) • Poor fine motor skills (unable to tie show lace) • Unable to recognize facial expressions and body language

4.3.2 Early Intervention and Assessment

Textbook chapters on human development and human behaviour assert the interaction of heredity and environmental forces in determining the individual's existing condition. Likewise, given that SLD is an impairment of cognitive processing (heredity), a child with SLD will respond and improve substantially if the treatment starts at an early stage (environment). Early positive experiences and supportive environment can work wonders for the child with SLD. However, the reality is far from this ideal condition. Numerous studies report that SLD goes unrecognized majorly owing to the lack of awareness of the teachers as well as the parents. This lack of knowledge about the condition can further cause problems when the child's sluggish progress in learning is considered a result of limited intellectual capacity and/or lack of interest and motivation.

Starting from the preschool years itself, SLD goes unrecognized till the onset of formal schooling. The child with SLD is often brought by parents as self-referrals or via school referrals. Often described as "lazy" or "trouble makers", these children fail to perform well academically as their age counterparts and often are subjected to punitive measures both at home and the school. The range of problematic behaviours reported in these referrals is varied, and it becomes important to ascertain that there is no presence of any comorbid disabilities. Comorbidities commonly coexisting with SLD include attention deficit hyperactivity disorder, conduct disorder, autism spectrum disorder, anxiety disorder, and various other emotional and behavioural disorders.

At present, there is no uniform screening procedure to be followed for referrals of children with SLD. Tools like Schwab Foundation for Learning and the checklist for LD in Sarva Shiksha Abhiyan Manual are commonly used to identify 'at risk' children. However, unfortunately in majority of the cases, the assessment tools are used as screening and identification purposes. Although children with SLD are referred primarily due to poor grades and/or behavioural problems, they must also be assessed on all areas like vision, hearing, general intelligence, motor abilities and the like. A complete assessment involves a battery of psychological tests that runs through a number of sessions, and detailed information from parents, teachers and school records (for example, past student report cards and notebook work). Based on the observations, test reports, and interviews (with the child, parents, and teachers), an individualised educational plan is made for each child with SLD. This is designed based on the strengths and weaknesses of the individual child. More recently in December 2020, the NIMHANS Battery has been accepted as the diagnostic tool for SLD. Any individual who tests positive on this Battery will be considered to have benchmark disability (disability of more than 40 percent).

Box 4.3: Children 'At Risk' of Developing Specific Learning Disability in Primary Schools

Based in six schools in Puducherry, Chordia and associates (2019) carried out a study to analyse the impact of socio-demographic risk factors on 'at risk' SLD children. Using a tri-phasic approach, the study comprised a total of 480 students. These primary grade students were subjected to Specific Learning Disability- Screening Questionnaire (SLD-SQ) by their teachers in Phase I. Those of them having tested positive in Phase I, were administered Vision, Hearing and Intelligence Tests in Phase II. Excluding students who displayed visual or hearing impairment and sub normal intelligence, the remaining students were administered the NIMHANS SLD Index in Phase III. Results point out toward a gender disparity, with boys (9.6%) more affected than girls (4.9%). A difference is also noted for the 'at risk' students studying in Government Schools (12.1%) and Private Schools (2.2%). Further on, SLD-SQ revealed punctuation errors and capital letters as the most common problem and the NIMHANS INDEX revealed dysgraphia as the commonest problem reported. The findings of this study imply that since SLD can be managed better with early identification and the instances of SLD going undiagnosed are also very high, screening tests should be made a routine compulsory procedure, and remedial centres should be easily available, accessible and affordable.

Source: Chordia, S. L., Thandapani, K., & Arunagirinathan, A. (2020). Children 'at risk' of developing specific learning disability in primary schools. *The Indian Journal of Pediatrics,* 87(2), 94-98.

Check Your Progress 2

1) The box given below has listed down the types of specific learning disabilities. Select the appropriate type and write it against the statements given:

   Dyslexia, Dysgraphia, Nonverbal learning disability, Dyspraxia, Dyscalculia

   i) Inability in recognizing facial expressions and body language ..... .

   ii) Difficulty in comprehending greater-lesser, big-small etc. ..... .

   iii) When reading, b becomes d, but becomes tub, p becomes q ..... .

   iv) Poor sense of direction ..... .

   v) Having difficulty in colouring within the lines ..... .

2) Identify the following as true or false:

   i) There is a standard uniform screening procedure for referrals of children with SLD. .....

   ii) Most often, SLD goes unrecognized till the child enters primary school. .....

   iii) SLD is reported to be more common in boys as compared to girls. .....

iv) Students will SLD also have poor intellectual capacity. .....

v) LD and SLD mean the same thing. .....

4.4 DEFINITION AND CLASSIFICATION OF INTELLIGENCE

In the simplest terms, intelligence has been defined as the general ability to learn. A more elaborated definition of intelligence includes "an ability to learn from experiences and application of the knowledge gained to achieve success in life and to effectively adapt to newer situations". The cultural viewpoint strongly asserts that conceptualizations of intelligence are culturally bound, and these conceptualizations and manifestations of intelligence will vary from culture to culture. An analysis of 'suktis'(good words) and proverbs in the Indian scholarly tradition reveal four dimensions of intelligence, viz., cognitive competence, social competence, emotional competence and entrepreneurial competence. Intelligence in the Indian context, is considered 'integral', owing to the focus of the person's functioning in relation to multiple contexts.

Alfred Binet (1905) developed a procedure to differentiate the mentally retarded students from the ones who were doing very well in academics. And since then, the conceptualizations of intelligence have constantly evolved. For a very long time, intelligence was considered as a decontextualized construct involving mental operations that were located within the individual. Intelligence came to be quantified and known as the Intelligence Quotient (IQ), which is the ratio of mental age upon chronological age, multiplied by 100. From the several reasons for the use of IQ tests, one important reason was also to identify individuals who largely deviated from the average intelligence. When the IQ scores of a given population are graphically plotted, we obtain a normal distribution and the two extremes of the normal curve are considered to deviate from the normal (the average). On one extreme are one-two percent of individuals on the higher end of the curve who are termed as 'genius' (refer Table 4.1). The lower end of the curve has two-three percent of individuals who are considered with intellectual disability. The bell-shaped curve (refer Figure 4.1) shows the distribution of intelligence, with the majority of cases falling in the middle (towards the mean) and at the extreme ends of the curve, are the genius (2.1 per cent) and with intellectual disability (2.1 per cent).

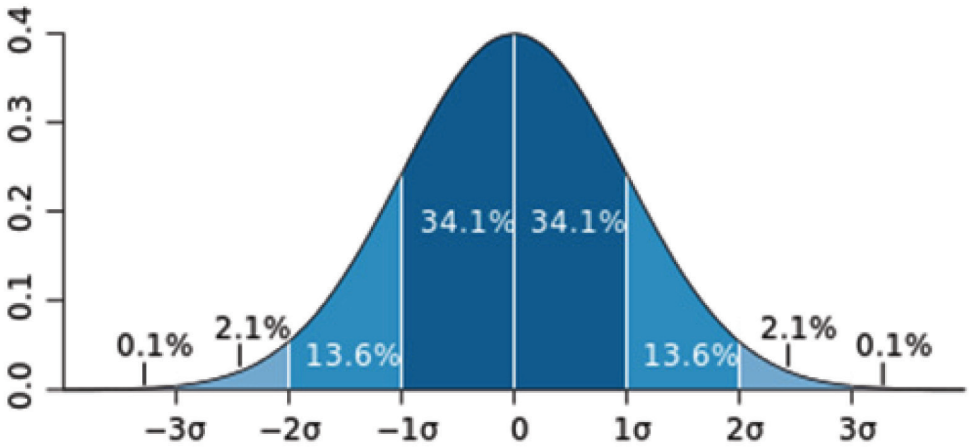

Figure 4.1: The normal probability curve, for the distribution of any psychological or behavioural trait.

Table 4.1 below shows the IQ classification by **Lewis Terman** and his first version of the Stanford-Binet Intelligence Tests, norms of which were obtained from white, American born human participants.

Table 4.1: Terman's Stanford-Binet original classification (1916)	
IQ Range	**IQ Classification**
Above 140	Genius
120-140	Very Superior Intelligence
110-120	Superior Intelligence
90-110	Normal or Average Intelligence
80-90	Dullness
70-80	Borderline deficiency
Below 70	Feeble mindedness

4.4.1 Intellectual Disability: Levels and Assessment

The term "Intellectual Disability"(ID) refers to significant impairment evidenced in cognitive processing and adaptive behaviour during the developmental years. Until the late 20th century, the term 'mental retardation' was used, but owing to reasons for reducing the stigma associated with this disability, DSM-5 has initiated the use of the term 'intellectual disability'. The World Health Organization has urged a change in terminology and hence ICD 11 will have the term 'mental retardation' replaced with Intellectual Developmental Disorders (IDD).

According to American Psychiatric Association (2000), the following table displays the classification of the levels of Intellectual Disability:

Table 4.2: Levels of Intellectual Disability		
Levels/ Classifications	**Range of IQ scores**	**Adaptive limitations**
Mild	55-70	Can academically progress up to grade 6, can be trained for independent living and becoming self-reliable
Moderate	40-55	Can academically progress up to grade 2; with supervision can work in sheltered environments
Severe	25-40	Learns to talk and is able to engage in self-care, but with constant supervision
Profound	Below 25	With very limited ability to learn, can be taught simple tasks, but characteristics of poor language skills and poor self-care

Assessment prevalence rates within a given context are likely to vary depending on whether impairment in either cognitive processing or adaptive behaviour or both are taken into consideration. Though ID can be identified in infancy or early childhood years, an accurate diagnosis is difficult to make before 5 years of age. Hence, the Global Developmental Delay (GDD) is more often used in replacement for children between the age groups of 3 months to 5 years.

The causes of intellectual disability can be categorised into hereditary as well as environmental factors. One-third of the cases are attributable to environmental factors, like, substance abuse (use of alcohol during pregnancy), prenatal infections and postnatal meningoencephalitis and for the rest of the cases, the causal factors are genetic. DSM-5 and ICD 10 strongly assert the need for assessment of intellectual functioning by the use of standardized tools that generate IQs. Clinical diagnosis is crucial to ascertain the severity of ID. While using tests in the Indian context, it is important to note that the tools are limited in a sense, and the norms

have not been updated recently. Owing to the **Flynn effect** (a rise in the IQ level over time), there is a risk that the current norm structure becomes obsolete. Following are the scales of intellectual functioning and adaptive behaviours that have been adopted and normed for the Indian population:

1) Seguin Form Board
2) Vineland Social Maturity Scale (VSMS)
3) Binet-Kamat Test of Intelligence
4) Stanford-Binet Intelligence Scale
5) Malin's Intelligence Scale for Indian Children Developmental Screening Test
6) Bhatia's Battery of Performance Test of Intelligence
7) Wechsler Intelligence Scale for Children – Fourth edition (India)
8) a) Standard Progressive Matrices
   b) Coloured Gessel's Drawing test

From the above listed tools, the VSMS is the only test that helps to assess the adaptive functioning of the individual client by generating a social quotient (SQ) in addition to eight domains of adaptive functioning. In case of inability to use VSMS, the clinician need to ask socially relevant questions based on the DSM-5 list of specifiers to gauge the severity of ID. For children below three years, the IQ tests are not applicable, and hence the Developmental Assessment Scales for Indian Infants (DAS II) and/or Developmental Screening Test is used to obtain developmental quotients which yield interpretations similar to that of the IQ scores. Some of the tools developed for education of children with intellectual disability in India are Madras Development Programming System (MDPS), Behavioural Assessment Scales for Indian Children with Mental Retardation (BASIC MR), and Functional Assessment Checklist for Programming (FACP). These tools are developed by department of Special Education National Institute for the Empowerment of Persons with Intellectual Disability, Secunderabad.

Check Your Progress 3

1) Which of the following is incorrect about Intellectual Disabilities?
   a) Global Developmental Delay is often used as a surrogate identifier for children in age group of 3 months to 5 years.
   b) Those with severe level of Intellectual Disability can be trained for independent living.
   c) There are no assessment tools available for children below 3 years.
   d) VSMS is the only tool that enables the clinician to assess the child's adaptive functioning.

Codes:

i) (a) and (d) are incorrect	i) (b) and (c) are incorrect
iii) (c) and (d) are incorrect	iv) (b) and (d) are incorrect

4.5 EXCEPTIONAL AND GIFTED CHILDREN

All children are special, and it is not the same as being gifted. With use of the term 'gifted' children, we describe a category of 'exceptional children'. Of course,

children exhibit various talents in arts and sports; but giftedness in education specifies the talent that has the potential of meeting exceptional levels. The gifted children need special attention since they have needs that are different from the needs of their age peers. There are certain characteristics that they possess, which set them apart from their classmates.

While it is strongly asserted that conceptualizations of 'giftedness' should be based on the cultural context, Indians have differed on their understanding of the 'gifted' child. Traditionally we have considered intellectual superiority as an index of 'giftedness', and in that context, the term 'genius' is more often used. This is true for children demonstrating academic excellence in school subjects. These children score high on IQ tests (with IQ scores in the range of 120-140, and above 140) and are often termed as having "superior intelligence". When considering excellence in creativity, more specifically in arts and sports, often the term 'talent' is used. 'Gifted' children are defined as those who possess natural abilities in any area that places the child in the top three percent when compared to his/her age peers. Their exceptionality is demonstrated early in life and upon training and mentoring, the child can reach newer levels of excellence.

India, being one of the world's most populous countries, is often divided along the lines of varied geographic and climatic conditions, multilingualism and multiculturalism. Approximately 60 per cent of India's population still lives in the villages. In the face of large percentage of school dropouts and unsatisfactory levels of students' performance, the country struggles with the primary goal of 'Right for Education to All". In a context like this, education for the gifted, fails to surface as a primary objective for the Indian education system. The curriculum design for Indian school boards fail to integrate the needs of the 'gifted' and exceptional children. Owing to these reasons, a large percentage of gifted children go unrecognized in the present Indian education system.

4.5.1 Identification of the Gifted Children in India

The process of identification of the gifted children was set into motion in the year 2010 when under the guidance of Prof. R. Chidambarum, a first of its kind, National Project was initiated by the Office of the Principle Scientific Advisor (PSA) to the Government of India. The National Institute of Advanced Studies (NIAS) collaborated with Delhi University and Agastya International Foundation to work on the project titled "Development of Parameters and Tools for the Identification of Gifted Children Age 3-15 years". All the three Institutes were given a free hand in development of an identification model for the gifted children in India. It is important to note that developing a single identification model is not possible for a country as vast and as diverse as India, and hence autonomy was granted to these Institutes to develop an independent model of identification of the gifted children within their respective population groups. The outcome of the project yielded three models of identification of the gifted children, which are undergoing the process of standardization. In addition, the three teams also designed resource materials for stakeholders (teachers, parents and gifted children), developed training modules for teachers and parents, created a website as well as registration of a national organization devoted to education of the gifted. Given below is a brief description of the three models:

I. The NIAS Model: Development of a three-level model for identification and mentoring of gifted children.

- At Level I, children were nominated by parents and teachers with the help of Teacher Nomination Behavioural Rating Scale (TNBRS) and Parent

Nomination Behavioural Rating Scale (PNBRS). The mentioned nomination forms were prepared by the research team.

- Level II involved psychometric screening tests on general mental ability and creative thinking. Case profiles were developed for selected children.
- Level III involved provision of mentoring services to the identified children, conducting parental workshops and training workshops for teachers, organizing summer and winter workshops for students, and writing articles in popular media to create awareness among the public about the 'gifted' children.

II. Delhi University Model: Development of a three-tier model for identification and mentoring of gifted children in and around the urban areas of the capital.

- Stage I: also known as referral stage, potential students are nominated by the school teachers.
- Stage II: also known as the selection stage, the nominated students are administered a Science and Mathematics Ability Test (SMAT) in order to select the highly potential gifted children from the pool of potential students.
- Stage III: the selected highly gifted children are guided through mentoring and other outreach program activities.

III. Agastya International Foundation Model: This model is based in the rural areas of Andhra Pradesh where the gifted children were identified based on nominations from teachers, parents, the community as well as screening bases on performance in science fairs, Olympiads, etc. The selected group of students were given a visit to the Agastya campus where the students were oriented on various topics of science and mathematics and students learnt through hands-on training, group and individual projects. Based on their performances, the students are mentored further. This Foundation also played a major role in teacher training workshops as well as summer and winter workshops for the gifted children.

4.5.2 Indian Government Funded Schemes for the Gifted and Talented Children

Following are the schemes funded by the Indian Government to cater to the needs of gifted children:

i) The INSPIRE Awards, MANAK –Innovation in Science Pursuit for Inspired Research (INSPIRE) is a program carried out by Department of Science and technology (DST) Government of India, every year. Students from Grade 6 to 10 are encouraged to share their innovations based on scientific principles and societal applications.

ii) National Talent Search Examination – Is a nationally held examination for grade 10 students conducted by NCERT for encouraging meritorious students by granting them scholarships.

iii) Pradhan Mantri Innovative Learning Programme, DHRUV – An initiative by the Ministry of Education, Government of India, for identification of talented children and to pave an encouraging path for them by enriching their skills and knowledge. Key feature is the mentoring and nurturance by experts from different fields, in order to tap their full talent potential.

iv) Olympiad Exam – Competitive exams held by various independent organizations at zonal, national as well as international level to identify

young genius in subjects like mathematics, computer, general knowledge, and language. Students earn scholarships, medals, cash prize and an opportunity to do research in their areas of interest.

v) Gifted Education Project– Initiated by the Office of Principle Scientific Adviser to the Government of India, to identify and train students with giftedness. The research project devised indigenous methods for identifying gifted children and this procedure was further developed, validated and standardised from 2010-2019 in various parts of the country.

vi) Navodaya Vidyalayas–Jawahar Navodaya Vidyalayas, a foresight of the National Policy of Education 1986, aimed at cultivating the talent in India's rural areas. The talent is drawn from a merit test, termed as Jawahar Navodaya Vidyalaya Selection test and held annually at district levels by Central Board of Examinations (CBSE). Located in rural areas, the Navodaya Vidyalaya adhere to the three-language formula – Hindi, English and a regional language, and promote for co-educational residential schools with free education.

Check your progress 4

1) State the following as true or false:

   i) The exceptionality of the gifted child is demonstrated early in life. .....

   ii) Gifted children achieve an IQ score of above 120 in the IQ tests. .....

   iii) The curriculum design for Indian schools has been successful in incorporating the needs of the gifted child. .....

   iv) A child who excels in a particular sport can also be termed as gifted. .....

4.6 ROLE OF SCHOOL PSYCHOLOGIST IN SPECIAL EDUCATION

In India, practicing psychologists working in the school set-up are often termed as "school counsellors" or "school psychologists". There is no definite structure of roles and responsibilities of a school psychologist in India as yet. The on-the-job duties are vastly varied and constantly evolving, owing much to the vision of the school principal and school management.

School psychologists play a vital role to aid in the academic, social, and emotional development of children and youth. The role of school psychologists becomes manifold, when it comes to children with special needs. A collaborative approach of working with educators, parents, and other professionals including special educators, physiotherapists, occupational therapists, and speech and language therapists can be utilised by a school psychologist to create a safe, healthy, and supportive learning environment for all students.

The following are briefly outlined roles of a school psychologist in the context of special education that needs to be ideally carried out:

- For students with any kind of learning disability or intellectual disability, a school psychologist can help the students by designing instructional strategies that target optimal learning.

- School psychologist plays an integral role in the development of individualised education plans for each child with special needs.
- School psychologist most frequently engages in consultation services. The intervention plan for children with special needs always requires the teachers and parents to be involved. Hence, the school psychologist can collaborate with the teachers and parents in a way that works for the benefit of the child in need.
- School psychologist also provides referrals to the parents for further assessment and intervention plan for children with special needs.

We need to understand how school psychologists can render positive support to parents or caregivers of children with special needs. For any parent or a caregiver, who gets to know about their child as a child having special needs, it is not a very easy experience in the first place. There are different emotions, ranging from denial and sadness to anger and disappointment. The challenges experienced while caring for the children with special needs, may range from personal, social, financial and which also calls for guided assistance to parents and caregivers. A school psychologist, with the help of colleagues and school administration, may arrange talks, discussions, teacher-parents meetings, strength-building/resilience-building workshops with parents or caregivers of children with special needs for facilitating and working with them towards their concerns and lend a helping hand, while they and their children are on a journey of various experiences.

4.7 SUMMARY

Now that we have come to the end of this unit, let us recapitulate all the major points that we have learnt.

- Educating children with special needs or disabilities and including them into regular schools, has been a constant challenge in India.
- Impairment refers to a loss (or a form of abnormality) in physiological, psychological or anatomical structure or function. Impairment can be corrected with the help of aids and/or appliances and does not always lead to a disability or handicap. Disability results from impairment, and refers to a lack of ability to perform functions that fall within the normal range of activities carried out by people of a specific age group. Handicap results from impairment or disability, refers to the disadvantage faced by an individual that causes an inability to perform normal roles as per his/her age, gender, and educational status.
- The types of SLDs are dyslexia, dysgraphia, dyscalculia, dyspraxia, nonverbal learning disability. The NIMHANS Battery has been accepted as the diagnostic tool for SLD.
- American Psychiatric Association (2000) classifies intellectual disability into mild, moderate, severe and profound.
- Gifted children are defined as those who possess natural abilities in any area that places the child in the top three percent when compared to his/her age peers.
- In the Indian context, RPWD Act, 2016 identifies 21 disabilities.
- There are three important models for the identification of gifted children. The models are the NIAS model, Delhi University Model, and the Agastya International Foundation Model.

- Some of the important schemes funded by the Indian government for the gifted and talented children are the INSPIRE Awards, MANAK;National Talent Search Examination; Pradhan Mantri Innovative Learning Programme, DHRUV; Olympiad Exam; Gifted Education Project; Navodaya Vidyalayas – Jawahar Navodaya Vidyalayas (schemes for the rural areas).
- The role of a school psychologist in Special Education is to design instructional strategies that target for optimal learning, engage in consultation services, and also provide referrals to the parents for further assessment and intervention plan for children with special needs.

4.8 KEYWORDS

Assessment: Considered primarily as a problem solving approach, is a process of collecting information from various sources and via various mediums, to base intervention and/or instructional decisions for the individual in need.

Early Identification: To identify children with special needs is of utmost importance to work on a prevention basis, and address the problem in its infancy, rather then when it becomes more unmanageable.

Segregation: This happens when education of the children with special needs is provided in a separate environment, like the establishment of a special school. Segregation also occurs when with a regular school, children with special needs are educated in a separate class, often known as resource classes.

Integration: Often also termed as 'mainstreaming, children with special needs are brought into the regular classes without any modifications in the delivery of education services. No individualised educational plan for these children is designed.

Inclusion: Characterized by a transformation of the education system, in terms of modifications in teaching methods, curriculum, evaluation pattern and availability of resources.

Global Developmental Delay: Evidenced in significant delay in two or more of the following areas of development: gross/fine motor, speech/language, social/personal, cognition, and activities of daily living.

4.9 REVIEW QUESTIONS

1) Define and differentiate the terms, disability, impairment and handicap.
2) Define intelligence and briefly outline the IQ classification.
3) What is Intellectual disability? Describe the levels of intellectual disability.
4) Describe the various government funded schemes for the gifted children of India.
5) How can gifted children be identified in India?
6) What is the role of a school psychologist in the field of special education?

4.10 REFERENCES AND FURTHER READING

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4.11 WEB RESOURCES

- Learning Disability

  Learning Disability In Children: Causes, Signs & Treatment | White Swan Foundation
- Disability in India

  https://www.nhp.gov.in/disease/non-communicable-disease/disabilities

Answers to Check your Progress

Check Your Progress 1

1) (ii) (a) and (c) are correct
2) (iv) 1(a), 2(c), 3(b)

Check Your Progress 2

1) i) Nonverbal Learning Disability
   ii) Dyscalculia
   iii) Dyslexia
   iv) Dyspraxia
   v) Dysgraphia
2) i) False
   ii) True
   iii) True
   iv) False
   v) False

Check Your Progress 3

1) (ii) (b) and (c) are incorrect

Check Your Progress 4

1) i) True
   ii) True
   iii) False
   iv) True

UNIT 5 INTERNALIZING PROBLEMS IN CHILDREN AND ADOLESCENTS*

Structure

LEARNING OBJECTIVES

After reading this unit, you will be able to:

- Differentiate between internalizing and externalizing problems;
- Explain depression and disorders related to depression;
- Elaborate upon the symptoms of anxiety and related disorders;
- Explain the aspects associated with social withdrawal and somatic complaints in children; and
- Identify body image issues and eating disorders in children and adolescents.

5.1 INTRODUCTION

A school day brings with itself a variety of new experiences, social situations and opportunities. Children deal with them in accordance to the feedback they receive from their teachers, peers and parents. They are supposed to behave as per the expectations usually set by the adults in their society. Dixon and Matalon (1999) explained that "some children behave contrary to what is expected of their age and stage of development". It has been seen that children suffer from various psycho-social impairments and impediments. Of those children, however, the ones that are most misunderstood are the ones with emotional and behavioral problems. Avoidance or neglect towards these children and their issues can lead to negative student behavior, resultant poor performance, and behavioral issues in other walks of life. The behavioral issues can also impact their academic focus,

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positive interaction with adults and even peers (Walker, Ramsey, & Gresham, 2004). They have also been found to have a high dropout rate and a very high unemployment rate in comparison to others who complete school (Sutherland & Wehby, 2001).

It is essential for the parents, teachers, and school professionals to implement strategies and practices to help students with various emotional and behavioural problems that they might be facing, to create a conducive environment for them to learn and succeed in classroom and eventually in real world (Salmon, 2006). For this, it is imperative to acknowledge and understand more about these problems and their manifestations. Sometimes, it can be tough to distinguish between a troubling behavior that's a part of growing up process and a problem that requires professional attention. But, if these behavioral signs last for weeks or months and become a hindrance in child's daily life activities at home or/and at school, or with friends, one must contact a specialized professional. According to the Individuals with Disabilities Education Act (IDEA 2004), one or more of the following characteristics may be exhibited (over a long period of time) by a child with emotional and/or behavioral disturbances (Gartin & Murdick, 2005).

- Lack in the ability to learn, which cannot be explained by any intellectual, sensory or other physical medical condition.
- Difficulty in building or maintaining satisfactory interpersonal relationships with peers and teachers at school.
- Display of inappropriate behavior or feelings under the seemingly normal situations.
- A general and persistent mood of unhappiness or depression.
- A probable tendency to develop physical symptoms associated with problems related to school or the ones that are personal in nature.

As defined by National Institute of Mental Health (NIMH), these emotional and behavioral difficulties are "characterized by behavioral or emotional responses in school programs so different from the age appropriate, cultural, or ethnic norms that it affects the educational performance- social, vocational, academic and even personal skills" (Benner, Nelson, & Epstein, 2002). It is important to note here that one cannot measure social, behavioral or emotional functioning of an individual, or child in this case using a single standard way. Deviance is to be understood in the context of a particular culture as what is deviant as per one culture might be completely acceptable or even sanctioned by another culture. Therefore, there is an amount of subjectivity that is to be understood and taken care of while identifying a behavior as deviant.

Box 5.1

In the case of younger children, benefits can be obtained from evaluation and treatment if they are found to display some of the following behaviors, impacting their daily life:

- Are quite irritable most of the times and are also found to throw frequent tantrums.
- Talk about their fears and worries often.
- Present frequent complaints of headaches or stomach aches with no known medical cause.
- Sitting quietly is difficult, except when playing video games or watching some videos.

- Sleep related issues, such as, sleeps too much or too little, may have nightmares, or may seem sleepy during the daytime.
- Having difficulty in making friends, least interested in playing with others.
- Deteriorating grades with time.
- Keep checking things due to the fear of something going awry.

Source: National Institute of Mental Health (NIMH), 2019, *Child and Adolescent Mental Health*.

Box 5.2

If older children and adolescents might be showing some of the following signs and symptoms, evaluation and then subsequent treatment may be beneficial in their case.

- Low on energy.
- Not interested in things and activities which they used to enjoy earlier.
- Sleeps too much or too little.
- Avoiding social activities with friends and/or family.
- Fear of gaining weight, thus, exercise excessively or follow a strict diet regimen.
- Involved in self-harm behavior, such as cutting, slashing themselves, burning their skin, taking unnecessary risks.
- May have suicidal ideation (thoughts).
- Usage of substance- smoke, alcohol, drugs etc.
- Feel that others are controlling their mind and may say that they can hear things (which others can't hear).

*Source***:** National Institute of Mental Health (NIMH), 2019, *Child and Adolescent Mental Health*.

A well-known distinction proposed "in the area of child psychology and psychiatry is between the emotional and behavioral disorders that are internalizing or externalizing in nature" (Achenbach & Edelbrock, 1978; Gresham et al. 1999). A child with 'internalizing' behavioural issues may be anxious, inhibited, become withdrawn, and have poor self-esteem. Their reactions to the outside world might just be contained within their own self or psyche and not played out, that is, no external manifestation of behavior (Anderson, 2012). They may experience loss of interest in academic, social and various other activities. Children and adolescents with internalizing behavioural problems may have a diagnosis of depression, anxiety, separation anxiety, post-traumatic stress disorder, or eating disorder. They may also exhibit school or exam fear, body image issues, or other somatic symptoms. It has been found that screening tools usually used for students to identify higher levels of internalizing behavior are not very sensitive and thus are not used much in practice (Wells et al., 2019).

On the other hand, externalizing behavioral issues refer to a group of problems that are apparent in terms of the actions that are displayed by the child. These might be negative reactions to the external situations (Liu, 2004). Refer to Table 5.1 to see some of the differences between internalizing and externalizing behaviors.

These externalizing issues may consist of disruptive, and hyperactive behaviour. Aggression, delinquency, truancy, aggression, and conduct related problems are also included within this construct. Childhood aggression has also been found to be a strong predictor of violence and adult crime (Eisenberg et al. 2001). It is also important to note that this dichotomy is not comprehensive by any means. In fact, there could be an overlap between the two. For instance, due to an internalizing problem of a child, there might be a negative impact on siblings, parents or people around him/her. Whereas, for a child with externalizing disorder may not harm people around him/her in the outside world but might be suffering internally. Interestingly, cultural tolerance of some behaviours for a particular gender may also perpetuate gender-based differences. For instance, certain cultures are more tolerant of externalizing behavior in boys than girls. Therefore, boys might be seen exhibiting externalizing behavioral problems more than girls (Lambert, Weisz, & Knight, 1989; Liu, 2004; Wells et al. 2019).

Table 5.1: Difference between Internalizing and Externalizing behaviours

Internalizing behaviours	Externalizing behaviours
Keeping emotions within, not expressing concerns	Outward expression and projection of emotions
Feelings of guilt, insecurity, helplessness very high	Difficulty in holding emotions such as guilt, shame within themselves
Exceedingly helping others and excessively feeling for others	Acting out (rage, anger) to communicate distress
Attempt to control and rationalize one's emotions, self-blame	Blame others, thinks others/situations are a problem

If left untreated, these problems may serve as a "gateway" for various other issues that the youth may encounter later in life, thus increasing the risk for development of various other emotional, behavioural and physical difficulties (Costello et al., 2003; Cummings, Caporino, & Kendall, 2013). In this unit, we will be discussing various internalizing behavioural problems in children and adolescents and the next unit will focus on externalizing behavioural problems.

5.2 INTERNALIZING BEHAVIOURAL PROBLEMS

Often misunderstood and overlooked, especially until about the 1980s, internalizing disorders comprise of a specific type of emotional and behavioural problem in children and adolescents (Merrell, 2013). It consists of issues that are based on 'over controlled symptoms' (Merrell, 2008). It refers to the fact that these problems are manifested when children have a maladaptive control of their own internal cognitive and emotional states. Thus, it can be said that these problems are developed and also maintained within the individual, making them difficult to diagnose or detect through external observation and measurement.

In this section, the internalizing behavioural issues that will be discussed are, depression, anxiety, social withdrawal, eating disorder and body image issues, school and exam fear, somatic or physical complaints and post-traumatic stress disorder.

5.3 DEPRESSION

Children and adolescents or even adults when face setbacks or disappointments in life, feel sad. However, it eventually fades or lessens over a period of time as they cope with it. Depression is not having a bad mood or an occasional feeling of being down or sad. Parents need to be concerned and contact professionals when sadness and other related symptoms (to be discussed further) last for weeks,

months or longer than that, hampering the child's ability to function in their daily lives. Thus, depression exists on a continuum of severity from mild and transient state of low mood to severe symptoms impacting the quality of life of an individual (as depicted in Table 5.2). It is primarily characterized by the following symptoms: depressed moods, loss of interest in activities, sleep related problems (hypersomnia or insomnia, that is, too much or too little sleep respectively), weight loss or gain, psychomotor retardation (slow physical movement) or agitation, loss of energy or fatigue, difficulty in concentrating, thinking or making decisions, feeling of guilt, worthlessness, and recurrent thoughts of death. It has been studied that the preoccupation with death and related thoughts is more often seen in older children and adults and might not be manifested in the younger ones as their concept of death is vague and not well-built. Irritability and certain physical complaints such as headaches, stomach aches, etc. are two additional physical complaints that are often seen in children and teenagers with depression (Merrell, 2013). It is important to note here that all these symptoms might not be present in one individual to diagnose him/her with depression. Presence of at least five of these symptoms (and at least one of the symptoms should be depressed mood or loss of interest in pleasurable activities) for a period of two weeks is necessary for the diagnosis. Also, if the child is young, it is more likely that loss of interest would be displayed more than the depressed mood.

Table 5.2: Continuum of Sadness and Depression

	Normal	Mild	Moderate	Depression-less severe	Depression-more severe
Emotions	Good mood	Feeling a bit irritable or low	Upset, sad, teary eyed	Intense sadness, crying spells, "heaviness"	Extreme sadness, crying spells, feeling hopeless
Cognitions	Thoughts about planning and organizing the day	Thoughts about difficulty of the day "something will go wrong"	Dwelling on negative thoughts, like rude behavior, making mistakes in a test	Pessimistic thoughts about future, self-harming thoughts, thoughts regarding personal deficiency	Strong self-harm intent, suicidal thoughts, may also give instructions to others in case of death
Behaviors	Getting up, following routine, going to school/ work	Takes longer than usual to get up, low concentration	Crash to bed without dinner, less/no sleep, less concentration	Inability to get up from bed, skipping work, withdrawing contact	Social withdrawal, loss of appetite (weight), suicide

Table 5.3: Depression at different stages (adapted from Poquiz & Frazer, 2016).

Age	Behavior	Probable Precursors
Preschoolers (2-5 years)	• Irritability, anger, throwing tantrums • Sadness, excessive crying • Loss of interest in toys that were favourite/ activities, decreased socialization • Lethargy • Headache, stomachache	• Family history of mental illness or depression • Family history of suicidal ideation and/ or attempt • Stressors such as divorce (in parents), someone's death
Middle Childhood (6-12 years)	In addition to behaviors listed above, • Withdrawn from family and friends • Bullying others or being bullied • Sleep related problems • Loss of appetite, weight loss (eating related issues) • Separation anxiety (especially from the caregiver) • Lack of concentration • Refusal to go to school • Poor academic performance • Thoughts of worthlessness • Hurting oneself	In addition to precursors listed above, • Inconsistent parenting • Low peer support • Social isolation • Being bullied • Academic pressure • Other mental health issues, such as anxiety, specific learning disorder

Adolescence (13-18 years)	In addition to behaviors listed above, • Hopelessness, pessimism about future • Loss of interest in pleasurable activities • Low self-worth and self-esteem • Substance abuse • Self-harming tendencies	In addition to precursors listed above, • Parent-child conflict • Onset of puberty

It is difficult for preschoolers (2-5 years) to verbalize their emotions, due to which early signs of depressions can be missed. Nevertheless, the persistent complaints about irritation, crying, tantrums and other physical complaints could be due to depression (Refer to Table 5.2). It is also important to note here that preschool depression can eventually lead to various other mental health illnesses in childhood and adolescence.

The ability to talk and express themselves increases gradually and till middle childhood (6-12 years), some of the symptoms that children have are similar to that of adults with depression. The younger children may still exhibit behavior similar to that of the preschoolers.

Researches have shown that the risk for depression increases with puberty. As adolescence (13-18 years) is the time to be involved in various different activities, become independent, choose a career, and form relationships. Warning signs can involve thoughts of future and friendships. Sometimes, parents and peers ignore the warning signs of depression by categorizing it as a teenage issue or attention seeking behavior but if the teen is indulging in substance abuse or has suicidal thoughts and/or tendencies, immediate help is required.

We have seen that children with depression may exhibit different behaviors at different ages and stages in their lives. It requires professional attention, if left untreated, it can lead to poor school performance, unhealthy relationships, and other mental health issues like delinquency, substance abuse and even suicide in some cases. So, the ideas such as, "it's just a childhood tantrum", "he will eventually come around", "she needs a new toy", "take them for vacations" need serious attention, because the child will not "snap out" of depression suddenly.

5.3.1 School and Academic Related Issues

Loss of motivation, concentration and a sense of worthlessness along with feelings of hopelessness can impact learning of the child. For instance, the child with depression may not be able to concentrate on the lesson being taught in the class, he/she may lack the energy to note down the homework or finish it. They might be convinced in themselves that they would fail at everything and thus would stop taking initiative or attempting anything. They may also be getting negative and unwanted attention from others around them, especially, teachers, peers and parents increasing their feelings of worthlessness. This could eventually lead to social withdrawal. Familial conflict, parental divorce, or normal difficulties with regard to learning can also lower down the child's school performance. However, if this continues over a period of time or if the decline in academic performance exists without a clear explanation, it should be a cause for concern.

5.3.2 Trouble with Peers

Healthy friendships are important as they promote positive behaviour, emotional adjustment and also lay the foundation for healthy relationships in future. Children with depression are usually ignored or rejected by their friends as they may come across as boring or slow. If the child is aggressive, they are avoided due to their rough and rude behavior. This rejection can result in their isolation, feeding

their thoughts such as, "no one likes me", "I am worthless". They are at higher risk of being bullied by others (Juvonen et al., 2003). It can further lead them to substance use and abuse. Thus, it is important for parents to be aware and keep a check on the social relationships of their children.

5.3.3 Self-Harming and Suicide

Suicidal thoughts are common in adolescents. Despite the fact that suicides are under reported in a country like India, it has been established that highest rates are among the ones below the age of 30 years, especially adolescents (Samuel & Sher, 2013). Thus, any and all expressions of suicidal ideation and behaviour are to be taken seriously. Depression and substance abuse are two of the primary factors leading to suicidal behavior. Thus, parents need to be careful if their child is showing signs of depression, withdrawal and/or self-harm.

Box 5.3: Causes for depression

Genetic factors: a family history of depression or any mental disorder may increase the risk in the child.

Brain chemistry: neurotransmitter and hormonal imbalances may also play a role and increase the risk.

Abuse: past physical, sexual or mental abuse can increase an individual's vulnerability to depression.

Death or loss: grief from loss of a loved one may increase the risk of depression. It is important to note that, natural or normal mourning period does not qualify for depression.

Major events in life: changes such as divorce of parents, moving to another place can contribute to depression.

Environmental factors: a stressful and chaotic home environment can cause depression, rejecting and bullying at school can also be a reason.

5.3.4 Other Disorders with Depression as a Feature

The above given presentation of symptoms is clinically called as major depression. However, there are various other mood or adjustment disorders that include depression as a major feature. In this section, we will briefly discuss them.

Dysthymia (or Persistent Depressive Disorder) shares many features with major depression but differs mainly in two aspects. First, individual with dysthymia exhibits fewer mild-to-moderate symptoms. Second, the depression lasts for a longer duration (at least 2 years for adults and 1 year for children and adolescents). Depressed mood (in dysthymia) may last for most of the day, but it if mild-to-moderate intensity.

Bipolar I disorder includes episodes of full-blown mania (extreme elation, lasts for 7 days) and periods of major depression. Bipolar II disorder would include episode of hypomania (lesser in severity than mania, lasts 4 days) and major depression. Period of mania or hypomania characterizes feelings of energy, invincibility, flood of ideas, flight of ideas, grandiosity, decreased need for sleep etc. and all of this may lead to poor decision making and risk taking. Finally, Cyclothymic disorder (also understood as a less serious version of bipolar disorder) includes depressed mood similar to the one in dysthymia and hypomania. In this, the depressed mood may characterize low energy, social withdrawal, feelings of inadequacy, and brooding attitude. Parents of children with cyclothymia may feel that their child is on an "emotional roller coaster" that rarely ends (Merrell, 2013).

Adjustment disorder with depressed mood is another presentation of symptoms of depression that may occur due to issues faced by the individual in adjusting to a major life event, such as, death of a loved one, divorce, change in circumstance etc. (lasts for 6 months or longer).

Check Your Progress 1

1) Mention the various symptoms of depression.

.....

.....

2) What is dysthymia?

.....

.....

3) What leads to depression?

.....

.....

4) Can you differentiate between the symptoms of depression in a preschooler from that of an adolescent?

.....

.....

5.4 ANXIETY

Some of us often feel distressed and worried in our day-to-day life situations, such as, before appearing in a test or exam, before a competition, when stuck in traffic, especially when already running late etc. The worry and anxiousness, decreases as we come out of these situations. But, if the individual (adult or child) remains anxious irrespective of the situation and is not able to cope with it, it could be an anxiety disorder and would require attention from a psychologist. Before we proceed with this, it is important to understand the difference between three terms that are often used synonymously – anxiety and fear (Refer to Box 5.4).

Box 5.4: Difference between Anxiety and Fear

One of the most common and important ways in which a distinction can be made between anxiety and fear is in terms of the actual external stimulus. Fear is experienced in the presence of a real danger or threat. Most people are usually found to be scared of these stimuli. On the other hand, anxiety is experienced in anticipation of danger when such danger might not be present or cannot even be specified at times. Thus, the source of danger is obvious in fear whereas anxiety involves a general apprehension about possible danger. It is a future oriented state.

Anxiety disorder is a broad category but all the disorders share certain common elements. All of them involve three basic areas of symptoms: physiological response (sweating, arousal, nausea etc.), behavioral symptoms (avoiding, escaping etc.), and subjective feelings (dread, discomfort etc.). Some of the common symptoms of anxiety disorders could be presence of unrealistic or negative thoughts, panic attacks, misinterpretation of events, physiological

arousal, oversensitivity to certain physical cues, fear of a specific situation, object or event, and excessive worry in general. Some of the anxiety disorders that have been identified are: generalized anxiety disorder, specific phobia, social phobia, panic disorder, and agoraphobia. Earlier, obsessive-compulsive disorder was also categorized under anxiety disorders but it is now the flagship diagnosis of a different category, namely, obsessive-compulsive and the related disorders.

5.4.1 Disorders with Anxiety as a Feature

There are a large number of diagnosable disorders that include anxiety as a common symptom but some of them are particularly important when working with children, such as phobias, separation anxiety or even post-traumatic stress disorder. In this section, we will discuss some of these disorders.

Phobias "can be defined, a persistent and disproportionate fear of a specific object or situation that presents little or no actual danger to a person" (Carson, Butcher, & Mineka, 2003). Phobias are similar to fears as both of them involve response to a specific threat, but the difference lies in the fact that phobias are more intense, persistent and maladaptive, in comparison to fears. For example, being detained by a few tough and physically strong bullies after school seems like a good enough reason to be scared of them and thus, show a fear response, but developing a debilitating fear of bugs, birds etc. is quite maladaptive. Three categories of phobias have been identified; specific phobia, social phobia, and agoraphobia.

Specific phobia is diagnosed in an individual when he/she shows a strong fear of a particular object or a situation. When encountering a phobic stimulus, the person shows immediate fear and may go to great lengths to avoid it or escape it. He/she may also avoid the picture or model of the phobic stimulus. The individual might have a phobia of animals such as, dogs, spiders, lizards, and insects; some natural environment such as, water bodies, heights; seeing blood, blood tests, medical procedures; a situation such as, enclosed spaces, elevators, driving, or something like fear of choking, loud sounds, or even vomiting after eating certain type of food.

Agoraphobia is the fear of crowded places such as shopping malls, or theaters etc. It comes from the word traditional Greek word "agora", which means public places of assembly, thus, agoraphobia means, fear of public places or assembly. It can also be a fear of having a panic attack in the situations where escape could be difficult or embarrassing.

Box 5.5: Why do Phobias Develop?

Genetic: phobias are acquired due to an individual's genetic make-up, temperament or personality. Kagan et al. (2001) concluded that behaviorally inhibited toddlers (shy, timid) show a higher risk for development of specific phobias later at the age of 7-8 in comparison to the uninhibited toddlers.

Family factors: a link may exist between an individual's specific phobia and anxiety of his/her parents. It could be genetic or a learned behavior (they may see their parents being afraid of spiders and may learn it).

A negative experience: experiencing a frightening or traumatic event may develop certain phobias and anxious reactions, for instance, being attacked by an animal, or being trapped in an elevator.

Learning about negative experiences of others: hearing about some negative information or event, such as a plane crash, or water body related accident.

There is nothing wrong about a child being shy, but if the child experiences extreme distress over everyday situations like reading in class, or playing with other kids, this can be a cause of concern. Social anxiety disorder (or social phobia) is described as "disabling fears of one or more specific social situation (such as public speaking, urinating in a bathroom, or eating or writing in public) where the person fears of being exposed to the scrutiny and potential negative evaluation of others or that he/she may act in an embarrassing or humiliating manner" (American Psychiatric Association, 2013). Due to it, the individual may either avoid the situation or face it with high levels of distress. Mainly two subtypes of social anxiety disorder have been identified, in situations that are performance oriented, such as, public speaking, and the situations that are non-performance ones but demand public presence or social interaction, such as, eating in public, or meeting someone new. It is important to note that in children, the anxiety should occur in a setting that may involve peers. Anxiety during interactions with adults should not be the only criteria for diagnosis. Their anxiety or fear is usually expressed by crying, tantrums, freezing, shrinking, clinging, or inability to speak in social situations. Excessive sweating or blushing is also a common overt manifestation. Often, children with social anxiety do not even want to go to school. Box 5.6 describes some of the common social anxiety triggers.

Box 5.6: Common Social Anxiety Triggers

- Meeting new people
- Public speaking/Performance on stage
- Being the center of attention
- Being watched while doing something
- Making small talk
- Being criticized by others
- Talking to authority figures
- Using public washrooms
- Being called in a class
- Eating or drinking in public
- Attending social gatherings

Box 5.7: Causes of Social Anxiety disorder

Inherited traits: like any other anxiety disorder, social anxiety disorder also runs in families. Thus, if the biological parents and/or siblings have a similar condition, the child becomes more vulnerable.

Brain structure: amygdala may play a role in controlling fear response of an individual. Thus, overactive amygdala may heighten the fear response, causing increased anxiety in social situations.

A negative experience: developing this condition after an unpleasant, embarrassing social situation, for example, being overly criticized or reprimanded in class.

Learning about negative experience of others: parents may model such social anxious behavior in front of children. Fearful and socially anxious parents may unknowingly transfer verbal or non-verbal information to their child about the dangers of a social situation. If the child sees or hears a caregiver being embarrassed in or by a social situation, even that makes him/her vulnerable.

Less exposure: if the child is not exposed to enough social situations and is not allowed to develop appropriate social skills, it can be a contributory factor.

Parenting: if one or both the parents are rejecting, controlling, critical or overprotective, the child may not form secured attachment, thus putting them at greater risk as they can not calm down or soothe themselves in stressful and chaotic situations.

Societal/cultural factors: sometimes certain aspects prevalent in a society might be responsible for development of social anxiety in some. For instance, growing up in a culture with strong collectivistic orientation. *Taijin kyofusho* (Japanese culture-specific syndrome) involves a fear of making other people uncomfortable and the concern regarding how one would fit in a larger group is emphasized.

Terms such as 'school refusal' or 'school phobia' are often considered as common features of separation anxiety disorder. A child is diagnosed with this disorder if he/she shows marked distress and is afraid of being away from certain people, especially a parent or primary caregiver. They may exhibit unusual fear, anxiety, and panic symptoms in response to going to school. They may cry, freeze, present somatic complaints (bodily complaints such as stomachache, headache, fever etc.), throw tantrums, and withdraw socially. They may also show fear of getting harm, getting lost or kidnapped, assault or permanently getting separated from the caregiver. Similarly, school refusal is the motivated refusal to attend school or difficulty faced by the child to remain in school and attend classes for the entire day. It may involve innumerable internalizing and externalizing behaviors but separation anxiety disorder has been found to be one of the major causes for school refusal or school fear (Kearney, Chapman, & Cook, 2005; Lingenfelter & Hartung, 2015). It can be an overwhelming feeling for the families as initially they may feel that their child is 'acting difficult', might drop out, but such behavior requires professional attention as it often leads to conflict, academic issues, friction with school officials and most importantly lost time for work, especially for the child (Kearney & Albano, 2000).

Box 5.8: A Case Example for Separation Anxiety Disorder

Rahul, a 5years-old, Indian school boy was presented as stubborn, always crying and throwing tantrums at the school gate for not going inside and leaving his mother. The child joined this school 4 months back and was excited to go to a new school, make friends and enjoy. After 2 months, summer vacations were announced which he had enjoyed at his maternal grandparents' place. But, after returning he became violent and refused to go to school. He became clingy and wanted to be with his mother at all times, even when at home. When he was forced to leave his mother (2-3 times by his father), he would cry violently to the extent that he would stop breathing or choke on his breath. While crying he would often say that his mother would leave him and he would die. The very next minute, he would apologize to the teacher and others present for his misbehavior. Ultimately, he was sent back home and after due to this repetitive behavior was sent to a psychologist.

Source: Vashishtha, K. (2015). Treatment of Separation Anxiety Disorder- A Clinical Case Study. *Case Studies Journal,* 6(4), 14-20.

Another related childhood anxiety disorder to be discussed here is selective mutism. It is the "consistent failure to speak in specific social situations in

which there is an expectation for speaking despite speaking in other situations" (American Psychiatric Association, 2013). It may co-exist with social anxiety disorder. The behavior is perceived as either shy or rude by others, but despite that such children are unable to speak in certain situations such as school. For instance, a child with selective mutism may remain silent for years in school but may speak freely at home or any other situation. This disturbance may interfere with educational or occupational achievement, social functioning, and language development (Gazelle, Workman, & Allan, 2010). It is important to note here that the failure to speak is not due to lack of development or knowledge of speech or spoken language. A hierarchical variation can also be seen in children diagnosed with selective mutism. For instance, some may participate in social activities, thus appear social but do not speak; then there are others who speak to peers but not adults. In some cases, they may speak to adults only when asked a question which requires short answers. In a more severe form, the disorder may progress until the person no longer speaks to anyone in any situation, this may also include family members. This state is called as "progressive mutism".

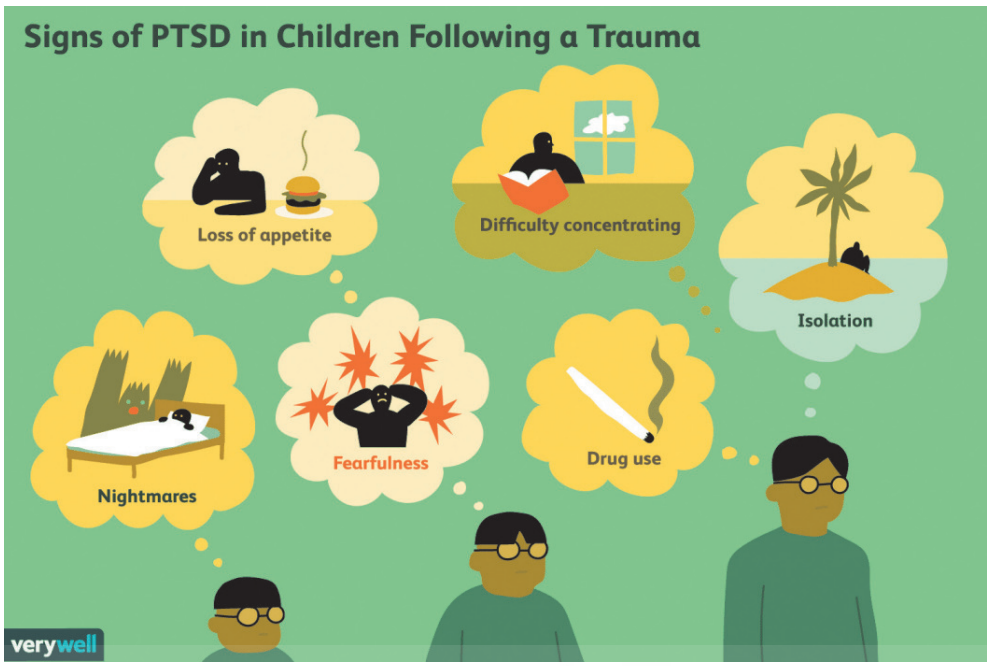
Generalized Anxiety Disorder (GAD)

It is a state of excessive and unreasonable worry about various life events or activities. In this disorder, anxiety is not anchored to a specific object or situation but is diffused in nature and thus, described as free-floating anxiety (Butcher, Hooley, Mineka, & Dwivedi, 2017). For instance, if the child starts displaying excessive, unrealistic and uncontrollable worry and anxiety across a range of topics and areas of life, such as friends, family, school, health, and sports. One of the prominent features is that they often anticipate worst-case scenarios or disasters. They are almost always apprehensive and are in a future-oriented mood state, constantly attempting to deal with any upcoming negative event. Some of the symptoms characteristic of this disorder are: sleep disturbances, nightmares, irritability, decreased concentration, poor decision-making, fatigue, variety of somatic complaints, especially muscle tension and aches in the neck and upper shoulder region. They are almost always hyper-vigilant for all possible signs of threats in their environment and attempt to avoid anxiety, unsuccessfully though, by procrastinating or indulging in checking activities.

Post-Traumatic Stress Disorder

It has been established that an extremely stressful event that could have been life threatening and is not a common everyday experience could lead to various psychological symptoms not only in adults but also in children. These traumatic stressors may include living in a concentration camp, combat, terrorist attack, rape, or natural disasters such as earthquake, tsunami, school violence, neglect, serious accidents or sudden loss of a loved one.

Stress symptoms are very common following a traumatic event, but they may decrease over time. Thus, it is important to remember that for a diagnosis of Post-Traumatic Stress Disorder (PTSD), the symptoms must last at least for a month. PTSD is "a traumatic event thought to cause a pathological memory" that is also the defining clinical symptom of the disorder (McNally, 2013). These memories can be brief bits of the experience and may also be related to the events that happened before the traumatic event or moment (Hackman et al., 2004). For children below the age of 6 years, their involvement in either of the following ways can lead to trauma: the child directly experienced the event, or the child witnessed the event in real (not seen on television, or some other form of media), or the child learnt about the traumatic event that happened to the caregiver.



Source: http://verywellmind.com/dsm-5-ptsd-criteria-for-children-2797288

Some of the following symptoms can be seen in the children, adolescents and adults diagnosed with PTSD: (i) Intrusion symptoms: re-experiencing the traumatic event through nightmares, intrusive images, flashbacks or any physiological reactivity may act as a reminder of the trauma; (ii) Avoidance symptoms: avoidance of any trauma related stimuli such as feelings, or thoughts. This can lead to change in routine for some individuals; (iii) Negative cognition and mood: they may be unable to recall the key aspects of the trauma, or may have overly negative thoughts about oneself and/or others (for example, "I am bad", "The world is very dangerous", "No one can be trusted", or "My whole nervous system is ruined"), distorted feelings like guilt, shame, and blame might be involved. Interest in otherwise pleasurable activities may go down and they may have difficulties in experiencing positive affect. This may eventually develop the feelings of alienation and isolation from others; and (iv) Arousal and reactivity: hypervigilance, reckless behavior, aggression, irritability, startled reactions are also very commonly seen.

Table 5.4: Signs and symptoms of PTSD at different stages

Preschool Children	School-going Children	Adolescents	College students
• Cry or scream a lot • Loss of appetite • Nightmares and night terrors • Extreme fear of being separated from parents/ caregivers	• Poor concentration • Insomnia and nightmares • Extreme feelings of guilt and shame • Anxiety and fear in various situations • Decreasing academic performance	• Loss of appetite • Self-harm • Feeling depressed • Social isolation • Substance abuse • Engage in reckless sexual behavior • Impulsivity • Poor decision-making • Decreasing academic performance	• Inability to concentrate • Decreasing academic performance • Social withdrawal • Isolation • Dissociative tendencies • Hypervigilance • Sleep related problems • Edgy, restless • Negative cognition and affect • Avoiding pleasurable activities

As mentioned, children and adolescents have similar reactions to the trauma, but in children less than 6 years of age, some other symptoms might be visible. For instance, they may end up wetting their bed even after being toilet trained. They may act out the scary, traumatic event during their play activities or may become too clingy to their parents/caregivers. Apart from showing symptoms similar to adults, older children may become disruptive or disrespectful and may even have thoughts of revenge.

It is important to note that every child who experiences trauma may not develop PTSD, but the parents, caregivers, teachers and other adults should be aware of the possible warning signs if the child has faced some kind of trauma recently and is suspected to be struggling.

Box 5.9: Causes and risk factors for Post-traumatic Stress Disorder

Abuse: any kind of abuse- physical, emotional or sexual can be traumatic for the child.Along with this any behavior that is perceived as abuse (bullying by adults or peers of the child) by the child can be traumatic and lead to PTSD.

Neglect: parental neglect or neglect from a primary caregiver may lead to attachment related issues in child and eventually can be a cause for PTSD. Instances such as being kept in a box as punishment etc. could also be a case in point.

Disasters: various natural disasters such as an earthquake, tsunami etc. where the child or the adult around feels helpless can be a source of trauma. Sometimes the after effects of the disaster may lead to uncertainty, fear and anxiety.

Accidents: car crashes, train or airplane accidents or any news related to it can be a trigger for the child. Accident such as house on fire, or short circuit at house can also cause trauma.

Violent acts: witnessing a parent being abused, kidnapping, riots, shooting or beatings at school are violent acts that may shook the child instilling trauma in them.

Death of a loved one: whenever any significant one of the child dies, his/her security may also die with that which can be traumatic for the child.

Significant changes in life: changes such as adoption of the child, divorce between parents can also be contributing factors.

Various anxiety related disorders have been discussed above and it is important to point out here that poorly managed anxiety during childhood may increase the risk for substance use in adolescence and young adulthood (Benjamin et al., 2013). It may also lead to poor quality of life with many affected individuals showing poor mental health in comparisons to those who have other chronic medical condition, such as diabetes, hypertension, arthritis etc. (Comer et al., 2011). Another important point to remember is that a lot of overlap exists between different anxiety disorders, depression and other internalizing problems. It is not unusual for someone to have a combination of co-occurring symptoms that may not be diagnosable as a specific disorder, but for all practical purposes constitutes and is thus called as a "general internalizing disorder" (Merrell, 2013).

Check Your Progress 2

1) Differentiate between fear and anxiety.

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2) Explain the symptoms of social anxiety disorder.

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3) What leads to post-traumatic stress disorder?

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4) Mention the symptoms associated with phobia in an individual.

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5.5 SOCIAL WITHDRAWAL

Social withdrawal has always been associated with constructs such as shyness, isolation, rejection, inhibition, passivity, social reticence, and peer neglect. It is now understood as an umbrella term describing a behavioral prototype derived from various underlying causes (Rubin & Coplan, 2004). Thus, behavioural inhibition has been understood as a biologically based wariness because of exposure to novel people and situations (Kagan et al., 2007). Shyness is the self-conscious behavior in situations of perceived social evaluation (Crozier, 1995). When an individual is watching others from far or is remaining unoccupied when in social company, it is called as social reticence (Coplan et al., 1994). Social withdrawal thus, is linked to psychological maladaptation as it represents behavioral expression of internalized thoughts and affect pertaining to social anxiety and depression (Vasa & Pine, 2006).

Although social withdrawal is not a specific type of disorder or internalizing problem, but it is present in most of these problems, specifically in depression and anxiety. Children who show symptoms of social withdrawal actively avoid companionship of others. They usually do not respond to initiations of other children and may exhibit behavioral deficits in various social situations, particularly in making and maintaining friendships. It may involve unrealistic self-appraisal of one's social performance and is complicated by excessive fear. Social withdrawal might be temporary or it could even be a long-term concern with implications on other aspects of life. For example, a socially withdrawn child may otherwise have good social skills but avoid social interactions due to his/her negative view about his/her social ability.

From early childhood till adolescence, socially withdrawn children are at risk for various negative adjustment outcomes and socio-emotional difficulties (for instance, anxiety, depressive symptoms, low self-esteem, and internalizing problems), peer difficulties (victimization, rejection), and other school difficulties (poor teacher-child relationship, school avoidance). Social withdrawal as induced by anxiety may yield sympathy and interest from others; whereas social

withdrawal induced by depression may actually elicit support in a way that actually causes others to withdraw from them further (Mullins at al., 1986).

Box 5.10 Case Vignette

An 8 years-old girl Emma was brought to a practitioner by her mother. She described Emma to be a precocious girl with verbal and cognitive skills like that of a fifth grader than a second grader. But it was reported that she would often talk about dying. She had difficulties in sleeping at night as she would feel hopeless and sometimes a sudden panic would rise in her. She had to be forced to go to school. At school and at home, she would often engage in "crying fits". Her mother reported that earlier Emma had been a gregarious girl but her peer relations significantly deteriorated that year and she saw that other kids actively avoided her.

Initial intake meetings with the therapist revealed a family history of clinical depression. Emma's father was convinced of the fact that "drugs are the only thing that work" and was not in favor of counseling sessions. A basic treatment plan of individual counseling was decided that focused on behavioral and cognitive changes for Emma, along with some aspects of emotional management. The child's progress was being monitored thoroughly after four sessions. The sessions comprised of, one hour per week sessions, follow-up meetings, phone checks (regarding progress) with Emma's parents, and weekly data collection to monitor progress. After 4 weeks of rigorous work, improvement was noticed in Emma's behavior. The concerns regarding Emma being a danger to herself and the possibility of medical evaluation diminished over time. 7 weeks into intervention and the depression, anxiety or social concerns were hardly noticeable. By 9 weeks, Emma seemed to be doing well in all the aspects of life. The 10th session was the concluding session where Emma was asked why she thought she was doing better than earlier and she replied, "I think I'm doing better because I think about my problems in a different way than I used to, and I do different things than I used to, and then I usually feel okay even if things aren't going okay." Follow- up sessions after 2-3 months revealed that she had maintained most of the progress she had made during her treatment.

Source: Merrell, K. W. (2013). *Helping Students Overcome Depression and Anxiety: A Practical Guide.* Guilford Publications.

5.6 BODY IMAGE ISSUES AND EATING DISORDERS

We live in an image conscious culture where messages regarding "the right look" are set and shared by media. Concerns about how we look in the mirror, how we eat, are we fat or overweight are very common, especially in adolescents. It has got an adaptive value also as it helps in maintaining a normal weight, reducing the risk of diabetes, hypertension and other such chronic ailments. But, when this concern goes overboard and people have extreme weight concerns and body dissatisfaction, it may qualify for eating disorders (See Table 5.4).

Weight concerns include feeling overweight most of the time, even when it is not the case. The individual may have a thin physique yet may talk about exercise vigorously due to a drive for thinness. It is possible that they may focus on certain areas of the body that they have to tone down or decrease in size. Body dissatisfaction is the distress with one's appearance and subsequent avoidance

of certain situations because they elicit body related concerns (Grabe & Hyde, 2006). Some of the feeding and eating disorders that would be discussed in this section are- anorexia nervosa, bulimia nervosa, binge eating disorder, pica, and avoidant/restrictive food intake disorder.

Table 5.4: Continuum of Eating Disorder

	Normal	Mild	Moderate	Depression- less severe	Depression-more severe
Emotions	Positive feelings about self	Some anxiety about body shape and weight	Moderately anxious about body shape and weight, feels down	Intense anxiety and sadness over not being able to lose weight	Severe anxiety regarding body shape and weight
Thoughts	"I am okay with my weight and body"	"I need to be more fit and so, let me cut back"	"I feel fat, I should cut down on my eating or else..."	"I feel fat all the time. I wish to have a thinner body. I need to cut back"	"I am extremely fat and I hate my body! I have to stop eating now!"
Behaviour	Eating without concerns	May eat less at meals	May regularly skip meals, take low calories food	Eats one meal a day, usually something like a salad, may also purge after meals	Eats rarely, when forced to do so, exercises vigorously and may purge frequently

Anorexia Nervosa

Individuals with anorexia nervosa have a distorted body image and a pathological fear of becoming fat. It usually leads to extreme dieting, exercise regimens and weight loss. The term *anorexia nervosa* literally means "lack of appetite induced by nervousness" but in some senses the name then becomes incorrect as here, lack of appetite is not the major problem, rather the issue is the fear of gaining weight, with a refusal to maintain even a minimally low body weight. They are very proud of their extraordinary self-control, to the extent that they may put their lives in danger.

Most commonly it begins in adolescents who are either overweight or perceive themselves to be. Usually, it follows descriptions of extreme fasting and exercise. They may look painfully thin, yet deny their problems. A large number of patients with anorexia nervosa try to conceal their thinness by wearing baggy clothes, carrying hidden bulky objects and drinking water before being weighed to increase their weight temporarily. As they are never satisfied with their weight loss, as per an account, hallmark of a successful anorexic was death from starvation and the one who has accomplished this should be respected and admired (Bulik, Sullivan, & Kendler, 2000). Thus, it is a life-threatening disorder. Box 5.11 explains some of the warning signs of anorexia nervosa in school-going children.

There are two basic types exist under anorexia nervosa- (i) restricting type: includes limiting food intake, monitoring calorie intake, eating very slowly, and disposing food when no one is seeing; (ii) binge eating/purging type: they may eat out of control which is followed by efforts to purge (removing food they have consumed from the body, for which they may self-induce vomiting, laxatives or even enemas. It is important to note here that it involves marked disturbance in body image, that is, they may see themselves as very differently in mirrors, not because of any eye-sight related issues, but their perception of themselves and their bodies is extremely distorted. It can lead to various medical complications such as cessation of menstruation, brittle hair, nails, dry skin and intolerance for cold temperature.

Box 5.11: School Specific Warning Signs of Anorexia Nervosa

- Weight loss- this is not due to loss of appetite but due to fear of eating and gaining weight.
- Avoidance of any physical exercise or swimming in school as it may involve undressing.
- Excessive exercise in other situations, "I felt driven to do more each day."
- Making themselves busy during lunch breaks, so that questions regarding food could be avoided.
- Wearing extra clothes most of the times to keep themselves warm and especially hiding their body.
- Focus on perfectionism to avoid anxiety
- Loss of friends as thoughts about food, dissatisfaction with body image dominate thinking most of the times
- Inability to focus in class because due to starvation concentration gets difficult.

Bulimia Nervosa

It is marked by binge eating and subsequent efforts to prevent weight gain by using inappropriate purging behaviour or exercise. *Bulimia* basically denotes hunger of such a proportion that a person can even eat an ox (eat abnormally large amount of food). Bulimia nervosa means literally "ox hunger". One of the major differences between anorexia nervosa and bulimia nervosa is that the former one is severely underweight whereas the latter is not. Thus, if the individual binges and purges and is also underweight, the diagnosis is anorexia nervosa. Purging is a dangerous behavior that may impact one's health very seriously, causing dehydration, hormonal imbalance, electrolytic imbalance, depletion of minerals and damage to certain organs.

Amount of food being consumed is important in bulimia as the eating is usually experienced out of control, followed by attempts to compensate it. They are usually preoccupied by the shame and guilt, efforts at concealment and struggle painfully, yet unsuccessful to master the frequent impulse to binge. It can be said that their self-esteem is determined by their body weight and shape. People with anorexia are proud of their dietary control, whereas bulimics are ashamed of losing control.

Binge Eating Disorder

It shares the binge eating criterion of bulimia nervosa, that is, consuming large quantity of food in a shorter duration due to loss of control, but it is not followed by inappropriate compensatory behaviour to purge it out through vomiting or laxative usage. It may lead to weight gain and various health issues associated with obesity, and/or future purging behaviour. The recurrent episodes of binge eating are usually followed by marked distress and the feeling that one just cannot stop eating. To be diagnosed with bulimia nervosa, body weight and shape must influence their self-concept, which is not the case in binge eating disorder. Here, the behavior, emotions and thoughts are mainly associated with binge eating only. They can be found to be eating more rapidly and uncomfortably full than 'normal'. They may consume large amounts of food even when not hungry and may usually eat alone due to embarrassment from the amount of food being consumed.

Box 5.12 Risk Factors for Eating Disorders

Genetic factors: eating disorders may run in families. Sometimes changes in brain chemicals may also increase the risk of developing eating disorders.

Psychological factors and personality traits: intense dissatisfaction with oneself and one's body or a negative outlook towards it could contribute to eating disorders. Traits such as perfectionism, impulsivity, need for control have also been found to be responsible.

Dysfunctional families and relationships: significant parental enmeshment or rigid/overprotective parenting could also be possible reasons or contributing factors.

Dieting and starvation: dieting is a major risk factor, along with it, starvation affects the brain which influences the mood and further reduces appetite. Starvation and weight loss may perpetuate restrictive eating behaviors, making return to normal eating habits difficult. There is strong evidence that many of the symptoms of an eating disorder are actually nothing but symptoms of starvation.

Involvement in activities that emphasize body shape and weight: sports that emphasize aesthetics or thinness, such as gymnastics, athletics. Appearance-centric activities such as modelling, beauty pageants or professions or activities such as that of ballerinas.

Stressful situations: change in life situation can bring stress increasing the risk of an eating disorder.

Pica and Avoidant/Restrictive food intake disorder

Most people only think of teenagers when talking about eating disorders, but they impact young children as well. In fact, physical growth is such an important aspect of childhood that eating disorders can cause significant damage to a child's body. Pica is a type of condition in which the child may eat non-food, or eat something that has no nutritional quality. They may eat relatively harmless items such as ice or may consume potentially dangerous substances, such as paint, soap, pieces of metal. The child is to be diagnosed with pica when the behaviour persists more than a month, the object being consumed is considered developmentally inappropriate (for instance, an infant who chews anything and everything would not qualify) and it is not a part of culturally sanctioned practice.

Avoidant/restrictive food intake disorder is another common eating disorder experienced by young children which involves eating in a narrow repertoire of food. Children with this disorder may experience a disturbance in eating which can include lack of interest in food, sensory aversion to certain foods-their appearance, taste, texture etc., brand presentation, or a past negative experience with the food. It can lead to nutritional deficiencies and various other negative health outcomes. In certain cases, it has been seen that the individual may completely exclude a particular food group from their diet, such as fruits. They may leave food on the basis of its color. Some may like it to be very hot or cold, soft-to-chew, crunchy or may avoid sauces, sticky food etc. Individuals may experience substantial weight loss or in children expected weight gains are not seen. There is no evidence of disturbance in perception of body weight or shape found in these cases. Physical gastrointestinal reactions to adverse food could be in the form of vomiting, gagging, and retching. Thus, they try to change their eating habits if they can (Nicholls et al., 2001).

It is important for parents, teachers and others around to cultivate and reinforce the idea of a healthy body image in the child. Discussions around self-image and reassurances that body shapes can vary may help the child in accepting his/her body. Elders should avoid criticizing body in front of their child. These discussions and reassurances of acceptance and respect for the body can build a healthy self-esteem that may eventually help the child in his/her later years of life.

5.7 SOMATIC PROBLEMS

Somatic problems are complaints related to body or the physical discomfort, pain, or illness. It is presumed that they do not have a known organic or medical basis, rather are caused by emotional distress and are psychological in origin. But, not having a physical origin does not mean that they are unreal or fake. It is important to consider here that the word "known" has been used while saying that a somatic symptom has no known medical basis. Thus, it is possible that the physical discomfort could be due to an injury or physical problem that is currently not within the limits of medical understanding and assessment technology. Very much like social withdrawal, somatic symptoms are a part of various internalizing problems such as anxiety and depression. It is also widely understood that somatic complaints and problems are very common in children and youth (Merrell, 2013). Some of the common complaints are: headache, stomachache, pain in the eyes, nausea, pain in the limbs or joints, breathing problems, skin rashes, and itching. They may also report feeling dizzy or faint. Some individuals with significant and long-lasting somatic complaints may develop an oversensitivity to physiological cues, thus, becoming too alert for any physiological change or sensation in the body which others may not be able to notice. In certain cases, these complaints might just be inconvenient and uncomfortable and not debilitating in nature, but, in some other cases, they may hamper daily adaptive functioning in life.

Check Your Progress 3

Check your understanding of eating disorders by identifying disorders in the following scenario:

1) Jai has been found to be having episodes lately when he eats unusual amounts of food. He has been gaining a lot of weight because of it.

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2) Ritika ate a whole cake, three bags of potato chips, and a few tarts. Later, she ran to the bathroom and it sounded as if she was vomiting. It can eventually lead to electrolytic imbalance raising other serious health concerns.

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3) Alina eats large quantities of food in short span of time. She then takes laxatives and exercises vigorously to prevent weight gain. She believes that she will become ugly and worthless if she gains even a few grams.

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4) Nikita has lost several kilograms over a period of time. She eats a small portion of food fearing that she will become fat. Her BMI is lower than 16. Since losing weight, she has also stopped menstruating. She sees herself as a fat person in the mirror.

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5.8 OVERLAP OF INTERNALIZING PROBLEMS

Internalizing problems have a very strong tendency to overlap or occur together with each other or with other problems. In clinical practice, the term "comorbid" is used to indicate the presence of one or more conditions often occurring together with another primary condition. It can be physiological or psychological in nature. For example, a child may have depression and social phobia at the same time. Importantly, the use of the term comorbidity to describe the relationship among various internalizing problems can be misleading. The term suggests that the two problems have a separate process of development. But, in reality, it is understood that the internalizing problems may exist in a symbiotic relationship- nurturing and sustaining each other. They may have developed due to a similar event, and may also have similar predispositions and patterns of responding.

Keeping aside the usage of words or terminology, it is widely known and understood that depression, anxiety, somatic complaints, social withdrawal, eating disorder may often co-occur. For instance, children with significant anxiety and those with depression may both develop somatic complaints such as headaches, muscle tension, stomach pain etc. Also, social withdrawal can either be a cause or effect of depression. It is also linked with various anxiety disorders. Interestingly, different internalizing and externalizing problems may also co-exist, for instance, substance use co-occurs with a wider range of other mental and behavioral problems, this may even include depression.

The things that make elementary children so interesting are the same that can make their upbringing tricky and difficult. A full school day brings with it a plethora of experiences, opportunities, and social situations; every child takes it in and deals with it differently. Thus, several issues crop up during these years and sometimes the child needs strategies, suggestions and help from professionals to guide him/her through these exciting years.

5.9 SUMMARY

Now that we have come to the end of this unit, let us recapitulate all the major points that we have learnt.

- National Institute of Mental Health defined emotional and behavioural difficulties as the ones that are "characterized by behavioral or emotional responses in school programs so different from the age appropriate, cultural, or ethnic norms that it affects the educational performance- social, vocational, academic and even personal skills".
- A person with internalizing behaviour keeps his/her emotions within, not expressing concerns, may have a poor self-esteem and usually have difficulty in coping with negative emotions.

- Depression is primarily characterized by symptoms of depressed mood, loss of interest in activities, weight loss or gain, sleep related issues, psychomotor difficulties, fatigue, difficulty in making decisions, feelings of guilt and thoughts about death.
- Specific phobia, previously known as simple phobia, has five sub types: animals (e.g., spiders, dogs); natural environment (e.g., water, heights); blood-injection-injury; situational (bridges, tunnels); others (vomiting, choking, 'space phobia' where the person has a fear of falling down if he/she is away from walls or support).
- A social phobia is a persistent, irrational fear generally linked to the presence of other people. It can be extremely debilitating
- Some of the triggers for the development of post-traumatic stress disorder can be abuse, parental neglect, accidents, natural disasters, death of a loved one, violent acts, or any other significant change in life.
- Some of the feeding and eating disorders enlisted are anorexia nervosa, bulimia nervosa, binge eating disorder, pica, and avoidant/restrictive food intake disorder.
- Various internalizing problems such as depression, anxiety, somatic complaints, social withdrawal, and eating disorders may often co-occur.

5.10 KEYWORDS

Anxiety: Feeling experienced in anticipation of danger or threat which is not present or cannot be specified.

Body Image: Person's perception of their own body, how they see themselves in comparison to the standards set by the society.

Generalized Anxiety Disorder: State of chronic, excessive and unreasonable worry about various life events and activities.

Phobias: Persistent and disproportionate fear of a specific object/situation that presents little or no actual danger to the person.

Post-traumatic Stress Disorder: A condition that develops after a traumatic event. The symptoms last more than a month and are severe enough to impact the daily, social and occupational functioning of an individual.

Selective Mutism: A disorder in which children do not speak in particular situations, such as a classroom.

Separation Anxiety Disorder: Characterized by fear, anxiety, or avoidance of a situation that may lead to separation from an attachment figure or primary caregiver.

Social withdrawal: Retreating from social situations and society at large, it characterizes avoiding companionship, exhibiting behavioural deficits in social situations, and lack of response to initiation of other children.

Somatic complaints: Complaints related to body or physical discomfort, pain or illness that does not have a known medical basis.

5.11 REVIEW QUESTIONS

1) Explain the term emotional and/or behavioural disturbances.

2) Differentiate between internalizing and externalizing behaviours with example.

3) Mention the clinical symptoms and probable causes of depression.

4) Elucidate few disorders with depression as a feature.

5) What is anxiety? Mention some of the triggers and causes of Social Anxiety Disorder.

6) Explain the symptoms and features of Post-traumatic Stress Disorder.

7) How is social withdrawal manifested in children?

8) Differentiate between anorexia nervosa and bulimia nervosa.

9) Explain the symptoms of Avoidant/Restrictive Food Intake Disorder.

5.12 REFERENCES AND FURTHER READING

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5.13 WEB RESOURCES

- Description of Internalizing behaviours

  https://study.com/academy/lesson/internalizing-behaviors-definition-examples-quiz.html

- Internalizing behavior in the classroom (Stanford medicine, Department of Psychiatry and Behavioral Science)

  Internalizing behavior in the classroom - YouTube

- What is social anxiety disorder? (Health matters, University of California, TV)

  VIDEO: What is Social Anxiety Disorder? - Health Matters - UCTV - University of California Television

UNIT 6 EXTERNALIZING PROBLEMS IN SCHOOL CHILDREN AND ADOLESCENCE *

Structure

6.0 LEARNING OBJECTIVES

After reading this unit, you will be able to:

- Explain externalizing behaviors;
- Elucidate disruptive, impulse control, and conduct disorders;
- Identify symptoms of attention deficit/hyperactivity disorder;
- Discuss the difference between substance use, abuse and dependence and its prevalence in children and adolescents; and
- Describe the associated features with truancy, pyromania, and kleptomania.

6.1 INTRODUCTION

Emotional and/or behavioural disorders are specific issues causing extreme difficulties in certain cases with both the aspects – emotions and behaviour. Impacting child's functioning in most or all the areas of life, they make it difficult for the child to regulate emotions, choose appropriate behaviour as per the situation and act on it. As you have learnt in the previous unit, some of these internalizing disorders affect the child's ability to learn in school, be successful in his/her academic endeavors, control actions and feelings in general and be happy in life. These disorders seem to impact every aspect of the child- feelings,

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behaviours, cognitive and social functioning, and academic achievement. Thus, they have a hard time coping with the demands that situations and life in general make from them.

In this unit, we will focus upon the externalizing problems such as aggression, conduct problems, hyperactivity, and the like. In contrast to the overcontrolled, keeping emotions to themselves, and sometimes 'invisible' or secretive nature of the internalizing problems, externalizing problems are thought to result from poor/ under-controlled self-regulation, wherein the individual is found to have an outward expression of emotions and is disruptive to others. Thus, the individuals with internalizing problems internalize (keep it to themselves) their maladaptive emotions, cognition and behavior and individuals with externalizing problems are found to externalize (manifest outside) these thoughts, feelings and behaviours. These children exhibit serious conduct related problems such as fighting, stealing, bullying, assaulting, and threatening others as they tend to have serious issues in regulating their emotional and behavioural expressions. Unlike internalizing behaviors, they can hardly be a secret as they are easier to identify and observed directly. Apart from emotional dysregulation, it involves impulsivity, aggression in opposition to social norms and authority figures. It may also include violating others' rights (Krueger, Markon, Patrick, & Iacono, 2005), losing temper often, excessive verbal and physical aggression, destruction of property and theft (McMahon, 1994). In order to be diagnosed with an externalizing problem, apart from these maladaptive symptoms, the individual must have a functional impairment in at least one of the areas- academic, social, occupational or family relationships; and the symptoms should be uncharacteristic of their cultural and environmental context.

6.2 DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDER

Oppositional Defiant Disorder (ODD) and Conduct disorder are categorized under Disruptive, Impulse-control and Conduct disorders as both focus upon aggressive or anti-social behaviour. Both of these disorders involve a child's relationship with societal norms, rules regarding conduct and involve behaviour that may or may not be considered against the law (juvenile delinquency). ODD is usually apparent by the age of 8, and conduct disorder is recognized by the age of 9; full blown conduct disorder usually develops by middle childhood through adolescence. According to various researches these disorders are closely linked with each other (Thomas, 2010). However, they are distinguished on the basis of the nature of seriousness of violations – relatively less serious in ODD in comparison to conduct disorder. ODD has also been considered as a milder precursor of conduct disorder.

6.2.1 Oppositional Defiant Disorder

An important feature if ODD is persistent negative, defiant, disobedient and hostile attitude and behavior towards authority figures. The symptoms of a child with ODD can be categorized under three groups – angry/irritable mood, argumentative/defiant behaviour, and vindictiveness. Angry/irritable mood would include losing temper, feeling touchy or easily annoyed, getting angry and resentful toward others. Argumentative/Defiant behavior may involve arguing with authority figures or adults, throwing temper tantrums, actively defying or refusing to comply with requests from authority, or questioning and non-compliance with rules. They may deliberately annoy others, blame others

for their own mistakes or misbehaviour. Finally, vindictiveness may involve being spiteful and revengeful towards others. Different levels of misbehavior are evident in oppositional and defiant children, for instance, there might be a young child who would throw temper tantrums often, or there could be an adolescent who would exhibit ODD kind of behaviour for years such as verbal and physical abuse, punching holes in walls etc. and feels justified doing so. Interestingly, they might see themselves as victims and thus justify their 'acting out' behavior. Their justification may also come from certain social role models who act out – actors, rock stars, politicians etc.

The ODD diagnosis calls for presence of at least four of these symptoms for at least six months with at least one person who is not their sibling and is causing impairment in at least one setting of life. It is important to note that not all cases of ODD further develop into conduct disorder, however majority of the cases of conduct disorder are followed by a diagnosis of ODD (Lahey et al. 2000). Research (Nock et al., 2007) indicates higher prevalence of ODD in boys, almost 11 per cent, in comparison to girls, almost 9 per cent. It has been found that girls may show symptoms of ODD that are different from boys, for instance, they may display their aggression more through words, and are more apt to lie and be uncooperative (Connor, 2002).

Sometimes the parents have trouble identifying or accepting the symptoms of ODD as a problem or a disorder in their child because they usually feel that their child "will grow out of it" with time or as he/she matures. It is often difficult to differentiate between ODD and the usual independence-seeking behaviour which is considered as a characteristic of early teen years. However, as per the evidence early intervention and treatment is useful in overcoming ODD and preventing its progression into another serious mental health concern (American Academy of Child and Adolescent Psychiatry, 2009).

Box 6.1: Can ODD be Prevented?

Research shows that intervention at an early stage, certain school-based programs, and individual therapy are really helpful in preventing ODD at an early stage itself (Burke, Loeber, & Birmaher, 2002). These early programs have also been found to be influential in preventing delinquency later in life. A program providing education, health and other services related to skill development, especially to low-income group children and their families could be very successful. Young children may learn social skills, communication skills, anger and conflict management (Connor, 2002). In the case of adolescents, psychotherapy (talk therapy), academic help, social-skills training, and vocational skills training has been found to be impactful in reducing disruptive behavior. In social skills and training, students can also be taught to stop bullying, improving peer relationships and thus reducing antisocial behaviour. A home visit to children at a high risk (low socio-economic strata, parents with mental health concerns, family discord etc.) also has been shown to help prevent ODD (Eckendroje, et al., 2000). Parents should also be taught to develop and nurture secure relationships with their child and creating healthy boundaries with them.

You will know more about interventions in Unit 8.

Box 6.2: Causes and Risk Factors of ODD

Biological factors

- A parent with a history of any metal health disorder- ADHD, mood disorder, etc.
- Use of substance by mother during pregnancy, such as alcohol, nicotine
- A parent with substance abuse
- Exposure to toxins as an infant or early in life
- Impairment in brain areas responsible for impulse control, reasoning, or judgment
- Neurotransmitter imbalance
- Lack of nutrition.

Psychological factors

- Indifferent, neglectful, or absent parent.
- Poor relationship with parents and/or siblings
- Difficulty in forming or maintaining relationships and understanding social cues.

Social factors

- Poverty or socioeconomic disadvantage
- Neglect and Abuse
- Lack of adult supervision
- Uninvolved parents
- Inconsistent discipline pattern
- Unstable family environment and family discord (divorce, moving away etc.).

6.2.2 Conduct Disorder

As mentioned above, both conduct disorder and ODD involve persistent disregard for rules, rights of others and authority. But, one of the major differences between the two (apart from the age of onset) is that ODD lacks the severe physical aggressiveness that children with conduct disorder may exhibit. Children with conduct disorder might show deficit in social behavior (Happe & Frith, 1996). The symptoms may include aggression towards other people, animals (Becker et al., 2004), destruction of property, theft, lying, deceit, and grave violation of societal norms. They may exhibit covert or overt aggression in the form of bullying, initiating fights in schools or in other settings, use of weapons that can harm or seriously injure another person, firesetting (Stickle & Blechman, 2002), robbery, vandalism, breaking into someone's house or car and even homicidal acts. Children with conduct disorder are also likely to be sexually uninhibited and might be found inflicting sexual aggression on others, especially younger children. They might also be at a high risk for unwed pregnancy and substance use, abuse and dependence (Yang et al., 2007). Two different courses of the disorder have been identified – first, life-course persistent pattern that starts early and continues even into adulthood; another one is the adolescence limited course where the antisocial behaviour begins in adolescence, had a typical childhood and would

later have a typical adulthood (with no antisocial issues and problems). Research has also provided evidence to the fact that early onset of conduct disorder is highly correlated with later development (in adulthood) of antisocial personality disorder (Goldstein et al., 2006). Conduct disorder is three to four times more common in boys than girls and its life time prevalence could range between 2 to 10 percent in the general population (Mohan, Yilani, & Ray, 2020).

Box 6.3: Causes and Risk Factors for Conduct Disorder

- **Genetic influences:** although researchers are not sure of the exact genetic component contributing to conduct disorder but inherited genes have been found to be responsible for development of conduct related issues. Mental health concerns in parents and siblings could also be a contributory factor.
- **Brain abnormalities:** certain brain abnormalities have been noticed in the children with conduct disorder such as damage or impairment to pre-frontal cortex (affecting judgment) and limbic system (impacting emotional responses).
- **Cognitive deficits:** low IQ, poor verbal skills, and impairment in executive functioning (associated with frontal lobe) may make the child more vulnerable to conduct disorder.
- **Traumatic event:** a traumatic event or abuse - physical, verbal or sexual might also be the contributory factors making children vulnerable.
- **Social issues:** lower or disadvantaged socio-economic status, poverty, disorganized and dysfunctional neighborhood, poor school conditions, family discord, harsh, neglectful or indifferent parenting are also strongly linked with conduct disorder.

Box 6.4 Case Study: Conduct Disorder

Rishabh is a 14 years old boy who is the eldest child of his parents, with two younger siblings. He recently dropped out of school and further refused to go back stating that teachers don't teach well. His teachers reported that he has been consuming tobacco since past eight months. When parents inquired, they got to know that he has been stealing money from his mother's purse and also from neighbor's house to buy tobacco. When parents questioned him, he blamed neighbors stating that they were framing him unnecessarily. On being caught red-handed parents decided to take professional help.

His parents and siblings reported that Rishabh has always had a temper and would often beat up his younger siblings. In school also, he would get into fights more than often. He would perform poorly in school and instead would focus on disturbing his peers, bullying them and constantly getting in conflict with them. Recently, he was also found misbehaving with other girls in class and passing sleazy and uncomfortable remarks.

Check Your Progress 1

1) Define externalizing behavioral problems.

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2) What could be the possible causes of Oppositional Defiant Disorder?

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3) How is Conduct Disorder different from Oppositional Defiant Disorder?

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6.3 ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Attention Deficit/Hyperactivity Disorder (ADHD) is another highly prevalent disorder among children and adolescents which impairs their daily functioning and might be disruptive for others around them. Children with ADHD may display difficulties in maintaining sustained attention, show excessive and exaggerated motor activity and impulsivity in their behaviour according to their developmental level. Thus, leading to social, occupational/academic impairments and problems in other areas. It has been categorized under three subtypes – combined presentation (including both inattention or attention deficit and hyperactivity), predominantly inattentive presentation (called as Attention Deficit Disorder or ADD), and predominantly hyperactive or impulsive presentation. It is important to note here that the most common presentation of these three is the combined presentation.

Box 6.5: Case Study: Attention Deficit/Hyperactivity Disorder

Rohit is a 9 years old boy, referred to a child psychologist by his teachers and school counselor. The teachers have several complaints against Rohit like, he is extremely restless, hardly ever sits on his seat and keeps roaming here and there in the class. He hardly ever pays attention to the lessons in class and rarely brings his homework. His classwork remains messy and incomplete. He also keeps disturbing other children by constantly getting up or speaking out of turn.

On his visit to the child psychologist, it was revealed that his behavioural difficulties have been there ever since he was a toddler. He has always been restless and quite energetic. Even at home he has always faced difficulties in understanding instructions and was scolded for not paying attention. He often forgets noting down his homework or bringing back his tiffin box from school. His mother shared that whenever she would make him do his homework, he would not listen, as if his mind has been somewhere else.

Inattention or attention deficit includes problems related to arousal, alertness, sustained attention, selective focus, vigilance, and distractibility. These issues can manifest themselves in various situations such as school, home, play areas making adequate functioning difficult for the child. Due to problems regarding arousal and alertness, children may fail to give attention to details, daydream, make careless mistakes, or lose track of time. Selective attention refers to the process of focusing on a specific object in the environment for a given period of time. Basically, it allows an individual to focus on certain matters (considered to be important) and overlooking or disregarding unimportant details. Thus, a child that lacks in selective attention may fail to understand or follow through the instructions given

in class or during their playtime (Wender, 2000). To someone else, he/she may appear as if is/she is "not listening" or that their "mind is somewhere else" or "is not interested in task at hand". Deficits in selective attention might be visible most in activities that are repetitive in nature but may also be seen in free play situations. It may lead the child to shift from one task to another quickly without finishing the one at hand without any obvious distraction being present. He/she may "tune out" during longer conversations or lengthy readings or tasks that require focused attention or alertness. They often have difficulties in organizing tasks and activities, or keeping them in an order, managing them sequentially. Thus, they often come across as messy (scattered notebooks, pens), with poor time management skills, failing to meet deadlines or completing homework. They often get scolded by parents and teachers for losing things, such as pencils, books, tiffin box, paperwork, keys, wallets etc. Due to their distractibility, they may attend to irrelevant information in the background such as noise, background conversations or some other object kept in the room. These attentional problems may also make them forgetful, for example, they may forget to bring required books, or tiffin box to school. Because of their inattention, they may lose track of conversations impairing their social functioning.

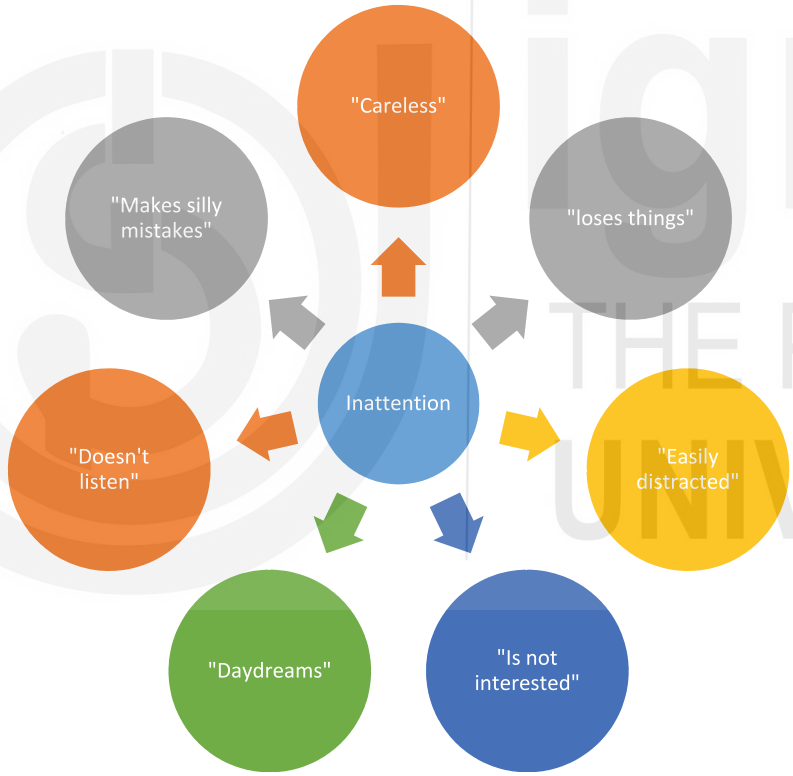

Figure 6.1: Description of children with significant attention deficit issues

Another major aspect of the disorder to be discussed is hyperactivity or impulsivity. Hyperactivity refers to excessive activity exhibited by an individual. It can be manifested in two forms: *motor hyperactivity* (for instance, restlessness, being fidgety, squirming, and unnecessary body movements) and *vocal hyperactivity* (excessive talking). In preschoolers, hyperactivity is usually noticed when the child engages in jumping excessively, climbs on furniture, running around the house, does not sit quietly while listening to a story (Nigg et al., 2005). In school going children similar behavior might be noticed, but may differ in frequency and intensity. Apart from this, he/she may have difficulties in sitting at one place or the designated place in class, may get up frequently, and may remain at the

edge of the seat (about to get up). It's not just limited to academic activities or school; they may have difficulties in sitting at one place even while watching TV or through meals. They are usually found shaking their legs, squirming or fidgeting with objects around them and are often called as children who are "driven by motor" or "are on the go". The characteristic of excessive talking has been found most in girls with ADHD. They might be seen interrupting others when talking and not taking cues regarding "turn-taking" in communication. In older children hyperactivity may be exhibited in terms of excessive speech, restlessness, increased aggression, and conflicts with others. Children with ADHD often have issues in sleeping at night and may also wake up early. Thus, they can remain hyperactive throughout the day and even at night.

Impulsivity is another most common complaint made against children with ADHD. It is displayed in the impatience evident in the child- difficulty in waiting for their turn, may blurt out answers in class, interrupting and intruding others in class or during play. Due to this, they may also get involved in accidents, knocking the objects, bang into people and things, or engaging in potentially harmful activities such as riding bicycle in traffic.

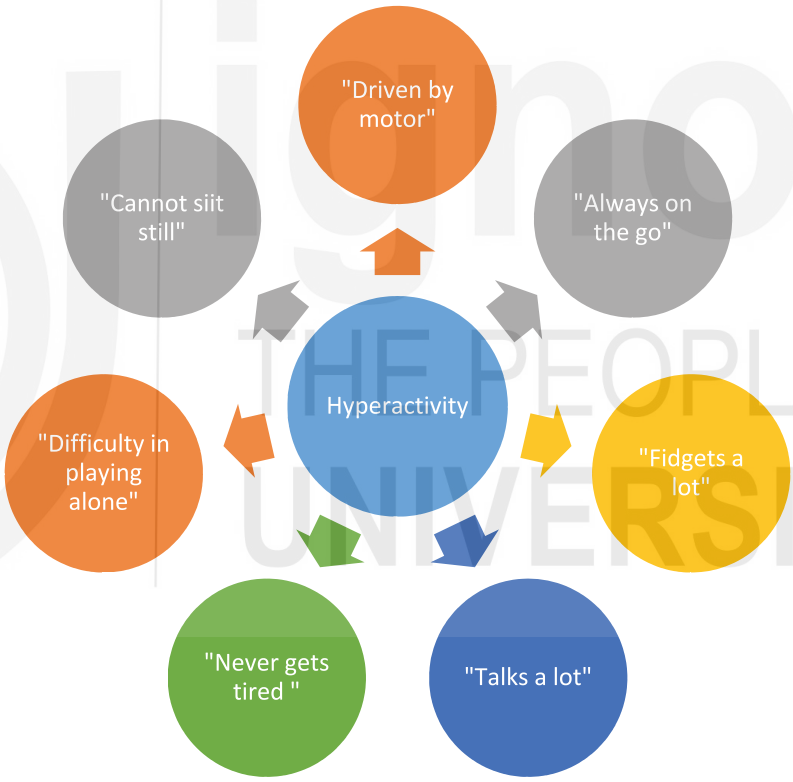

Figure 6.2: Description of children with hyperactivity

There are certain other problems associated with ADHD, which are not the symptoms of ADHD but are perhaps secondary problems associated with it. Due to their behavioural problems, they are often lower in intelligence – about 7 to 15 IQ points below average (Barkley, 1997) and may also be at a risk for learning disability and having a lower academic intelligence than their peers and counterparts (Biederman et al., 2004). Due to their excessive talking, missing out on social cues, they are usually rejected by their peers. They are not unfriendly, but more than often their peers are not able to "keep up" with their hyperactivity and thus get tired of them. Rejection or neglect from peers, negative criticism may impact their self – concept and self – esteem which can either make them aggressive or prone to depression.

Box 6.6: Causes and Risk factors of ADHD

- **Genetic influence:** parents and siblings with ADHD or any other mental health disorder may put the child at risk. Certain genes might also be implicated in it.
- **Brain abnormalities:** neuropsychological studies have shown structural and functional differences in brains of people with ADHD- impairment with frontal lobe, basal ganglia, and cerebellum. This may impact their higher cognitive processes, working memory, attention, and lead to deficits in inhibition of responses.
- **Exposure to environmental toxins:** toxins such as lead, pesticides can lead to ADHD in children. This exposure at an early age could be the reason or consumption of such toxins during pregnancy may also make the child vulnerable.
- **Other risks:** maternal use of drugs, alcohol or smoking during pregnancy may put the child at risk.
- **Premature birth:** also been seen as a reason in certain cases.
- **Social factors:** parenting style, peer relations and schooling may also moderate the type and degree of impairment in children with ADHD.
- **Role models:** aggressive and hyperactive portrayal of characters in TV shows, cartoons have also been found to be a reason for increase in difficult behavior in children.

Box 6.7: Some ways to help children with ADHD

- Getting started and staying on tasks: important to read directions with them to start. Create a checklist and divide assignment in parts to accomplish the goal. Always set short goals with them.
- Combat attention busters: try to minimize distractions, add novelty to the task to avoid boredom and keep giving movement breaks.
- Recognition, acknowledgment and praise: appreciate good behaviour of the child as praise motivated the children to repeat good behaviour.
- Establish rewards: a reward system can be an effective way to help children with ADHD to stay on track. These positive reinforcements could be time for choice activities, earning some marbles in a jar that can be exchanged later for a reward.
- Environmental accommodation: their seating arrangement should be preferential to them, for instance, standing work stations are preferred by many, adding structure and organization to their desk- clutter or presence of more than one task may distract them, visual support and prompts are important.
- Give effective instructions: gain the child's complete attention before giving the instruction – let them know clearly that you are talking to them and then give one instruction at a time, for instance, "please clean your room". In order to ensure if the child has fully understood, ask him/her to repeat it.
- Use consistent consequences or disciplining techniques: don't praise the child for something today and punish him/her for the same thing tomorrow.

Taking away privileges etc. could be some of the disciplining techniques that are used.

- Help them in calming: take a break in a low stimulation area, teach self-regulation techniques lie counting backwards, stretching, deep breathing etc.

Check Your Progress 2

1) Classify the sub-types of ADHD.

.....

.....

2) Define impulsivity.

.....

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3) Mention some ways that can be used to help children with ADHD.

.....

.....

6.4 SUBSTANCE USE DISORDERS

Children and youth are perhaps any nation's most valuable asset. They represent the bright future of our nation. Unfortunately, they are also the most vulnerable members of the society. School and colleges are supposed to be an era of self-discovery, of unbridled potential complemented by lifelong friendships, freedom, and experiencing what the world has to offer. But for tens of thousands of students, the weight of demanding expectations placed on them by their parents, teachers, society and other students, is made worse by having to adopt a facade of being a "young go-getter" with the world in the palm of their hands. They are pulled in different directions leading to face relentless amounts of pressure and it may become too much to handle. This stage of pre-adulthood and young adulthood situate the youth in conditions where substance use/abuse seems to be a convenient way out, or a 'cool' thing to do, rather than making them see the evil side of its usage (Dineshkumar, 2019). All these factors coming together can create a perfect storm of anxiety and depression leading to indulgence in temptation. Use of tobacco, alcohol and other substances among children and adolescents is a public health concern in several parts of the world, including India (Dhawan, 2017). Substance abuse at this age is likely to interfere with the normal child development and may have a lasting impact on the future life (Lander, 2013). Not only the child, but the family and society as a whole are likely to be affected as a result of early onset of substance use (Lander, 2013).

One of the serious concerns is that the global problem of addiction and substance abuse is responsible for millions of deaths and millions of new cases of HIV every year (Singh, 2013). In recent years, India is seeing a rising trend in substance use. The most common use of drug in India is alcohol, followed by cannabis and opiates (Peacock, 2018). The use of the term "Addiction" has now been dropped from the scientific literature because of its derogatory connotation and instead the use of "Substance use disorder" is preferred (Kelly, 2004). Substance refers to the

spectrum of drugs that can be potentially abused, such as illegal drugs (marijuana, heroin, etc.), licit drugs (alcohol, tobacco, etc.), and prescription drugs (Kilpatrick, 2000). The words "abuse" and "dependence" are often used interchangeably to describe a destructive relationship to alcohol or drugs (Nichte, 2004). Mental health professionals and addiction specialists make a distinction between abusing a substance and becoming dependent on it (Karberg, 2005). Abuse refers to the use of a substance when it is not medically indicated or when its use exceeds socially accepted levels (Gans, 2020). Although these two conditions are not the same, they're often interrelated. Substance abuse is characterized by repeated use of a substance or substances in situations where use leads to or may contribute to markedly negative outcomes. This terminology has often led to confusion, both within the medical community and with the general public (Hasin, 2006). However, overindulgence and dependence on a drug or other chemicals have detrimental effect on an individual's physical and mental health and/or welfare of others around them. Substance abuse may lead to addiction or eventually substance dependence (Hasin, 2006). Dependence almost always implies abuse, but abuse frequently occurs without dependence, particularly when an individual first begins to abuse a substance. Dependence involves physiological processes, while substance abuse reflects a complex interaction between the individual, the abused substance, and society (Bedendo, 2016). For example, a person who may be abusing alcohol or drug may:

- miss school/college/university/work frequently because she/he is incapacitated.
- fail to fulfil a role obligation such as pick-up kids from school because she/he is too drunk to drive, or turn up for school play/match on time.
- get involved in legal problems such as arrested for drug or alcohol related behaviour.
- getting into physically hazardous situation such as drive drunk on a regular basis.
- having persistent or recurrent social or interpersonal problems such as argues with a spouse or breaks up with a partner over drug or alcohol use.

The National Institutes of Health stresses that while abuse may lead to dependence but if a person is dependent on substance, he/she may show the following signs (National Institute of Health, 2007):

- Develop a tolerance to the substance, so that she/he needs to use more and more of the substance to get the desired effects.
- Experience physiological symptoms such as nausea, vomiting, tremors, wariness, sweating, or low blood pressure within a few hours of stopping the drug.
- May experience psychological symptoms such as irritability, sadness, anxiety or unclear or vague thoughts if s/he can't get access to the substance.
- The person may go into denial that s/has a problem with a particular substance, in spite of the damage that it's doing to her or his health, her or her relationships or her/his finances.
- Attempt to quit using the substance repeatedly without success.

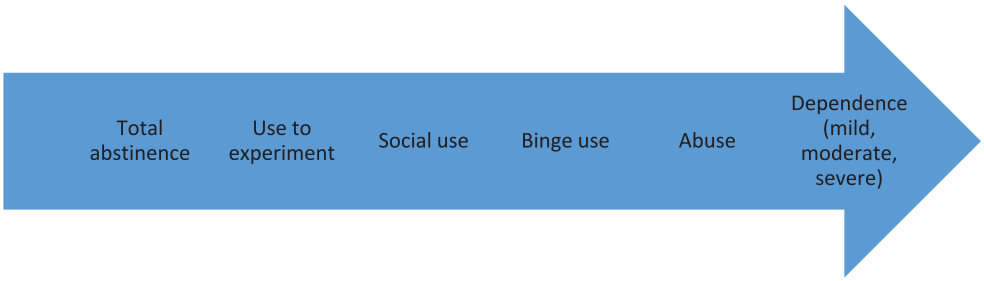

Figure 6.3: Progressive use and abuse of a substance

As defined by World Health Organization (WHO, 2004), "Substance ill-use alludes to the unsafe or dangerous utilization of psychoactive substances (substances that affect mental processes), including liquor and illegal drugs. Psychoactive substances utilization can prompt reliance disorder, a bunch of behavioural, psychological, and physiological phenomena that grow after rehashed substance utilization and that commonly incorporates a powerful urge to take the drugs, challenges in controlling its utilization, continuing in its utilization in spite of destructive results, a higher need given to drugs use than to different exercises and commitments, expanded resistance, and at times a physical withdrawal state."

An individual with substance use disorder may display some of the following symptoms. They may take or consume a substance in larger amounts or for longer periods than mean to be. They may feel or say that they wish to reduce or stop using the substance but fail in doing so. These individuals are seen spending a lot of time in procuring (getting), using or recovering from use of the substance. Cravings and urges to use the substance increase with time. Continuous usage may lead to problem in various spheres of life- social, occupational/academic, relationships etc., thus they may eventually give up on important commitments and activities. Continue to use the substance even when it puts them in danger. Their continuing usage may worsen their existing physical problems but this also deter them from further using it. With time, a tolerance gets build and they may need more of the substance to get the desired effect. They develop withdrawal symptoms and get relieved by consuming more of the substance. In order to diagnose an individual with substance use disorder, an individual should exhibit at least three of the above-mentioned symptoms (mild substance use disorder). Someone who has four or five of these symptoms, is diagnosed with moderate substance use disorder and when six or more symptoms are met the intensity is classified as severe in nature. Substance use related disorders are usually classified in six categories (depicted in Figure 6.4)

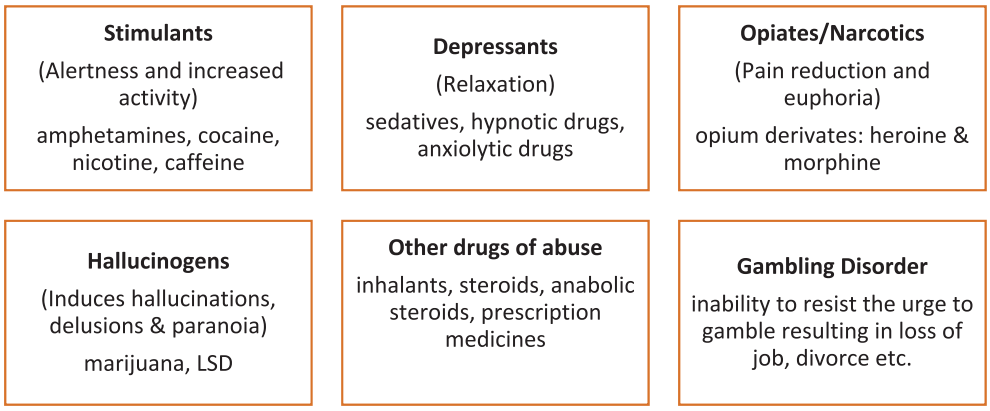

Figure 6.4: Classification of Substance and Behavioural Addictions

Most children and adolescents begin to experiment with substances at an early age (Pierce, 1998). In fact, there are many factors that play a part in initiation and maintenance of drug abuse in childhood and adolescence. Initiation of drug use is complex with multiple factors contributing in the onset of this behaviour. The social and cultural factors influencing the initiation of tobacco use vary from country to country, from developed world to developing nations, region to region and culture to culture (Chadda, 2020). Some of the factors are discussed in the following section.

Freedom from any kind of supervision: Adolescents have more freedom and independence than younger children and they are less closely supervised and monitored. They spend more time with their friends and less with their families. This serves to increase peer influence and decrease family influence on behaviour and lead to the perception that everyone drinks and its cool encouraging them to drink (Blanton, 1997).

Pressure and experimentation: Adolescents face many stresses and drinking or "doing drug" is perceived as a means of soothing oneself thus, substance use is likely to start during adolescence (Lebese, 2014). Many adolescents and children consider smoking and drinking as harmless habits that make them look more adult like (Lantz, 2003). Other reasons for adolescent's or children's abuse of substances include coping with stress, peer group pressure and following the example set by adults (Ekpang, 2014).

The fact that adolescents take substances is also a reflection of the element of experimentation and sensation seeking prevalent in that age and stage of life (Margolin, 2013). They indulge in substance abuse as a way of trying to passage their heightened energy (Rikhotso, 2002). Another reason for trying substances is to have fun or sensual pleasure or to gain and seek an exciting sexual experience (Rice & Dolgin, 2008). Furthermore, adolescents often use substances as a means of escaping stress, dullness and the pressures of life (Visser & Routledge, 2007; Zastrow, 2004).

Biological reasons: Research has shown that some people, such as the children of people who abuse alcohol, have a high risk of developing problems with alcohol because of an inherent motivation to drink and sensitivity to the drug (Butcher et al., 2004). Children who have parents who are extensive alcohol or drug abusers are highly vulnerable to developing substance abuse and related problems themselves (Johnson, 1994).

Media Influence: Children and adolescents are persuaded by the huge advertising industry from their early years (Story, 2004). An increasing number of cigarette advertisements is designed to appeal to them. Research has shown that over 90% of teenagers are aware of such advertisements and most say the adverts influence their behaviour as they substance with excitement, relaxation, or being in style (Ellickson, 2005). Furthermore, substance such as cigarette smoking is identified with masculinity, independence, nature, beauty, youth, sex appeal, sociability, wealth, and the good life (Pechmann, 2002), thus, encouraging children and adolescents to consume it in order to fit these ideals, especially boys. In a longitudinal study of non-smoking adolescents who had a favorite cigarette advertisement were twice as likely to subsequently begin smoking or had the intention to do so (Davison et al., 2004). Adolescents are also bombarded with TV commercials in which beer is associated with athletic-looking males, bikini-clad women and "good times" so it seems adolescents use drugs because they give in to the persuasive message targeted at them (Agostinell, 2002). Most

media especially those for alcohol, associate substance use with success and happiness (Jernigan et al., 2007) further encouraging its use even if it is in an indirect manner.

Family Factors and Influence: Parenting skills or parental behavior is also related with substance use among children and adolescents (Marcenko, 2000). Alcoholic parents are less likely to keep check of what their children are doing and this lack of monitoring often leads to children and adolescents' affiliation with substance abusing peers (Marcenko et al., 2000). An unstable or disturbed family environment, one or both parents who had immigrated, or death of parents are associated with substance abuse (Sun, 2001). Thus, family structure along with characteristics of these families also account for substance abuse. Parental control patterns that involve setting clear requirements for mature and responsible behavior, in contrast to power-assertive or authoritarian techniques of discipline, resulted in less substance use (Liddle & Rowe, 2006). Although, they may place family members at risk of substance abuse, family factors may also be protective as researchers have found that effective family relationships, for example, family involvement and communication, proactive family management, or attachment to family serve to protect youth against substance abuse across racial and cultural groups (Liddle & Rowe, 2006).

Availability: Adolescents use substances because all kinds of substances are available easily (Liddle & Rowe, 2006). The degree to which alcoholic beverages and substances are accessible to people affects the amount and pattern of alcohol use for example, many social settings such as cultural ceremonies and parties alcohol is easily available . With regard to smoking, if cigarettes are perceived as being easy to get and affordable, the rate of smoking increases (west, 2017).

Negative outcomes of substance use and dependence: Research suggests that children who binge drink are at an increased risk of experiencing negative outcomes associated with it (Turrisi, 2006). Furthermore, students who are considered heavy drinkers (binge drink five or more times a month) usually advance from less to more severe consequences as their behavior progresses (Merrill, Wardell, & Read, 2014). Some of the more common negative consequences students experience as a result of drinking and abusing substance include: poor academic performance, alcohol-induced blackouts, physical injury and assault, sexual assault, driving after drinking, police involvement, alcohol overdoses and its synergistic effects, death, and development of an Alcohol Use Disorder (Anderson, 2005; Ginzle, 2007). According to Hingson (2009), driving after drinking (DAD) is a primary cause of death and injury for college students. Hingson & White, (2013) suggested that approximately three million college students choose to drive after drinking annually and by doing so put themselves and other people at risk. Children and adolescents engage in a multitude of maladaptive behaviors when intoxicated, including driving after drinking and have the propensity to necessitate the involvement of law enforcement. With the inhibited reasoning ability, decision making and critical thinking skills along with alcohol intoxication, college student involvement with law enforcement has also been attributed to student alcohol misuse (Worfler, 2016). Binge drinking and alcohol overdoses have been positively correlated due to the high volume of alcohol consumed and small timeframe; such episodes can be autonomously fatal and dangerous leading to blackouts (White & Hingson, 2014). Furthermore, adolescents abusing alcohol are more likely to think of taking their lives or do things which they might later regret (Black, 2020).

Substance abuse is a significant public health concern around the world, with particular consequences for youth. The fight against substance abuse cannot be effective without proper involvement and guidance. Thus, it is important to note that when someone in the family other than the person with presenting symptoms is involved with alcohol or illicit drugs, issues of blame, responsibility, and causation will arise. With the help of a counselor, therapist, psychiatrist or a practitioner, the family needs to refrain from blaming, and help in improving the family interactions that create conducive conditions for substance use to discontinue. Figure 6.5 describes the substance use status and care continuum in this regard.

Positive Physical, Social, and Mental Health	Substance Misuse	Substance Use Disorder
A state of physical, mental, and social well-being, free from substance misuse, in which an individual is able to realize his or her abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to his or her community.	The use of any substance in a manner, situation, amount, or frequency that can cause harm to the user and/or to those around them.	Clinically and functionally significant impairment caused by substance use, including health problems, disability, and failure to meet major responsibilities at work, school, or home; substance use disorders are measured on a continuum from mild, moderate, to severe based on a person's number of symptoms.

Substance Use Status Continuum

Substance Use Care Continuum

Enhancing Health	Primary Prevention	Early Intervention	Treatment	Recovery Support
Promoting optimum physical and mental health and well-being, free from substance misuse, through health mmunications and access to health care services, income and economic security, and workplace certainty.	Addressing individual and environmental risk factors for substance use through evidence-based programs, policies, and strategies.	Screening and detecting substance use problems at an early stage and providing brief intervention, as needed.	Intervening through medication, counseling, and other supportive services to eliminate symptoms and achieve and maintain sobriety, physical, spiritual, and mental health and maximum functional ability. Levels of care include: • Outpatient services; • Intensive Outpatient/ Partial Hospitalization Services; • Residential/ Inpatient Services; and • Medically Managed Intensive Inpatient Services.	Removing barriers and providing supports to aid the long-term recovery process. Includes a range of social, educational, legal, and other services that facilitate recovery, wellness, and improved quality of life.

Figure 6.5: Substance Use Status and Substance Use Care Continuum
Source: https://www.ncbi.nlm.nih.gov/books/NBK424859/figure/ch4.f1/

Check Your Progress 3

1) Differentiate between substance abuse and substance dependence.

.....

.....

2) Name some of the general categories of substance abuse.

.....

.....

3) Explain the role of media in substance use disorder.

.....

.....

Box 6.8: Debunking myths and facts regarding substance abuse

× Substance abuse and addiction are the same things.

✓ No, a person may hurt self or can even bother others under the influence of a substance but may not be addicted to it.

× People who can't stop using drugs are weak or immoral.

✓ It simply means that the person has a real illness and needs help.

× It's a problem in lower socio-economic strata of the society.

✓ It impacts every layer of the society and can be found irrespective of age or gender.

× People can quit drugs whenever they want, it requires will power.

✓ Addiction takes a powerful hold over mind and body of the individual, one needs a rehabilitation center and addiction counselors to help break the cycle.

× Prescription drugs are safe drugs.

✓ They can also be dangerous if abused for non-medical reasons.

× Detox is enough.

✓ Detox involves getting the toxins out of the system, it is the first step not the final one.

× Rehabilitation doesn't work, it's for rich people.

✓ Rehab provides with necessary education and lifestyle. It teaches skills to battle cravings.

× If you relapse after rehab once, you're back to square one.

✓ It's normal and expected to relapse, it's not defeat. Try again!

× Medication during recovery is switching from one drug to another.

✓ Medication- assisted treatment is a part of the recovery plan and helps to calm cravings etc., its use under doctors' supervision is useful.

6.5 OTHER EXTERNALIZING BEHAVIOURS AND PROBLEMS

6.5.1 Pyromania

It is an impulse control disorder in which individual fails to control his/her impulse to deliberately start fires. The individual indulges in such a behavior for instant gratification or to gain pleasure (Hale, 2008). They may have fascination with or curiosity about fire and its situational contexts. Another important contributor in this case is stress. In teens with pyromania, stressful attitude towards family and friends is quite evident (Gale, 1998), which could be an important contributor to the disorder. It is important to note that the fire setting is not done for monetary gain, to conceal some criminal activity, to express anger, take revenge, as a response to hallucination or delusion or due to impaired judgment. One of the major issues is in differentiating between pyromania and the curiosity or experimentation of childhood which may involve playing with fire, its consequences and the pleasure that may be involved in it.

6.5.2 Kleptomania

It is an impulse control issue characterized by the recurrent inability to resist an urge to steal things that the person actually doesn't need. They usually lead secretive lives as they are embarrassed about their lack of behavioural and emotional self-control and thus are afraid of seeking treatment. They have difficulty in resisting the temptation or powerful urge to steal something that is not even required by them. It is usually increased tension, anxiety or pent-up arousal that leads to theft followed by pleasure, relief or gratification. They also feel remorse, self-hatred, shame or fear of arrest after the act of theft. Unlike shoplifters, they don't steal for personal gains, for revenge etc. These episodes are usually spontaneous (not pre-planned) and without help from another person as an ally. They usually steal from public places, such as supermarkets, stores, or may be from parties etc.

6.5.3 Truancy

Truancy is the habitual act of being absent form school without permission and has emerged as one of the most important issues faced by schools today (Bye, 2010; Huck, 2011). It has been a constant discussion that children who do not attend school consistently perform poor in academic areas and have lower self-esteem. This is understood as "lower quality and economic status in adult life" (Reid, 2010, p.3). It also puts the child at a high risk of criminal activity later in life. Many researchers have explicitly identified attendance as the single most variable critical in measuring students' achievement level and thus corrective action against absenteeism is necessary. To eliminate this behavior, it is imperative to understand the possible causes involved. Some of them are as follows:

- **Family factors:** Parents' education, supervision and household income could be important contributory factors. For instance, Henry (2007) concluded that lower the father's education, more likely the child will commit truancy. Usage of drugs or alcohol at home may lead to chaotic or disturbed family environment increasing the risk of truancy. Presence of mental health disorder in family may also contribute to it. Issues such as divorce, physical or verbal abuse and frequent moving from one place to another can also cause chronic absenteeism.

- **School factors:** Class size, attitude of teachers, peers, inability to meet unique needs of a student, discipline policies may lead to truant behavior. Children who feel alienated in school settings, less comfortable, less valued try, and escape school. Tobin (2009) concluded that imposing punishments may also increase truancy.

- **Student related variables:** Physical and mental health issues, substance use and abuse, and poor perception of self may lead to absenteeism. Truancy could be an indicator of an emerging or existing mental health disorder in the child, for instance, PTSD, depression, anxiety, etc. DeSocio et al. (2007) suggested that truancy is representative of school disengagement, detachment and lack of commitment to school, poor achievement, and low aspirations for future.

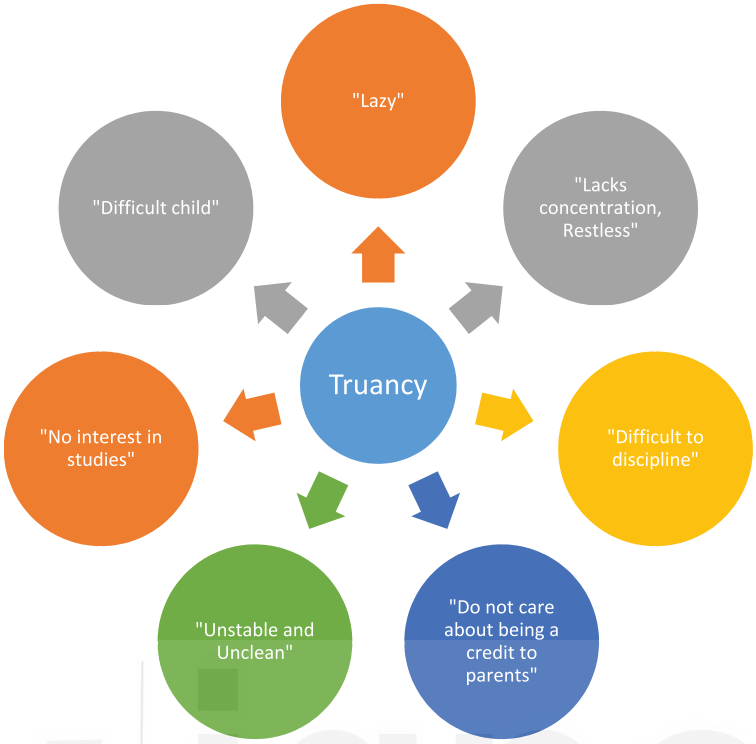

Figure 6.6: Description of children with truant behaviour

Check Your Progress 4

1) What is pyromania?

.....

.....

2) How is kleptomania different from stealing and theft?

.....

.....

3) What could be the possible causes behind school absenteeism?

.....

.....

6.6 OVERLAP BETWEEN EXTERNALIZING PROBLEMS

Externalizing disorders co-occur with various other disorders. For instance, ADHD is a common condition that co-exists with ODD. Unruly behaviour is present in both, but the unruly behavior of ODD is deliberate, whereas in the case of ADHD, it is attributed to poor attention or the impulsivity of the child. Thus, understanding the basis of the symptom is very important for the clinicians before diagnosis. Similarly, conduct disorder has been found to be comorbid with substance-use disorder (Goldstein, 2009). Truancy may exist with any of the other externalizing behaviours. Co-occurrence of more than one externalizing disorder is called as *homotypic comorbidity*.

Although it has been well established that internalizing and externalizing disorders are different domains, but it is not unusual for children to exhibit both types of problems at the same time. Thus, individual with co-occurrence of internalizing and externalizing disorders have *heterotypic comorbidity*. For instance, a child can be depressed or anxious and at the same time may engage in hostile or destructive activities. According to O'Connor and colleagues (1998), substance abuse and depression are frequently occurring conditions. Thus, it is not uncommon for a child with externalizing problems to develop both internalizing and other externalizing problems across their lifespan.

6.7 SUMMARY

Now that we have come to the end of this unit, let us recapitulate all the major points that we have learnt.

- Externalizing behavioural problems refer to problems that are manifested in outward behavior of children. They may reflect the child negatively acting on the external environment, for instance, being disruptive, impulsive, hyperactive or aggressive.
- Oppositional Defiant Disorder and Conduct Disorder come under the major category of Disruptive, Impulse-Control and Conduct Disorder as they share the core feature of aggression or anti-social behaviour.
- Conduct Disorder is mostly preceded by diagnosis of Oppositional Defiant Disorder in early childhood and may lead to Anti-Social Personality Disorder later.
- Children with Attention Deficit/Hyperactivity disorder exhibit difficulties in maintaining sustained attention, excessive motor activity, hyperactivity, and impulsivity leading to various social, occupational/academic impairments.
- Substance dependency refers to a severe form of substance use disorders, characterized by tolerance and withdrawal symptoms that affect various areas of an individual's life.
- Intentional, unjustified act of absenteeism from school is called as truancy. This does not include legitimate absences, such as medical conditions or permission by parents etc.

6.8 KEYWORDS

Oppositional Defiant Disorder: Characterized by the presence of persistent defiant, disobedient, and hostile behavior, especially towards authority figure.

Conduct disorder: Repetitive and persistent pattern of behaving in a way that violates societal norms and rights of other people.

Attention Deficit/Hyperactivity Disorder: Difficulties in maintaining sustained or focused attention, exaggerated motor activity, hyperactivity and impulsivity leading to social, occupation/academic issues.

Substance Abuse: Maladaptive drug use, that is, repeated and/or excessive use of substance leading to problems in various areas of life.

Substance Dependency: Characterized by tolerance and withdrawal symptoms that may affect many areas of lives causing significant stress.

6.9 REVIEW QUESTIONS

1) Children with ..... have difficulty in controlling their activity in situations that require sitting still, such as during mealtime, playing board games etc.
2) Hyperactivity is manifested in two forms: ..... hyperactivity and ..... hyperactivity
3) Discuss the causes and risk factors involved in Oppositional Defiant Disorder and Conduct Disorder.
4) Why do children and adolescents engage in substance use and abuse?
5) Explain the terms- inattention, hyperactivity and impulsivity.
6) Explain the characteristics associated with truancy.
7) Can internalizing and externalizing disorders co-occur? Explain.

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6.11 WEB RESOURCES

- Substance Use Disorder by Psych Hub

  https://youtu.be/Hgn7MJjMfkk
- What is ADHD by Psych Hub

  https://youtu.be/5l2RIOhDXvU
- Substance Use Disorders

  https://youtu.be/tPhcRBkVmUM

Answers to Review Questions (1-2)

1) attention deficit
2) motor; vocal