Indira Gandhi
National Open University
National Centre for Disability Studies

MCFTE-002

Child and Adolescent Counselling and Family Therapy

Block

2

THERAPEUTIC INTERVENTIONS

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BLOCK 2 THERAPEUTIC INTERVENTIONS

In the previous Block, we got familiar with socio-developmental perspectives influencing children and adolescents. In this Block on ''Therapeutic Interventions'' we will study about the therapies used for intervention with children and adolescents. This Block has five Units.

Unit 5 is on ''*Life Skills Training*''. It discusses the importance and types of life skills. Further, the Unit highlights the steps involved in learning life skills. Methods of imparting and implementing life skills training in India have been outlined.

Unit 6 is entitled ''*Play Therapy*''. As the title suggests, the Unit is on use of play therapy as an intervention therapy with children. The importance of play in relation to play therapy is the focal point of this Unit. Play and its influence on child development has been described. Relevance of play therapy in India has also been discussed.

Unit 7 focusses on ''*Training Parents of Children/Adolescents with Disabilities*''. It begins by emphasizing the need for training parents of children/ adolescents with disabilities. Models of parent training and method involved in parent training has been discussed. In the end, evaluation of parent training programmes has been described.

Unit 8 is entitled ''*Counselling for Trauma and Abuse in Childhood*''. As the title suggests, the Unit gives you a holistic overview of trauma and abuse in childhood. The meaning, symptoms and the causal factors of child abuse, neglect and trauma have been outlined. Prevention and management of trauma and abuse in childhood has also been discussed in the Unit.

Unit 9 is ''*Cognitive Behavioural Therapy for Childhood/Adolescent Disorders*''. The cognitive behavioural therapy has been discussed in length in its intervention role for childhood and adolescent disorders. The therapy assessment and process has been described in the Unit. In the end, future directions for use of this therapeutic intervention have been discussed.

UNIT 5 LIFE SKILLS TRAINING

Structure

5.1 INTRODUCTION

The stage of adolescence in the life cycle of an individual is surrounded with problems, dilemmas, stresses and excitement. Today adolescents are living in a complex world, with an easy and over exposure to the multitude of experiences.

Hence they need to be equipped with a number of skills to function as individuals and as members of social groups. Effective acquisition of life skills can foster the ability to successfully cope with and meet the challenging demands of life, enhancing mental wellness and social adeptness.

Objectives

After studying this Unit, you will be able to:

- Define life skills;
- Differentiate between different types of life skills;
- Outline the importance of life skills; and
- Describe the programmes for life skill training in India.

5.2 CORE LIFE SKILLS

5.2.1 Definition and Meaning of Skills and Life Skills

A skill is an ability or capacity needed to execute a specific task or assignment using knowledge effectively and readily in performance, transforming knowledge into action. The World Health Organization has defined life skills as, **"**the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life." Life skills are not some ability that we are essentially born with, but can develop and enhance in the course of our life so as to achieve a balance between knowledge, attitude and skill. Life skills are essentially those abilities that help promote mental well-being and competency in young people as they face the realities of life. Life skills allow us to match our potential with difficult or apparently unsolvable complex tasks. According to Vygotsky, life skills contribute to adolescents' theory of value, knowledge, and the ambiguous/unpredictable human nature. A simple approach to be followed then is the three question paradigm which involves proposing the following three questions to yourself:

- What is happening?
- What are the feelings involved?
- How else can it be resolved?

5.2.2 Importance of Life Skills

Adolescents of today are facing myriad challenges in addition to those otherwise present with the developmental stage itself. These are socio-cultural changes, shift from collectivistic orientations to individual orientations, access to bulk information, reduction in time spent in parenting etc. In addition, some adolescents:

- Have low frustration tolerance
- Demand immediate gratification
- Are short tempered and get easily agitated
- Have low self esteem or an inflated sense of self esteem

- Externalize the locus of control
- Are unable to create and sustain long term meaningful friendships

Adolescence is a very crucial stage of one's development and the training we can impart to ourselves in this life stage serves as the foundation of our life. Life skills training allows one to bring about positive changes in his/her mental and emotional world, which makes bringing about positive change in the outer environment much easier. The major reasons why life skills are needed are:

1. Adolescence is a transitional stage where individuals engage in experimental and risk taking behaviour. They are emotionally sensitive and feel a certain degree of separateness from their families, feeling an eagerness to achieve independence.
2. It is a stage of identity formation. Life skills can ensure the development of a competent and mature self.
3. Adolescents gather a lot of inappropriate and incomplete information due to which impulsively taken decisions can have adverse consequences for themselves and others.
4. Media plays an important role in shaping adolescents' perceptions thereby making their lives, expectations and values very different from their parents.
5. With the gradual break down of the joint family system, the traditional mechanisms for transferring life skills may no longer be feasible in many families and societies.
6. Adolescents lack opportunities for building a sound self concept (self esteem, self efficacy and self confidence) which aids in goal setting and career planning. Life skills can help in resisting or coping with peer pressure and pursuing their personal dreams.

Life skills occur over the developmental period of one's life. Growth and development are the two important tasks of childhood. Growth is physical and mainly observed as increase in height, weight and appearance of age related changes in the body. For example, secondary sexual characteristics in adolescence. Optimum development on the other hand, is more complex and involves mastering those characteristics and tasks, which help one to grow into an adult who has good self-esteem, is socially integrated, faces changes and challenges, copes and adapts to conflicts and stress. He/She is independent but still is connected with others in the family and society. To be able to achieve this, the development has to take place in various areas — intellectual, social skills, communication and language abilities, emotional adjustment and moral values. A child develops mastery over tasks in the various areas mentioned in overlapping stages. Hence these stages are called development phases. Such a development occurs continuously throughout childhood and adolescence (also in adulthood). It is a dynamic process where both the child and environment play an active role in learning or not learning a particular skill. Both 'nature' and 'nurture' play a significant role in the psychological maturity to be able to go through the developmental processes. Often the environment — parents, friends and teachers stimulate and maintain the particular task. Thus skills are developed by the person by various methods — trial and error, modeling, correction and reinforcement in an interactive manner. Certain developmental tasks are given more importance and relevance than others. Specific methods are used to nurture them Universally intellectual tasks and acquisition of knowledge are given premium

and schools are established as means to achieve them. Language and communication are stressed due to the day-to-day needs. Both of these are universal. Development of moral values and emotional adjustment are often considered innate and cultures differ vastly in promoting them in their children. However, for successful living, all developmental tasks are necessary and there is no method by which one can say one is more relevant than the other.

As an end, all development tasks provide one with Life Skills to be able to steer oneself through life competently and comfortably indicating development. While most people learn the skills to certain extent, they often lack abilities to use the correct skill at the appropriate place, time and extent. Hence there is a need for persons involved and concerned with child development to be aware of this Skill Development and nurture and enhance all in every single child/adolescent they are in contact with.

5.2.3 Types of Core Life Skills

In this Unit we will study the core life skills that are termed as important for the healthy development of an individual and which come in handy at different stages in one's life. The 10 generic life skills that are identified by WHO are:

1. ***Critical Thinking:*** It is the ability to analyse information and experience in an objective manner.
2. ***Creative Thinking:*** It is an ability that helps us look beyond our direct experience and address issues in a perspective which is different from the obvious or the norm. It adds novelty and flexibility to the situation of our daily life. It contributes to problem solving and decision making by enabling us to explore available alternatives and various consequences of our actions or non-actions.
3. ***Decision-Making:*** The process of making assessment of an issue by considering all possible/available options and the effects different decisions might have on them.
4. ***Problem Solving:*** Having made decisions about each of the options, choosing the one which is the best suited, following it through the process again till a positive outcome of the problem is achieved.
5. ***Interpersonal Relationship:*** It is a skill that helps us to understand our relations with others and relate in a positive/reciprocal manner with them. It helps us to maintain relationship with friends and family members and also be able to end relationships constructively.
6. ***Effective Communication:*** It is an ability to express ourselves both verbally and non-verbally in an appropriate manner. This means being able to express desires, opinions, and fears and seek assistance and advice in times of need.
7. ***Coping with Emotions:*** It is an ability, which involves recognizing emotions in others, and ourselves, being aware of how emotions influence behaviours and being able to respond to emotions appropriately.
8. ***Coping with Stress:*** It is an ability to recognize the source of stress in our lives, its effect on us and acting in ways that help to control our levels of stress. This may involve taking action to reduce some stress for example changes in physical environment, life styles, learning to relax etc.

9. ***Self-Awareness:*** Includes our recognition of ourselves, our character, strengths and weaknesses, desires and dislikes. It is a pre-requisite for effective communication, interpersonal relationship and developing empathy.

10. ***Empathy:*** Is an ability to imagine what life is like for another person even in a situation that we may not be familiar with. It helps us to understand and accept others and their behaviour that may be very different from ourselves.

Let us now study these in detail and understand how we can arm ourselves with these to be able to better cope with challenges of daily living.

Check Your Progress Exercise 1

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

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

Answer the following in 4-5 lines.

1. What is the meaning of life skills?

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2. Why do adolescents need life skills?

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3. What are the different types of core life skills?

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5.3 CATEGORIES OF LIFE SKILLS

Life skills can be divided into three categories:

1. **Thinking Skills**
   - Problem solving
   - Goal setting
   - Decision making
   - Time management
2. **Social Skills**
   - Self awareness
   - Raising self confidence and building self esteem
   - Interpersonal relationship skills involving communication skills and empathic understanding
3. **Negotiation Skills**
   - Coping with stress and emotions
   - Assertiveness training: Deal with peer pressure and learn to say "no" to one self and others

These skills enrich our personality and we can be benefited when we use them together. Adequate applications of these skills in our daily life serve as a "Psychological Vaccination" against mental health problems. Now let us understand these skills one by one. Acquisition of one skill will foster the acquisition or polishing of the other.

5.3.1 Thinking Skills

These are functional skills which are instrumental in a wide range of situations. These can be cultivated through education and experience.

Problem Solving

Problem refers to a situation where an individual is motivated to reach a goal but is blocked from obtaining it by some obstacle. Problem solving therefore is a skill that trains an individual to generate appropriate solutions and strategies that would allow the attainment of the desired goal.

There are 3 main aspects to problem solving:

1. It is goal directed
2. It requires the use of cognitive processes (thinking, reasoning, memory) rather than automatic processes (reflex, insight)
3. Problems arise when the solver lacks some relevant knowledge or ability to produce an immediate solution.

Goal Setting

Adolescence is a period when individuals build a vision for their future life. Hence it is important that they learn at this stage to identify their motives and

aims to move steadily in a direction that will enable them to take a positive step forward towards fulfilling their aspirations. Goals need to be set with both a short term (e.g. studying hard for the coming mid term exams) and long term perspective (e.g. to become a Journalist, in addition to getting good marks in our exams, we also need to simultaneously be aware of current scenario and develop our writing skills). The skill of goal setting once acquired can be adapted to any setting, whether academic, interpersonal, intrapersonal, vocational amongst others. Advantages of setting goals are:

1. Goals focus attention towards goal-relevant activities and away from goal-irrelevant activities
2. Goals serve as an energizer; higher goals will induce greater effort while low goals induce lesser effort
3. Goals affect persistence
4. Goals activate cognitive knowledge and strategies which allow us to cope with the situation at hand

Decision Making

Decision making is the study of identifying and choosing alternatives based on the values and preferences of the decision maker. Making a decision implies that there are alternative choices to be considered, and in such a case we want not only to identify as many of these alternatives as possible but to choose the one that (1) has the highest probability of success or effectiveness and (2) best fits with our goals, desires, lifestyle, values, and so on. This skill enables individuals to weigh the pros and cons of alternatives and choose the best option available and accept responsibility for the consequences of the decision.

Decision making is influenced by the predisposition of the decision maker, the context, the relative importance assigned to the decision, the weight of the consequence amidst other considerations. Also, decision making gets more complicated when there are certain conflicts attached to the decision choices. These are:

Approach-Approach Conflict: Both the choices that one needs to pick from appear equally desirable.

Approach-Avoidance Conflict: One choice is desirable in relation to the other but the doubt arises with the correctness of choice

Avoidance-Avoidance Conflict: Both the choices available are equally undesirable and yet a decision has to be taken.

When faced with these complexities, it is important for the adolescent to approach them with self awareness and confidence with a perspective of one's short term and long term goals and take the decision based on adequate problem solving.

Time Management

Time Management is a worthy skill which comes handy through all stages of life, whether it is adolescence, early adulthood or late adulthood. However, as adolescent phase is when we build our foundation, learning how to effectively and efficiently manage our time by scheduling our tasks is of paramount importance. It begins with curbing the urge to procrastinate i.e. delay tasks till the last minute. Managing our time well would also allow us to fit in more activities than we

earlier would have thought possible to accomplish in a single day and also reduces stress and anxiety that is created with piled up work.

5.3.2 Social Skills

Social skills comprise those skills that are necessary for competent social interaction i.e. for both verbal and non verbal communication. They enhance developing and maintaining relationships with significant others, are influenced by one's culture and increase with positive social reinforcement.

Self Awareness and Building a Strong Self Confidence

Self-awareness is a self-conscious state in which attention focuses on oneself. It makes people more sensitive to their own attitudes and dispositions. To be aware of oneself is to acknowledge one's strengths and weaknesses i.e. one's strong points and one's weak points. We can understand our self and our peers like a basket of fruits. Each fruit is unique and has certain good features (like specific vitamins, a pleasing colour, and good taste) and also has some distasteful features (like many seeds, thick peel). Similarly we too possess unique abilities which instead of being compared with others, should be understood and worked at. With this knowledge we can be more adept in utilizing the opportunities that are available to us and protect our self from the threatening ones.

Being self aware thereby enables one to build a strong personal and social identity. According to Erik Erikson's psychosexual stage theory, ego identity is the conscious sense of self that we develop through social interaction. According to Erikson, our ego identity is constantly changing due to new experience and information we acquire in our daily interactions with others. In addition to ego identity, Erikson also believed that a sense of competence also motivates behaviours and actions. Each stage in Erikson's theory is concerned with becoming competent in an area of life. If the stage is handled well, the person will feel a sense of mastery, which he sometimes referred to as **ego strength** or **ego quality**. If the stage is managed poorly, the person will emerge with a sense of inadequacy. By integrating life skill of reinforcing our strengths and working at our weakness we can develop such ego strength. Through social interactions, children begin to develop a sense of pride in their accomplishments and abilities. During adolescence, individuals are exploring their independence and developing a sense of self. Those who receive proper encouragement and reinforcement through personal exploration will emerge from this stage with a strong sense of self and a feeling of independence and control. Those who remain unsure of their beliefs and desires will feel insecure and confused about themselves and the future. Adolescents who are encouraged and commended by parents and teachers develop a feeling of competence and belief in their skills. Those who receive little or no encouragement from parents, teachers, or peers will doubt their ability to be successful.

Interpersonal Relationship Skills Including Communication Skills and Empathy

Establishing and sustaining healthy interpersonal relationships is central to maintaining a healthy and all round personal functioning. It involves creating positive relationships by making mutual compromises, engaging in clear **communication** (both speaking and listening) and also developing empathy. In this regard communication is a dynamic process through which we convey a thought or feeling to someone else. How it is received depends on a set of

events, stimuli, that person is exposed to, as well as the manner in which it is said. Hence developing this life skill is very important in our day to day life. The essential components of effective communication are **listening and speaking skills**. Body language, facial expressions, gestures and our voice modulations are as important as spoken words and may also leave a greater impact on the listener.

Sometimes adolescents experience difficulty in discussing issues like marriage, career and sexual behaviour with peers, parents and teachers. Often they might not agree with other's views which results in conflict and turmoil. It is therefore important to learn the skill of communicating effectively with clear and rational thinking, expressing own views while simultaneously respecting difference in opinion. Relationships demand understanding one's own and other's role and constraints.

Some Facts about Emotions, Feelings and Body Language

Self confident people and leaders frequently:

- Are good listeners, walk with confidence and have a self assured smile
- Have a firm handshake and maintain eye contact
- Have an erect posture and square their body to the person they are speaking with

Confused people frequently

- Use verbal repetition
- Show repetitive motion

Embarrassed people frequently:

- Show nervous laughter and avoid eye contact
- Shake their heads or turn away

5.3.3 Negotiation Skills

Negotiation Skills enable the individual to accept the reality of the situation and simultaneously deal effectively with it so as to not give in. Developing and honing these life skills polish an individual's mental wellbeing by allowing effective stress management.

Coping with Stress and Emotions

Stress and conflicts are part of every stage of an individual's life; however these issues are experienced at an intense level when adequate measures of dealing with them are not available to the individual. Adolescence is termed as a life stage of "Friction, Fights & Fireworks", so it is much more important for these at-risk individuals to learn this life skill. Sometimes certain situations place the adolescents under stress and they cannot manage to take a right and thoughtful decision or end up taking steps that adversely affect them. In this time, feeling low or negative can only worsen the situation. For example, failing in an exam or having a terrible fight with a friend or parent can put the adolescent under stress and sometimes lead to taking extreme steps as well which can emotionally ruin them or even threaten their life.

An important understanding which can help us deal more positively in times of stress can be that it is not the event or the person that makes us weak/vulnerable or angry; but it is our perception of that particular situation. When we feel incapable of handling the emotional baggage or the weight of the consequences that it might bring up, it is then that we need to learn to switch our negative coping of denial and avoidance to a more positive problem focused coping.

Assertiveness Training

Assertiveness is the ability to express yourself and your rights without violating the rights of others. It is appropriately direct, honest and open communication which is self enhancing and expressing. It is the right to your own values, beliefs, opinions and emotions and the right to respect yourself for them, no matter what the opinion of others. However, in adolescence especially there is a great need to be accepted by the peers. This need may lead them to do things that they may not want to do themselves. The adolescents may have certain value system and are not comfortable with doing these things but just to prove that they are like the rest, may give in to the pressure from the peers and may take up activities like smoking or drinking. When you realize that giving in to these temptations can be harmful for yourself, it is time to say NO to oneself.

Check Your Progress Exercise 2

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

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

Match the following:

1.	Problem solving	a.	Negotiation Skills
2.	Coping with stress	b.	Social Skills
3.	Empathy	c.	Thinking Skills

5.4 STEPS IN LEARNING THINKING SKILLS

Now that we have understood the importance of life skills in our day to day living, let us now focus on understanding how we can learn these and apply in our life.

5.4.1 Problem Solving Skills

The type of problem and the context in which it occurs along with the personal disposition of the solver varies in different situations. However, psychologists agree that in a problem situation, the following 5 simple steps form the framework to resolve any problem. These are:

Stop-think-evaluate-act-react

Further a detailed procedure that can be adopted is:

1. *Problem Identification* : The recognition that a problem exists and identifying the issues, obstacles and goals involved.

   For example, suppose you have misplaced an important notebook. The first step would be to acknowledge that the notebook has been lost. Further you need to move on to formulate how much work had already been done in it, what can be the possible repercussions of losing it & who all could assist you in finding it.

2. *Formulate potential solutions* : Generate a vast number of possible solutions and options you have to view the problem and solve it. The first stage of solution generation can be very vast taking inputs from previous experiences as stored in your long term memory.

   For example, you can ask retrace your memory as to when did you use your notebook last, ask others several questions whether they have seen it, go to the different spots in your school and home where there is a possibility that you could have taken it, ask your friends if you would have lent it to someone.

3. *Evaluation* : Take the relative pros and cons of each solution ascertaining the possibility/feasibility of its application.

   For example, evaluate which appears to be the quickest and surest way to find your notebook.

4. *Try potential solutions and evaluate them on the basis of the effects they produce* : Apply the short listed solution and ascertain whether the problem has been completely or partially solved.

   For example, on asking a friend tells you he/she saw your notebook lying stray in the canteen. This is partial solution of the problem, so for a complete solution ensure that you ask the canteen incharge. If the problem has been solved, then you can store this method in your memory as a success otherwise go back to step 2 and proceed with another solution.

   Learning the life skill of solving problems can be generalized to any arena of your personal and social life.

You can apply methods like:

- *Divide and conquer:* Break down a large, complex problem into smaller, solvable problems
- *Hill-climbing strategy:* Attempting at every step to move closer to the goal situation. Many challenges require temporarily moving farther away from the goal state
- *Means-ends analysis:* Setting of subgoals based on the process of getting from the initial state to the goal state when solving a problem
- *Trial-and-error:* Guess and check
- *Brainstorming:* Thinking of various possible solutions to the problem
- *Analogy:* Has a similar problem (possibly in a different field) been solved before?
- *Reduction (complexity):* Transforming the problem into another problem for which solutions exist
- *Hypothesis testing:* Assuming a possible explanation to the problem and trying to prove the assumption

5.4.2 Goal Setting

Setting appropriate goals not only give us a clear direction in which to proceed but also motivate us to achieve our targets in stipulated time periods. Hence,

learning the skill to set goals for ourselves is very important. There are 2 types of goals that we set for ourselves:

(A) *Short Term Goals*: Goals that we aim to achieve in a short period of time and would serve as stepping stones towards the greater goal/vision we have for ourselves.

(B) *Long Term Goals*: These goals take a perspective on what we want to achieve in the future. Having a solid long term goal in our mind helps us push forward by succeeding at short term goals.

Steps to be followed are:

1. *Identify your goal*: In addition to setting the target, also understand, why you want it? What it means to you? What end would it serve? When the drive to achieve would be enhanced, the speed and determination with which we move towards our goal would also be enhanced.

2. *Clearly define your goal*: Instead of having an abstract goal, set and define a concrete goal for yourself. E.g., instead of setting your goal as 'I want to be a successful student', set 'I want to increase my grades by let us say 5%'.

3. *Setting SMART goals is the key*:

   S = Specific: Goals should be straightforward and emphasize what you want to happen. Specifics help us to focus our efforts and clearly define what we are going to do.

   M = Measurable: Set such a goal for which you can measure the change or the progress, however small it may be.

   A = Attainable: Set a goal that is neither to easy nor too difficult to be achieved. An optimal level of challenge when associated with the goal will motivate you and encourage you to develop your abilities by deepening your commitment. It will allow you to utilize each opportunity that comes your way instead of shrugging it off being considered out of reach.

   R = Realistic: Realistic means "do-able". Setting too high a goal to start with could result in failure and prevent us from trying any further, while too simple a goal would not motivate us enough.

   T = Timely: Set a time frame for your goals as setting such an end point would keep us consistently moving forward and gives a clear temporal target to work towards.

   Time must be measurable, attainable and realistic.

4. *Evaluate:* It is important to consistently evaluate or grade your progress. Such assessment of the self would allow identifying the lacuna or weaknesses in the progress which can be checked and worked at in time.

5. *Feedback and Reinforcement:* Rewarding oneself for positive growth and giving oneself negative feedback are both equally important. Impartial feedback would keep the pace going without you losing the focus of your goal and rewarding yourself for your efforts would keep the motivation to perform going.

5.4.3 Decision Making

Decisions need to be made at every step of our life and the implications of the choices that we make are for us to be faced. Therefore it is important to make well thought of, informed and wise decisions instead of taking decisions only under the influence of emotions. Some decision making strategies are:

1. *Optimizing:* This is the strategy of choosing the best possible solution to the problem, discovering as many alternatives as possible and choosing the very best. How thoroughly optimizing can be done is dependent on

   - importance of the problem
   - time available for solving it
   - cost involved with alternative solutions
   - availability of resources, knowledge
   - personal psychology, values

   Note that the collection of complete information and the consideration of all alternatives is seldom possible for most major decisions, so that limitations must be placed on alternatives.

2. *Satisficing:* In this strategy, the first satisfactory alternative is chosen rather than the best alternative. If you are very hungry, you might choose to stop at the first decent looking restaurant in the next town rather than attempting to choose the best restaurant from among all (the optimizing strategy). The word *satisficing* was coined by combining *satisfactory* and *sufficient*. For many small decisions, such as where to park, what to drink, which pen to use, which tie to wear, and so on, the satisficing strategy is perfect.

3. *Maximax:* This stands for "maximize the maximums." This strategy focuses on evaluating and then choosing the alternatives based on their maximum possible payoff. This is sometimes described as the strategy of the optimist, because favourable outcomes and high potentials are the areas of concern. It is a good strategy for use when risk taking is most acceptable.

4. *Maximin:* This stands for "maximize the minimums." In this strategy, that of the pessimist, the worst possible outcome of each decision is considered and the decision with the highest minimum is chosen. The Maximin orientation is good when the consequences of a failed decision are particularly harmful or undesirable. It's the philosophy behind the saying, "A bird in the hand is worth two in the bush."

5.4.4 Time Management Skills

Learning to effectively and efficiently manage the time well is a mark of a high achieving person. Once we learn how to schedule our tasks and manage our time, we would become capable in meeting deadlines and deliver well even under pressure. The first step towards this is to tackle with the problem of procrastination i.e. tendency to put off things for a later time over and over again.

Some techniques to manage your time well are:

1. *Make a To-Do list*: Write down all the tasks that you need to achieve, no matter how long the list may turn out to be. If the tasks are too big then reduce them to their smaller component parts such that each task would not require more than 1-2 hours.

2. *Prioritize the To-Do list*: This must be done according to importance and urgency by applying the following time management grid:

URGENT IMPORTANT	URGENT NOT IMPORTANT
IMPORTANT NOT URGENT	NOT IMPORTANT NOT URGENT

3. *Maintain an activity log:* This will make you aware of the pattern in which you spend your day. You would be alarmed to find out how much time is wasted on relatively low value tasks. Maintaining a log would also help you ascertain the time periods through the day when you are most active and productive. Based on this, schedule your day such that your tasks from the priority list are organized through the day and the urgent and important tasks can be done in the time period when you are most alert.

4. *Tackle with your tendency to procrastinate:* Begin with recognizing that you are procrastinating, try understanding why you are doing so – whether the task is unpleasant or too difficult to be handled. If the task is unpleasant, you may motivate yourself using the following simple steps:

    a) Make up your own rewards

    b) Ask someone to keep checking on your pace

    c) Identify the unpleasant consequences of NOT doing the task.

However, if you are finding yourself unable to carry out the task because of its difficulty level, then you can take up the following steps:

    a) Break the task into a set of smaller, more manageable tasks.

    b) Start with the simple bit, smaller achievable tasks. As you see yourself proceed it will motivate you

    c) Seek help where you cannot move forward on your own, but do not stop.

5.5 STEPS IN LEARNING SOCIAL SKILLS

In our day to day life, we face numerous situations where we need to engage in social interactions, whether it is individually or within a group. As we have understood the importance of the skills that come handy in such situations, let us learn to adapt them in our lives.

5.5.1 Self Awareness

Being self aware prepares us to face known and unknown conditions, interact with strangers or face unpredictable situations. It also allows us to make realistic estimates of our achievement, set appropriate goals and cultivate self respect and self confidence which would keep us from feeling defeated in front of others. Some simple steps with which we can cultivate them are:

1. Establish a baseline of your strengths and negatives. You may arrive at this through gaining inputs from friends, teachers and family.
2. Set a goal (personal, social, academic, vocational) for yourself. An appropriate goal can be set as per the goal setting strategies explained. In this regard, having a role model can help.
3. Identify the life skills which would assist you in the accomplishment of your goal and seek to foster them. Remember not to lose confidence in the beginning as the start is always difficult.
4. Evaluate your progress.
5. Suitably reward yourself according to the evaluation. If the end result is negative, restart from the first step.

5.5.2 Raising Self Confidence and Building Self Esteem

Being a person with self confidence and a high self esteem begins with accepting yourself as you are and being comfortable with yourself. The way you perceive yourself greatly impacts the way others perceive you. The ideal is to not be lacking in self confidence and neither being arrogant about our abilities. Though building confidence is not an overnight journey or a skill that can be mastered in 5 minutes, it is a worthwhile skill to practice, learn and mature with over time. Some simple strategies that can be followed for the same are:

1. *Concentrate on your strengths rather than on your weaknesses:* Keep the focus on the present. Write 5 positive things about yourself and concentrate on your potential.
2. *Remind yourself of past successes.*
3. *Take risks:* Approach new experiences as opportunities to learn instead of occasions to win or lose. Doing so brings you new opportunities and can improve your sense of self-acceptance. Not doing so turns every possibility into an opportunity for failure, and inhibits self-growth.
4. *Use self-talk:* It can be used as an opportunity to contradict destructive beliefs. Then, remind yourself to “stop” and replace with more realistic assumptions
5. *Visualize your future success.*

5.5.3 Interpersonal Relationship Skills

The manner with which we handle our social situations, conduct ourselves in front of others, communicate our feelings, needs and expectations greatly determines how healthy and satisfying our interpersonal relationships would be. Learning social skills can thereby not only assist us in tackling new and unpredictable social situations but also in maintaining and enhancing our current relationships. In this league, effective communication is of paramount importance. Communication is the process of getting a message across to another person; sharing ideas, thoughts or feelings. Often it involves the use of language but does

not depend solely on verbal language. To develop communication, answering the following questions for your self is important:

- *Why:* It is important to learn that communicative behaviour can make something happen. Making the effort to communicate is the cause that needs to be made to see the manifested effect in your life. We communicate to respond to someone else, request something we want, to protest/refuse/ complain, to get someone's attention, to comment on something, to gain/ give information, to share ideas and feelings.
- *Want:* Do I have the desire to communicate? Here it is important to begin with making a conscious interest in other people and recognizing that another person can help.
- *Who:* Communication is a 2 way process. Hence, you may choose an appropriate partner to start working with, with whom you feel comfortable and can learn the skill to share your thoughts and feelings beginning with prompting, taking cues, one word utterances to express your needs and gradually moving towards complete sentences.
- *What:* Find out something to communicate about. Being prepared with the content you would like to share will help lower the anxiety associated with communication.
- *How:* Communication entails both verbal (sounds, words, sentences) and non verbal (eye contact, postures, gestures, body movements, facial expressions, signs) components. It is important to follow the 80/20 rule. When someone is speaking to you, you should listen 80% of the time and speak only 20%. Each has a boundary around them. Do not unnecessarily enter the personal space of another. Every communication should be carried out and interpreted with respect to context.

To sustain relationship, **making mutual compromises** is important. Adolescents should also learn to adjust to other people as per the needs and modify their actions. Developing empathy can thereby aid them in this regard. **Empathy** means to have the ability to imagine oneself in the shoes of someone else and experience their emotions. One can then understand their concerns, worries, fears, needs and how they feel.

5.6 STEPS IN LEARNING NEGOTIATION SKILLS

Many a times we face situations and events that we could not expect or predict or feel unprepared to handle. However, experiencing these feelings does not contribute towrds reduction of the felt anxiety or bring about a solution. It is in these situations, that negotiation skills come handy. These skills, as the term itself suggests, enables one to negotiate from the environment the best possible alternative that buffers us from an emotional breakdown.

5.6.1 Coping with Stress and Emotions

Everyday life is full of hassles, running between schedules and deadlines, meeting expectations, performances and appraisals. In addition to such anxiety evoking stressful conditions, one may also face trauma and crisis of various forms. Stress can be understood as any event that exceeds our resources or abilities required to deal with it. However, stress is not always bad or negative. The positive form of stress is known as eustress which motivates us to exert ourselves and perform well. However distress emerges when the mind and body cannot adequately

cope with such demands. It causes major damage to your health, your mood, your productivity, your relationships, and your quality of life. Long-term exposure to stress can lead to serious health problems. Chronic stress disrupts nearly every system in your body. It can raise blood pressure, suppress the immune system, increase the risk of heart attack and stroke, contribute to infertility, and speed up the aging process. Long-term stress can even rewire the brain, leaving you more vulnerable to anxiety and depression.

Many health problems are caused or exacerbated by stress, including:

- Pain of any kind
- Heart disease
- Digestive problems
- Sleep problems
- Depression
- Obesity
- Autoimmune diseases
- Skin conditions, such as eczema

The psychological definition of coping is the process of managing taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce or tolerate stress or conflict. Skills of coping with stress include defining the problem, understanding one's strengths and limitations, thinking rationally and talking to an adult can enable one to think positively and deal effectively with the stress.

Factors influencing stress tolerance level

- *Support network* – A strong network of supportive friends and family members serves as a buffer against life's stressors. Being lonely and isolated, cut off from social networks makes one more vulnerable to stress.
- *Sense of control* – Sense of self confidence in one's ability to overcome stress and challenging situations enables one with a sense of agency of the events happening in one's life. However, if one adopts the attitude of self pity and feels driven by events in life, that individual is more predisposed to succumbing to effects of stress.
- *Attitude and outlook* **–**An optimistic attitude to embrace challenges, having a strong sense of humour, ability to accept and adapt to change buffers one against stress.
- *Preparation and knowledge of resources needed and available* **–** Being aware of the potential stressors, the temporal quality of these stressors and being adept at adequately dealing with them buffers us from suffering from distress.

Common external causes of stress

- Major life changes
- Work
- Relationship difficulties
- Financial problems
- Being too busy
- Children and family

Common internal causes of stress

- Inability to accept uncertainty
- Pessimism
- Negative self-talk
- Unrealistic expectations
- Perfectionism
- Lack of assertiveness

Stress Warning Signs and Symptoms	
Cognitive Symptoms	***Emotional Symptoms***
• Memory problems	• Moodiness
• Inability to concentrate	• Irritability or short temper
• Poor judgement	• Agitation, inability to relax
• Seeing only the negative	• Feeling overwhelmed
• Anxious or racing thoughts	• Sense of loneliness and isolation
• Constant worrying	• Depression or general unhappiness
Physical Symptoms	***Behavioural Symptoms***
• Aches and pains	• Eating more or less
• Diarrhoea or constipation	• Sleeping too much or too little
• Nausea, dizziness	• Isolating yourself from others
• Chest pain, rapid heartbeat	• Procrastinating or neglecting responsibilities
• Loss of sex drive	• Using alcohol, cigarettes, or drugs to relax
• Frequent colds	• Nervous habits (e.g. nail biting, pacing)

By now, we have understood the meaning of stress and that coping is possible through modifying our thinking, feeling and acting components. There are 3 responses that one takes to when under stress. These are:

- An angry or agitated stress response: Being over emotional, angry, being highly strung.
- A withdrawn or depressed stress response: Tendency to block out others, stay alone, toned down responsiveness to stimuli
- A tense and frozen stress response: Tendency to not take an overt action but being emotionally agitated covertly.

Let us now learn coping strategies that would enable us to deal more effectively with our problems. These can be divided as follows:

1. *Appraisal-focused strategies*: These strategies focus on modifying one's thought process i.e. altering how we think about a problem, the meaning and value we attach to the goal, or how we distance our self from the problem. Some individuals may also use the strategy of denial, which entails denying the presence of the stressful situation all together. We can also learn to cope with the negative situation by introducing humour into it.
2. *Problem-focused strategies*: These try to deal with the cause of the problem. Problem-solving coping involves attempts to do something constructive about the stressful conditions that are harming, threatening or challenging an individual. This involves a thorough information

search regarding the problem, generating possible solutions, collating the available resources that would help reduce the stressor or buffer one from its impact.

3. *Emotion-focused strategies*: These are strategies to regulate emtions associated with the stressful situations. Some strategies adopted are releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating, using systematic relaxation procedures amongst others.

5.6.2 Assertiveness

Assertiveness is an honest, direct and appropriate expression of one's thoughts, beliefs and feelings. Learning to say no to temptations strengthens your will power and induces the capability to resist them. It is important for adolescents to be firm in their words and actions when they are dealing with the societal, family or personal issues. At the same time they should neither be aggressive insisting others to accept their points of views or action, nor be too passive. Assertiveness should be based on wanting to achieve soft targets like:

1. Confidently asking for what is rightfully yours
2. Criticizing another's thinking/behaviour without using abusive or derogatory language.
3. Accepting criticism of self without being defensive
4. Being able to stand up for your rights
5. Being able to refuse unreasonable requests from friends, teachers or other persons of authority

Following are some strategies which can be adopted to develop assertiveness:

- *Broken Record Technique*: Simply repeat your request every time you are met with illegitimate resistance. However, a disadvantage with this technique is that when resistance continues, your requests lose power every time you have to repeat them. If the requests are repeated too often it can backfire on the authority of your words.
- *Fogging*: It involves finding some limited truth to agree with what an antagonist is saying.
- *Negative inquiry*: It consists of requesting further, more specific criticism. It would enable you to understand why you are being denied fulfillment of your request. Depending upon the said reasons, you can further evaluate for yourself and take adequate action.
- *'I' statements*: These can be used to voice one's feelings and wishes from a personal position without expressing a judgement about the other person or blaming one's feelings on them. It involves taking responsibility for one's own thinking and feeling.
- *Collecting adequate information*: Being aware of all the facts about the situation at hand and conducting yourself with self assuredness and self confidence.

- *Role Play*: it involves enacting a given situation with a friend or supportive senior, where you and the other party can turn by turn change roles and learn how a situation can be handled from a different angle. Repeated practice would allow you to be more fearless, be more confident and sharpen both your verbal and non verbal communication skills.

5.7 METHODS OF IMPARTING AND IMPLEMENTING LIFE SKILLS TRAINING IN INDIA

Imparting life skills education in Indian children is faced with myriad challenges, owing to it being a new concept in aiding the holistic development of students. The life skill education programmes started at the level of schools and gradually with the involvement of NGO's is spreading at the community level. In many schools counselling/life skill education is compulsory whereas in some schools there is no awareness of the same. Hence a multilevel approach towards implementing life skills training is the key forward. Life Skill Education in school is an important means to promote psycho-social competence among young individuals. In the Indian scenario considering the heterogeneity of the levels of childcare givers ranging from school teachers to grass root level NGO workers, the need of training is varied. The Indian youth is currently at crossroads. India being a vast and diverse country, the Indian youth is slowly undergoing a cultural transition in their outlook due to globalization, communication and media. In absolute numbers the Indian youth are a significant population of the world's youth population. A significant proportion of the Indian adolescents are not in school, and those in school are under severe stress due to a very competitive system of evaluation, heavy syllabus, and a low teacher-student ratio. Due to the above reasons motivation to stay in the schools system is very low especially in the rural areas. There are various programmes and workshops that are conducted across schools and neighbourhoods in India in order to empower children and adolescents with core life skills. Following are a few of these:

a) WHO's Life Skills Development Programme: (Developed in collaboration with National Institute of Mental Health and Neurological Sciences and World Health Organization) This was implemented in 4 stages:

- Preliminary seminar for a heterogeneous group consisting of school teachers, pediatricians, social workers, member of NGO working with child care etc.
- Workshop for removing doubts, planning lessons and worksheets and implementing theoretical concepts.
- Residential camp for popularizing life skills and testing out how more than one life skill is used in one given performance.
- Students formed the "training of trainers" group. These students worked in groups and functioned as overall coordinators for the programme.
- Training of teachers to sensitize them to life skills, using life skills in everyday teaching, identifying students who would benefit from life skills training.

b) Training of trainers for peer education:

It is a curriculum tool to prepare peer education trainers. The programme uses participatory techniques based on a variety of theoretical frameworks to ensure that future trainers are skilled and confident in their abilities to train peer educators and serve as informed resources for their peers. It involves:

- Educating the participants about the meaning of peer education and its rationale
- Imparting appropriate training exercises, modules and worksheets to maintain homogeneity in the training method
- Conducting a sample peer education session
- Giving out participant handouts

c) National Peer Educators' Forum (NPEF) formed by Expressions India: 'Peer Educator groups' formed in over 110 schools (1 teacher and 4 adolescents in the age group of 14-17 years selected from each school and trained as 'master trainers/peer educators') who in turn reach out to at least 3000-4000 students annually. In addition, about 30 youth peer educators from various colleges, who have been associated since adolescence (as school peer educators) and are instrumental in taking the movement forward among college youth. A peer educators alumini is being formed for the mission of building perspectives for the fresh adolescent peer educators henceforth.

5.8 BENEFITS OF LIFE SKILLS

Life skills aim at developing the individual personally and socially. Our individual lives are shaped by our social lives i.e. our intrapersonal lives are shaped by our interpersonal lives. Life skills thus play a crucial role.

5.8.1 Advantages of Having Good Life Skills

- Creating a positive and safe environment
- Developing individual resilience in the face of future crisis or other stressful life events
- Adopting appropriate release of frustration and aggression
- Developing a healthy self concept which allows taking personal responsibility for situations in life

5.8.2 Consequences of Having Poor Life Skills

- Difficulty in interpersonal relationships and varied social contexts
- Evoke negative responses from others that lead to high levels of peer rejection
- Anxiety, depression and aggression which may be directed at self or others
- Lowering of self confidence and gradual withdrawal from social situations
- Poor performance at work or education

5.9 LET US SUM UP

The adolescent stage in an individual's life is afflicted with numerous stresses and struggles. To cope with them and function adequately at a personal, interpersonal and societal level we need life skills. It is evident that the life skills are comprehensive including various areas like thinking, behaviour, and emotions. The final target is to develop self-awareness, self-esteem and accepting others. In an individual, life skills develop over the years continuously in an active manner. There are many skills, which are needed to successfully negotiate each and every interaction. These skills can be learnt and imbibed in our life through education, experience and exposure. These serve as a Psychological Vaccination against problems of mental health. These include various thinking skills, social skills and negotiation skills. In a given situation, we need to apply a good mix of these skills as no one in particular can be applied to solve any problem in our life and make us more capable. We begin with practicing these skills consciously and even in simulated set ups like role plays but with time and repeated trials, these skills get imbibed in our own life. Lately, life skill education has become a part of school curriculum as their importance is being greatly realized.

5.10 GLOSSARY

Assertiveness : Ability to put forth one's opinion clearly without passivity or aggression.

Conflict : State of opposition between two given choices/goals.

Coping : Ability to generate resources to deal effectively with a problem or feeling state.

Decision making : Weighing of different pros and cons to be able to make a choice between given alternatives.

Empathy : Ability to identify with another person.

Feedback : Information about the result/effect/consequence of an action.

Frustration : A state that arises out of being blocked from achieving the desired goal.

Life skill : Skills needed in daily life to enhance one's mental wellbeing and competency.

Negotiation : Discuss in order to reach an agreement.

Non verbal communication : Channel of communication other than verbal messages; body language, posture, tone of voice, gestures that add expression to the content of communication and facilitate communication.

Problem : Obstacle blocking the attainment of a goal.

Problem solving : Generation of appropriate solutions and strategies that would allow the attainment of the desired goal.

Reinforcement : Strengthening the likelihood of a response being repeated or not repeated.

Skill : The abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life.

Stress : An event that exceeds the individual's ability to cope.

5.11 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. The World Health Organization has defined life skills as, **"**the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life." Life skills are not some ability that we are essentially born with, but can develop and enhance in the course of our life so as to achieve a balance between knowledge, attitude and skill. Life skills are essentially those abilities that help promote mental well-being and competency. Life skills allow us to match our potential with difficult or apparently unsolvable complex tasks.

2. Life skills enable the adolescent to effectively deal with challenges associated with their developmental stage and also pave the way for development of a sound adult personality. Life skills empower the individual to gain mastery over the environment, gain sense of identity and self concept, to make wise and timely decisions, become capable to solve their own problems, managing stress effectively and to engage in purposeful communication. In addition life skills also empower individuals to have meaningful relationships, from making new friends, to sustaining relationships and withstanding peer pressure.

3. The core life skills are critical thinking, creative thinking, decision making, problem solving, interpersonal relationship skills, effective communication skills, skills to cope with emotions, skills to cope with stress, self awareness and empathy.

Check Your Progress Exercise 2

1. c

2. a

3. b

5.12 UNIT END QUESTIONS

1. Define life skills. Discuss the use of life skills in school going adolescents.

2. With help of an example, describe the use of life skills to help an academically low scorer student of class VII.

5.13 FURTHER READINGS AND REFERENCES

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UNIT 6 PLAY THERAPY

Structure

6.1 INTRODUCTION

This Unit focuses on the significant role of play in childhood. Most adults view play as a non-serious activity in children's lives or a time when adults wish children to be engaged in so as to keep them busy. However, play is more than just an activity and theorists of play have studied and highlighted many benefits of play. Play helps in the overall development and growth of children. It is a universal form of activity across cultures, which interests children. Children are comfortable in expressing themselves through play. This inherent value of play and its varied role is the focus of the present Unit.

The objectives here are to understand the meaning of play and its role in child development. The benefits of play in childhood and how it can be used to help children grow in a healthy manner has been explored. Play therapy is one of its benefits. Although play therapy uses the benefits of regular play but it is different from just playing. It is a systematic approach to address various difficulties a child is facing. This method has evolved from various schools of thought over last 100 years and its historical development has been traced. Populations who have benefited and can benefit have been mentioned further with the material requirement to conduct the sessions.

Objectives

After studying this Unit, you will be able to:

- Understand play and its role in child development;
- Discuss stages of play; and
- Explain play therapy and its significance.

6.2 WHAT IS PLAY?

Play is a pleasurable activity in which children love to engage anytime, anywhere. It is highly engaging and a natural medium of expression. Children create what they live in play and try to understand the big world around them. It is considered to be one of the primary needs of children and all adults must be sensitive towards it. Babies begin to play with their fingers, a young child may involve himself in pretend play, and older children may prefer playing games or do engage in hobbies. In adolescence or young adulthood leisure activities may replace these play forms. Thus, at each stage children are exploring and trying to look for activities which are fun and satisfying as well. Children may enjoy playing individually or in groups. They decide what they want to play and how they wish to proceed. They may exchange ideas and plot themes together to learn certain ways of playing from each other or else they may voluntarily opt out to indulge in a different play elsewhere. Both nature and nurture contribute to the development of the skills needed to play. Play is a learning experience and has a significant role in emotional, social, cognitive and physical-motor development of the child. Looking at this important role of play in child development; the United Nations High Commission for Human Rights has recognized it as a right of every child.

Free Play Versus Structured Play

Free play occurs in those situations when a child leads the play. The child is the director of the play and chooses to organize the scenario in the way that s/he desires. The tone and the pace are set by the child. A monster may be projected lazy or active, kind or attacking, a fire or a water symbol, strong or weak; it all depends on the child. The number of monsters, their life span and which ones come how and when is all set by the child. To the observer, the play may seem to be happening too fast or too slow but for the child the pace is just right. The pace has been decided by him and means something to and for him. Free play has its own value and meaning to the child as the child is controlling the play. It is a deeply engrossing activity. Free play can occur in pairs or alone (solitary play). While playing together children will express creative ideas and bring forth various skills. Free play captures the holistic picture and allows children to benefit largely from this involvement.

In structured play, the adult leads and plans the pace of play. Unlike free play the child depends here on the adult to guide him as he progresses in play. The child participates and enjoys but the level of involvement for some children may not be as much as in free play. The child may be asked to play with toys in a certain manner or they may be asked to do a specific painting. Choices here are limited for children. A child is not given opportunities to decide what he wants to do and for how long can he indulge in the same. The purpose here is to teach something to the child.

6.3 PLAY AND CHILD DEVELOPMENT

As mentioned before, play helps in the overall development of the child. The following areas develop while children engage in play.

6.3.1 Cognitive Development

While children are engaged in their favorite activities, they develop and understand concepts. As they play, they discover about different coloured and shaped objects. They explore various properties of the objects, as big or small, wet or dry, light or heavy, sticky or non-sticky etc.

Piaget, a developmental theorist viewed play activities to be essential in cognitive development. He followed the lines laid down by his theory of intellectual development and viewed that all forms of understanding are created through the workings of two inborn intellectual processes: organization and adaptation. Adaptation occurs through two complementary activities: assimilation and accommodation. If a child observes a dog, s/he will try to assimilate what s/he is observing by interpreting the new experience in the light of the schemes he already possesses i.e. the four legged category. The child will then try to modify or accommodate this new creature by the name 'dog'. So while they are assimilating, children may understand it as a four legged creature with a tail, looks like a cat etc. but during accommodation a new category of experience is created, like the dog.

Through play the child learns internal manipulation of external objects or events. It becomes critical in balancing the subjective conceptions of reality with objective quality of reality. Representational thought is enacted through symbolic play, one object used for another. Pretend activities strengthen symbolic or representational thinking. In today's expanding and changing world, adaptive skills are highly desirable to cope with various demands of life.

6.3.2 Emotional Development

Play promotes emotional development in all stages of childhood. Through play, infants learn to trust their environment. They indulge in various activities and learn about constancy and continuity between internal and external events. They may be given a shaker or other toys which they may use to comfort themselves and become more autonomous. During toddlerhood, push-pull toys and construction-destruction activities, for example with blocks will allow for symbolic action and promote self esteem. In childhood, it allows for expression of positive and negative emotions. When children are experiencing a difficult moment in their lives, they may recreate that situation in play. While doing so, they explore options to find meaning in the given situation and look for alternative solutions to their problems. Erikson views play to be an infantile form of human ability to deal with experience by creating model situations to master reality by experiment and planning. This affective development in play has been studied extensively and is one of the predominant reasons for it being systematically used in therapy.

6.3.3 Language Development

As children grow, their language keeps expanding. Play gives many opportunities to build language. Children spontaneously express what they are doing to each other using words or brief sentences in preschool years. This process of exchanging ideas helps children to frame different sentences about what they are

seeing and how they are planning to proceed ahead. Even a child who is from a different culture may pick up certain words of another language when playing in a multi-cultural group. Children bring out different themes in play and will use vocabulary related to it. Children invent plenty of ways of practicing language through fun activity. Adults may join in and use various other sentences to promote language skills. It is through this kind of social interaction, we notice language to be gaining momentum. Play not only helps to build language but takes social relationships a step further which provides a base for gaining more language skills. Older children like playing games and use language to negotiate and explain their intentions.

6.3.4 Physical and Motor Development

Gross and fine motor skills are developed through play. Children run, hop, jump, skip and develop large muscles through various play activities. Fine motor skills are developed when children engage in a puzzle, beading, joining the dots, tracing and other activities involving pincer grip.

6.3.5 Social Development

Infants initially enjoy playing with inanimate objects and as they grow, slowly extend themselves in play activities with other children. As they play in groups, they begin to interact and learn social rules. While playing they express their needs, learn to communicate and take turns, resolve conflicts and tend to explore possibilities to be able to care for others' feelings and be fair. Thus social development through play is a process of awareness and involvement. This developmental process has been discussed further in the next section on stages of play.

6.4 STAGES OF PLAY

The main stages of play are discussed below. Each child goes through the stages and moves at his own pace depending on the ability, experience and opportunities to be involved in play.

Solitary play usually extends from 0-2 years wherein minimum regard is given to others' play and the toddler enjoys playing alone.

Onlooker play extends from 2-2½ years wherein children watch other children play. They may offer suggestions and enjoy observing them but never actively participate in their play.

Parallel play is the next stage between 2½-3 years wherein two or more children may begin to play what other children are playing around. They try and imitate them. A few questions and ideas may be exchanged as well but they do not join each other's play.

Associative play usually takes place in 3-4 year old children. This occurs when a child is playing in a group and will begin to interact with others. Children may exchange toys with each other but there are no group goals which are achieved.

Cooperative play extends from 4 years +, wherein children have shared group goals. They interact and support each other. This kind of play usually occurs in primary school.

6.5 BENEFITS OF PLAY

Times have changed and so have our lifestyles. Parents and other caregivers are leading busy lives focusing on doing more in less time. They are often hurried, pressured and trying to be trendy by purchasing hi-tech/ computer games that have replaced the normal outdoor free play opportunities and is worrisome for health professionals. We need to protect 'play' so that children are given due opportunities to develop and grow in a healthy manner. Play has many benefits:

- Children use their imagination in play and become more creative.
- Children reveal their inner self easily through play.
- Play helps to promote social interaction from a very early age.
- Children are able to bring out in play what is bothering them and are able to explore various possibilities to solve the problem.
- Children play to make themselves aware about the society's functioning. They enact and practice adult roles.
- Play helps build social skills.
- Children involve themselves in free play and learn to make decisions. They decide with each other what they would like to play.
- It promotes physical activity and allows children to utilize their energies in a constructive manner.
- If parents join their children's play, adults are able to understand the child's perspective which in turn facilitates development of healthy family relationship.
- Play helps children to adjust in various settings, to a new school, new neighbourhood, transition etc.

Looking at the above mentioned benefits, it is the duty of each parent to find time for their children to allow them to engage in free play. These benefits of play have been utilized in therapy and its therapeutic use is being discussed below.

6.6 WHAT IS PLAY THERAPY?

When play is used to diagnose and treat behavioural/emotional/social problems, it is known as play therapy. Play therapy is to children what counselling is to adults. In the playroom toys are used like words and play is their natural language. When children can communicate or play out how they feel to a trained play therapist who understands, they feel better as their feelings have been released (Landreth, 1991).

Play therapy is different from regular play as the therapist follows principles of a particular school of thought and is helping the child to systematically address and resolve their problems.

6.7 HISTORICAL DEVELOPMENT OF PLAY THERAPY

Sigmund Freud developed psychoanalytic therapy and with its development came the application of Freud's theories to children in early 1900s. Many other

theories of play therapy evolved following Freud's work and some of the predominant ones include: Psychoanalytic, Jungian, Adlerian, Release, Relationship and Child-centered play therapy. Along with these, other predominant directive play therapies include Gestalt, Filial therapy etc. These theories were different from old traditional methods wherein adult principles were applied to child population. The traditional methods encouraged children to talk than express in their own language of play. Landreth (1993) has emphasized that child's language development lags behind his cognitive development. This characteristic of play and child development is utilized in therapy.

Psychoanalytic play therapy evolved when analysts discovered that their methods did not work with children. Sigmund Freud was the first to use play in therapy in 1909 in an attempt to uncover the unconscious fears and concerns of his client. Hermine Hug Hellmuth began including play in her treatment with children in 1920s and 10 years later Anna Freud formulated the theory of psychoanalytic play therapy. According to her, the child's play helps us to understand his/ her world and the therapist must establish a good relationship before making an interpretation. Whereas Melanie Klien in 1919 understood play to be a direct substitute for verbalization and used play as a means of analyzing children under 6 years. Unlike Anna Freud, she equated play with free association in adults. Although there is a difference in their approach but both are prevalent in practice today. It is because of these approaches, that various other approaches of play therapy evolved.

Jungian play therapy was developed by Carl Jung in 1912. Jung separated himself from Freud and developed his own theory on the development of personality. Jung does not view the therapist to be the leader but sees therapist as having a very active and an interactive role with the child. According to Jung the child's psyche knows where it needs to go and it is the therapist's job to follow it there. Jungian play therapy depends a great deal on the therapist to build trust with the child and to have a discussion with the child about their play with sensitivity and skill. According to Jungians self is a part of psyche that organizes aspects of personality, both conscious and unconscious. John Allan and Margaret Lowenfield are major contributors to the world of Jungian play therapy.

Adlerian play therapy is based of Alfred Adler's concept of individual psychology. Individual psychology began with the compilation of ideas of Alfred Adler, Freud and Jung. Individual psychology proposes the concept that individuals are 'socially embedded' the child's environment; emphasizing the importance of. This therapy used techniques to provide encouragement, reveal family constellation, encourage early recollections, reveal goals of child behaviour, form tentative hypotheses about child's behaviour and re-educate the child.

In 1930s, David Levy developed 'release play therapy'. Unlike psychoanalytic play therapy, interpretation was not important according to this approach. The major role of the therapist was to recreate through selected toys the experience that precipitated the child's anxiety. The belief was that reenactment of the traumatic event would allow the child to release pain and tension. This evolved from Sigmund Freud's concept of 'repetition-compulsion' as Levy was very fascinated by this concept.

In 1933-34 Taft and Allen developed 'relationship play therapy' which was based on the work of Otto Rank. Rank deemphasized the past and unconscious and stressed on the importance of the therapist-client relationship. They gave

children the choice to play or not to play and direct their own play. The primary focus was on present feelings and reactions. Children were viewed as having the inner strength and the capacity to alter behaviours.

In 1940s Virginia Axline applied client-centered principles based on Carl Rogers work with children. This therapy was called 'non-directive therapy' and was based on the belief that children strive towards growth and self-direction. Children have a drive towards self-actualization. Children were given freedom to choose to play/ talk. The goal was to create a secure relationship that would allow the child to be herself or himself. Garry Landreth and Louise Guerney are two other major contributors in the world of child-centered play therapy. Axline's book, 'Dibs in search of self', clearly explains the benefits of child-centered play therapy.

The eight basic principles that guide the therapist to conduct the sessions are as follows:

1. The play therapist must create a warm and a friendly relationship with the child.
2. The play therapist accepts the child exactly as s/he is.
3. The play therapist establishes the feeling of permissiveness in the relationship so that the child feels free to express his feelings.
4. The play therapist recognizes the feelings the child is expressing and reflects those feelings back to the child in such a manner that insight is gained.
5. The play therapist has a strong respect for the child and his ability to solve his own problems.
6. The child leads the way and the therapist follows.
7. The play therapist does not attempt to hurry the child along. Play therapy is a gradual process and is honoured as such by the play therapist.
8. The play therapist establishes only those limits that are necessary to ground children to the world of reality and to make the child aware of his responsibility in the relationship.

Towards the end of this Unit, these principles have been further linked to child-rearing patterns of the Indian culture.

6.8 SUGGESTED PLAYROOM MATERIALS

The play materials used in play therapy have broadly been divided into three categories as listed below:

- Real life toys: Doll house, telephone etc.
- Acting out or Aggressive toys: Toy gun, knife, handcuffs etc.
- Creative expression: Chalk, scissors, paper, play-dough etc.

When conducting sessions with Indian children, some of the toys need to be adapted to the Indian context. It is helpful to have the dolls costumed in the traditional Indian dresses. India is a country of 21 languages and 1800 dialects, with each state representing a sub-culture of its own. Children identify with females costumed in a *sari* and male dolls in *kurta-pyjama*. Children coming

from lower socio-economic group identify with *chulahs* in the kitchen than gas stoves. Toy *chulahs* are easily available in the kitchen sets in toy shops. Also, a large population of our country travels on two wheelers, it will be helpful to introduce some toy scooters in the playroom.

6.9 WHO CAN BENEFIT FROM PLAY THERAPY?

Play therapy can help children having various mental health, familial or educational problems. Research has shown play therapy to be effective with children having various difficulties. These are listed below:

Excessive anger

Worry/ Sadness

Fears

Behaviour which is immature for the child's age

Failure to learn or other school problems

Behaviour which interferes with making friends

Problems with eating, sleep or elimination

Pre-occupation with sexual behaviour

Physical symptoms such as headache and stomach aches which have no medical cause

Difficulty adjusting to family changes

Excessive shyness

Experiencing trauma such as:

Chronic illness

Illness or injury of family member

Divorce or separation of parents

Death of a close family member or friend

Disasters such as accidents, fires or flooding

Hospitalization

Painful or frightening medical procedures

Physical, emotional or sexual abuse

Witness to domestic violence

6.10 RELEVANCE OF CHILD-CENTERED PLAY THERAPY WITH INDIAN CHILDREN

We know that play in a child's life is one of the most wanted activities as it is pleasurable and non-threatening in nature. From the child's perspective, the

activity is most absorbing and engaging. What makes a difference is the manner in which it is played out and understood by others. The perspective of others brings in the role of culture as therapists from various cultures vary in knowledge, values and perception. The perspective of others is characteristic of the Indian context for this Unit. It will help us to study the context and promote our understanding of the child and the applicability of non-directive principles.

Children in India primarily like to play with marbles, clay, *pithu* (hitting a pile of seven blocks), dollhouse, do teacher role play, hopscotch, hide & seek, and so on. Most Indian parents view play to be a purposeless activity, something for children to engage in during free time. Academic achievement holds more importance over play or any other activity in our culture.

Play therapy has not emerged as a widely applicable approach in India. Due to paucity of trained professionals and resources, it has been used in much less elaborate fashion. However, parents are slowly becoming more comfortable in approaching a counsellor or a family therapist or a psychologist for various mild to severe concerns that their child may be facing.

Let us now take a look at the meaning of child-centered principles in Indian context:

Principle I: Emphasis on developing a warm, caring relationship

A child from any culture would welcome a caring attitude on part of the therapist. How the child responds to this principle can vary depending on his background and experience.

Below are listed three dimensions that may contribute to different patterns of communication within the family.

Multiple caregivers: The family of origin plays a very significant role in the life of the child. Joint or extended families live together as a single unit. This includes the grandparents, uncles, aunts, parents, and children. The role of the grandparents in raising the children is highly valued and they are a link to the Indian culture, religion and heritage. Trends are changing with time and the concept of nuclear family is emerging. A child who resides in an extended or a joint family receives love, affection, suggestion, guidance and rebukes from other members of the family. As a result some children may expect the therapist to be behaving like another caretaker and test her role within the playroom. The therapist must be aware of the developing relationship and must continue establishing rapport.

Overprotection: Children in most Indian families are overprotected. A female child is viewed to be most vulnerable. She is not allowed to go out and play by herself and is usually escorted by another family member. Thus some children may have difficulty disengaging from their parents or trusting other people in the environment easily. They are constantly vigilant.

Suppression of feelings: Parents shower a lot of warmth, affection and love towards their children. Parents do understand that children have their own emotions but fail to acknowledge them openly. In trying times, they want their children to maintain a brave front even if they are deeply scared inside. A therapist who is aware of this aspect will be able to offer enough patience if child is not ready to open up and is guarded in the playroom.

Principle II: Emphasis on qualified acceptance of the child

In India, relationships are hierarchial in nature between the socio-economic groups, sexes as well as between generations. Focusing on the family, authority is invested in the most senior male members. Elder siblings have a responsibility over younger siblings for their welfare. It is pressurizing for a male child as it is assumed that he has to adopt a greater sense of responsibility. This pushes the female child in the background, not allowing her to be a point of contact with the social world.

In regard with the hierarchical nature of relationships, feelings of rejection and low self-esteem are observed in children coming from low-socieconomic backgrounds. The respect offered to each child irrespective of their background and status will be received positively by any child to contribute towards a positive therapeutic relationship.

Principle III: Emphasis on safety and permissiveness for self-exploration

The playroom is a new place for the child and the therapist is a complete stranger. It is natural for a child to feel unsafe. In day-to-day life parents tend to be worried and often repeat instructions to be careful with the strangers and always be in company of their friends. Children go out to play in daylight and are supposed to be back before it is dark. A child who disobeys or violates instructions may be questioned, scolded or even spanked. S/he is not to argue with adults. The level of permissiveness always varies in different families. In view of this, permissiveness becomes an important dimension for structuring the relationship with the child. The unconditional positive regard will allow the child to open up easily and explore the inner self, which has had to inhibit its expressions now and then. Children will test the level of permissiveness within the playroom. They may explore the level of permissiveness by testing limits.

Principle IV: Emphasis on being sensitive to a child's feeling and reflecting them in manner that facilitates self-understanding

Indian children are encouraged to have a regard' for others' feelings than their own. They are viewed to be selfish and boastful if they express opinions that heighten sense of self. In having regard for feelings of others, children learn to anticipate needs of others. For example, if the child offers water or food to an adult on his own he gets social acclaim in front of relatives or significant others. This reinforces the behaviour in turn. Although taking care of others' feelings is encouraged, but for self, containment of feelings is preferred over open expression. There is an emotional bond in the families, but families do not openly talk about their intimate family and health issues. This form of privacy promotes internalizing of feelings over externalizing them for the child's benefit. This is the general pattern. The therapist therefore has to be very sensitive in understanding what the child is experiencing to be able to make an accurate reflection of his or her feelings.

Principle V: Emphasis on the child's capacity to act responsibly and respect his ability to solve personal problems

The capacity to act responsibly and solve problems is vital in promoting self-concept of the child. The development of self largely revolves around the child rearing practices, which in India is believed to foster dependency and submissiveness. Children from the lower socio-economic groups assume greater responsibility as they are pushed in the community to earn their living. Some

children may be disinhibited while some may be scared to explore. Children who seem dependent may seek permission for various things in the playroom, while the disinhibited may be acting out as they may find this as a freeing experience to venture forth in those areas which they never thought of exploring before. In the process, they may be worried about leading and being disrespectful as well.

The therapist needs to be sensitive to these aspects.

Principles VI & VII: Emphasis on allowing the child to lead in all areas and emphasis on the therapist not to hurry the therapy process

As discussed above, children may have difficulty leading in all areas and the therapist may have to demonstrate a lot of patience to be able to understand the child and allow him to move into those areas which s/he has not allowed himself before.

Principle VIII: Emphasis on establishing only those limits that help a child to accept responsibility

The therapist must be very clear about the kind of limits that s/he may want to set within the playroom. This clarity will help both the child and the therapist. This is necessary as most Indian families lack consistent limit setting. In India, a limit is set and alternatives to the problem situation are rarely explained. An emphasis is placed on the feelings of the authority figures over children. Children will learn better self-control when a therapist will acknowledge the child's feelings, communicate the limits consistently and provide alternatives.

6.11 LET US SUM UP

Play helps in the overall development and growth of children. It is a universal form of activity across cultures, which interests children. The benefits of play in childhood and how it can be used to help children grow in a healthy manner has been explored. Play therapy is one of its benefits. Children may enjoy playing individually or in groups. They decide what they want to play and how they wish to proceed. They may exchange ideas and plot themes together to learn certain ways of playing from each other or else they may voluntarily opt out to engage in a different play elsewhere. Both nature and nurture contribute to the development of the skills needed to play. Play is a learning experience and has a significant role in emotional, social, cognitive, physical and motor development of the child. Each child goes through the stages of play and moves at his own pace depending on the ability, experience and opportunities to be involved in play. Times have changed and so have our lifestyles. Parents and other care givers are leading busy lives focusing on doing more in less time. They are often hurried, pressured and trying to be trendy by purchasing hi-tech computer games that have replaced the normal outdoor free play opportunities and is worrisome for health professionals. We need to protect 'play' so that children are given due opportunities to develop and grow in a healthy manner. The use of play in therapy was elucidated by pioneers like Anna Freud who applied Freud's theories to children in early 1900s. Many other theories of play therapy evolved following Freud's work and some of the predominant ones include: Psychoanalytic, Jungian, Adlerian, Release, Relationship and Child-centered play therapy. Along with these, other predominant directive play therapies include, Gestalt, Filial therapy etc. These, theories were different from old traditional methods wherein adult principles were applied to child population. The traditional methods encouraged children to talk than express in their own language of play. However, it has been

recognized that child's language development lags behind his cognitive development. This characteristic of play and child development is utilized in therapy. Play therapy can help children having various mental health, familial or educational problems. Research has shown play therapy to be effective with children having various difficulties.

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UNIT 7 TRAINING PARENTS OF CHILDREN/ADOLESCENTS WITH DISABILITIES

Structure

7.1 INTRODUCTION

The importance of involving parents in the care of children/adolescents with disabilities began to be recognized only in the 1950s. Now parents are able to assume an active, varied and complex role in the management and training of their special children. Children with special needs include children with mental retardation, autism, children with physical, speech and hearing, or visual impairment and multiple disabilities. Children with severe Specific Learning Disability (dyslexia) and Attention Deficit Hyperactive Disorders (ADHD) will also be a part of this group. Such children need long term training and management, and parents have to be empowered to do so. In this Unit, you will learn how to give this training.

Obectives

After studying this Unit, you will able to:

- Identify need for training parents of children/adolescents with special needs;
- Describe models of parent training; and
- Appreciate evaluation of parent training programmes.

7.2 NEED FOR TRAINING PARENTS OF CHILDREN/ADOLESCENTS WITH DISABILITIES

The skill deficits and behaviour problems accompanying disability of any type suggested the need for trained parents and have led to the development of various parent training programmes, though more work has been done for children with mental retardation, autism, ADHD and specific learning disability. The rationale for the focus on parents stems from several sources. First the very nature of the problems accompanying children with special needs necessitates the constant availability of a trainer, able to conduct training in the home and to do so over a long period of time. The availability of personnel able to fulfill such requirements falls way short of the mark. Second, there is strong preventive value in equipping parents play an important role in shaping and maintaining behaviours and behaviour problems. Training them in the systematic application of learning principles can be most beneficial. Indeed, parents serve as the most potent sources of reinforcement for their children and adolescents. Third, the very proximity of the parents to the child is an advantage. In this entire context, however, one must not forget the parents' own stresses and their need for information.

The factors mentioned above have stimulated the parent training movement. The search for the most appropriate paradigm continues. Parents are now being taught to assess, plan, implement and even evaluate entire training programme for children with special needs.

Parents have been taught to teach a variety of skills, behaviours and to tackle behaviour problems, individually, in groups, in clinics, and in the home. Even the training of parents by other parents has been attempted. Variations with regard to the method of teaching, the basic principles used, the teaching tools employed and indeed, the training content itself, are numerous. A recent trend deserving special mention is the stress laid on parent-child interaction. Multiple-step training programmes have been used to foster fairly complex behaviours through parent-child interaction.

An immense variety of target behaviours have been addressed by parents who have been equipped with training skills. These target behaviours include: problem behaviour such a noncompliance, tantrums, aggressive and destructive behaviour, hyperactivity, self help skills such as proper toileting, dressing, bathing, prosocial behaviours and pre-academic skills.

7.3 MODELS OF PARENT TRAINING

Only a few decades ago, parent intervention consisted mainly of psychoanalytically interpreting the parents' feelings. Also intervention was limited only to children who appeared to be physiologically different. More recently, however, various frameworks for parental intervention have been developed and implemented.

Dynamic Model

In this model, treatment is formulated on the premise that internal factors or dynamics are directly related to how the parents will behave and carry out

the parental role. Treatment is hence directed at the parents and at exploring these dynamics. The resolution of negative feelings is strongly believed to help the parent accept the child. It is to be noted that the dynamic model is based on treatment rather than training per se, and is utilized whenever the parents undergo a crisis, such as that caused by marital discord, financial difficulties etc.

More recently, the concept of attachment has provided an impetus for observing and influencing the interaction of parents, usually the mother with their mentally retarded offspring. It assumes that with greater interaction the mother-child bond will strengthen, thereby enabling the mother to learn activities in which to engage her child. The dynamic model has the ability to both conceptualize parental behaviour and to intervene with parents, but it does not help the parents in terms of teaching skills.

Family Model

In the model, family members of the person meet as a group for discussion. In behavioural family therapy, in addition to discussion of feelings, there is learning of new styles of interaction.

Several reports have described the effectiveness of family therapy with families of children who are mentally ill, behaviourally disordered or otherwise disordered.

In India this model has been adopted at some places (NIMHANS and Vellore). Families stay together in the ward and through group interaction, are trained to look after their children.

Early Intervention/Educational Models

Tymchuk (1979) adapted this model of parent therapy, developed in a medical setting, for use with families of handicapped children in special settings. He found that parents, mostly mothers, in a group setting, had similar needs to those seen in clinics. These parents were trained in child development resources in a community set up. Positive changes in the attitudes of mothers towards their children were seen. Services were provided in community and in an educational setting, where intervention with mothers would be linked to their child's training in natural settings. Educational approaches do have some merit but more work is required in this area so that it can be assimilated with other models.

Early intervention model is very important with all children with special needs like autism, spasticity, speech and hearing, multiple disabilities and mental retardation. Early identification can bring positive changes in the child in less time.

Educational training programme is very helpful for children with specific learning disorders. Parents can be involved in training sessions for modification of spelling mistakes, reading, writing and maths. In this group many parents tend to form on their own creative and simple methods of teaching.

Behavioural Model

To modify undesirable behaviour, operant conditioning techniques have been utilized extensively with parents of the mentally handicapped, autistic children to enable them to be the behaviour-modifiers of their own children. These techniques, based on the systematic application of established principles of learning have

been used for wide range of problem behaviours, and pre-academic skills. Problems are viewed within this model, as being products of inappropriate learning and are dealt with by correcting this learning. This is the most successful approach to training of children with special needs, because it lays down specific steps to be followed and can be learnt by almost anyone without previous experience. These programmes are related to following activities:

- Attention and concentration enhancement techniques
- Memory enhancement techniques
- Self confidence enhancement techniques
- Methods to teach spelling
- Methods of teaching speech
- Techniques to learn subject matter
- To improve fine motor skills
- Techniques to improve psycho-motor ability

7.4 PROCEDURE OF TRAINING PARENTS OF CHILDREN/ADOLESCENTS WITH DISABILITIES

You need to develop a comprehensive model for parents to make the intervention effective. One must also aim at making the intervention readily available and easy to deliver. The approach to training should be cost effective, providing the parents with as many skills as possible. The maximum possible benefits must be achieved in the shortest possible time by utilizing the available knowledge and teaching aids. Most essential, the intervention should lead to preparedness to deal with problems likely to be encountered in the near and distant future.

An adequate model is one which makes the services easily available to those who require them. Intervention services for the parents of the large number of handicapped children in our country must be available at every possible level. Deliveries of intervention services may be routed through hospital clinics as well as through community out-reach services. Parents with different educational background can be easily trained in these intervention methods. The eventual aim should be to train a sufficient number of people to make the intervention as decentralized and deprofessionalized as possible to ensure both cost effectiveness, and a wider spread of the services.

The procedure to develop an intervention programme should consist of following steps:

- Developmental screening
- Detailed assessment of family and child
- Individual counselling
- Intensive training
- Group sessions
- Follow up

1. Developmental screening and early identification

The importance of early identification cannot be over-emphasized for any intervention with children with disabilities. If the intervention is to be effective, the child must be at an age when development is still occurring. This is essential from a medical point of view as well, since in certain cases (e.g. hydrocephalus, cretinism etc.) intervention must be initiated as early as possible. A complete intervention regimen must include developmental screening, particularly at the rural level, where parents may be less likely to voluntarily seek help as compared to the urban population. Parents may be trained in basic developmental screening, using simple developmental schedules.

2. Detailed assessment of the child and family

Great degree of emphasis is placed on thorough assessment as numerous variables can contribute to the success of training.

a) Assessment of the Child

Each child's detailed history including information on presenting complaints should be taken. Target behaviours should be identified and intelligence should be assessed on standardized intelligence tests.

b) Assessment of the Family

i) Parental characteristics – Such variables as the parent's motivation level and interest in the training, perception of the problem and acceptance of the child can make an immense difference to training results. Until such time as there are tests to measure these variables, rating scales must be used. The mental state of the parents, their willingness to take responsibility for the child's wellbeing, their own feelings and problems, are important variables. The question of parental feelings is one that cannot be neglected in any complete intervention. Parental depression has been found to significantly predict the mothers' perception of their children's maladjustment. The parents' reaction and involvement in training must continuously be rated.

ii) Overall family situation: The trainers must take careful note of the particular persons involved in the care of the child. In the joint family system prevalent in India, it is often persons other than the parents themselves who look after the child. In such cases, it is important for these persons to participate in the training. Family problems that interfere with the child's upbringing (e.g. financial problems, marital conflicts etc.) should be taken into account.

3. Individualized parent counselling

Although group training is more cost-effective, there are several issues that can be tackled only through individual counselling sessions. The first of these is to inform the parents about the nature of the problem. The misconceptions common in the rural regions of India, and the attitudes and expectations which parents tend to have about medicine providing a miraculous cure for the child, slow down the pace of acceptance of the problem. At this stage, parents not only require to be given accurate information about the nature of the child's problem, its casual factors, and management issues, they also require reassurance, support and help to accept the problem realistically. Handling this sort of problem in a group session would tend to diminish its importance. Therefore, the counsellor

must pace the information and help at the rate at which the parents are able to receive it. A realistic understanding of the problem is essential for the success of the training which is to follow.

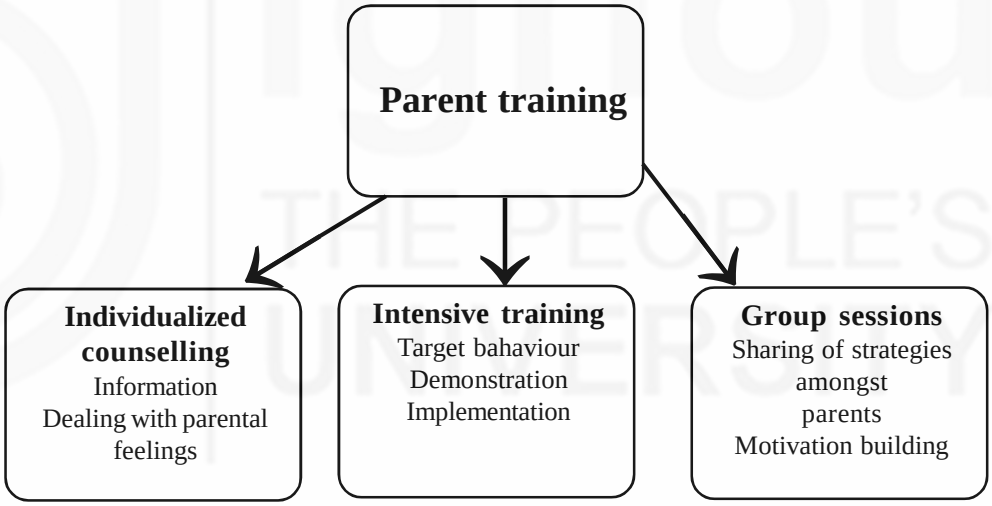
A major aim of the individualized counselling sessions is to lay the ground work for the intensive training to be given to the parents. The parents must be led to an understanding of the importance and benefits of special training for the child.

It is at this point that the parents may be persuaded to participate in the training. Low motivation, non-acceptance of the problem, low priority given to the problem, etc. are factors that lead to a high dropout rate. We need to convince the parents of the long term benefits of such training.

It is through individual counselling sessions that parental feelings and problems may be explored and dealt with. Several kinds of problems can interfere with the parents' handling of the child, and help for such problems must be given to the parents.

3. Intensive training in modification and education skills

Psychologists, social workers, and at a community level, teachers and *anganwadi* workers can be trained, at least to some extent, to achieve this aim. The assessment may be done in two or three sessions. This is followed by parent training, the components of which are summarized in the following chart :



Intensive daily exposure to training skills must be provided to parents and any other family participants for a period of one week. Many parents who come for help are not able to remain in the city for a longer period and hence the greatest possible must be achieved in the shortest possible time. During a period of one week, the parents may receive information on how to make the behaviour of their children more adaptive. Since behavioural methods have been found to be the most effective in this situation, the training should be mostly along this line. The parents can be put through an entire behaviour modification programme wherein they learn techniques of decreasing and eliminating problem behaviours, increasing adaptive behaviours, and developing new skills and behaviours. Some of the techniques included are behavioural contracting, differential reinforcement, reward assessment and training task analysis and shaping, prompting, modeling, extinction procedures etc. They can also be given grounding in the basic principles of learning. The techniques mentioned above are readily acquired by almost anyone with a brief period of training, and hence may be learnt by parents without much difficulty. Social workers, and other health workers can also

acquire these skills. Training in behavioural methods can also be supplemented with other methods, such as play activities etc. Equipped with these techniques, the parents should be able to deal with problem behaviours and to teach their children basic self-help, and pre-academic skills. The training may include selection, observation and recording of target behaviour, setting goals for training, selecting techniques and reinforcers, implementing techniques, monitoring change in behaviour, and assessing the effectiveness of the training.

4. Group sessions

Individual counselling and intensive training must be supplemented by group sessions. Group sessions have the advantage that they enable universalization of the problem, the sharing of an experience and catharsis. Group forces often bring about change of attitude that is not achieved by other means.

In the group sessions, demonstration of the use of the techniques can be made. Special aids such as video films on the subject, slides etc., can be shown to reinforce the knowledge acquired by the parents. The use of manuals may also be explained, and the need for regular follow-up emphasized. The parents should be then given an opportunity for discussion.

5. Follow-up

An earnest attempt must be made to ensure followup of the parents and children. Beginning with a followup of once a week, this may gradually be phased out to once in six months. During followup visits, which should be individualized, problems encountered may be taken up, and the trainer may assess the effectiveness of training both in the parent and the child. Social workers and the Primary Health Centre workers can make home visits to assess and reinforce the training.

7.5 EVALUATION OF PARENT TRAINING PROGRAMMES

The evaluation of efficacy of parent training programmes remains one of the most critical issues of this field. So great is the diversity in the literature on effectiveness of parent training that it is difficult to establish the validity of reported data. Difficulties arise with regard to the type of population studied, adequacy of research design and problems in ascertaining the intervention content. What effective parent training should consist of is viewed differently by people from different disciplines or using different approaches.

Effective parent training can be assessed on three points :

1) Acquisition and implementation of training skills by parents,

2) Resulting change in child and parent behaviour and

3) Parent attitude and generalization of changes achieved in the child's behaviour.

While the acquisition and implementation of skills has received considerable attention from researchers and professionals, the other issues have not been so easily open to study. The acquisition of training skills as well as their implementation can be either observed directly or tested by written means. Assessing change in behaviour and attitudes, its generalization and persistence, both in parents and children, is more difficult. As the majority of training programmes these days are based on behaviour modification, the evaluation of efficacy is mostly concerned with evaluation of behavioural training.

7.5.1 Methods of Acquisition and Implementation of Training skills

a) **Training Methods**: There are two general approaches being used to train parents of children with disabilities. With the first, parents receive instruction in the principles and procedures of child management and training through lectures, audio-visual presentation and possibly demonstration. They then apply what they have learnt, in the home and return to the clinic to discuss the results and receive advice from the professionals. The effects of the training are determined by reported or observed changes in the child's behaviour. In the second approach, parents are taught directly and are required to demonstrate the procedure either with their child or by role playing in simulated conditions. The desirable changes in the parent and child behaviour are observable in the initial sessions of training in the clinic itself. Since both the approaches have their merits and limitations, many training programmes use a combination of specific teaching techniques from both approaches. The specific teaching techniques which have been used as primary or supplementary tools with parents are media presentation, Manuals, curriculum guides, films, demonstration, practice role playing, modeling and behavioural rehearsal.

Training in clinical practice is mostly done in individual consultation with one set of parents or the mother only. Since this is very time consuming, parents are being trained in groups. Group training has proved to be a cost effective way of increasing parent teaching and behaviour management skills. Several studies have found group training to be as effective as the individual training approaches. Parent groups have been varied in a number of ways. Group training has sometimes been combined with an individual approach. Though group training methods are becoming very popular in the West, this approach still needs to be evaluated in India. Mehta (2002) reported that group method was not found to be very effective for specific problems of the children.

b) **Content of Parent Training Programme**: The training content should ideally be related to the parents' longterm needs. Parents have been taught either to apply specific techniques to particular circumscribed problems or a more comprehensive range of concepts and techniques. There is a very little guidance from literature on how to decide what to teach. In determining the content of the training programme, however, one must take into account whether parents understand the extent of the child's learning difficulties, their personal investment in direct training, and the awareness of their potential as trainers.

At present, there is a trend to teach more than a single technique to deal with a specific behaviour problem. Parents are currently learning multiple step programmes like task analysis, use of operant principles and aversive techniques. Some of the techniques can be learnt easily by the parents and have proved efficacious in building up desirable new behaviours as well as decreasing problem behaviours. These techniques are – assessment and delivery of rewards and punishment, prompting, time out and overcorrection.

c) **Common Target Behaviours**: The determination of effectiveness requires the clear definition of programme goals and selection of valid and reliable

measures. For behaviourally oriented parent training programmes, amelioration or acquisition of target behaviours are the goals. Target behaviours are specified in a majority of the studies but it is very difficult to select the outcome measures and to collect data according to those measures.

The common target behaviours where success has been reported by parents are: tantrums, problems of attention, play or social interaction, sleep disturbance, high activity rates and destructive or aggressive acts.

In addition to managing problem behaviour, success has been reported for a variety of skills in a number of areas. These areas include: preacademic skills, self help skills such as toileting, feeding and social skills.

d) **Length of the training programme**: The length of the training programmes reported in literature has varied from eight days to two months. No studies are reported on the optimum period of training. In our study, a 15 days period was preferred by the parents as compared to a two months period.

e) **Training in New Skills**: With comprehensive training, parents of mentally handicapped children are equipped to make new programmes for their children as and when required. A number of comprehensive training programmes advocate a sit-down-and-train approach while others emphasize interaction and use of manuals. The more natural and less formal training approach has the advantage that it requires a shorter training time, uses natural consequences and does not require special sessions for generalization to the primary setting.

Most studies focus on parent performance rather than emphasizing the result on parent and child behaviours after the initial training target is achieved.

f) **Prevention:** One anticipated impact of a cadre of trained parents would be the prevention of disorders. Some early intervention programmes focus on altering the interaction of parents with their children in a way that encourages the child's development.

g) **Problems in Implementing Training**: A parent's possession of appropriate skills does not ensure their use. The most important phase in an intervention programme involves the parents' independent implementation of skills in the natural environment.

The parent characteristics, which can interact with implementation, probably include most biological, physiological, emotional and cognitive components of the individual. Ideally, it may be taken for granted that a parent is functioning sufficiently well in all of these areas. However, a significant deficit in any one of them may hinder intervention. The bridge between training and implementation relies on memory, information storage, retrieval and strength of conditioning. Some interventions with children require physical stamina and tolerance of frustration. Excessive anxiety and depression, the parents' educational background, work habits, cultural values, previous child experience, beliefs regarding appropriate child management, perceptions and their expectations of their child and history of compliance to authority may influence the implementation.

Parental attitudes and values may lead to rejection or difficulty in implementing behavioural principles. The goal of behavioural approaches is that new behaviours should be maintained by intrinsic and naturally occurring reinforcers. Some parents may be reluctant to use reinforcers because they think, unfortunately, that reinforcers are always goods or sweets.

Other attitudinal problems can emerge in the process of implementing a behavioural approach: parents may have difficulty underrating their child's problem and their own role in it. The training may arouse feelings of anxiety and guilt because the explicit statement that parents can be effective in modifying the child's behaviour may convey the hidden message that they are to be blamed for causing the current state of affairs in the first place. Parental feelings of inadequacy can be aroused or strengthened by ill chosen teaching techniques or by other excessive demands during training.

7.5.2 Change in Parental Behaviours and Attitude

The outcome measures chosen are to a large extent, determined by the objective of training. Studies have found that parents are able to effectively change the behaviour of their children.

7.5.3 Change in Child's Behaviour

The ultimate aim of parent intervention is to bring about the desired change in the child's behaviour. Indeed, the extent and direction of change in the behaviour of children is the real test of the effectiveness of parent training. Assessment of change in the child's behaviour is most frequently carried out by monitoring the target behaviour throughout training so that any change in frequency and severity level may be noted. This may be done by the trainers. Trained observers may also be used to rate the change at regular intervals. The parents' subjective idea of change in their child is also an important indicator of the effectiveness of the training. Most studies related to efficacy of training utilize this approach. In our experience, a change in problem behaviour was noticed in a shorter duration than the learning of skills.

a) Generalization

Although there are a number of studies reporting success in parent training programmes, problems do emerge when treatment is carried out in the natural environment. Difficulties arise at home inspite of genuine concern on the part of the adults to help the children.

The skills taught to parents or children will be of little value if they are not used outside of the training setting. There are not many studies of generalization of trained behaviour. Studies which have evaluated this dimension of training indicate that generalization to natural settings does not occur automatically. The child's ability to generalize is dependent upon such factors as setting similarity, instructions to generalize and the feedback.

b) Durability

Research indicates that in most cases, parents do not use the newly acquired skills after the training programmes have ended. There is a need to directly assess whether the results of parent training efforts are maintained after training and to develop and evaluate strategies.

7.6 LET US SUM UP

Training parents with children/adolescent with disabilities is very important for the management at home. Children with special needs could be having mental retardation, autism, specific learning disability, speech and hearing problems, motor coordination or visual difficulties. There are different models of parent training – dynamic model, family model, early intervention/education model and behavioural model. Out of all these models, behavioural model is most commonly used as it has specific steps for training and is most cost effective. Parent training model based on behavioural method includes developmental screening, detailed assessment of child and family, and individualized counselling to parents to cope up with the disabilities of the child. Intensive training programme is planned and parents carry out under the supervision of the counsellor. These training programmes could be in group sessions. The efficacy of the training programme can be evaluated out on the basis of methods of acquisition and implementation of training skills, change in parents' behaviour and attitude and change in child's behaviour.

7.7 GLOSSARY

Attitude : A tendency to behave in a preferential manner.

Dynamic model : Intervention model based on psychoanalytical theory.

Operant conditioning : Method of learning based on reward and punishment.

Target behaviour : Problem behaviour identified for modification.

7.8 UNIT END QUESTIONS

1. Discuss advantage and disadvantaes of different training approaches used for parents of children/adolescents with disabilities.

7.9 FURTHER READINGS AND REFERENCES

Mehta M. & Bhargava M. (1992). Training parents in managing their mentally handicapped child: Efficacy and proposed model. In Child Mental Health in India (Ed. Malhotra S. et al). Macmillan India Limited, N.Delhi, p.155-177.

UNIT 8 COUNSELLING FOR TRAUMA AND ABUSE IN CHILDHOOD

Structure

8.1 INTRODUCTION

Study of child and adolescent development stands incomplete without understanding how is well-being conceptualized for them and what influences it. It is commonly understood as a multidimensional construct incorporating mental/ psychological, physical and social dimensions. Any untoward event that threatens the child of control over self and environment and that threatens their sense of security is perceived as traumatic for the child. Childhood is not only a delicate period of development but is also the one that lays foundation for the sound development of a complete and balanced adult personality. In India, the scenario is not completely different from Western set ups and children are abused and neglected in various forms. Childhood trauma is such an aspect which can easily go unnoticed for some time without receiving its due attention and support as the child may find it uncomfortable to articulate his/her felt emotion and relate with an adult with ease. Hence as adults, it becomes our responsibility to recognize potential sources of trauma for the child, be vigilant towards a child showing symptoms of being traumatized and seek adequate help to support the child to cope with the distress.

Objectives

After studying this Unit, you will be able to:

- Understand the concept of trauma and abuse in children;
- Identify in what all areas can trauma occur;
- Discuss impact of abuse and trauma on children's sense of well-being; and
- Prevent and manage abuse and trauma.

8.2 TRAUMA IN CHILDREN

The occurrence of trauma brings up images of suffering and pain of adults in our mind. However, the occurrence of trauma in children is widespread. Because it manifests itself differently and children find it difficult to understand and articulate the experience, the understanding becomes even more difficult. Trauma can be of varied nature, ranging from a car crash to burglary or from ragging/bullying at school to being exposed to domestic violence. Let us understand this in greater detail.

8.2.1 Meaning of Trauma

Emotional and psychological trauma is the result of extraordinarily stressful events that shatter your sense of security, making you feel helpless and vulnerable in a dangerous world. Traumatic experiences often involve a threat to life or safety, but any situation that leaves you feeling overwhelmed and alone can be traumatic, even if it doesn't involve physical harm. It's not the objective facts that determine whether an event is traumatic, but the individual's *subjective emotional experience* of the event. The more frightened and helpless the feeling, the more likely the chances are to be traumatized. Psychological trauma is a type of damage to the psyche that occurs as a result of a traumatic event. The trauma process is not the same across individuals exposed to the same event. Vulnerability towards being traumatized results from many different factors like presence of ongoing stressors, ability to cope, personality and temperamental characteristics, previous life experiences etc.

A stressful event is most likely to be traumatic if:

- It happened unexpectedly and you were unprepared for it.
- You felt powerless to prevent it.
- It happened repeatedly or a single blow was very intense.
- Someone was intentionally cruel.

There are broad classifications describing types of trauma. These are:

1. Type I trauma: it involves a single traumatic event.
2. Type II trauma: it involves multiple incidents of traumatic events

Emotional and psychological trauma can be caused by single-blow, one-time events, such as a horrible accident, a natural disaster, or a violent attack. Trauma can also stem from ongoing, relentless stress, such as living in a crime-ridden neighborhood or struggling with cancer.

Childhood trauma increases the risk of future trauma

Traumatic experiences in childhood can have a severe and long-lasting effect. Children who have been traumatized see the world as a frightening and dangerous place. When childhood trauma is not resolved, this fundamental sense of fear and helplessness carries over into adulthood, setting the stage for further trauma.

With such an understanding of trauma, let us also understand which kinds of children are more susceptible to being traumatized or abused:

- A child who is weaker and/or in the minority
- A child with subnormal intelligence
- A child with a submissive/introvert personality type
- A child who is more willing to be accommodating
- A child who is dependent and at the receiving end of a deal

8.2.2 Symptoms of Being Traumatized

The felt experience of trauma differs from person to person and so does its manifestation. However, broadly the symptoms of an individual, who has been exposed to trauma, are given below. Some of these are considered normal and some abnormal reactions to trauma. The symptoms may last for days, weeks, or even months after the trauma ended.

Emotional symptoms of trauma

- Shock, denial, or disbelief
- Anger, irritability, mood swings
- Guilt, shame, self-blame
- Feeling sad or hopeless
- Confusion, difficulty concentrating
- Anxiety and fear
- Withdrawing from others
- Feeling disconnected or numb

Physical symptoms of trauma

- Insomnia or nightmares
- Being startled easily
- Racing heartbeat
- Aches and pains
- Fatigue
- Difficulty concentrating
- Edginess and agitation
- Muscle tension

Check Your Progress Exerciese 1

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

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

1. Mark the following as 'True' or 'False':-

   i. Difficulty in concentration is a physical symptom of trauma.

   ii. A child with mental subnormality is more vulnerable than an intellectually normal child for being traumatized.

   iii. Childhood trauma does not influence development of adult personality.

   iv. Anxiety, fear and self blame are symptoms of being traumatized.

8.3 CAUSAL FACTORS OF TRAUMA

Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's familiar ideas about the world and of their human rights, putting the person in a state of extreme confusion and insecurity. Psychological trauma may accompany physical trauma or exist independently of it. Typical causes and dangers of psychological trauma are sexual abuse, bullying, domestic violence, the victim of alcoholism, the threat of either, or the witnessing of either, particularly in childhood. Catastrophic events such as earthquakes and volcanic eruptions, war or other mass violence can also cause psychological trauma. Long-term exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, can be traumatic (though verbal abuse can also potentially be as traumatic as a single event). Childhood trauma results from anything that disrupts a child's sense of safety and security, including:

- An unstable or unsafe environment
- Separation from a parent
- Serious illness
- Intrusive medical procedures
- Sexual, physical, or verbal abuse
- Domestic violence
- Neglect
- Bullying

8.3.1 Child Abuse

Meaning of Child Abuse

Abuse was first defined with respect to occurrence in children when it first received sustained attention in the 1950s. However, clinicians and researchers now recognize that children can suffer abuse in a number of different circumstances. Abuse refers to harmful or injurious treatment of another human being that may include physical, sexual, verbal, psychological/emotional, intellectual, or spiritual maltreatment. It is the intimidation or manipulation of another person for the purpose of controlling that individual. It is generally a long term pattern of behaviour; however, short term practices can also be labeled as abusive. It cuts through different socio-economic classes, religions and genders.

Child abuse may be defined as any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm. Abuse may coexist with neglect, which is defined as failure to meet a dependent person's basic physical and medical needs, emotional deprivation, and/or desertion. Neglect is sometimes described as passive abuse.

Causes of Abuse

The causes of abuse are multifaceted, complex and overlapping. Some of these are:

1. *Early learning experiences:* More often than not, abuse is a learned behaviour and is learnt early in childhood, thereby placing great importance on the child rearing practices and family environment. When the child learns early in life that their needs can be met and the power equation can be maintained by using abusive behaviour, these patterns stay on as a part of adult personality and behaviour. This pattern is sometimes also described as the intergenerational flow of abuse whereby the pattern of abuse flows within the family, for example, passed on from father to son. Many abusive parents were themselves abused as children and have learned to see hurtful behaviour as normal childrearing. At the other end of the life cycle, some adults who abuse their elderly parent may claim to be paying back the parent for abusing them in their early years.

2. *Ignorance of developmental timetables:* Some parents have unrealistic expectations of children in terms of the appropriate age for toilet training, feeding themselves, and similar milestones, and attack their children severely and punitively for not meeting these expectations.

3. *Economic stress:* Inability to meet financial demands posed on the bread earner towards the care of dependent children can sometime cause passive aggression or active aggression by the individual translating as abuse in daily living.

4. *Lack of social support or social resources:* Children and adolescents who lack the support of an extended family, religious group, intimate relationships or close friends and neighbours are more likely to lose their self-control under stress or easily respond aggressively to intimidation.

5. *Substance abuse:* Alcohol and mood-altering drugs do not cause abuse directly, but they weaken or remove a person's inhibitions against violence toward others. In addition, the cost of a drug habit often gives a substance addict another reason for resenting the needs of the dependent person. The children who abuse such drugs and substances therefore are at a higher risk of not only being abusers but also being abused themselves within the group or take to the group as a result of being abused to cope.

6. *Mental disorders:* Depression, personality disorders, dissociative disorders, and anxiety disorders and psychotic illnesses can all affect parents' ability to care for their children appropriately. The situation is also reversed with children with behavioural and developmental disorders like autism, mental retardation, conduct and oppositional defiance disorders acting out abusively towards parents.

7. *Belief systems:* Belief systems, cultural practices and status quo between relationships and genders play a role in an individual adopting the abusive role. For example, some men might believe themselves to be superior than women or some people regard parents' rights over children as absolute.

8. *The role of bystanders:* Research in the social sciences has shown that one factor that encourages abusers to continue their hurtful behaviour is discovering that people who know about or suspect the abuse are reluctant to get involved. In most cases, bystanders are afraid of possible physical, social, or legal consequences for reporting abuse. The result, however, is that many abusers come to see themselves as invulnerable.

Types of Child Abuse

Physical Abuse

Physical abuse refers to striking or beating another person with the hands/legs or an object, but may include assault with a knife, gun, or other weapon. Physical abuse also includes such behaviours as locking someone in a closet or other small space, depriving someone of sleep, burning, gagging, or tying them up, etc. Physical abuse of infants may include shaking them, dropping them on the floor, or throwing them against the wall or other hard object. In children it may be a result of over-discipline or physical punishment given to the child inappropriate to his/her age.

Verbal Abuse

Verbal abuse refers to regular and consistent belittling, name-calling, labeling, or ridicule of a person; but it may also include spoken threats. It is one of the most difficult forms of abuse to prove because it does not leave physical scars or other evidence, but it is nonetheless hurtful. Verbal abuse may occur in schools, neighbourhoods and families. For example, belittling the child when he/she under-performs.

Emotional/Psychological Abuse

Emotional/psychological abuse covers a variety of behaviours that hurt or injure others or intimidate them emotionally even though no physical contact may be involved. One form of emotional abuse involves the destruction of someone's pet or valued possession in order to cause pain. Another abusive behaviour is emotional blackmail, such as threatening to commit suicide or harm oneself unless the other person does what is wanted. Other behaviours in this category include the silent treatment, shaming or humiliating someone in front of others, or punishing them for receiving an award or honour. It serves as a strong predictor of suicidal behaviour later in life. All forms of abuse have an emotional component such as fear or intimidation with physical abuse or loss of self-esteem with verbal abuse. This is seen most prominently in children within families and often goes unnoticed or as another parenting style.

Social and Economic Abuse

Social abuse is a new term and is generally defined as follows: 1) the coercion of an individual in a public setting (for example, making fun of the dressing of an individual in front of the whole group) or 2) the collective abuse by a group of people toward an individual (for example, the whole family intimidating the child on receiving poor results). One person can often manipulate a group to

control another individual as at school. Social abuse uses the power of the group to embarrass and to intimidate. For example, the entire class troubling a new child who wears the uniform in a manner different than them or batch mates troubling an under-performing child and rejecting him/her from group play. Economic abuse refers to the control of another person by controlling the money or resources available to him or her. An example of this type of abuse could be parents/primary caregivers refusing economic resources essential for the survival of the child.

Intellectual Abuse

Intellectual abuse refers to the punishing behaviours for having different opinions or ridiculing the other individual's intellectual capacity, individual's learning style or way of thinking and intellectual interests. Such abusive behaviour can be seen in school or home situations where an underperformer child is often termed as "slow" or "stupid".

Spiritual Abuse

Spiritual abuse refers to such behaviours as punishing someone for having different religious beliefs from others in the family, preventing them from attending worship services, ridiculing their opinions, and the like. Anything an adult does that interferes or distorts a child's spiritual growth may be abusive. For example, adults are spiritually abusive when they assert they can speak for God. This happens when an adult says, "If you don't do what I tell you, God will punish you." Telling a child, that he or she is evil is also abusive since the child's behaviour may be bad but the child is not. Spiritual abuse can also be the corruption by an older person of a child's value system. This can also involve preventing people from practicing their religion.

Exploitation of Children: Child labour and Child Sexual Abuse

Exploitation is understood in a different manner in children as compared to that in adults. In children the element of exploitation is the basis of inducing fear, encashing voicelessness and choicelessness. *Child labour* refers to the consistent, full time and regular employment of a child for the sake of supporting their or/ and their family's survival when the child is under the age stated by the law (14 years in India). Even though it is deemed as a punishable offence, it is rampant in our country where young children are employed in textile factories, fire cracker factories, tea shops, in our homes amongst other places. Not only does it deprive the child of his/her right to education but also impinges on their right to childhood by making them enter inhuman job conditions at a very young age. It takes a severe toll on not only the physical health of the child but also predisposes them towards other social evils like gang activity and substance abuse. They are grown up in neglected households and are more vulnerable to being victims of child sexual abuse. *Child Sexual Abuse* is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. It is a major source of threat to the well-being, growth and development of children and the nation at large. There are many governmental and legislation laws to protect the basic rights for the child. However, this form of abuse is still present at many levels: families, neighbourhoods and society. Child Sexual abuse (CSA) refers to inappropriate sexual contact between a child or an adult and someone who has some kind of family or professional authority over them. Sexual abuse may

include verbal remarks, fondling or kissing, or attempted or completed intercourse. Child sexual abuse can be both intra-familial and extra-familial sexual abuse. Intra-familial sexual abuse, also known as incest means sexual contact between a child and a biological relative, although the term is also extended to cover sexual contact between a child and any trusted caregiver, including relatives by marriage. Girls are more likely than boys to be abused sexually.

Sexual acts comprise of:

- Exhibitionism
- Voyeurism
- Forcing or tricking the child to watch pornography
- Sexual intercourse (vaginal/anal/oral)
- Forcing a child to undress
- Making the child touch the private parts (Fondling)
- Use of children in pornographic films
- Using a child to perform sexual activities with others

Factors that increase vulnerability for CSA are:

- Children and adolescents of single parent – Due to lack of adequate supervision
- Lack of education – Children and adolescents due to lack of education, lack of being well-informed may get induced to sexual activities by strangers easily
- Poverty – High risk of getting sexually abused because of poor socio-economic conditions.
- Parental factors – Loss of job, substance abuse like alcoholism, drug addiction.
- Mentally and physically–challenged children and adolescents
- Unloved, uncared children and adolescents

Signs of sexual abuse are:

- Difficulty in walking
- Refuses to participate in physical activities
- Sleep problems or nightmares
- Bedwetting
- Withdrawal from family and friends
- Unusual aggressiveness
- Refusal to go to school

8.3.2 Neglect

Neglect occurs when a parent or other primary caretaker chooses not to fulfill their obligations to care for, provide for, or adequately supervise and monitor the

activities of their child. Parental and caregiving obligations include the physical, emotional, and educational well-being of the child. Thus, neglect can also occur when:

- The parent or caretaker does not seek adequate medical care for the child.
- The parental figure does not provide sufficient food, clothing, or shelter.
- When parents abandon the child, or simply have no time to spend with the child, in essence leaving the child to raise himself.
- Educational neglect often occurs when one child is responsible for other children in the family. Shifting the responsibility of caring for younger children to another child in the family prevents the caregiving child from participating in age-appropriate activities for themselves, such as attending school.

Factors Associated with Neglect

- Parental figures who neglect may have been neglected or abused themselves.
- There is a tendency for parental figures that neglect their children to have low self-esteem, poor impulse control, and to experience anxiety or depression.
- Parents having inadequate information about child development, including age-appropriate expectations of what children may be able to do.
- The parents may also feel overwhelmed by parenting responsibilities, and feel negatively about the child's demands on them. Such parents may never have fully adopted the role of parent or the caregiving the parental role requires.
- Internal pressures often push the caregivers to take care of their own needs (perhaps inappropriately), while ignoring the needs of the child.
- Substance abuse is often associated with neglect, particularly for those parents who are more self-absorbed and focused on their needs rather than their child's.
- Some neglectful parents have an inability to be empathic, or to understand the feelings and needs of others.
- Neglect is more often associated with severe levels of poverty and lower educational level.
- The external stressors may feel more extreme in single parent families as well, leading to neglectful behaviour.
- Families that are disorganized and socially isolated are more likely to neglect the children in their care.

8.3.3 Personal Loss and Family Related Factors

Family forms the primary caregiving, supportive and educative unit for the child. When this unit itself poses challenges for the overall healthy growth of the child, the experience can be severly traumatic to the growing child. This can include:

1. *Loss of a loved one:* Children are very sensitive to the presence and absence of not just the physical parental figures but also emotional caretakers who induce a sense of comfort and safety within the child. These could include figures from extended families like grandparents, aunts or uncles; it

could also include a trusted and protective elder sibling or neighbourhood mate. The loss of such a protective figure by way of death or extended physical separation can induce feelings of loneliness, depression, abandonment, not being good enough etc.

2. *Parental divorce:* Research studies indicate that more than the mere occurrence of divorce, it is the blame game, scapegoating and parental violence that affects the wellness of a child. The trauma associated with divorce can be reduced by:

   - Trying as much as possible to not introduce the changes in the environment of the child (school, friend circle, neighbourhood)
   - Explaining the reasons for divorce without blaming or labeling either parent or the child himself
   - Not letting the child feel abandoned and uncared for or as a liability keeping unhappy parents together.

3. *Direct or vicarious exposure to domestic violence:* This is a very common incidence of trauma in Indian children and occurs across all socio-economic strata. Children's exposure to domestic violence typically falls into three primary categories:

   a) Hearing a violent event;

   b) Being directly involved as an eyewitness, intervening, or being used as a part of a violent event (e.g., being used as a shield against abusive actions);

   c) Experiencing the aftermath of a violent event.

Children's exposure to domestic violence may also include being used as a spy to interrogate the adult victim, being forced to watch or participate in the abuse of the victim, and being used as a pawn by the abuser to coerce the victim into returning to the violent relationship. Some children are physically injured as a direct result of the domestic violence. Some perpetrators intentionally physically, emotionally, or sexually abuse their children in an effort to intimidate and control their partner. While this is clearly child maltreatment, other cases may not be so clear. Children often are harmed accidentally during violent attacks on the adult victim. An object thrown or weapon used against the battered partner can hit the child. Assaults on younger children can occur while the adult victim is holding the child, and injury or harm to older children can happen when they intervene in violent episodes. In addition to being exposed to the abusive behaviour, many children are further victimized by coercion to remain silent about the abuse, maintaining the "family secret."

Possible Symptoms in Children Exposed to Domestic Violence

- Sleeplessness, fears of going to sleep, nightmares, dreams of danger;
- Physical symptoms such as headaches or stomachaches;
- Hypervigilance to danger or being hurt;
- Fighting with others, hurting other children or animals;
- Temper tantrums or defiant behaviour;

- Withdrawal from people or typical activities;
- Listlessness, depression, low energy;
- Feelings of loneliness and isolation;
- Current or subsequent substance abuse;
- Suicide attempts or engaging in dangerous behaviour;
- Poor school performance;
- Difficulties concentrating and paying attention;
- Fears of being separated from the nonabusing parent;
- Excessive worrying;
- Bed-wetting or regression to earlier developmental stages;
- Dissociation;
- Identifying with or mirroring behaviours of the abuser.

8.3.4 Socio-Economic Factors

The sense of well-being in children can also be threatened by the socio-economic-cultural environment. The role of school and society forms an integral aspect. Some of the factors that can be understood as traumatic by the child are:

1. *Unsafe society:* In a society, where the child feels constantly threatened for survival and safety, the full growth and development of the child would not occur. In addition to the physical deprivation, the child would also be gripped with emotional and psychological trauma. For example, a child alone in a society park would feel threatened in the absence of caregivers around.

2. *Poverty:* In a country like India, poverty serves to be a large factor contributing to not just economic deprivation in children but also serves as a spring for other forms of trauma and neglect. This would include increase in vulnerability towards physical abuse, sexual abuse, child labour, violation of the right to medical health and education. Inability to meet personal and familial needs and awareness of disparity between classes can further create frustrations in the child and make him/her vulnerable towards themselves adopting the role of an abuser.

3. *Bullying:* Bullying involves intentional and repeated actions and words designed to intimidate or hurt another person. There is usually an imbalance of power, either physical or psychological, between the perpetrator and his or her victim. Occasional name calling and shoving is not considered bullying because they are usually not repetitive events. On the other hand, if a child is on the receiving end of taunts and name-calling by any persons regularly, then that is considered bullying. Physical aggression, social alienation, verbal aggression, and intimidation are the four main categories of bullying.

How to tackle bullying?

- Be self confident, make good eye contact, speak clearly and loudly enough to be heard.
- Walk away from the encounter; tell the bully firmly that he is in the wrong, and to tell a teacher, parent or other adult what is happening.
- Parents of bullies should also intervene to stop the behaviour and make it clear that bullying will not be tolerated or ignored
- Psychological counselling when cases are severe

4. *Situational Trauma:* Trauma can be caused by man-made and natural disasters, including war, abuse, violence, earthquakes, mechanized accidents (car, train, or plane crashes, etc.) or medical emergencies.

Check Your Progress Exercise 2

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

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

1. Name 5 possible causes of abuse.

.....

.....

.....

2. Name 5 possible types of abuse.

.....

.....

.....

3. Can the following factors be traumatic for the child. Answers in 'Yes' or 'No'

a. Loss of loved one .....

b. Witnessing domestic violence .....

c. Being in a car accident .....

d. Being bullied/ragged in school .....

e. Poverty .....

8.4 IMPACT OF CHILD ABUSE, NEGLECT AND TRAUMA

Gaining from the understanding we have arrived at regarding how trauma occurs in children, we can easily understand the impact it has on the well-being of children, the kind of adults they develop into, their present and future relationships and their overall physical and psychological health. Mostly the effects are cumulative and overlapping and cannot be distinguished as emerging out of a very specific cause only. However, all these effects negatively influence a child's development. In general, there are 4 categories of consequences that the children face as a result of traumatic experiences:

- *Behavioural problems:* Higher levels of aggression, anger, hostility, oppositional behaviour, and disobedience; avoidance or withdrawal, self injurious behaviour, controlling behaviours.

- *Social and emotional problems:* Fear, anxiety, stuttering, uncontrollable rage, passiveness, inappropriate affection, shame and guilt; depression; poor peer, sibling, and social relationships; low self-esteem, insomnia, nightmares and poor emotional regulation.

- *Cognitive and attitudinal problems:* Lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem-solving skills, memory loss, hypervigilance, powerlessness, intrusive thoughts that make them appear as if they are in a daze, isolation, loneliness, acceptance of violent behaviours and attitudes, belief in rigid gender stereotypes and male privilege.

- *Long-term problems:* Higher levels of adult depression and trauma symptoms, eating and sleep disorders, increased tolerance for and use of violence in adult relationships, traumatized memories, fear of walking up and seeing the abuser, difficulty with sexual intercourse, problems with closeness to other adults, lack of trust, secretiveness, embarrassment, fear of retaliation.

In addition, let us understand consequences in detail:

1. Post Traumatic Stress Disorder is the most severe form of emotional and psychological trauma. Its primary symptoms include intrusive memories or flashbacks, avoiding things that remind you of the traumatic event, and living in a constant state of "red alert".

2. Common physical and psychological reactions to neglect include stunted growth, chronic medical problems, inadequate bone and muscle growth, and lack of neurological development that negatively affects normal brain functioning and information processing ability. Processing problems may often make it difficult for children to understand directions, may negatively impact the child's ability to understand social relationships, or may make completion of some academic tasks impossible without assistance from others. Lack of adequate medical care may result in long-term health problems or impairments such as hearing loss from untreated ear infections.

3. Long-term mental health effects of neglect are inconsistent. Effects of neglect can range from chronic depression to difficulty with relationships; however, not all adults neglected as children will suffer from these results. Some individuals are more resilient than others and are able to move beyond the emotional neglect they may have experienced. Characteristics of resilient individuals include an optimistic or hopeful outlook on life, and feeling challenged rather than defeated by problems.

4. Children who live with domestic violence face numerous risks, such as the risk of exposure to traumatic events, the risk of neglect, the risk of being directly abused, and the risk of losing one or both of their parents. All of these can lead to negative outcomes for children and clearly have an impact on them.

5. Children also display specific problems unique to their physical, psychological, and social development. For example, infants exposed to violence may have difficulty developing attachments with their caregivers and in extreme cases suffer from "failure to thrive".

6. Preschool children may regress developmentally or suffer from eating and sleep disturbances. School-aged children may struggle with peer relationships, academic performance, and emotional stability. Adolescents are at a higher risk for either perpetrating or becoming victims of teen dating violence.

7. Reports from adults who repeatedly witnessed domestic violence as children show that many suffer from trauma-related symptoms, depression, and low self-esteem.

8. Increased co-morbidity with psychiatric illnesses like sleep disorders, eating disorders, body dysmorphic disorder, stress disorders (acute stress disorder and post traumatic stress disorder)

9. Dissociation is frequently seen in children as an attempt by the self to direct attention towards stressors through bodily symptoms and in a manner to avoid confronting the stressor. For example, a child who is frequently bullied in school, complains of headache or abdominal pain just before going to school. This serves two purposes: increases likelihood of avoiding the noxious school going activity and directs parental attention to possibility of stressor. In addition the child also receives secondary gains like increased attention from parents and decrease in stress related to finishing studies.

10. Child sexual abuse (CSA) syndrome: This category is suggested to complete the understanding of CSA as stress disorders do not give full justice to the resulting trauma of CSA. Three of the following clusters should be observed. At least three symptoms from each cluster should be present.

(a) Cognitive impairments: Intense shame, guilt, self blame, feeling alone, feelings of emptiness, problem solving difficulty

(b) Emotional dysregulation: Psychic numbing, feeling rage, frozen feeling, terror, guilt, sudden loss of control over emotions, mood swings.

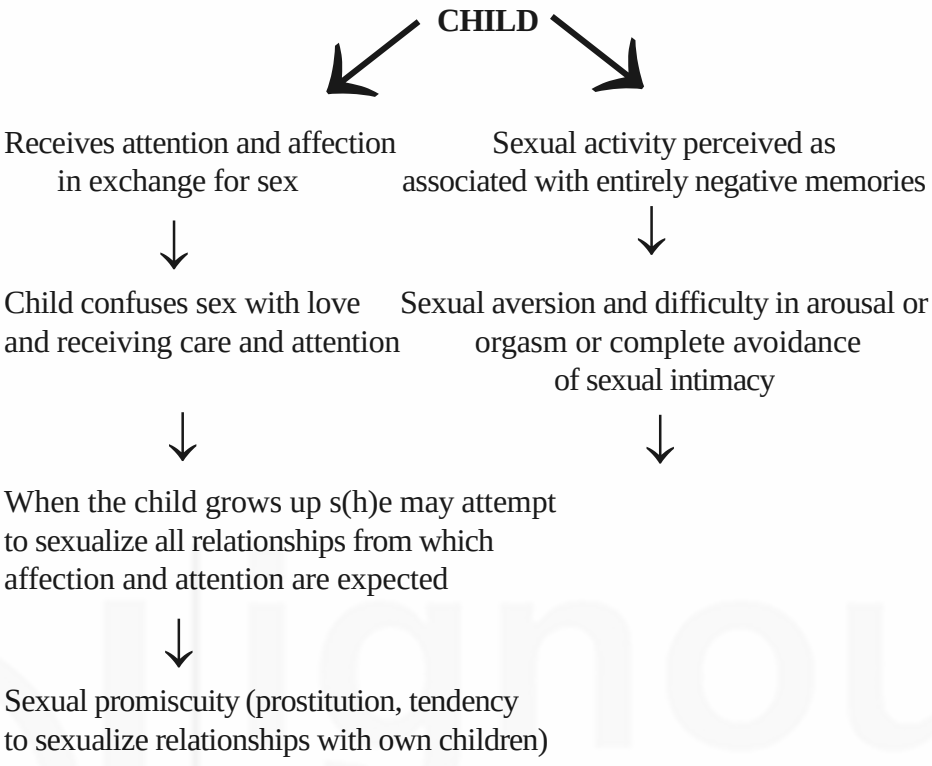
(c) Behavioural dyscontrol: Self injurious behaviours, aggressive acting out, running away, fighting, cleaning self frequently, withdrawal, passivity, nervousness, disrespectful of own body or other person, quick to startle.

Factors determining amount of impact of CSA are:

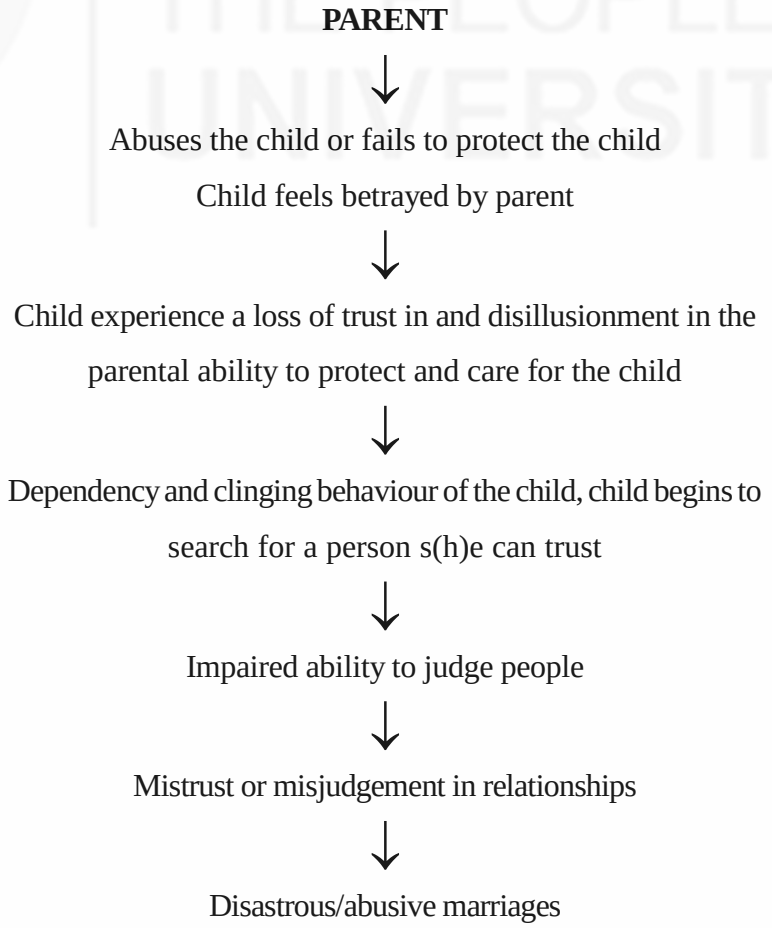
- Age at onset of abuse
- The duration, type and frequency of the abuse
- The degree of force used
- The relationship of the abuser to the child
- Child's interpretation of the abuse (I passively submitted – it happened because of me)
- Whether or not they disclose the experience
- How quickly they report it
- Parental Reaction

Since the impact of child sexual abuse can be most extreme, we will provide it in a little more detail. Following are categories of impact of CSA:

Traumatic sexualization



Consequences of betrayal



Consequences of stigmatization

Child is sexually abused
Activity perceived as being wrong
↓
Child begins to feel dirty or damaged
(the stigma of abuse is carried around like a heavy weight attached to oneself)
↓
Sense of worthlessness and poor self esteem
↓
As the child grows (s)he is likely to become an outcast, prone to alcohol or drug abuse, self-injury, criminal activity and isolation

Consequences of powerlessness

Child
↓
(Physically weaker and developmentally immature as compared to the older adolescent or adult abuser)
Unable to stop the abuse
↓
Child feels powerless, anxious and unable to control his/her own life
↓
As the child grows he/she may:

Feel anxious, inefficient with impaired coping skills, a tendency to run away from problems, despair and depression, possibility of revictimization, potentiality for aggression and becoming an abuser.

Check Your Progress Exercise 3

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

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

Match the following consequences of traumatic experience:

1.	Behavioural problem	a.	lack of adequate conflict resolution skill
2.	Cognitive problem	b.	self injurious behaviour
3.	Social and emotional problem	c.	shame and guilt

8.5 PREVENTION OF CHILD ABUSE

As the adage goes, prevention is better than cure; it could not apply better to any other situation than that of child abuse and neglect. Preventive strategies involve:

1. Awareness of what factors can impair the well-being of children through governmental bodies, NGOs, community outreach programmes and education in school

2. Child helplines where the children can feel comfortable in sharing personal and familial stress and report abuse as well if noticed.
3. Increase in employment opportunities for adults and education opportunities for children.
4. Legislative laws regarding substance abuse and child labour to be strictly implemented
5. Empower children/adolescents to take part in their own protection by giving them age appropriate information, skills, and self-esteem.
6. Teach children/adolescents that their body belongs only to them and nobody had the right to touch them in a way they do not like or understand; give them knowledge of sexual organs and functions.
7. Teach assertiveness skills, helping children to stand up for their own rights without violating the rights of others.
8. Build self-esteem of each child to empower them to practice assertiveness skills for their own protection.
9. To be bold/make friends – but when it comes to sex learn to say no.
10. Build the support system of each child, including the family, school, community, and friends
11. Educating parents about correct parenting: through home visits during pregnancy and regular follow ups till the child is at least 14years of age. These visits should focus on the parent-child relationship, review of appropriate expectations for the child's behaviour (based on child development principles), and teaching basic parenting skills. Individual needs like substance abuse treatment or empathy training skills can also be intertwined in these visits.

8.6 MANAGEMENT OF TRAUMA AND ABUSE

Although efforts are made at all levels to prevent disruption of a child's sense of security and wellness by preventing the occurrence of child abuse and neglect, in the conditions where this has occurred, the following treatment strategies are note worthy. However, it must be noted that not all individuals are symptomatic after a traumatic event. A sleeper effect is seen where the symptoms start developing after 12-18 months. In the asymptomatic but identified group, psycho-educational models to prevent further victimization and to clarify/normalize feelings and educating of parents is beneficial. For the symptomatic group following are the treatment types that are used:

1. *Allow to grieve*: Grieving is normal after a traumatic event. Whether or not a traumatic event involves death, survivors must cope with the loss, at least temporarily, of their sense of safety and security. The natural reaction to this loss is grief. This process, while inherently painful, becomes easier with support of friends, family members or counsellor. Instead of the survivor being blamed for the mishap or for increasing burden on the already suffering family, the child must be encouraged to take care of themselves and express their feelings.
2. *Anxiety management*: Traumatic events bring along with them the anxiety response in the child accompanied by fear. Anxiety management training in this regard is extremely important. This includes:

- Relaxation Training: The child is trained to relax following exercises of deep breathing and progressive muscle relaxation with focus on the breathing and cycle of muscle tension and relaxation. For young children, play techniques like bubble blowing are used to help the child relax.
- Imagery: The child can be taught to visualize scenes interesting to the child – a fairy land, a secure place in home, a beautiful garden etc. The key element is to form clear images, as if real, with all its details of sights, sounds, colours, smells and textures. With guided practice the child can be able to reduce his anxiety and other negative emotions. The imagery scene is a 'virtual' safe and secure place for the child to retreat into whenever confronted with extremely disturbing negative emotions. Once calmed down and feeling in control, the child can learn to process such emotions effectively and integrate them better.
- Distraction techniques: They serve to bring temporary relief from anxiety symptoms. The child can be instructed to count back in 3s from 200, counting backwards from 100, counting number of cars on the road or any other item in their environment, focus on a different activity like reading a book etc.

3. *Exposure therapy*: Children are encouraged to confront the fear-inducing thought or memory in varying levels of exposure that can be imaginal or in vivo. Gradually and repeatedly, they are guided through a vivid and specific recall of traumatic events until emotional reactions decrease through a process of habituation. The safe, controlled context of the therapeutic relationship helps clients face and gain control of the fear and distress that they previously experienced as overwhelming.

4. *Systematic desensitization*: Developed by Wolpe in 1958, it is an effective form of treatment for individuals who prefer gradual recall rather than immediate total recall of traumatic memories. When using systematic desensitization, clients are supported through deep muscle relaxation techniques and diaphragmatic breathing. These techniques are taught to clients before treatment is administered; they are used during therapy whenever a client's anxiety increases. Once clients have established a hierarchy of fear-inducing stimuli and gained competence in using relaxation techniques to overcome these situations, the least upsetting situation is recalled. The client proceeds to systematically recall the least distressing aspects of the traumatic experience. If negative reactions ensue, relaxation is induced. Otherwise the client ascends up the hierarchy to recall the next distressing stimuli. In this systematic method, clients work toward overcoming and integrating their worst fears.

5. *Somatic experiencing*: It takes advantage of the body's unique ability to heal itself. The focus of therapy is on bodily sensations, rather than thoughts and memories about the event. By concentrating on what's happening in the body, the child gradually gets in touch with trauma-related energy and tension. From there, the natural survival instincts take over, safely releasing this pent-up energy through shaking, crying, and other forms of physical release.

6. *Eye Movement Desensitization and Reprocessing (EMDR)*: It incorporates elements of cognitive-behavioural therapy with eye movements or other forms of rhythmic, left-right stimulation. In a typical EMDR therapy session, the child is made to focus on traumatic memories and associated negative

emotions and beliefs while tracking the therapist's moving finger with their eyes. These back-and-forth eye movements are thought to work by "unfreezing" traumatic memories, allowing the child to resolve them.

7. *Coping strategies and skills*: Children with poor coping skills are more likely to experience problems than children with strong coping skills and supportive social networks. Children who utilize problem-solving strategies targeted directly at the source of disagreement demonstrate fewer maladaptive symptoms. Emotion-focused strategies, however, are less desirable because they often target internal responses to a stressful situation, which can result in less effective coping methods (e.g., children fantasizing that their parents' are "getting along"). Hence treatment modalities focus on developing problem solving skills and using effective problem focused coping strategies.

8. *Cognitive-behavioural therapy*: Using components of both cognitive and behaviour therapy, it focuses on allowing the child to weaken the connections between troublesome thoughts and situations and their habitual reactions to them. Cognitive therapy teaches clients how certain thinking patterns may be the cause of their difficulties by giving them a distorted picture and making them feel anxious, depressed, or angry (Beck, 1995). Cognitive dissonance, which occurs when thoughts, memories, and images of trauma cannot be reconciled with current meaning structures, causes distress. The cognitive system is driven by a completion tendency: a psychological need "to match new information with inner models based on older information, and the revision of both until they agree". The fluctuation between symptoms of hyperarousal and inhibition are commonly seen among trauma survivors. During the acute phase of the trauma, in an attempt to comprehend and integrate the traumatic experience, the trauma survivor normally replays the event that has been stored in active memory. Each replay, however, distresses the traumatized individual, who may inhibit thought processes to modulate the active processing of traumatic information. This observable inhibition gives the appearance that the traumatized individual has disengaged from processing the traumatic memory. Thus, some trauma survivors, as a result of excessive inhibition, display withdrawn and avoidant behaviours. However, when an individual is unable to inhibit traumatic thoughts, the intrusive symptoms are expressed in the hyperarousal symptoms of flashbacks during the waking states and nightmares during sleep states (van der Kolk, 1996). For this reason, researchers commonly observe trauma survivors as oscillating between denial and numbness, or intrusion and hyperarousal. Once clients can reappraise the event and revise the cognitive schemas they previously held, the completion tendency is served. These common reactions and cognitive processes seen among trauma survivors can be explained using the framework of cognitive theory. CBT primarily involves working with a client's cognitions to change emotions, thoughts, and behaviours.

CBT techniques focus on the following:

- Learning skills for coping with anxiety (such as breath retraining or biofeedback).
- Using cognitive restructuring to change negative thoughts.
- Managing anger.

- Preparing for stress reactions (stress inoculation).
- Handling future trauma symptoms.
- Addressing relapse prevention and other substance abuse issues.
- Communicating and relating effectively with people (social skills)
- Addressing thought distortions that usually follow exposure to trauma
- Challenge the negative thought processes, self defeating and doubting schemas or irrational generalizations of distrust and fear of all.

9. *Correcting maladaptive self talk*: Based on the framework that maladaptive thinking is related to maladaptive behaviour, CBT approaches help children identify their negative and defeatist self dialogue and correct it through evidence generation and re-looking at past experience. Self-talk is our internal thought language or dialogue we have with ourselves, or an inner voice. Children going through traumatic, exploitative situations often have negative self-talk that is highly critical of themselves and their own behaviour. Their internal dialogue is unrealistic and leads to negative feelings, making them feel worse. If negative irrational self-talk (E.g. 'I'm a bad person', 'I cannot do anything right') is replaced with positive self talk (E.g. 'I'm not bad, I just made some mistakes' or 'With practice and effort, I can achieve a lot'), the stressful emotions experienced can change to pleasant experiences and feelings. Children can be taught to keep practicing such positive and coping thoughts and self talk to change the way they feel from helpless and hopeless to that of positive coping and a sense of mastery and control.

10. *Thought Stopping*: It is used for reducing intrusive, repetitive disturbing thoughts of trauma of abuse experiences. Whenever such thoughts come into the mind, the child is instructed to say 'STOP' loudly or in her own mind. The child can be taught to simultaneously snap her fingers or pull at a rubber band worn on her wrist as he/she says STOP. This procedure is done repeatedly and consistently whenever negative, stressful thoughts occur. After the thought is interrupted, the child is instructed to think of some pleasant, positive images to take its place in the mind.

11. *Stress Inoculation Training*: One of the most commonly used anxiety management treatments for PTSD is stress inoculation therapy (SIT). It incorporates psycho-education and skill-building techniques such as relaxation, thought stopping, breath retraining, problem solving, and guided self dialogue.

12. *Play Therapy*: It is based on the understanding that play is children's natural medium of self expression. It is an opportunity that is given to the child to 'play out' his feelings and problems just as the adults 'talk out' their difficulties. Play therapy is ideal for pre-school age children or older children who face significant difficulty in understanding and communicating their emotions and thinking styles. Children often worry about numerous things that they keep bottled up inside and play forms a medium for allowing expression of and addressing of these concerns. The basic principles of play are:

    - The therapist develops a warm and friendly relationship with the child.
    - The therapist accepts the child exactly as he/she is.

- The therapist establishes a feeling of permissiveness in the play so that the child can express as freely as possible all his/her feelings.
- The therapist is alert in recognizing the feelings that the child is expressing and reflects them back to the child in such a manner that enables the child gain insight into his/her behaviour.
- The therapist maintains a deep respect in the child's ability to solve his/her problems if given an opportunity to do so.
- The therapist does not attempt to direct the child's actions or conversations in any manner. The child leads and the therapist follows.
- The therapy cannot be hurried and the therapeutic process moves at the speed comfortably determined by the child.

13. *Brief psychodynamic psychotherapy*: It is an abbreviated form of psychodynamic therapy in which the emotional conflicts caused by the traumatic event are the focus of treatment, particularly as they relate to the client's early life experiences. The rationale of brief psychodynamic psychotherapy is that a client's retelling the traumatic event to a calm, empathetic, compassionate, and nonjudgmental therapist will result in greater self-esteem, more effective thinking strategies, and an increased ability to manage intense emotions successfully. Throughout the process, the therapist helps the child identify current life situations that trigger traumatic memories and exacerbate PTSD symptoms.
14. *Family counselling*: It is aimed at communication skills and appropriate expression of affection and emotion within the family. The family members can be trained to check their communication patterns, both verbal and non-verbal and the strategies they use to make each other feel safe and secure. In conditions where betrayal of trust has occurred, stepwise programme can be devised to allow for the gap to be bridged and appropriate roles to be taken up again. However, the security of child at no step should be compromised.

Self Help Tips to Recover from Trauma

- **Don't isolate.** Following a trauma, you may want to withdraw from others. But isolation makes things worse. Connecting to others will help you heal, so make an effort to maintain your relationships and avoid spending too much time alone.
- **Ask for support.** It's important to talk about your feelings and ask for the help you need. Turn to a trusted family member, friend or counsellor.
- **Establish a daily routine.** In order to stay grounded after a trauma, it helps to have a structured schedule to follow. Try to stick to a daily routine, with regular times for waking, sleeping, eating, working, and exercise. Make sure to schedule time for relaxing and social activities, too.
- **Take care of your health.** A healthy body increases your ability to cope with stress. Get plenty of rest, exercise regularly, and eat a well-balanced diet. It's also important to avoid alcohol and drugs. Alcohol and drug use can worsen your trauma symptoms and exacerbate feelings of depression, anxiety, and isolation.

Check Your Progress Exercise 4

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

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

Answer the following in 4-5 lines

1. Name 3 strategies to prevent trauma and abuse in children.

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   .....

2. Name 5 strategies to manage trauma and abuse in children.

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   .....

8.7 LET US SUM UP

In this Unit we have paid attention to those specific events in a child's life that can serve to physically, emotionally and psychologically harm the child. These events can occur at the home, school or society. The impact of traumatic events and the reactions and responses to them differ from child to child depending upon various factors like their personality characteristics, skills available, family and community support available and the child's interpretation of the event. As far as possible, these events must be prevented but in cases where this has occurred, remedial steps involving anxiety management, life skills education, cognitive behaviour therapy and family counselling must be used to help the child cope better and lead a normal life.

8.8 GLOSSARY

Abuse : Harmful or injurious treatment of another human being that may include physical, sexual, verbal, psychological/ emotional, intellectual, or spiritual maltreatment

Bullying : Act of pressurizing/intimidating/persecuting others

Bystander : Person who stands by but does not take part; mere spectator

Child Labour : Consistent, full time and regular employment of a child for the sake of supporting their or/and their family's survival when the child is under the age stated by the law

Coercion	:	Act of persuasion or restrain by force
Exploitation	:	To make use of/take advantage of another person/ resource for one's own end
Grieving	:	Suffer grief
Insomnia	:	Inability to sleep/ habitual sleeplessness
Minority	:	Relatively small group of people differing from others on some variable of importance e.g. religion/caste
Personality	:	Relatively stable set of characteristics that determine an individual's behaviours and attitudes
Post Traumatic Stress Disorder	:	Experience of traumatic symptoms of fear, helplessness and horror following exposure to traumatic event
Stigmatize	:	Describe as unworthy or disgraceful
Trauma	:	Distress/ shock following stressful life event

8.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. (i) False, (ii) True, (iii) False, (iv) True

Check Your Progress Exercise 2

1. Presence of psychiatric disorders in the parents, role of belief systems, lack of social support and social resources, ignorance of developmental timetables and role of early learning experiences.
2. Physical abuse, verbal abuse, economic abuse, emotional abuse and spiritual abuse.
3. a-e: Yes

Check Your Progress Exercise 3

1. -b, 2. -a, 3. -c

Check Your Progress Exercise 4

1. Starting child help-lines, stabilizing the adult job market, life skills training for children-teaching them communication skills, assertiveness skills, coping skills and interpersonal relationship skills.
2. Cognitive behaviour therapy, stress inoculation therapy, family counselling, play therapy and enhancing adaptive coping styles

8.10 UNIT END QUESTIONS

1. Explain in detail the consequences of explain child sexual abuse.
2. What do you understand by neglect? What are the factors associated with neglect of children?

8.11 FURTHER READINGS AND REFERENCES

Carson, R.C., Butcher, J.N. & Mineka, S. (2000). Abnormal Psychology and Modern Life. Pearson Education.

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UNIT 9 COGNITIVE BEHAVIOURAL THERAPY FOR CHILDHOOD/ ADOLESCENT DISORDERS

Structure

9.1 INTRODUCTION

The growing incidence of psychiatric disorders among children and adolescents poses a challenge for those who are suffering from the disorder, caregivers, mental health professionals, policy makers and the society at large. The management of psychiatric disorders of children and adolescents includes a host of options such as both pharmacological and non-pharmacological therapies. There is a growing need for management of psychiatric disorders using non-pharmacological therapies such as Cognitive Behaviour Therapy.

Objectives

After studying this Unit, you will be able to:

- Understand the concept of cognitive behaviour therapy;
- Elaborate on methods of cognitive behavioural assessment; and
- Describe the process of cognitive behaviour therapy with research evidence.

9.2 COGNITIVE BEHAVIOUR THERAPY

Cognitive behaviour therapy is based on the inter-relationships between our thoughts, emotions and behaviour (Beck, 1995).

9.2.1 Definition and Concept

Cognitive behavioural therapy focuses on understanding the physiological, emotional, behavioural, cognitive as well as social factors involved in the precipitation and maintenance of symptoms, distress and disability experienced by a person. It emphasizes the role of negative thoughts and increased emotional distress in increasing maladaptive behavioural responses. It employs a range of cognitive and behavioural techniques such as relaxation, cognitive restructuring and problem solving to reduce symptomatic distress (Lipchik, Holroyd & Nash, 2002).

The contraindications for cognitive behaviour therapy include mental retardation, organicity, severe emotional and thought disturbance and developmental disorders.

The common goals of cognitive behavioural interventions targeted at managing psychiatric symptoms usually fall into the following categories: (1) psycho-education, (2) addressing the lifestyle and personality factors associated with vulnerability to developing a psychiatric illness, (3) provision of alternative, non-catastrophic interpretation of symptoms in cognitive behavioural terminology, (4) challenging catastrophic thoughts related to psychiatric symptoms, (5) modification of the dysfunctional beliefs associated with symptoms through behavioural experiments, (6) reversal of avoidance and maladaptive coping behaviours, (7) inculcating behavioural coping skills, and (8) instilling problem solving skills (Brown, 2007).

9.2.2 The ABC Model and Cognitive Behavioural Conceptualization

Cognitive behavioural model can be described as the ABC model – A refers to the affect or emotions, B refers to behaviour and C refers to the cognition or thoughts. These three are inter-related and change in one subsequently produces changes in the other components.

For example, in a case of childhood depression, the affect would be sadness (A), behaviour would constitute crying spells (B) and cognitions may constitute thoughts or ideas of self harm such as “I feel like dying”.

Conceptualizing a case in terms of ABC may be at times reductionistic and hence a detailed cognitive-behavioural formulation may be adopted, which constitutes of the following factors:

The factors central to conceptualizing a case suffering from headaches can be discussed under the following heads (Brown, 2007):

a) ***Predisposing factors***

These factors include:

- *Childhood trauma* – This constitutes physical, emotional or sexual abuse by parents or caregivers as well as neglect or lack of care. Persons with a history of trauma in childhood are thought to focus on

bodily symptoms as a means of avoiding the cognitive and emotional processing associated with the traumatic experiences

- *Childhood experience of illness* – The children with a history of physical illness in childhood that is reinforced by anxious parents may increase the focus on bodily symptoms, anxiety and illness behaviour in adulthood as well as resorting to maladaptive coping behaviours.
- *Personality* – Negative affectivity or neuroticism personality factors have been found to be associated with somatic preoccupation, illness behaviour as well as symptom misinterpretation in persons with somatic complaints.

b) *Precipitating factors*

These factors include:

- *Physical illness* – Recent physical illness may increase anxiety related to health, which may precipitate development of multiple somatic complaints in persons such as recurrent headaches.
- *Life events* – Somatic symptoms such as headaches may be preceded by life events such as trauma, interpersonal difficulties or financial problems. This relationship between life events and development of somatic illness may be medicated by factors such as anxiety or depression or body focus to avoid unwanted cognitive and emotional processes associated with those life events.

c) Maintaining factors

These factors include:

- *Illness beliefs* – Some beliefs about physical health and illness have been found to be associated with maintaining somatic complaints such as headaches. Example of such beliefs include those involving beliefs about inability to tolerate stress or having vulnerability to illness, beliefs about importance of maintenance of vigilance about symptoms, cost of illness or death, danger of anxiety as well as all or none beliefs about personal competence.
- *Illness behaviours* – Certain illness behaviours such as avoidance of certain stimuli or physical exercise, compensatory behaviours, repeated medical consultations and body check-ups may maintain somatic illness or symptomatic distress.
- *Cognitive factors* – Excessive rumination or worry about causes, implications and treatment of symptoms and physical health often maintain somatic complaints experienced by persons. A selective attribution bias for information confirming symptoms has been found to be associated with maintenance of somatic symptoms.
- *Affective factors* – Emotional distress such as anxiety and depression has been associated with increase in rumination, catastrophizing and worrying about the somatic symptoms as well as increase in illness behaviour and increase in other somatic symptoms.
- *Social factors* – Excessive reassurance/care-seeking from significant others may increase somatic preoccupation. The stigma associated with

emotional distress and psychological illness by others may reinforce assigning physical causes to symptoms as well as increase illness behaviours. Increase in visits to doctors may at times increase misattributions regarding symptoms especially if causal factors associated with somatic symptoms are explained in an ambiguous way to the patient.

- *Physiological factors* – Certain physiological factors such as sleep and appetite changes, organic illness, and medication overuse can maintain the illness behaviour, associated emotional distress as well as cognitive misattributions and hence, exacerbate somatic symptoms.

Check Your Progress Exercise 1

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

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

1. Define cognitive behaviour therapy.

.....

.....

.....

.....

2. What is the ABC Model?

.....

.....

.....

9.3 COGNITIVE BEHAVIOURAL ASSESSMENT

The cognitive behavioural conceptualization as well as treatment plan is aided by assessment of certain factors. The goals of assessment include: firstly, to establish whether possibility of any physical disease has been ruled out. Secondly, to engage the patient in a therapeutic process. Thirdly, to gain information regarding cognitive behavioural formulation of the presenting complaints. Lastly, to understand the medical and psychological conditions that the person is suffering from. The assessment strategies can be discussed as below:

- *Interview*

This involves interviewing the child/adolescent and informant regarding the symptoms, history of development of symptoms, personality/temperament of the child (easy going, difficult), any associated medical conditions, history of psychiatric illness in family and developmental history. This can also be supplemented with a mental status examination (appearance, perception, thought, mood, affect, thought, gait, attention and concentration, eye contact, higher mental functions and insight).

- *ABC Chart, Diary*

The child/adolescent is asked to maintain an ABC chart to record the situations, beliefs and consequences to help identify maladaptive thought, feeling and behavioural patterns. A daily record of dysfunctional thoughts can be maintained in which the situation, thoughts, feelings and behaviour can be recorded. The symptoms severity and frequency can also be monitored through a symptom diary. The caregiver may be asked to maintain the symptom diary so as to be a co-therapist in the therapeutic process. Examples of an ABC chart, Daily record of dysfunctional thoughts are illustrated in the Figures 9.1 and 9.2.

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

Fig. 9.1: Example of an ABC Chart

Situation	**Thoughts**	**Feelings (0 – no distress, 100 – extreme distress)**	**Behaviour/ Symptom (0 – no distress, 100 – extremely severe)**
Seeing a dog on the road	"He's going to bite me"	Fear and anxiety (90)	Runs away (80)
Doing homework	"I can't do anything properly"	Irritation (80)	Headache (90)

Fig. 9.2: Example of Daily Record of Dysfunctional Thoughts

- *Questionnaires and Tests*

Certain paper-pencil tests or questionnaires as well as certain projective techniques can be employed to elicit maladaptive patterns of thinking, feeling and behaving. These are helpful for children suffering from both internalizing and externalizing disorders.

- *Observation*

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

Check Your Progress Exercise 2

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

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

Fill in the blanks

1. …….. is a method of assessment, which includes recording the situations, beliefs and consequences.
2. ……. can be used as a method to take information about the case history.

9.4 COGNITIVE BEHAVIOUR THERAPY PROCESS

The process of cognitive behaviour therapy can be discussed under the following heads:

9.4.1 Target Groups

Among children and adolescents with psychiatric disorders, cognitive behaviour therapy is applicable and efficacious with a range of externalizing and internalizing conditions. The most suitable groups of children and adolescents with psychiatric disorders include:

- Mood Disorders – particularly those with Depression and Dysthymia
- Anxiety Disorders
- Somatoform Disorders
- Conduct Disorders
- Oppositional Defiant Disorders
- Substance Use Disorders
- Eating Disorders

9.4.2 Planning Sessions

Cognitive behaviour management of psychiatric disorders in children is based on principles of agenda setting, guided discovery and collaborative empiricism. The steps or techniques involved in the cognitive behavioural management of psychiatric disorders in childhood and adolescence can be elucidated as below:

- **Socialization**

The first session is focused on forming a working therapeutic alliance with the patient and psycho-educating the patient regarding the nature and course of chronic headaches as well as the role of stress and other psychological factors in precipitating and maintaining the illness. The patient is made aware of what cognitive behavioural therapy entails as well as provided him/her with an individually tailored cognitive behavioural conceptualization. The second session involves explaining the ABC model of cognitive behaviour therapy using an example. This further involves making the patient aware of how physical symptoms can be maintained or worsened through certain thoughts and behaviour patterns. These if modified can help to manage the symptomatic distress better.

- **Goal setting**

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

1) a consistent of approach to activity

2) reduction in reassurance seeking and repeated discussion of symptoms which can interfere with a person's socio-occupational functioning

3) engaging a family member as a co-therapist so as to minimize negative reinforcement of illness behaviours

4) reduction in symptomatic distress (headache, anxiety/depression)

- **Cognitive and Behavioural interventions**

Certain behavioural interventions can be used in management of psychiatric disorders (Beck, 1995). These include:

- *Relaxation exercises* – These include abdominal breathing, tensing and relaxing muscle groups progressively. These can be used with anxiety disorders, somatoform disorders as well as disorders where the child/ adolescent may feel excessive anger/aggression.

- *Imagery* – The child/adolescent is asked to imagine a pleasurable scene e.g., a garden, beach etc. and focus his attention of the details of the scene like the colours, smells etc to have a calming effect. This technique is useful with anxiety and somatoform disorders.

- *Distraction techniques* – These techniques involve taking one's attention away from the symptoms and refocusing the attention on other neutral or pleasurable stimuli. Example, if a child is experiencing pain, he may be asked to divert his attention away from the pain by listening to music or playing a computer game he/she likes. This technique is effective with anxiety, somatoform and mood disorders.

- *Activity scheduling* – This constitutes asking the child/adolescent to involve themselves with activities so that they spend less time engaging in maladaptive patterns of thinking, feeling and behaving. This is especially useful for anxiety, somatoform and mood disorders

- Incorporation of *pleasurable activities* in daily routine – This helps the child/adolescent feel better and engage in adaptive behaviours. Additionally it provides a sense of mastery to the child/adolescent. This is especially useful for mood disorders like depression.

- *Behavioural experiments* – These can be used to test the maladaptive predictions, for example, a child suffering from a phobia with dogs, who may have beliefs that all dogs are dangerous and bite, can be asked to visit a friend with a pet dog, who is playful and not ferocious. This technique is especially useful for anxiety disorders, mood disorders and somatoform disorders.

- *Assertiveness skills training* – This involves teaching the child/adolescent the differences between submissive, aggressive and assertive behaviours and teaching skills using examples to demonstrate assertive behaviours. For example, a child who may be experiencing bullying and be submissive, is taught to assertively not comply with the bully's demands and tell him that he doesn't appreciate the bully's actions. This is very useful for anxiety disorders and somatoform disorders, especially social phobia.

- *Problem solving* – This involves the steps of describing a problem, thinking of possible solutions and testing the solution which is best suited. This is a coping skills strategy and is especially useful with children/adolescents

suffering from anxiety, somatoform disorders and mood disorders. It may also be applied with conduct problems and substance use disorders.

- *Disputation* – This involves challenging the negative thoughts the child/ adolescent experiences. For example, if the child has a thought that nobody loves him, it can be disputed with questions like "what evidence do you have to support this belief?" This is an excellent method for disorders related to anxiety, somatoform and mood disorders like depression.

- *Cognitive Restructuring* – This involves restating the negative thoughts/ beliefs in a positive manner. For example, "I can't do well in exams" can be changed to "I can do well in some subjects." This is a useful cognitive strategy for anxiety, depression and somatoform disorders.

- *Contingency Management* – This is a behavioural strategy, which involves reinforcing positive behaviours. This can be done through token economy (e.g., giving child a token for every positive behaviour and then the child can exchange a number of tokens for something tangible he likes), star charting (providing stars for positive activity and then if the child has stars every day for the week he can be rewarded). An illustration of the star chart is provided in Fig. 9.3. This is a useful method for both social and life skills training and can be used across a spectrum of childhood disorders.

Activity	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Doing homework	☆	☆	☆	☆			
Helping mother in a chore	☆		☆	☆	☆		

Fig. 9.3. An example of a star chart

- *Role plays* – These involve enacting the problematic situations with the child/adolescent and helping elicit the maladaptive thoughts, feelings and behaviour as well as helping them change these patterns and adopt more adaptive patterns.
- *Other Behaviour Therapy Techniques* like thought stopping (saying stop aloud when the repetitive/obsessive thought comes to the child/adolescent's mind) and exposure and response prevention (the child may be exposed to an anxiety provoking situation and is asked not to engage in the neutralizing actions), for example, if the child feels like washing his hands when he/she sees mud, he/she is exposed to a situation where mud is but is asked not to wash hands). This helps to reduce the anxiety gradually and eliminate maladaptive thought and behaviour patterns. These are especially useful in anxiety disorders, particularly, obsessive-compulsive disorder.
- **Terminating therapy**

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

Check Your Progress Exercise 3

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

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

1. Match the following columns:

i. Breathing exercises	a. contingency management
ii. Rewarding positive behaviours	b. relaxation
iii. Challenging the maladaptive beliefs	c. role play
iv. Enacting the situation with the therapist as client	d. Disputation

9.5 RESEARCH EVIDENCE FOR COGNITIVE BEHAVIOUR THERAPY

Cognitive behaviour therapy has been found to be effective across a spectrum of psychiatric disorders among children and adolescents. A review of 16 meta-analyses conducted by Butler et al. (2005) found that cognitive behaviour therapy was highly effective for adolescent unipolar depression, generalized anxiety disorder (GAD), panic disorder with/without agoraphobia or social phobia, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), schizophrenia, anger management, bulimia nervosa, internalizing childhood disorder, sexual offences and chronic pain disorders. Further, the effects of cognitive behaviour therapy were found to be maintained, across many disorders, for considerable periods after treatment had ended. The research evidence for the efficacy and effectiveness of cognitive behaviour therapy for children and adolescents diagnosed with psychiatric disorders can be summarized under the heads of internalizing and externalizing disorders:

9.5.1 Internalizing Disorders

The strongest evidence of Cognitive Behaviour Therapy is for anxiety disorders. In a review of randomized controlled trials and what constitutes cognitive behaviour therapy in children with anxiety disorders, Arnold et al. (2005) concluded that CBT may be the optimal treatment modality for anxiety disorders in children and adolescents. In another study by Compton et al.(2004), that reviewed 21 randomized, controlled studies of CBT for various anxiety disorders, including separation anxiety, social phobia, generalized anxiety/overanxious disorder of childhood, panic disorder, agoraphobia, and simple phobia, CBT was suggested to be the first line treatment of all types of anxiety disorders. In a review conducted by Kulhara & Nischal (2009), it was noted that cognitive behaviour therapy was the most well studied intervention.

Among the studies conducted on cognitive behaviour therapy for anxiety disorders, the strongest evidence has been reported for obsessive-compulsive disorder. This point can be substantiated in the light of a summary of recent multisite, randomized, controlled trials funded by NIMH, which concluded that cognitive behaviour therapy was required for optimal treatment of obsessive-compulsive

disorder in children and adolescents. Additionally, while the outcomes were enhanced by pharmacotherapy combined with cognitive behaviour therapy, the study suggested that cognitive behaviour therapy alone was more efficacious than pharmacotherapy (Steiner et al., 2007).

In a recent review of randomized controlled trials of cognitive behaviour therapy for depression by Compton et al. (2004), cognitive behaviour therapy was found to be superior to other active treatment. Similarly, the Treatment for Adolescents with Depression Study (TADS) by Kennard et al. (2006) found that compared to pharmacotherapy alone, cognitive behaviour therapy plus pharmacotherapy was superior for adolescent depression in the first 18 weeks of treatment. Further, it was also noted that patients who achieved remission with cognitive behaviour therapy alone had a slightly higher rate of recovery than treatments including pharmacotherapy.

Literature for Trauma Focused Cognitive Behaviour Therapy for post traumatic stress disorder (PTSD) has been found to be efficacious for children with single incident traumas, such as car accidents and experiencing or witnessing interpersonal violence (Smith et al., 2007). It was found to be as effective as supportive therapy and to a waitlist control for children with post traumatic stress disorder, who have experienced sexual abuse from multiple perpetrators (King et al., 2000).

Kroenke (2007) conducted a review of 324 randomized controlled trials and found that among most studies, cognitive behaviour therapy was the most effective treatment modality for children and adolescents suffering from somatoform disorders, somatization disorder, undifferentiated somatoform disorder, hypochrondriasis, conversion disorder, pain disorder, and body dysmorphic disorder. Cognitive behaviour therapy has been found to be particularly useful in management of headaches among adults, adolescents and children (Mehta and Dhal, 2010).

9.5.2 Externalizing Disorders

In contrast to internalizing disorders, there is poor research support for the efficacy and effectiveness of cognitive behaviour therapy as a treatment modality among externalizing disorders. There is little or no data to support the use of cognitive behaviour therapy as a treatment modality for attention deficit hyperactivity disorder; however, some behavioural treatments involving parents and teachers are recommended as adjunctive treatments to medications. Further, there is lack of evidence to suggest the use of cognitive behaviour therapy for oppositional defiant disorder which has been found to show some responsiveness to parent management training and family therapy (Pliszka, 2007).

Among the externalizing disorders for which cognitive behaviour therapy has been found to be effective are substance use disorders. A recent metaanalysis of evidence-based psychosocial treatments for adolescent substance abuse suggested that group cognitive behaviour therapy was found to be a well-established intervention and that individual cognitive behaviour therapy appeared promising but needed further testing (Waldron & Turner, 2008). In another review of 31 randomized controlled trials, cognitive behaviour therapy was found to be an effective outpatient intervention for adolescent substance abuse (Becker & Curry, 2008).

9.6 CONCLUSIONS AND FUTURE DIRECTIONS

Cognitive behavioural therapy focuses on understanding the physiological, emotional, behavioural, cognitive as well as social factors involved in the precipitation and maintenance of symptoms, distress and disability experienced by a person. The evidence for effectiveness of cognitive behaviour therapy has been found to be more robust for internalizing disorders as compared to externalizing disorders. Future research should focus on adapting culturally oriented cognitive behaviour therapy and studying its effectiveness for a spectrum of psychiatric disorders. Also further research is required for psychological problems which do not warrant psychiatric diagnoses.

9.7 LET US SUM UP

The key points can be summarized as follows:

- Cognitive behavioural therapy focuses on understanding the physiological, emotional, behavioural, cognitive as well as social factors involved in the precipitation and maintenance of symptoms, distress and disability experienced by a person.
- It is based on the ABC model which suggests that A is the affect, B is the behaviour and C is the cognition.
- There are different assessment modalities used such as ABC chart/thought diary, observation and interviews to elicit the maladaptive patterns.
- It is useful for a variety of childhood and adolescent internalizing and externalizing disorders such as depression, anxiety, somatoform, conduct and oppositional defiant disorders.
- The planning of session involves socializing, using cognitive and behavioural techniques and terminating.
- It has been found to be most efficacious for internalizing disorders, particularly for anxiety disorders.

9.8 *G*LOSSARY

ABC : Affect, Behaviour and Cognition.

ABC Diary : Noting down situations where the maladaptive thoughts, behaviour and emotions occur

Activity scheduling : This constitutes asking the child/adolescent to involve themselves with activities so that they spend less time engaging in maladaptive patterns of thinking, feeling and behaving.

Assertiveness skills training : This involves teaching the child/adolescent the differences between submissive, aggressive and assertive behaviours and teaching skills using examples to demonstrate assertive behaviours.

Behavioural experiments : These can be used to test the maladaptive predictions by actively engaging in the fearful situation

Cognitive behaviour Therapy : Cognitive behavioural therapy focuses on understanding the physiological, emotional, behavioural, cognitive as well as social factors involved in the precipitation and maintenance of symptoms, distress and disability experienced by a person.

Cognitive restructuring : This involves restating the negative thoughts/beliefs in a positive manner.

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

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

Disputation : This involves challenging the negative thoughts the child/adolescent experiences.

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

Interviews : Using a set of open ended or structured questions to elicit information

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

Problem solving : This involves the steps of describing a problem, thinking of possible solutions and testing the solution which is best suited.

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

Role plays : These involve enacting the problematic situations with the child/adolescent and helping elicit the maladaptive thoughts, feelings and behaviour as well as helping them change these patterns and adopting more adaptive patterns.

9.9 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress Exercise 1

1. Cognitive behavioural therapy focuses on understanding the physiological, emotional, behavioural, cognitive as well as social factors involved in the precipitation and maintenance of symptoms, distress and disability experienced by a person.

2. The ABC model suggests that A is the affect, B is the behaviour and C is the cognition.

Check Your Progress Exercise 2

1. ABC Charting/diary
2. Interviews

Check Your Progress Exercise 3

1. i. b
   ii. a
   iii. d
   iv. c

9.10 UNIT END QUESTIONS

1. Discuss the various techniques used in cognitive behaviour therapy.
2. Write a note on the assessment methods used in cognitive behaviour therapy.
3. Describe the process of cognitive behaviour therapy briefly.

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MCFTE-002 CHILD AND ADOLESCENT COUNSELLING AND FAMILY THERAPY

OPTIONAL PAPER 2