CHILD PSYCHOLOGY

• Disorders first diagnosed in childhood
• Roles of child psychologist
• Assessment
• Attachment
• Disorders
• Intervention/Treatment
Clinical Child Psychology

• Increasing interest in child psychopathology
• 8 to 22% have behavioral, emotional, or learning disorder
• Lifelong consequences
  – Adult disorders rooted in childhood disorders
• Early intervention and prevention more effective than later intervention
Subspecialties

- Clinical Child Psychology
  - Related to physical, social, & developmental influences on childhood mental health

- Pediatric Psychology
  - Interdisciplinary field
  - Physical and mental development, health,
  - Illness issues affecting children, adolescent, and families
Training

• PH.D. with specialty track
• Areas of training
  – Lifespan development
  – Developmental psychopathology
  – Child, adolescent, family assessment
  – Intervention for children
Disorders usually first diagnosed in infancy, childhood, or adolescence

<table>
<thead>
<tr>
<th>Mental Retardation</th>
<th>Mild, Mod, Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning</td>
<td>Reading, Math</td>
</tr>
<tr>
<td>Motor Skills</td>
<td>Developmental coordination</td>
</tr>
<tr>
<td>Communication</td>
<td>Expressive, stuttering</td>
</tr>
<tr>
<td>Pervasive</td>
<td></td>
</tr>
<tr>
<td>Developmental</td>
<td>Autism, Asperger’s</td>
</tr>
<tr>
<td>Attention deficit</td>
<td></td>
</tr>
<tr>
<td>&amp; Disruptive</td>
<td>ADHD, conduct,</td>
</tr>
<tr>
<td>Other</td>
<td>Separation anxiety</td>
</tr>
</tbody>
</table>

Prof. Laura Fazakas  http://www.laurafazakas.com
Factors Effecting Attachment:

- Infant temperament
- Infant health (premature birth)
- Caregiver behaviors
  - rejecting
  - Critical
  - Withdrawn
  - Illness
  - “Fit” between infant/cargiver
- Environmental factors
  - chaos
  - abuse
  - neglect
## Attachment Styles

<table>
<thead>
<tr>
<th>Classification of Attachment</th>
<th>One Year</th>
<th>Response in Strange Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Securely attached</td>
<td>60-70 %</td>
<td>Explores with M in room; upset with separation; warm greeting upon return; seeks physical touch and comfort upon reunion</td>
</tr>
<tr>
<td>Insecure: avoidant</td>
<td>15-20 %</td>
<td>Ignores M when present; little distress on separation; actively turns away from M upon reunion</td>
</tr>
<tr>
<td>Insecure: resistant</td>
<td>10-15 %</td>
<td>Little exploration with M in room, stays close to M; very distressed upon separation; ambivalent or angry &amp; resists physical contact upon reunion with M</td>
</tr>
<tr>
<td>Insecure: disorganized/dischoriented</td>
<td>5-10 %</td>
<td>Confusion about approaching or avoiding M; most distressed by separation; upon reunion acts confused and dazed</td>
</tr>
</tbody>
</table>
• Consequences of Attachment Problems
  – Eating problems
  – Bizarre soothing behaviors
  – Emotional problems (depression & anxiety)
  – Indiscriminant attachment (as safety-seeking)
  – Aggression
  – Lack empathy
  – Poor impulse control
  – Sometimes lack remorse
  – In childhood, ODD
  – In adulthood, personality disorders, APD
Clinical Roles

- Assessment
- Consultation
- Expert witness
- Intervention
- Research
- Program development/evaluation
- Teaching
Clinical Assessment

- Not self-referred
- Must manage multiple sources of info
- Interviews - Observations
- Personality
- IQ & Achievement
- Development
- Family Assessment
Childhood Stressors

• School
• Parental divorce and conflict
• Child maltreatment
  – Significant overlap with domestic violence 30-60%
• Hurt directly and indirectly
  – Affected by exposure
  – Hurt accidentally
  – Hurt intentionally
# POTENTIAL EFFECTS OF ABUSE

<table>
<thead>
<tr>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulties with school &amp; peers</td>
</tr>
<tr>
<td>Cognitive deficits</td>
</tr>
<tr>
<td>Moral reasoning deficits</td>
</tr>
<tr>
<td>Aggressive acting out behavior (Hostile attributions)</td>
</tr>
<tr>
<td>Anxiety Disorders (e.g. Separation anxiety)</td>
</tr>
<tr>
<td>– Effects of Trauma (PTSD or Personality Disorders)</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Self-destructive/suicidal behavior</td>
</tr>
</tbody>
</table>
DISORDERS

• INTERNALIZING DISORDERS
  – Mood disorders
  – Anxiety disorders
  – More prevalent in girls

• EXTERNALIZING DISORDERS
  – ADHD
  – Conduct disorder
  – ODD
  – Acting out component/
  – More prevalent in boys
Parenting

Defiant Children (Barkley, 1987)
• Paying attention to good behavior
• Positive feedback and approval
• Paying attention to compliance
• Giving effective commands***
• Home point system
• Time out
## Giving effective commands

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean it!</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Do not present command</strong></td>
<td>as a question or favor</td>
</tr>
<tr>
<td><strong>Limit # of commands</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Make sure child is paying attention</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ask child to repeat command</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Make up chart</strong></td>
<td></td>
</tr>
</tbody>
</table>
Normal childhood fears

- 0-6 - loss of support, loud noise
- 7-12 - strangers, sudden objects
- 1 year – separation, strangers
- 2 years – noise, darkness, animals
- 3 years – darkness, masks, animals
- 5 years – bad people
- 6 – supernatural beings
Separation Anxiety Disorder

- Age inappropriate, excessive, and disabling anxiety about being separated from parent(s) or home
- Most common anxiety disorder
  - Prevalence 3 to 12%
- May appear suddenly
- or follow stressful events
- Related to later psychopathology
Treatment for Separation Anxiety

- Modifying 4 primary problems
  - Excessive escape avoidance behaviors
  - Emergency physiological reactions
  - Feeling lack of control
  - Distorted information processing
- Behavioural treatment
  - Exposure
  - Systematic desensitization
  - Modeling
- Cognitive
  - Modifying maladaptive thought patterns
- Meds
Disorders of sleeping

• Dyssomnias
  – Disturbance in the amount, timing, or quality of sleep

• Protodyssomnias
  – Difficulty getting to sleep

• Hypersomnias
  – Sleeping too much
Sleep Disorders

• Narcolepsy
  – Sleeping attacks

• Obstructive sleep apnea
  – Breathing stops during sleep
## Nightmares vs sleep terrors

<table>
<thead>
<tr>
<th>Nightmares</th>
<th>Sleep terrors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Occurs during REM</td>
<td>• Non REM</td>
</tr>
<tr>
<td>• mid to late night</td>
<td>• First 1/3 of night</td>
</tr>
<tr>
<td>• Subdued verbalization</td>
<td>• Verbalizations usually present</td>
</tr>
<tr>
<td>• Moderate arousal</td>
<td>• Intense arousal</td>
</tr>
<tr>
<td>• Slight or no movement</td>
<td>• Extreme motor activity</td>
</tr>
</tbody>
</table>

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<table>
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<tr>
<th>Nightmares</th>
<th>Sleep terrors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to waken</td>
<td>Difficult</td>
</tr>
<tr>
<td>Often remembered</td>
<td>Limited</td>
</tr>
<tr>
<td>memory</td>
<td></td>
</tr>
<tr>
<td>Common</td>
<td>Less so</td>
</tr>
<tr>
<td>Reluctant to return</td>
<td>Quickly</td>
</tr>
<tr>
<td>to sleep</td>
<td></td>
</tr>
</tbody>
</table>
Depression

- Expression changes with age
- Irritability and withdrawal
- Under age 7, tends to be diffuse and more difficult to recognize
- School-aged kids may have tantrums, eating disturbances, esteem problems or sadness
- After 11, more prevalent in girls
Suicide

- Most often due to depression
- 25-34% of depressed children & teens attempt suicide
- Increasing over past 25 years
  - Accounts for 12% of total teen deaths
  - 2nd leading cause of death among 15-24 year olds
- Girls show more suicidal ideation but often use less lethal methods
Interventions for Children

General Goals of Child Therapy

- Enhance child’s self control, self-concept, and self-efficacy.
- Help child become aware of his or her feelings.
- Have a place where child can feel safe in exploration of self.
- Learn and practice self-control and alternative behaviors.
- Develop capacity to trust adults.
- Develop capacity to relate to an adult in an open, positive and caring manner.
Intervention

• Play
• Art therapy
• Medication
• Behavioural
• Cognitive
• Parenting
• Psychoanalytically oriented
Interventions for Children

• Child-Centered Play Therapy (Virginia Axlin)

Major Premises of Theory

• Comes from Rogerian model.
• Called child-centered play therapy.
• Is Non-directive
• Reflects feelings, restates content, and returning responsibility to the child.
• Believes that children are able to work out their problems through use of unconditional positive regard.
Premises of Child-Centered Play Therapy

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he/she is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his/her feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feeling back to him/her in such a manner that the child gains insight into his/her behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversations in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of her responsibility in the relationship.
Interventions for Children

Play therapy:
  Symbolic
  Concrete
  The world of the child
  Allows acting out real life conflicts and issues

Five Phases of Child-Centered Play Therapy
  1. Child uses play to express diffuse negative feelings.
  2. Uses play to express ambivalent feelings (e.g., anxiety, or hostility).
  3. Express mostly negative feelings, again, but the target is now more specific, i.e., parents, sibs, or therapist.
  4. Ambivalent feelings resurface again but the target is now more specific, as in #3.
  5. Positive feelings are now predominant, but negative feelings are more grounded and realistic.