UNIT-11 Problems of Middle Childhood

Learning Outcomes

By the end of this unit the learner will be able to:

- ✓ Discuss the problems of middle childhood.
- ✓ Identify the causes and development of fears and anxieties in childhood.

Unit 11

Problems of Middle Childhood

Conduct Disorder

Specific Symptoms of Conduct Disorder

The main characteristic of conduct disorder is a consistent routine of behaviour by a child or teenager in which the simple rights of individuals are denied and societal norms, or rules, are broken. These behaviours fall into four main categories: aggressive conduct, that is the reason for or threatens physical injury to other individuals or animals, non-aggressive action that causes property loss or damage, deceitfulness or theft, and breaking of norms repeatedly.

Conduct disorder is diagnosed by a consistent routine of behaviour in which the simple rights of individuals or other age-suitable societal norms or regulations are broken, as manifested by the presence of three (or more) of the following events in the past year, with at least one event occurring within the past six months:

Aggression to People and Animals

Destruction of Property

- usually annoys, threatens, or scares others
- often sparks physical bursts
- has used a dangerous item that can cause injury
- has been physically cruel to people
- has been physically cruel to animals
- has robbed someone
- has raped someone

Deceitfulness or Theft

- has gone into someone else's house, building, or car
- often does not tell the truth to get things or to avoid obligations
- has taken objects of large value without asking the owner

Serious Violations of Rules

- often stays out at night despite parental prohibitions, starting before thirteen years old
- has run away from home overnight at least twice while living with parents or a parental surrogate's home (or once without returning for a long period of time)

- is often skipping school, beginning before thirteen years old

This bad behaviour causes problems in social, academic, or occupational functioning.

Two sub-sections of conduct disorder are usually seen and based on the age at onset of the disorder (i.e., Childhood-Onset Type and Adolescent-Onset Type). The sub-sections change in regard to the features of the presenting conduct issues, developmental course and prognosis, and gender ratio. Both sub-sections can occur in a mild, moderate, or a severe form. In assessing the age at onset, facts should preferably be received from the youth and from adults. Since such behaviour may be concealed, caregivers may underreport symptoms and overestimate the age at onset.

Childhood-Onset Type: This sub-group is defined by the onset of at least one factor of conduct disorder prior to ten years old. People with childhood-onset type are usually male and they often show physical aggression towards other people, have interrupted peer relationships, may have had Oppositional Defiant Disorder during early childhood, and usually have symptoms that meet full criteria for conduct disorder before puberty starts. These individuals are more likely to have constant conduct disorder that grows into adult Antisocial Personality Disorder than are those with Adolescent-Onset Type.

Adolescent-Onset Type: This sub-group is defined by the absence of any criteria factor of conduct disorder before ten years old. Compared to those with the childhood-onset type, these people are less likely to show aggressive behaviours and tend to have more normal peer relationships. These people are less apt to have consistent conduct disorder or grow into adult Antisocial Personality Disorder. The ratio of males to females with conduct disorder is smaller for the adolescent-onset type than for the childhood-onset type.

Conduct Problems

Available studies imply that a mix in conduct problems occurs in the following areas:

- Severity, from mild and infrequent to severe and frequent
- Duration, from recent to long-standing
- Pervasiveness, from home-based to home-, school- and community-based
- Age of onset of issue, from childhood onset to adulthood onset
- Peer influences on conduct problems, from peer-group-based socialised conduct issues to solitary conduct difficulties
- The amount of deceit involved, from overt aggression to stealing and lying
- The presence or absence of concentration issues
- The presence or absence of hyperactivity issues
- The presence or absence of depression and other bad moods
- The presence or absence of specific learning problems

Hormonal Theory

One of the more clear indicators that help in determining the biological factors of conduct problems is a connection between aggressive behaviour and increased testosterone levels in male teenagers.

Arousal Theory

Children with conduct conditions have lower arousal levels than those without conduct conditions and are hence not as responsive to treats and consequences (Raine, 1988). They have a lesser threshold for responding to the positive reinforcement. Therefore, they fail to learn pro-social behaviour or to avoid antisocial behaviour. It is suggested that this unusual low level of arousal is inherited, and the results of twin research supports this in part (Kazdin, 1995). Treatment based on this statement must have a greatly organised and intensive learning situation if social rules are to be learned.

Attachment Theory

Bowlby (1944) suggested that children, who were separated from their primary caregivers for long periods of time, during their first months of life, failed to develop secure attachments and so in later life did not have the mental capacity for strong, trusting relationships. He categorized these children as showing affectionless psychopathy. Since moral behaviour is based upon functional mentality of how to behave oneself in trusting relationships, such children behave immorally. Treatment of this situation should try to provide the child with a solid attachment relationship or corrective emotional experience. This will lead to the growth of a well rounded mentality and hence provide a basis for moral behaviour.

While the provision of a secure attachment experience within the context of out-patient weekly individual therapy is a non-working treatment for children with conduct disorder, a secure attachment relationship is a vital treatment factor in some effective treatments, such as treatment foster care (Chamberlain, 1994). Here, the foster parents provide the child with a secure attachment experience and pair this with good behavioural management.

Cognitive Theories

Problems with processing social information and social ability deficits are the main factors highlighted in cognitive theories of conduct issues.

Social Information-Processing Theory

Research on Social Information Processing in children with conduct disorders has shown that in unclear social situations their cognition is characterised by a hostile bias (Crick and Dodge, 1994). Children with conduct issues attribute hostile intentions to individuals in social situations when the intentions of others are unclear. The aggressive behaviour of children with conduct disorders in such settings are, therefore, intended to be reactive. The aggression is seen as unjustified by those who have been attacked and this

leads to impaired peer relationships. The reaction of peers to such apparently unjustified aggression provides confirmation for the aggressive child that their peers have hostile intentions, which justifies further retaliatory aggression.

Social Skills Deficit Theory

A second line of research establishes the social ability deficits of children with conduct disorders (Spivack and Shure, 1982). These children do not have the skills to make more than one resolution to social issues, such as dealing with an apparently hostile person. They also do not have the skills to put in place solutions to social issues. Within this cognitive-behavioural tradition, group-based social ability schedules have been created.

They aim to train children in the following skills:

- Correcting hostile bias
- Accurately looking at problematic social situations
- Generating a mix of solutions to such problem situations
- Predicting the short-term and long-term impact of these solutions
- Implementing the most sensible solution
- Learning from what others say

Behavioural Parent Training

With young children who have oppositional defiant problems, teaching parents to use behavioural techniques for disciplining children and keeping positive relationships with them is a key part of good treatment. In such schedules, parents are helped through psychological education to see that their child's issues are being helped by antecedent triggers. They also learn to identify and monitor acceptable and unacceptable target behaviours. Parents are trained in methods for making corrections which involve using the factors of the social learning theory to increase pro-social target behaviours and aggression or reduced the occurrence of undesirable target behaviours. These solutions rely mainly on changing rewards and punishments.

Family-Based Communication and Problem-Solving Training

To handle adult conduct issues in most industrialised cultures, parents (and in some instances, step-parents, foster parents, and grandparents) must share a strong bond and agree on household norms, roles, and patterns that establish what is and is not acceptable behaviour for the teenager. Consequences for breaking rules or not following routines must be very clear. Once agreed upon, rewards and consequences regarding with rules, roles, and routines must be put in place consistently by parents (and step-parents, foster parents, or grandparents, if they are involved in the teenager's day-to-day life).

Home-School Liaison Meetings and Remedial Tuition

Many children with conduct issues participate in destructive school-based behaviour and have co-morbid learning problems. School interventions should take into account both conduct and academic issues.

Parent Counselling

Children with good conduct problems usually come from multi-issue families in which parents have few skills for coping with high levels of stress and low levels of social caring. Frequently, these parents find it hard to follow through on ideas to create rules, roles, and patterns worked out in therapy classes. The parents' own psychological problems, marital issues, and life problems prevent them from adhering to their ideas to give consistent rewards or punishments for rule-following or rule-breaking behaviour. This may occur even in the early sessions of therapy. As a result, the child's conduct problems continue.

There are two effective solutions to this problem: parent counselling and treatment foster care. With treatment foster care, the child may be put with a foster family experienced in social-learning-theory based treatments for socialising children with conduct issues.

Fear and Anxiety Problems

Fear is the normal response to a stimulus which poses a threat to well-being, safety or security.This response includes cognitive, affective, physiological, behavioural, and relational areas.

Development of Fears and Anxieties

In the first six months of life, extreme stimulation like loud noises or loss of care brings out fear. However, with the making of object constancy and cause-and-effect schemas in the second half of the first year, a typical concern with separation begins and the child fears strangers and separation from caregivers.

In the middle part of childhood, as the child's awareness of the natural universe and of the world grows, they begin to fear natural disasters, such as floods, thunder, lightning, and media-based fears, for example, those of disease epidemics. In middle childhood, failure in academic and athletic performance at school causes additional concern.

With the onset of adulthood, which is the period of formal operational thinking, room for different thoughts emerges. The child can predict what will happen in the future and, with considerable sophistication, potential hazards, threats and dangers in many areas, especially that of social relationships. Fears of peer rejection appear in this stage.

Children's Fears and Anxieties

Children's brains and feelings are often changing and growing. They do not all develop at the same rate so it is difficult to distinguish between typical fears those that need special attention. Newborn babies are typically afraid of falling and very loud sounds. The fear of strangers starts at six months and continues until the age of two or three. Pre-school children often are scared of separation from their parents; they might also be afraid of big animals, dark settings, masks, and large animals. Older children might worry about death in the family, failure in school, and events in the news such as wars, terrorist attacks, and kidnappings. Adults have sexual and social worries, and concerns about their own and the world's future. These worries become an issue only if they persist and cause serious distress, destroy family harmony, or negatively affect a child's development or education.

Generalized Anxiety Disorder*:* This was formerly known as over-anxious disorder of childhood, normally children are seen as having the same condition of uncontrolled worry that occurs in adults. Children with this condition are self-conscious, self-doubting, and very worried about meeting other individual's standards. They need constant reassurance and approval from adults. They might worry about school grades, storms, burglary, hurting themselves while playing, or the amount of gas in the tank. They often feel stressed and tense and complain of headaches, stomach aches, and other physical ailments.

Social Anxiety Disorder (Social Phobia): Children with this condition are very shy and fear exposure to anything unusual. They cling to their parents and might be afraid of other children as well as adult strangers at an age when it is no longer typical. They might be scared of reading aloud, starting a conversation, or going to a birthday party.

Obsessive-Compulsive Disorder: This condition consists of thoughts which are not requested which cause stress and are exhibited by repetitive actions. It is normally labelled as a worry illness because the addictions often have a fear, such as catching a disease or the death of a parent.

Panic Disorder: In a panic attack, a sudden feeling of overwhelming dread or impending doom is experienced with intense physical sensations. Constant panic attacks and fear of panic can make the person think about future attacks and their implications, including thoughts of losing control, 'going crazy', or dying. A typical result of this worry is agoraphobia-stopping an enlarging amount of places and settings in which a panic attack might occur.

Separation Anxiety: This is the feeling afraid of being away from home or from their parents. This is normal in younger children. It is known as separation anxiety disorder and continues as a child ages. Children with separation worries might to go to a sleepover, sleep at a good friend's home, or go to a party without their care-givers. They might follow their parents to most places and even try to get into their bed at night. When the child senses a threat with separation from one of the parents, they develop psychological abnormalities. They usually are afraid of a separation and fear that either they or their parents will hurt

them. In older children, these feelings of might be associated with certain memories of falls, disease, or breaking the law.

Simple Phobias: Fear of specific objects or scenes is typical, normal, and usually temporary in young children. These phobias develop rapidly up to ten years of age and need conditioning for treatment only if they are excessive and unreasonable, continue for a long time, or occur at an inappropriate age. Some phobias include fear of thunderstorms, water, elevators, choking, blood, large animals, and insects.

Post-Traumatic Stress Disorder: This condition is the consequence of experiencing or witnessing a traumatic or horrifying event, such as a major accident, natural disaster, or physical or sexual assault. Severe child abuse can also be a cause. There are three kinds of symptoms. One is re-experiencing through intrusive memories, nightmares, a tendency to re-enact the traumatic event in compulsive way, and worry when exposed to anything that recalls some factors of the experience. The second group of symptoms results from a desperate need to stop thoughts and feelings about the people and places that are associated with the trauma. This avoidance might encompass more and more of life, eventually causing a numb detachment from one's own feelings and estrangement from others. The third set of symptoms is higher than usual arousal, shown through irritability, angry outbursts, jumpiness, insomnia, and poor concentration.

Causes of Childhood Anxiety

Children's anxiety conditions have both genetic and environmental roots. Anxiety disorders run in families. Twin and adoption research shows that heredity is a cause. This temperamental shyness impacts the later development of anxiety disorders. In recent researches, adults who had been judged as behaviourally inhibited at age two showed high activity in the amygdala, a focal point of fear scheduling, when they looked at the faces of strangers. Fearful emotions in monkeys and in humans are associated with abnormalities in the activity of the neurotransmitters dopamine and serotonin, and with high levels of corticotrophin releasing a hormone, which triggers the stress response.

The early home life can also add to anxiety conditions. Child abuse as a cause of post-traumatic stress conditions are a clear example, but less severe stress is also a factor. Children have a need to be close to their mothers or other guardians for physical and emotional well-being. Their fearful emotion of separation is deep in the emotional bonding needed for survival. Children who are not well attached are more likely to have anxiety conditions. Worried or mentally ill parents might make their children feel unsafe or neglected.

According to behavioural learning theory, fears arise from classical conditioning. An object, person, or situation becomes scary by pairing with something that is naturally frightening. This conditioned learning might then be moved onto other things. Operant conditioning, or learning by reward and punishment, also

helps to maintain anxiety conditions. For example, parents may pay attention to their child when the child exhibits worry.

Treating Children's Anxiety

Acknowledging these conditions in children can be hard because fear and worry are parts of many other diseases, which includes depression, Bipolar Disorder, and Attention Deficit Disorder. Parents are not always knowledgeable about children's symptoms of worry and teachers frequently give useful views based on their work with many children. Before diagnosing an anxiety problem, it is vital to first determine whether the child phobia is based on sound reasoning, such as abuse by a parent or a person picking on them at school.

The typical treatments reflect those for adult anxiety conditions, although children's developmental needs must be addressed and the family should be involved.

Cognitive and Behavioural Treatment

Cognitive Behavioural Therapy is the best treatment for anxiety disorders in children and adults. Its effectiveness has been shown in research that was conducted for as long as four years. A common method is by step-by-step exposure to scary objects or situations, with treats for success in facing fears. Young children with phobias, for example, can be put near the feared object and allowed to do something calm and enjoyable such as eating or playing with a favourite toy. Older children can be taught how to use deep breathing or muscle relaxation, or be taught how to talk themselves out of self-defeating and fear-provoking thoughts. Another method is modelling by asking the anxious child to copy the therapist or another child who expresses no fear.

Cognitive and behavioural methods usually works best in groups, which gives shy and fearful children the opportunity to make friends, increase self-confidence, and the opportunity to try new types of behaviour.

Involving the Family

Parents and other family members can help in many ways. They can be taught how to manage a child's anxiety. They can make room for cognitive behavioural therapy by giving models of self-confidence and problem-solving or treats for addressing fears. Sometimes, a family dispute, is the source of the child's anxiety, or an anxious child thinks they are the cause of any dispute in the family. In that case, joint family therapy in which all members take part might be a good idea.

Long-term study on the treatment of these conditions is rare and we know little about what works specifically for children, as opposed to adults. The influence of family and marital issues are substantial but difficult to number. There is little strong evidence that shows the positive and negative impacts of medications. Fortunately, children normally grow out of their fears or can be successfully treated. Shy

children do not always become adults with anxiety conditions. Even the effects of traumatic stress might disappear over the years. This is one field in which optimism is a good attitude for mental health professionals.

Repetition Problems

Obsessive Compulsive Disorder (OCD), Tourette's Syndrome, consistent repetitive rituals, hair pulling (trichotillomania), nail biting, simple motor and vocal tics, and isolated compulsions and obsessions all form part of a wave of psychological problems which is a focal point of the psychological concern. Children, who exhibit these behaviours (not Tourette's syndrome), often do so in respond to the stress associated with change.

Protective Factors

The probability that a treatment programme for OCD will work is determined by a mix of personal and environmental protective factors. It is important that these be looked at and included in the treatment plan since it is protective factors that usually serve as the basis for therapeutic change. Good health, a high IQ, an easy temperament, high self-esteem, an internal locus of control, high self-efficacy, and an optimistic attitude are all vital personal protective factors. Other important personal protective factors include mature defence strategies, functional coping mechanisms, advanced problem solving abilities, and an ability to make and maintain friendships.

Within the family, tight parent-child bonds and disciplined parenting are vital protective factors, especially if they happen within the context of a flexible family structure in which there is clear communication and high marital happiness and where both parents share the day-to-day activities of child support.

Good parental settling is also a protective factor. When parents have an internal locus of control, high self-efficacy, high self-esteem, internal working models for secure attachments, an optimistic style, mature defences, and functional coping mechanisms, they are better equipped to manage their children's OCD well. Of course, reliable knowledge about OCD is also a protective factor.

Within the broader social network, high levels of care, low levels of stress, and membership in a high socioeconomic group are all protective factors for children with OCD. When families are embraced in social networks that provide a high level of support and place few stressful demands on family members, then it is less likely that parents' and children's resources for dealing with OCD will become depleted. A well-equipped educational placement may also be seen as a protective factor. A good educational placement is where teachers have a clear understanding of OCD and have enough time and flexibility to go home. School liaison meetings add to good outcomes for children with OCD.

Within the treatment system, cooperative working relationships between the treatment team, the family, and good coordination of a multi professional input are protective factors.

Families are more likely to be positive about a treatment plan when they agree that the formulation of the problem is given by the treatment team and that they are committed to working with the team to fix it. If families have successfully had similar issues before, then they are more likely to benefit from treatment and in this sense, previous experience with similar issues is a protective factor.

Somatic Problems

Children and adults might be referred for psychological help with the focal point being a somatic problem. Somatisation or conversion symptoms, pain, adjustment to chronic illness, and preparing for anxiety-provoking medical and dental procedures are among the more common reasons for referral. In this chapter, normal childhood problems in each of these areas will be sorted out. Other conditions where somatic factors are involved include enuresis and encopresis, sensory impairment, head injury, eating disorders, drug abuse, and injuries attributed to physical abuse.

Development of the Concept of Pain

The growth of the child's idea of pain is affected by both cognitive maturation and the child's previous experience of pain (McGrath, 1995). Children, younger than 18 months, can indicate they are in pain by crying or simple speech but are unable to differentiate between or label different levels of pain intensity. Rating scales rather than self-report scales are considered the best way to look at changes in pain levels in children at this stage of development (McGrath, Johnson *et al.,* 1985). Children of eighteen months can express that pain hurts. They can say where the pain in their own bodies is located and they can see pain in others. They can understand that their experience of pain may be relieved by asking for medicine or receiving hugs and kisses from caregivers. They may also try to relieve pain in other people by offering to hug them. At approximately two years of age, more elaborate descriptions of pain happen and children can more clearly attribute pain to external causes. By three or four years of age children can differentiate between differing intensities and qualities of pain and tell about their pain. Poker chips or counters might be used as concrete symbols of pain, and children as young as three years might be asked to identify the intensity of their pain using such concrete signs (Hester *et al.,* 1990).

By three years old, children are also aware that certain methods such as distraction might be used to deal with pain. Children at this age might be aware that playing when they have hurt themselves may help them feel better by distracting them away from the pain. Children between ages five and seven become better able at stating differing levels of pain intensity and may be able to use face scales to show changes in pain experiences (Bieri *et al.,* 1990). On face scales, children show the intensity of their pain by selecting, from a range of faces expressing a mixed amount of pain, a face which most replicates their own experience of hurt. Between the ages of seven and ten years, children can answer why pain hurts. Once they reach adolescence, they can describe the adaptive value of pain for protecting people from harm.

A psychological method to address somatic complaints might have one or more of the following features:

- Close liaison with referring physician
- Careful contracting for assessment
- Thorough child and family assessment
- Careful contracting for treatment
- Family-based methods
- Psychological-education
- Monitoring of symptoms
- Relaxation-skills teaching
- Cognitive-restructuring and self-instructional-skills teaching
- Coaching parents in contingency leading

Family-Based Treatment Approach

A family-based approach to illness leadership tries to help family members communicate clearly and openly about the condition, symptoms, and related problems. This helps in defining family limits and increase the autonomy of the child in symptom management; to decrease the emotional level of parent-child interactions related to the symptom; to agree on joint parental issue solving with respect to the symptom: to maximise the parents' support of the poorly treated child and siblings; and to maximise parents' use of health-care and support groups.

To meet these objectives, children may attend treatment classes with other children to help them learn symptom-management techniques such as relaxation exercises, breathing exercises, visualisation, distraction, and self-instruction. Nevertheless, other treatment classes should involve the parents and siblings, who may feel forgotten if family life is organised around the ill child.

Psychological Education

In psychological educational classes, parents, sick children, and their siblings are trained in the basic facts about the illness and specific facts about the symptomatic child's particular condition. Information on clinical factors and predisposing, precipitating, maintaining and protective factors should be provided, along with the effects of the condition on cognition, behaviour, family adjustment, school adjustment, and health over the person's lifetime.

Information about the medical treatment scheduling, covering medication, exercise, physiotherapy, diet, tests, medical crisis management, should be given both orally and in written form in a format that is easily understood by the parents and the child. Psycho-educational training might be offered in individual classes, family classes, or group classes. For many conditions such as diabetes, there are now interactive step-by-step software programs available that allow children to learn about their condition at their own

speed. These have the benefit of being highly motivating for children and interesting to use. Nevertheless, these programs should always be given with individual help to answer the child's specific enquiries. Family psycho-educational classes allowed the family to share an understanding of the condition.
Group psycho-educational classes provide a forum where children and parents can meet other families in the same situation. This has a positive effect on future care for family members.

Monitoring of Symptoms

For all somatic issues, it is good to teach children and parents to write down information frequently about each symptom, the factors about its occurrence, and treatment adherence. Intensity levels, frequency counts, duration, and other features of symptoms may be recorded regularly. Intra-psychic and interpersonal events that happened before, during, and after the symptoms, may also be noted. The amount of medication used; particular foods that were eaten; particular exercises that were completed; and results of tests such as blood sugar or peak-flow meter levels might all be monitored in normal ways on a constant basis. When inviting parents and children to use a monitoring system, the chances of their co-operating are good if a basic system is used to start. Later, more complex versions of it may be introduced. For example, children with headaches may record the levels of their pain three times a day for a week to begin. Later, when they have become used to the practice of self-evaluating, they might be invited to also record information about drug usage. A page from a plain diary can be used with headaches, abdominal pain, and other types of pain.

Relaxation-Skills Training

Stressful events that increase physiological arousal may precipitate, maintain, or exacerbate many symptoms including pain, asthma attacks, epileptic seizures, and changes in diabetic blood-sugar levels. For this reason, teaching relaxation skills is a core element of most treatment schedules.

Cognitive Coping Strategies

The degree to which children focus their attention on their symptoms, the way in which they study them, and the behavioural and interpersonal routines that they do to manage their symptoms; all tends to encourage children's overall psychological change to somatic complaints. In specific settings, it may be necessary for children to study ways to distract themselves from their symptoms by thinking about something else or becoming engaged in an activity that stops them from thinking about their illness. Distraction might be good for dealing with a number of pain types, especially continuous abdominal pain, which might come from focusing on and worrying about little things in internal physiological moods. Children might be helped to make their own distracting activities, such as listening to their favourite music or favourite story on a personal stereo; playing with a favourite toy; or reciting favourite poems.

When children have created weakened behaviour routines and interpersonal routines in response to their symptoms, they might be helped to break out of the unwell character by planning different ways of acting and dealing with their interpersonal relationships. That is, they might be invited to think of ways to replace illness or pain with being healthy.

Further Reading:

- ✓ ***Emotional And Behavioural Difficulties In Middle Childhood Identification, (1994), By Maurice Chazan, Alice F. Laing, Diane Davies***
- ✓ ***Developmental Contexts in Middle Childhood: Bridges to Adolescence and Adulthood, (2006), By Aletha C. Huston, Marika N. Ripke***
- ✓ ***Development During Middle Childhood: The Years from Six to Twelve, (1984),edited by W. Andrew Collins***