Unit 1.1

Foundation Concepts for child and youth practice

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Unit 1.1: Foundation concepts for child and youth mental health practice

Unit Descriptor

This unit provides an introduction to foundational frameworks used in conceptualising what is happening for a young person and their family when they come to consult with a clinician at child and youth mental health. It explains the usefulness of the bio-psycho-socio-cultural model and the importance of understanding developmental continuums and interruptions to these.

This unit also provides a basic introduction to the stages of development and the developmental issues arising in childhood and adolescence. It addresses biological, psychological and social development across the stages and discusses the causes of developmental delay/failure and the impact of abnormal development on functioning. It provides clinicians with a framework for understanding children and adolescents and describes how such information can have implications for assessment, diagnosis, treatment planning and development of the therapeutic relationship.

Additionally, the unit also provides a brief overview of common presentations seen at CYMHS but is by no means a comprehensive analysis. Further study on each diagnostic category should be undertaken to provide a sound clinical understanding.

Objectives

- Identify some of the foundational frameworks used in CYMHS
- Identify the importance of taking a history over time from preconception to now, through developmental stages and across bio-psycho- social and cultural dimensions
- Describe the limitations of a single model approach to formulating understandings
- Discuss useful schema around categorising disorders as internalising or externalising disorders
- Identify the common mental health disorders of childhood and adolescence
- Provide an overview of the principles / continuums of child and adolescent development
- Outline causes of developmental delay or failure to negotiate developmental tasks.
- Identify common psychological and emotional problems in children and adolescents.
- Outline basic strategies to communicate effectively with children and adolescents.

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Unit 1.1

Foundation Concepts for child and youth practice

DVDs and Associated Learning Materials

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DVD 1: Foundation Concepts for child and youth mental health practice

Presenter: Associate Professor Brett McDermott

DVD Overview

Associate Professor Brett McDermott speaks about useful models for understanding the complexities of child and youth mental health presentations. He describes an approach to collection of information on a developmental continuum across bio-psycho-social aspects of a child's life and located in culture.

He also speaks of developmental trajectories, interruptions to the continuum of development and the predictors for success of therapeutic intervention and change.

Please now watch the DVD and to enhance the retention of your learning, answer the questions related to the DVD in the section on Reflection Questions.

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Associated Learning Materials

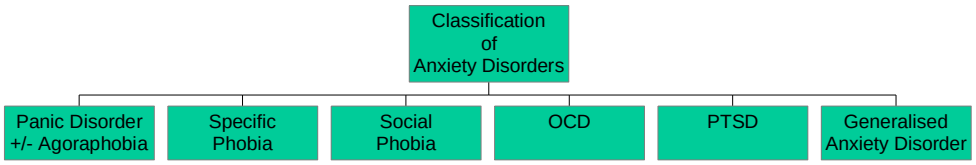
1. Notes from Power Point : Foundation Concepts for Child and Youth Mental Health Practice

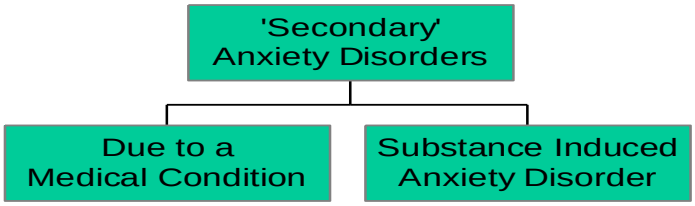
Assoc. Professor Brett McDermott
University of Queensland
Director Mater Child and Youth Mental Health Service

Key Elements

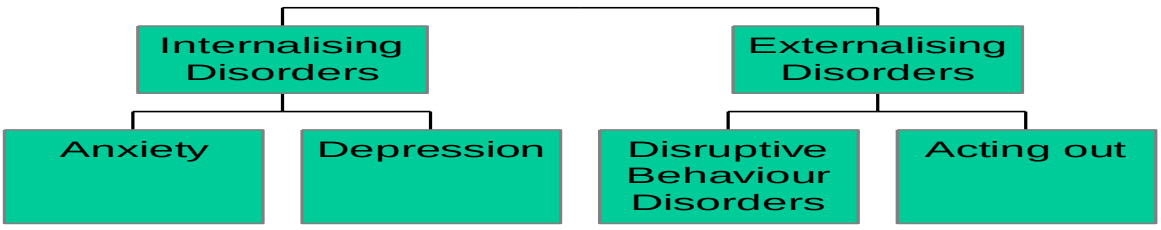
- A Developmental Framework
- A Systemic Perspective
- A Holistic 'Bio-psycho-social' view
- Understanding mental health co morbidity

Medical ('categorical') Diagnostic Schema





Modified Diagnostic Schema



Separation	Grief	Oppositional DD
OCD	Reactive	Conduct Disorder
Phobias	Depression	ADD+-H
School Refusal		

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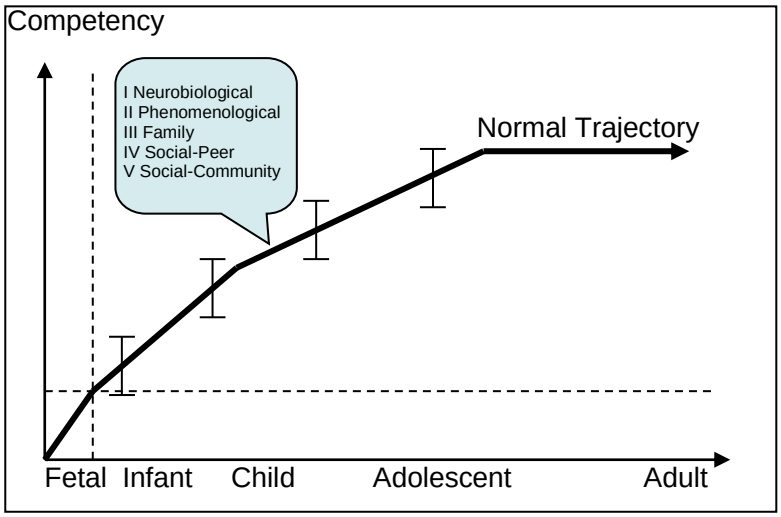
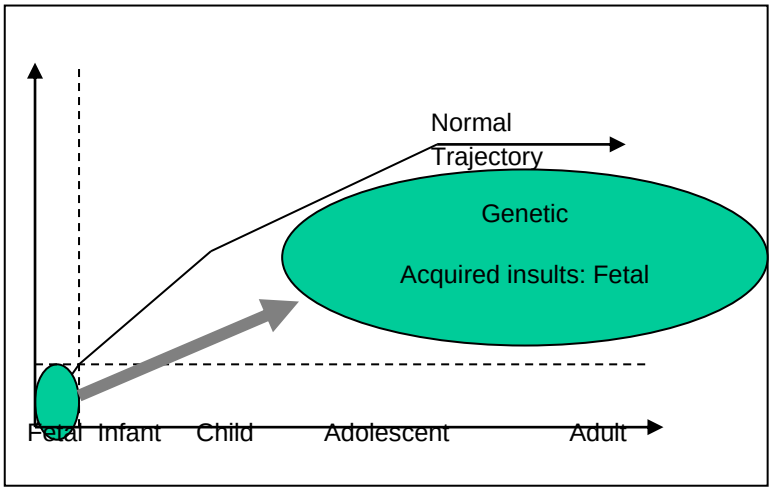
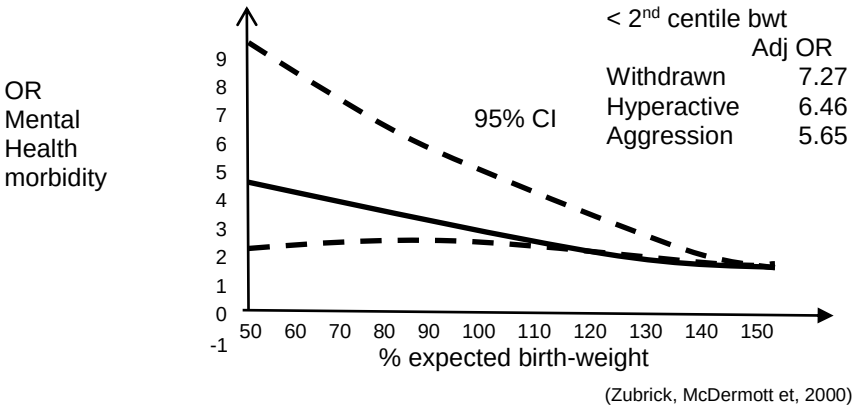
Developmental Perspective



Fetal



Intrauterine growth retardation



(Zubrick, McDermott et, 2000)

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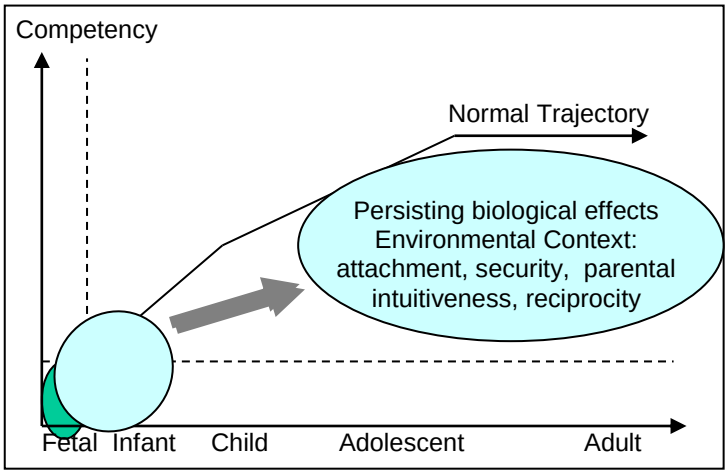
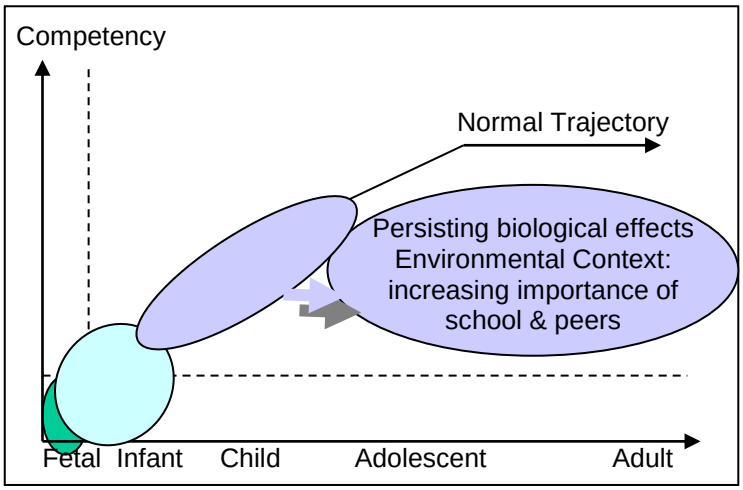
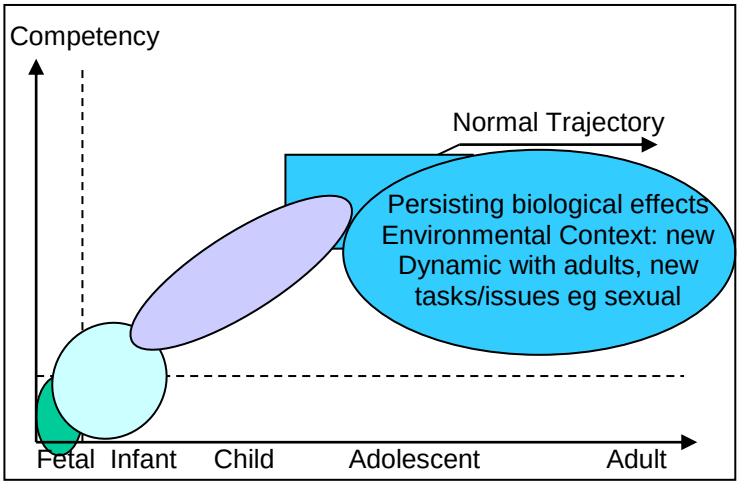
Infant



Child



Adolescent



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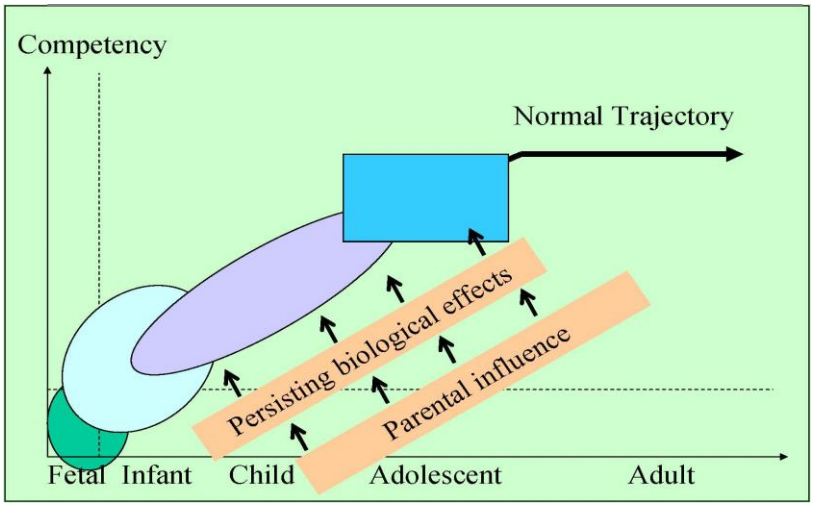
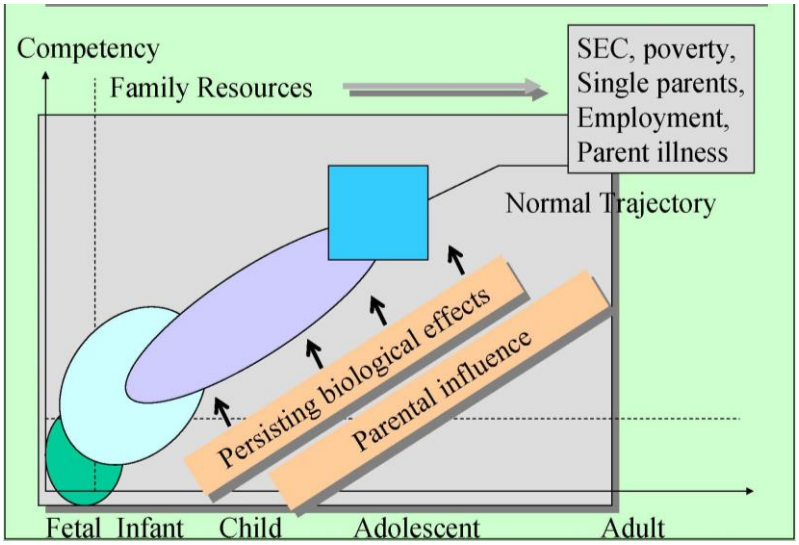
Continuous influences



Environmental influences



Language exposure?

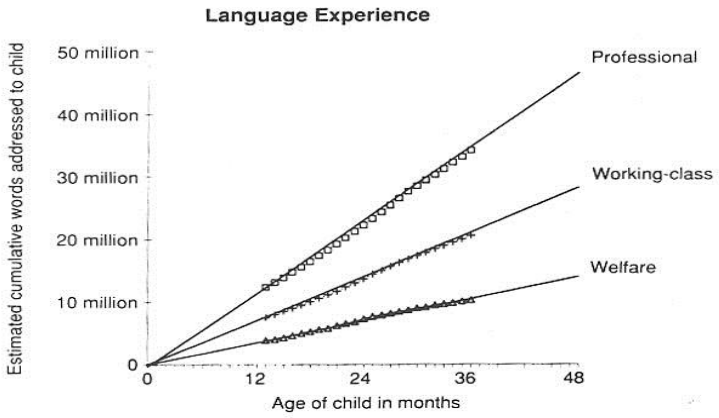


Figure 19. Estimated cumulative differences in language experience by 4 years of age. (See Appendix B for a detailed explanation of this figure.)

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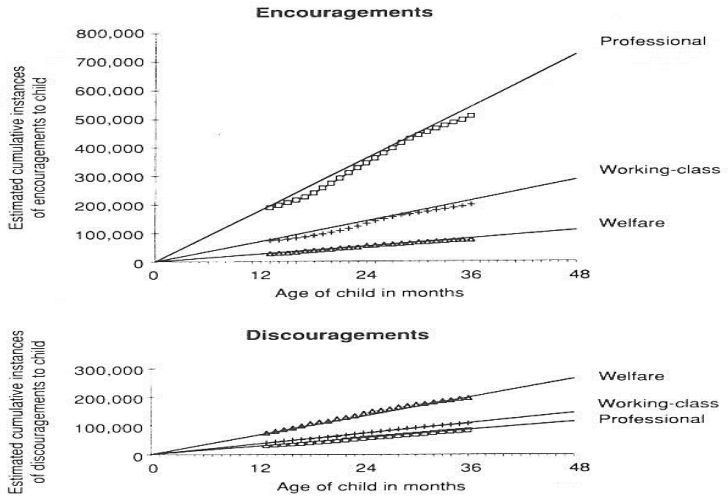
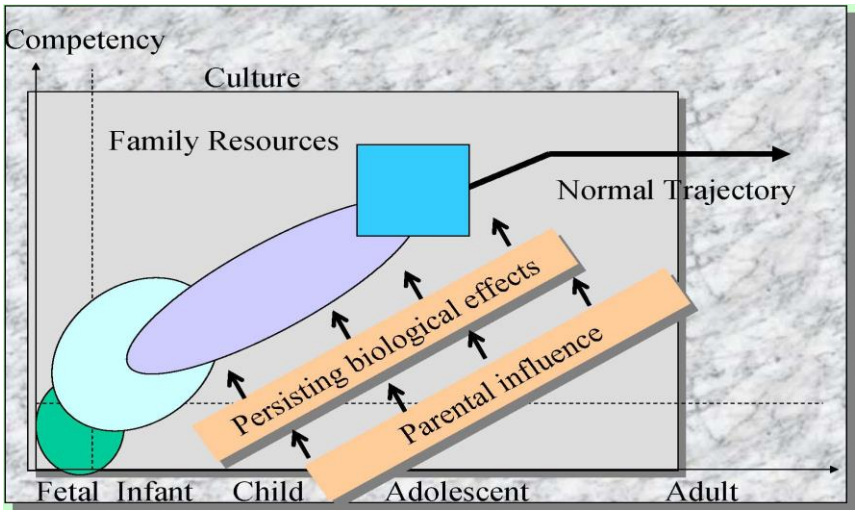
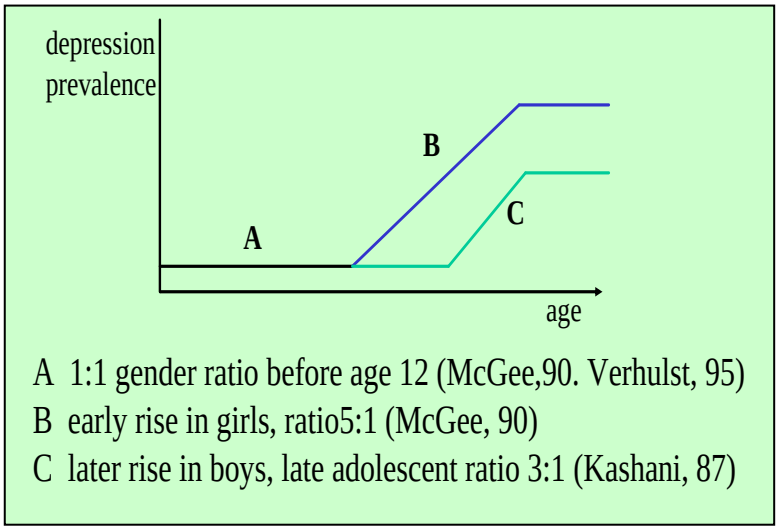


Figure 20. Estimated cumulative differences in confidence-producing experience by 4 years of age. Note the reversal of the lines in the bottom graph, reflecting the prevailing negative Feedback Tone in the welfare homes. (See Appendix B for a detailed explanation of this figure.)

Cultural influences



Epidemiology of Depression: Developmental Perspective



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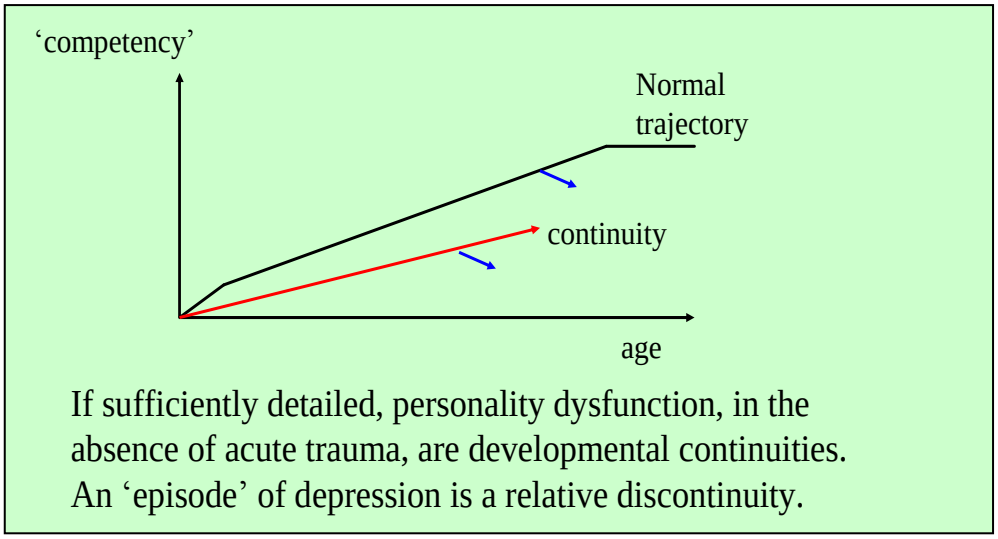
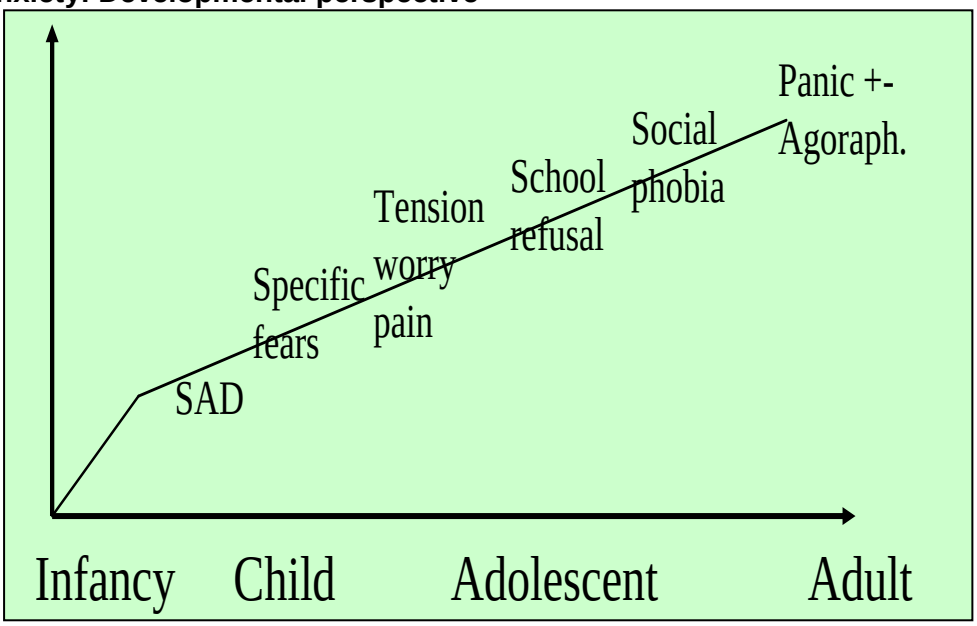
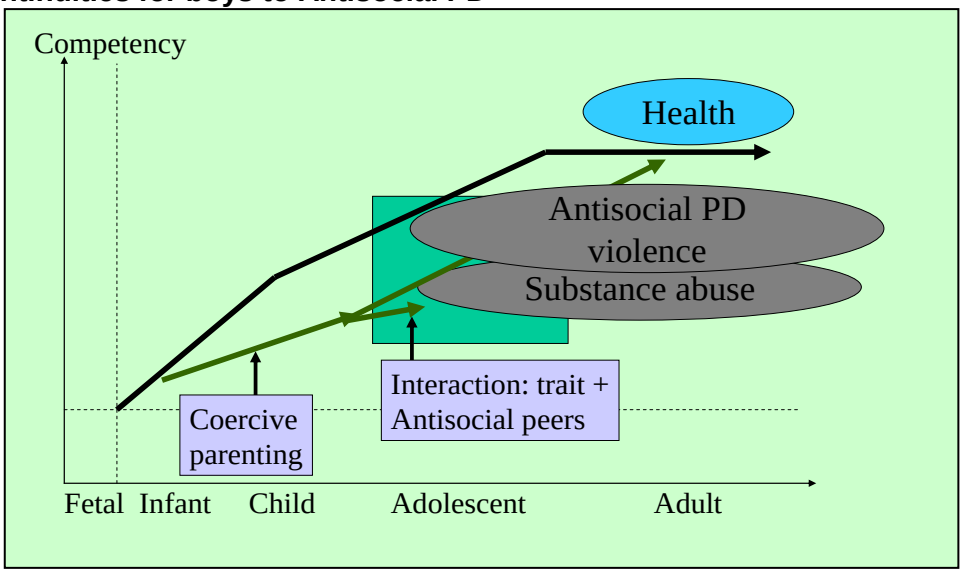
Depression: diagnostic issues: state versus trait



Anxiety: Developmental perspective



Continuities for boys to Antisocial PD



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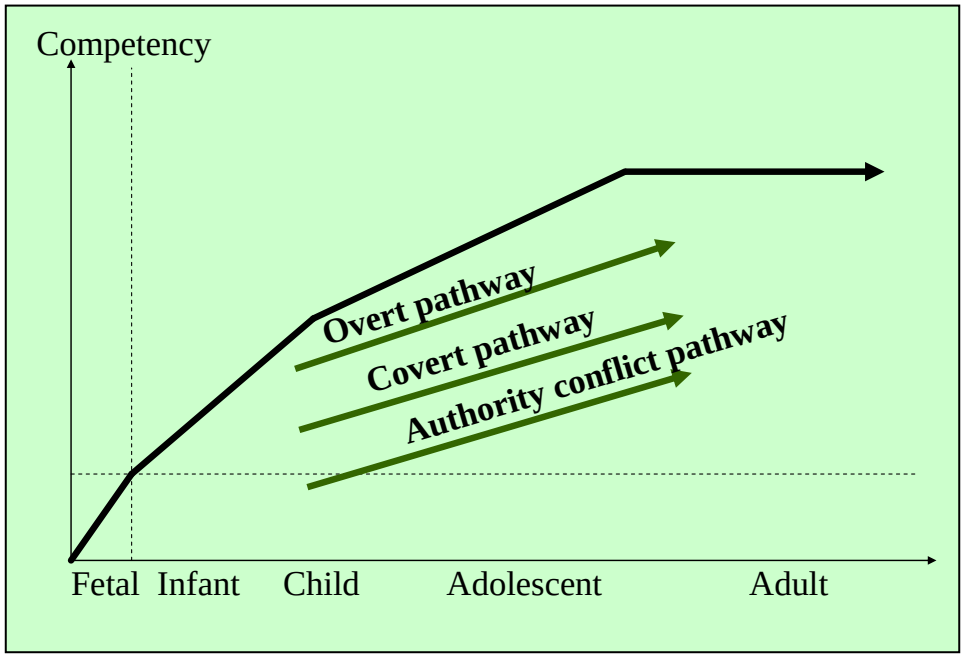
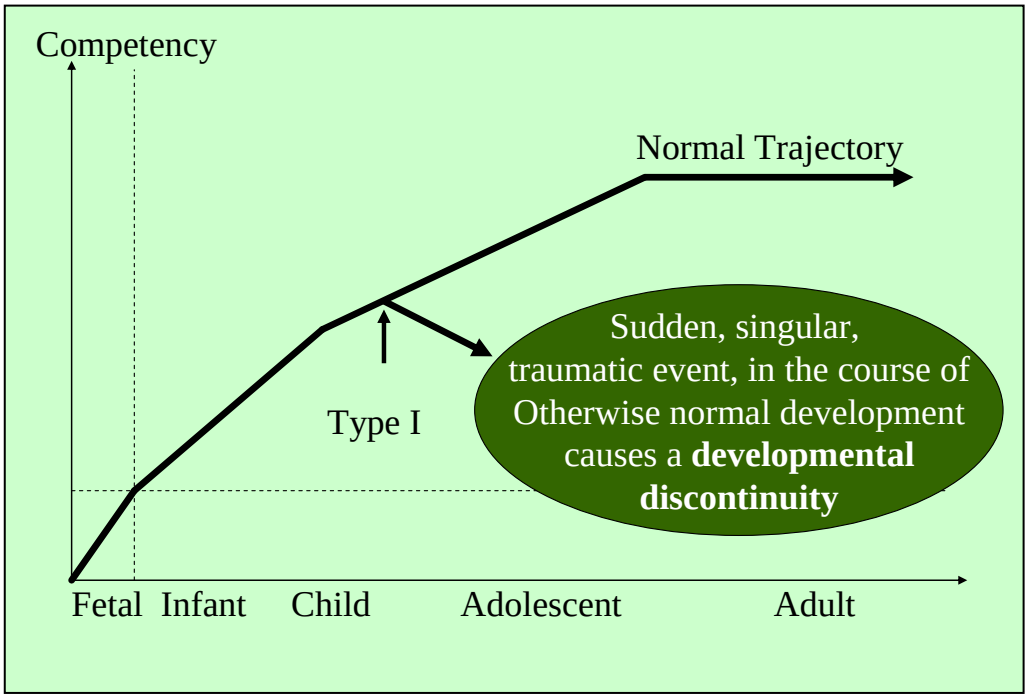
Continuities for boys to Antisocial PD



Emotional trauma/PTSD: type I (versus II)



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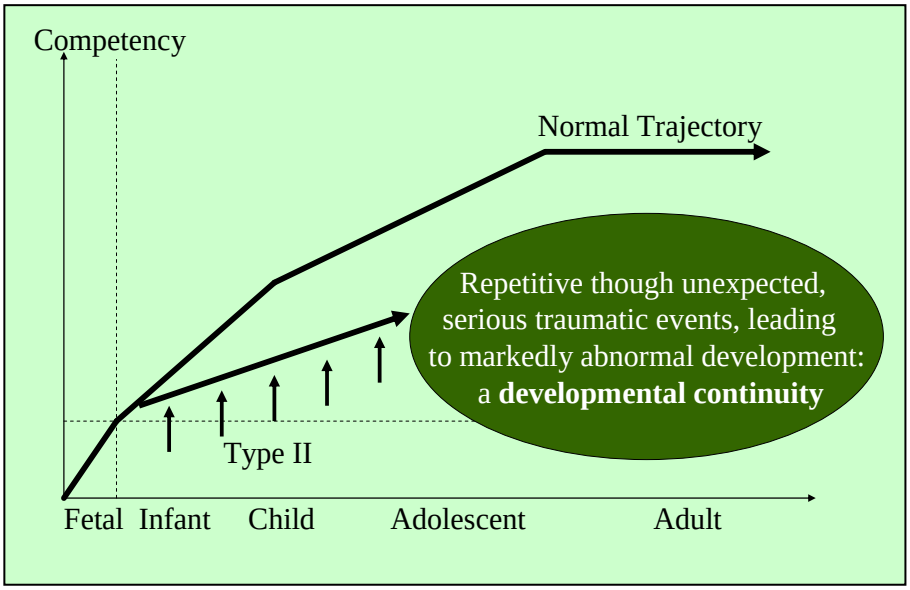
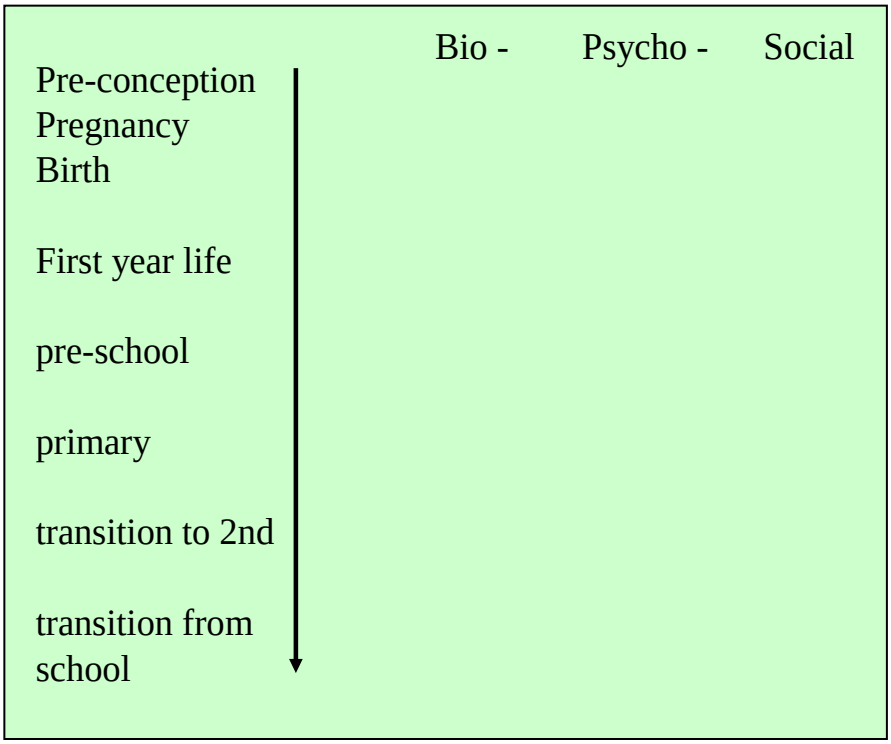
Type II trauma



Time-Line



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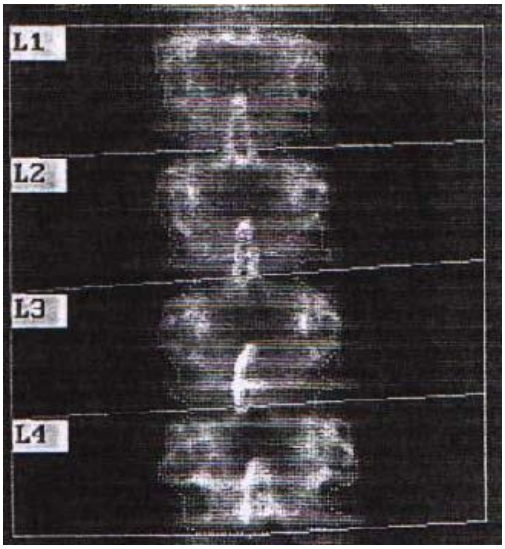
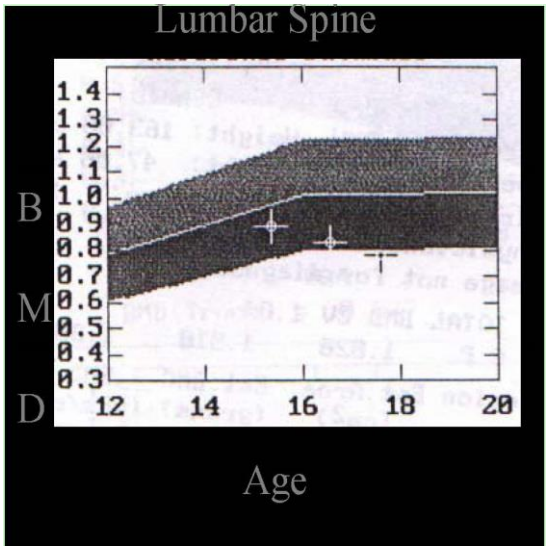
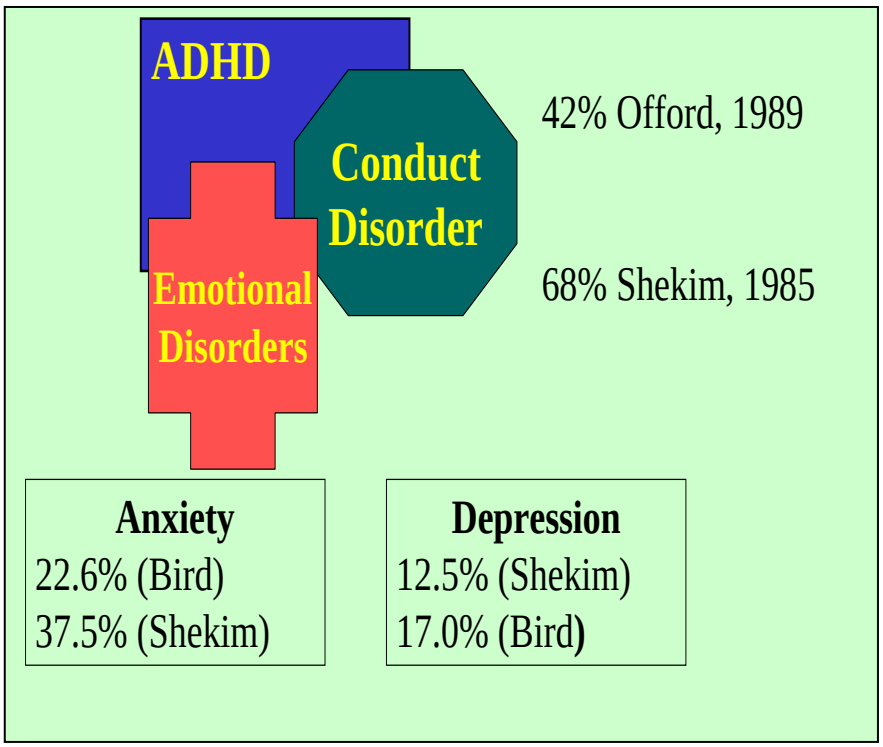
Lumbar spine Density in 15 yr old with Anorexia nervosa





Comorbidity



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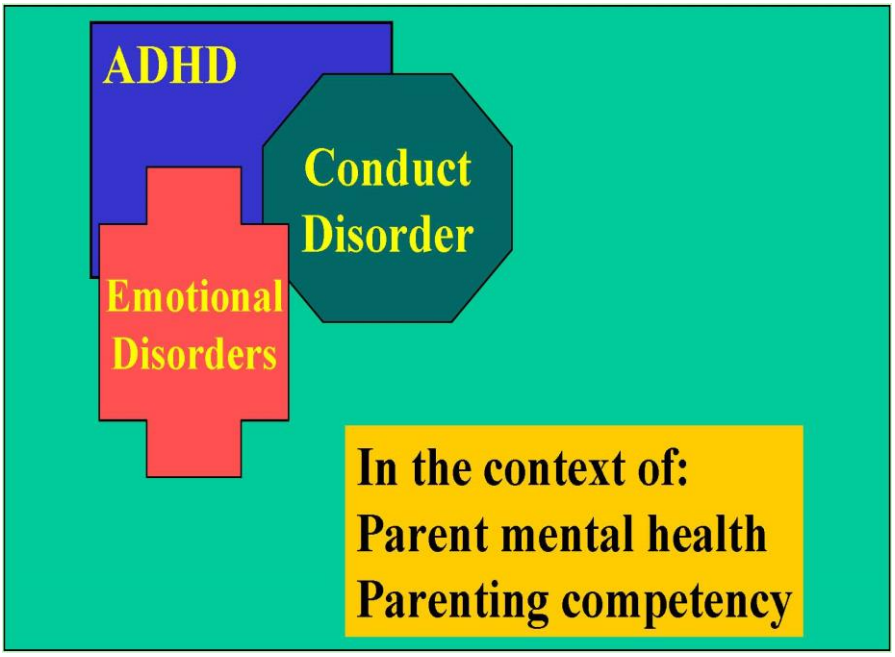
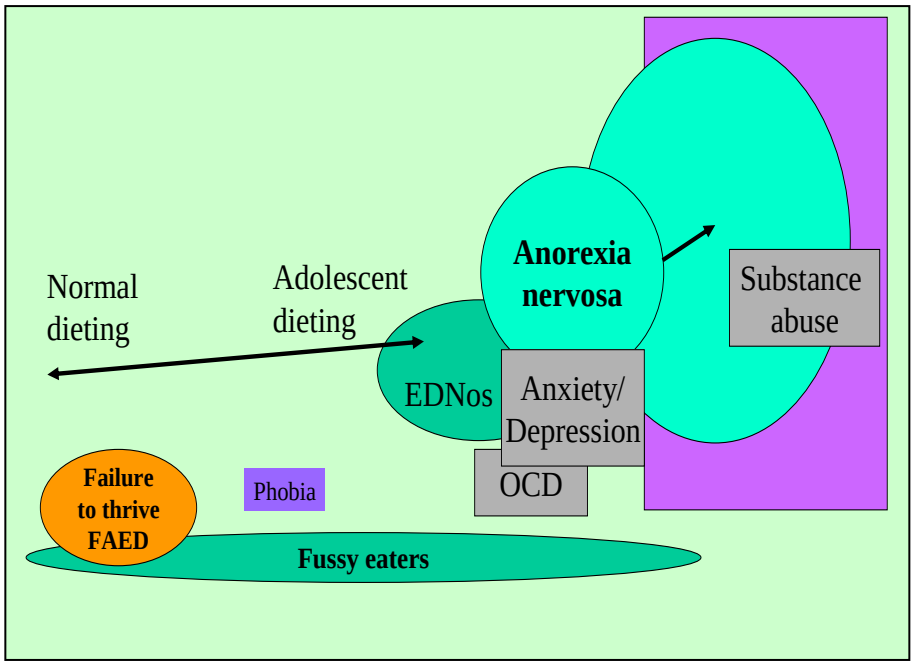
Comorbidity in CYMHS



Development & co-morbidity



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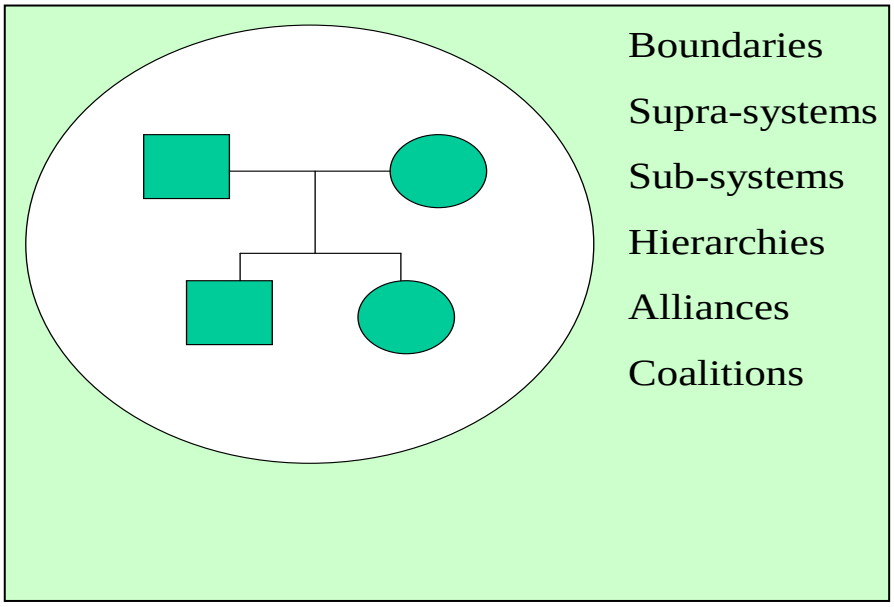
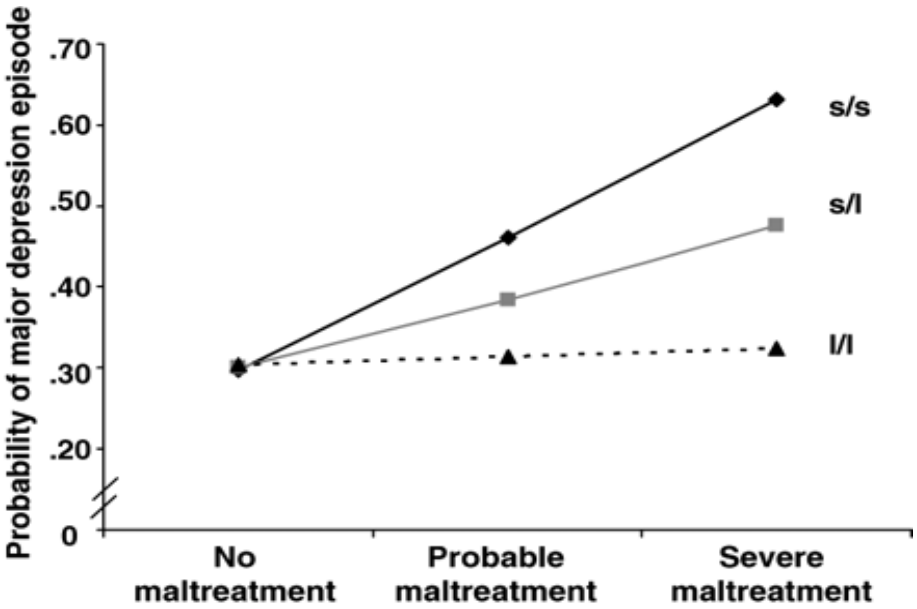
Systemic Issues



GxE: 5-HTT

Functional polymorphism in promoter region of serotonin gene.



Caspi et al., Science, 2003

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Summary

- Medical model does not get you very far in child and adolescent mental health
- Understanding the child's social ecology = a system perspective
- Understanding where a child is across it's lifespan = a developmental perspective
- Understanding the child = a bio-psycho-social stance
- Dimensional constructs often as useful as categorical (where categorical =diagnostic)

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Reflection Questions

Please answer the following questions from the information presented on DVD 1 and from the accompanying power point summary and notes provided.

1. Why is using a single model approach to child and youth mental health not considered very useful?

2. Can you describe some of the components of a holistic view.

3. List as many of the main internalizing disorders seen at CYMHS as you can

4. List as many externalising disorders seen at CYMHS as you can.

5. Which behaviours are the most easily identified and reliably reported on by parents and teachers?

6. At what stage should collection of a history start from and why would we be interested in this stage?

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7. What are 2 reasons why infancy is such a crucial period of development?

_____

_____

_____

8. Identify 2 of the tasks that require mastery at the Early Childhood stage?

_____

_____

9. What are some of the struggles of adolescence that Professor McDermott mentions? (These relate to developing crucial orientations and the forming of identity conclusions)..

_____

_____

_____

_____

_____

10.. What caught your attention related to the power of families in the data presented from the '*Every day experience of American children"* study?

_____

_____

_____

_____

11. A discontinuity occurs in development when a one off episodic event causes the young person to fall below the normal developmental trajectory in some way. Can you provide an example of this?

_____

_____

_____

_____

12. Name 3 transitional times across the educational time span.

_____

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Suggested Responses to Reflection Questions

The answers following are suggested responses and do not represent all possible answers. Check with your supervisor if you are unsure if your answers are fitting or if you require feedback.

1. *Why is using a single model approach to child and youth mental health not considered very useful?*

   A- There are multiple influencing factors, systems and changes at play during this period. To use one model (such as the medical model) is to ignore the complexities of the presentation of not only the individual but also their family.

2. *Can you describe some of the components of a holistic view.*

   A- A holistic view entails looking at the child and their surrounding systems from a biological, psychological and social point of view, across time and located in a context of culture

3. *List as many of the main internalizing disorders seen at CYMHS as you can*

   A – Anxiety : Separation anxiety, OCD, Phobias, School refusal, PTSD, Generalised Anxiety Disorder.
   Depression: grief, reactive depression

4. *List as many externalising disorders seen at CYMHS as you can.*

   A – Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit Disorder (with or without hyperactivity)

5. *Which behaviours are the most easily identified and reliably reported on by parents and teachers?*

   A – Externalising disorders as they are the most easily observed and usually affect others in a more obvious way

6. *At what stage should collection of a history start from and why would we be interested in this stage?*

   A – A history from the parents should start form the Preconception phase. We are interested in whether the child was wanted and to get some idea of the context of the environment, pressures and relationships the child would be entering in to.

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7. *What are 2 reasons why infancy is such a crucial period of development?*

   A- The brain is making the most synaptic connections that it does across the whole life span. 40,000 synapses per second in the first month of life. It is also the main time in life to build key constructs which will sustain relationships over the life span. Through the relationship with the primary caregiver, experiences of security and attachment are established.

8. *Identify 2 of the tasks that require mastery at the Early Childhood stage?*
   Developing play skills – learning to play co-operatively and share toys. Mastery of co-ordination skills – gross and fine motor. Learning about boundaries and limits/ rules in a school environment. Early social skills and continuing language development.

9. *What are some of the struggles of adolescence that Professor McDermott mentions? (These relate to developing crucial orientations and the forming of identity conclusions).*
   A -Struggle in passage through the developmental tasks in establishing crucial orientations around
   1. Sexuality
   2. Morality
   3. Political leanings
   4. Educational and occupational pathways
   5. Experiment with peer groups
   6. Experiment with defining identities eg: Emos, Goths, sports jock

10. . *What caught your attention related to the power of families in the data presented from the 'Every day experience of American children" study?*

    A- There were great differences in both the amount of and experience of the type of words used between professional families and working class and welfare families. Children from professional families had by far a greater exposure to words and also to encouraging words from their parents. As well as possibly promoting language development, this would indicate a more positive and emotionally supportive home environment.

11. *A discontinuity occurs in development when a one off episodic event causes the young person to fall below the normal developmental trajectory in some way. Can you provide an example of this?*

    A – A child has a car accident, has no previous history of anxiety but now has anxiety problems. Difficulties are mostly around leaving the house.

12. *Name 3 transitional times across the educational time span.*

    A- Starting preschool, starting primary school, starting high school, changing schools and leaving school

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Unit 1.1

Foundation Concepts for child and youth practice

Additional Learning Materials

Thank you to the following people who contributed information to this section:

Margaret Morrison-Cash, CYMHS Rural and Remote Practice Supervisor
Narelle Anger, Principal Speech Pathologist, CYMHS
Matthew Cartwright, Senior Project Officer, Queensland Health

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Additional Learning Materials
Child and Adolescent Development

Adapted from: CYMHS Inpatient Training Program - Introduction to Mental State Assessment and Interviewing the Child and Adolescent . Developed by Matthew Cartwright, Senior Project Officer, CYMHS

Introduction

The purpose of this module is to provide staff with a basic introduction to developmental issues of childhood and adolescence. The reader is encouraged to explore this area in more detail. Understanding normal and abnormal development assists with assessment, diagnostic reasoning, treatment planning and development of the therapeutic relationship.

The stages of development can be seen as a "psychosocial crisis" which arises and demands resolution before the next stage can be satisfactorily negotiated. These stages are conceived in an almost architectural sense: satisfactory learning and resolution of each crisis is necessary if the child is to manage the next and subsequent stages satisfactorily, just as the foundation of a house is essential to the first floor, which in turn must be structurally sound to support the second storey, and so on.

Helping the child through the various stages and the positive learning that should accompany them is a complex and difficult task, but an understanding of these stages for the inpatient clinician will assist in the child in mastering and negotiating the tasks.

Principles of Development

The strands of bio-psychosocial development**:**

Human development proceeds via the acquisition of structures and functions in biological, psychological and social domains.

Biological development occurs in the following**:**

- Physical structure and function
- Autonomic, immunological, neuroendocrine and subcortical controls
- Sensorimotor integration

Psychological development occurs in:

- Information processing
- Communication
- Conscious and unconscious images, emotions, thoughts and attitudes re self, mind, body, other people, and the world (i.e., working models or representations of the self, significant others and the world).
- Moral reasoning
- Methods of coping with stress (including defence mechanisms)

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Social development occurs in:

Social skills. The capacity to understand and predict others' feelings or intentions, to interact with others in a competent manner, to conduct a discourse, and to solve inter-personal problems

Developmental stages

Even those developmental theories that de-emphasize the concept of developmental stages find it convenient to describe development in epochs such as the following:

- Infancy (0 - 1 1/2 years).
- Early childhood (1 1/2 - 5 years).
- Middle childhood (6 - 11 years).
- Adolescence (12 - 20 years).
- Young adulthood (21 - 35 years).
- Middle adulthood (35 - 55 years).
- Late adulthood (55 - 70 years).
- Senescence (70+ years).

Developmental Failure – causes include:

- Chromosomal abnormality
- Exposure to physical hazards (pre- and post-natal).
- Deprivation or loss of physical needs.
- Failure of appropriate stimulation at a sensitive period.
- Deprivation or loss of psychosocial needs and lack of appropriate learning experiences.
- Sociocultural disadvantage.
- Exposure to psychological trauma or developmentally distorting experiences.

Abnormal Development

- Genetic deviance in interaction with adverse intrauterine, perinatal, and extrauterine environment.
- Lack of appropriate or adequate stimulation during a sensitive period can lead to retardation or arrest. For example, lack of early attachment leading to affectionless psychopathy.
- Abnormal development is manifest as slowing, arrest, regression, precocity, unevenness, or deviance (compare, respectively, profound mental retardation, mild mental retardation, precocious intellectual development, infantile autism, and the idiot savant phenomenon).
- During abnormal development systems interact in such a way that disturbance in one-system affects related systems

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Speech and Language Development , The Development of Theory of Mind and Symbolic Play Development

Are all showcased via tables on the following pages.

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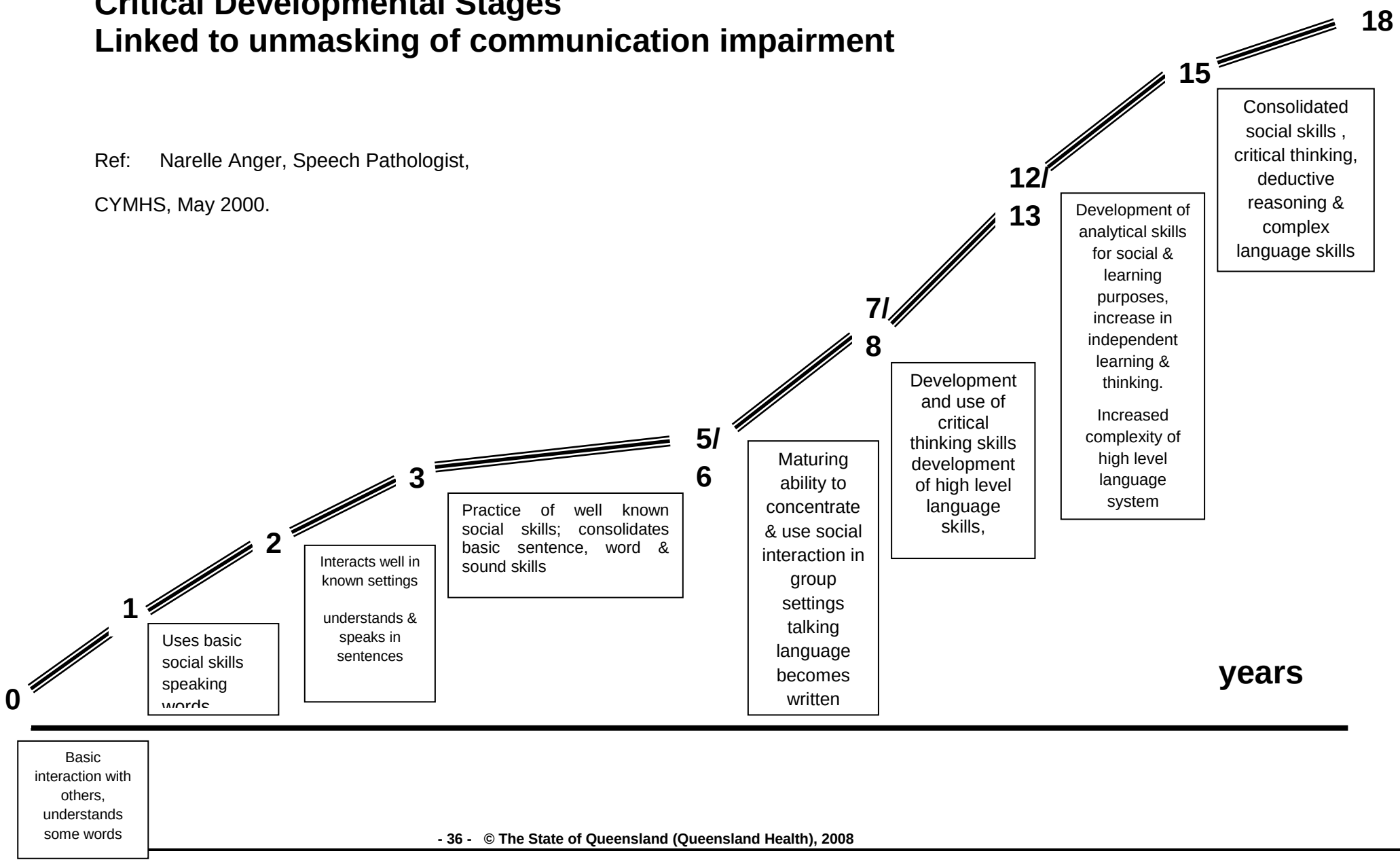
Critical Developmental Stages
Linked to unmasking of communication impairment

Ref: Narelle Anger, Speech Pathologist,

CYMHS, May 2000.



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Age	Receptive Language	Expressive Language	Pragmatics
0 to 12 mths	• responds to loud sounds • recognises familiar voices eg. mums voice • recognises familiar routines eg. bathing • responds to his name • understands the difference between a angry voice and happy voice • recognises common objects by name eg. car • understands "No" • follows simple commands	• cries when hungry • smiles • makes sounds in response to speech • copies speech sounds • uses simple gestures such as wave or clap • shouts to attract attention • responds by shaking or nodding head • says 2 - 3 words beside "mum or dad" • names familiar objects or people • indicate basic wants and needs eg. biscuit or juice • recognises a word as a symbol for an object eg. "car - points to a garage "	• enjoys being cuddled • lifts head to look at sound • enjoys looking in the mirror • enjoys Peek a Boo • friendly with strangers • shows anxiety when someone leaves the room • looks for a toy falling from a table or pram and searches for a toy rolling out of sight in the correct place • watches the movements of other people • uses gestures such as waving
1 to 2 years	• shakes head correctly for simple yes/no questions • enjoys simple rhymes and songs • recognises name • gives a toy on request • understands simple directions • recognises some body parts eg. "nose" • looks for a toy when it rolls out of sight in the correct place • understanding many words	• names familiar objects • names familiar people • uses 10 - 20 words • combines two words eg. "all gone" • uses two word to make wants known eg. "more up" • points and gestures to call attention to an event or to show wants • echoes the prominent or last words said	• plays alone but likes to be near an adult • alternates to clinging and resistance • uses gestures • maintains eye contact • looks at speaker • engages in simple turn taking eg. roll the ball
2 to 3 years	• points to 5 body parts • understands simple questions and commands • listens to stories with pictures • match sounds to animals eg. cat - meow • select correct items from a choice of five upon request eg. "Show me the cup" • understands simple time concepts such as "last night " or "tomorrow" understands "big" & "little" • matches three to four colours	• has 300 to 450 words. • knows first name • sentences of 2-3 words • forms some plurals by adding "s" • uses past tense • combines nouns and verbs • asks " What and Where " questions • uses "No " or "Not "and may say "No " when actually means "Yes" • can name common pictures or objects that he/she comes into regular contact with. • refers to self by using "Me"	• copies housework • have no idea of "sharing" eg. toys and adult attention • plays near other children but not with them , occasionally join in for a few minutes • usually very active or restless • tantrums when frustrated shows emotions eg. happy , sad, excited

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Age	Receptive Language	Expressive Language	Pragmatics
3 to 4 years	• knows time concepts eg "night", "day", "lunch time", "summer", "tonight" • understands prepositional phrases, e.g. "put the block under the chair" • identifies object by function, e.g. "what do we eat with" • knows several nursery rhymes • seems to understand most of what is said to him • listens eagerly to new stories • can match primary colours	• knows his/her last name, gender, name of street. • Can tell a story or relay an idea to someone • has a sentence length of 3-4 words • has a vocabulary of 1000 words • asks "What" questions frequently • names one colour	• can stay with an activity for 8-9 minutes • enjoys dramatic make-believe play including pretend objects and people • joins in and plays with other children • show affection for younger siblings • understands sharing although won't always do so
4 to 5 years	• understands past, present and future (e.g. today, tomorrow, yesterday) • understands some simple opposites • puts simple objects into groups (e.g. foods) • knows several colours • follows commands even though objects aren't present • identifies triangles, circles, squares	• has a sentence length of 4-5 words • asks "who" and "why" questions • begins to say complex sentences • uses past tense correctly • has vocabulary of 1500 words • asks many questions although more interested in how answers fit with his/her own thoughts • tells long stories often confusing fact and fantasy • gives a connected account of recent events and experiences.	• takes part in a short group time activity • stays with one activity for 11-12 minutes • talks to friends while playing • understands turn-taking • shows concern for younger siblings and sympathy for playmates in distress
5 to 6 years	• knows spatial relations like "on top", "behind", "far" "near" • understands common opposites like "big / little", "hard / soft" • understands "same" and "different" • uses future, present and past tense • understands humour • knows "right" and "left" • learns how to tell and use time	• describes what objects are made of • has a sentence length of 5-6 words • has a vocabulary of around 2000 words • counts 10 - 30 objects • carries a plot in a story • asks questions for information • speaks in complete sentences • uses speech that is fluent and grammatical • asks the meaning of abstract words	• can stay with an activity for 12- 13 minutes • general behaviour is sensible, controlled and independent • understands the need for rules and fair play • continue a game from one day to another • be protective towards other children • chooses own friends

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Age	Understanding Language	Expressing Language	Pragmatics
6 to 9 years	• **Little understanding of metaphor, literal interpretation eg. "as stony as a guard's face" interpreted as the face is stony because the prison has stone walls);** • **Emerging ability to understand words can have more than one meaning (eg. sweet - a lolly or a taste);** • **Greater understanding of complex sentences:- implied negation (eg" These two are different"), passive sentences (eg "The ball was kicked by the boy), clause structure : if, then, neither/nor** • **firm grasp of all tense forms that is past, future and present progressive.**	• **Able to describe an object by associating it with other like objects. (eg. "bottle - is like a can only you can see through it)** • **Difficulty in conversing about events that are not visible;** • **Ability to express metaphor is visual or concrete (eg "soft as a pillow; bright as the sky");** • **Able to express a complex sentence using coordination (ie. and, or, but) to link ideas progressing to clause structure (ie. because, when, before);** • **Tell a true story with character development, good sequencing of events and resolution of problems**	• **Negotiating - rely on threats, bribes, insults and praise to settle disputes;** • **Repeat feelings and self beliefs eg. "Tear your eyes out" or inverse the statement to "No I'm not";** • **Will ask others to stop actions if they disagree eg. "Don't rip up that book";** • **Progression from no adaptation to the listener to undifferentiated awareness of listener characteristics eg. "I'm sorry I'm late"** • **uses polite requests consistently, "Please pass the salt";** • **Awareness and use of non verbal cultural norms eg. personal space, eye gaze, facial expressions**
9 to 12 years	• **Emerging awareness of metaphor, interpretation will reflect some understanding of abstract meaning (eg. "as stony as a guard's face" interpreted as the guard would look at you like a statue)** • **Ability to understand words with more than one meaning;** • **Ability to link words with a psychological meaning (eg sweet as in the temperament of a person)**	• **Able to tell jokes using play on word meaning;** • **Able to express a wide variety of complex sentence structures using higher level clause structures: - more than one clause in a sentence; - use of higher level clause markers eg. however, although, unless;** • **Able to talk about emotional states and link words such as "cold" to a person's character;** • **Able to summarise stories as funny, sad or "Long, complicated"** • **Able to describe using analogy eg "A pebble is like a small rock"**	• **Able to adapt to listener needs through reduced expectation, statement of reasons and justification eg. "I'm very sorry I'm late but my mum had to go to the doctor";** • **Able to state reasons for disagreement "Don't rip up the book it's my favourite"** • **Able to reason giving another person's perspective "Don't rip up the book because its my friend's favourite";** • **Awareness of gender non verbal cultural norms**

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Age	*Receptive Skills*	*Expressive Skills*	*Pragmatic Skills*
11 to 13 years	• understands multiple meaning words (eg tree trunk, elephant's trunk, trunk of the car) • begins to understand proverbs • can gather and organise information • can take notes from an oral presentation • can skim written text to locate information	• able to express complicated stories • increasing use of complex sentence structures (clauses) • ongoing mastery of cohesive devices (eg ellipsis) • plays with words using double meaning words & humour • able to summarize information • able to categorize information either subjectively (eg funny, sad), or objectively (eg maths, science) • can report on a given topic	• able to change communication style to suit the age, status or relationship to the listener - can express self in acceptable language; • can participate in group discussions ; • can participate in group problem solving situations; • able to provide reasons that involve the perspective of others; • can explain how and why an answer was achieved; • negotiation skills directed towards self orientated short term solutions - unilateral conflict resolution strategies • males spend approx. 4 hours/day just talking - females spend 8hrs/day
13 to 15 years	• can listen for detailed directions; • can distinguish between essential and non-essential information; • develops understanding of the requirement for humour.	• can read aloud in class • can explain how and why an answer was achieved; • can develop paragraphs into book reports, letters; • can identify the theme of a literary work; • able to explain why something was funny; • able to create alternative answers for riddles;	• can make a formal speech
16 to 18 years	• understanding of most forms of figurative language • can distinguish between fact and opinion; • can draw conclusions from information that is given orally; • can identify the main idea of a range of message forms - eg identify the main ideas in messages about health related news; • can listen effectively to spoken English.	• figurative expression becoming more sophisticated (eg idioms) • able to generalize about a story's meaning • can formulate abstract statements about a story's theme • can evaluate orally • can express and defend with evidence, their point of view • can ask & answer questions effectively • can write a critical paper on literature • can give concise & accurate directions • can describe differences in opinion & another's views	• can give an impromptu presentation • aware of social & personal space • can speak with appropriate rate, volume, and clarity in social situations • can use gestures to enhance listener's understanding • can use appropriate non-verbal signs to indicate sympathy to a friend • can perform complex social rituals eg introduce self at beginning of a job interview, introduce strangers to one another

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Development of theory of mind.

Age	Theory of Mind	Understanding Emotions Recognising	Using and Manipulating Emotions
8-17 months	▪ follow line of regard ▪ joint attention on objects	▪ exhibits emotions of happy, mad, sad, surprised, disgusted, afraid ▪ respond to emotional reactions of others ▪ use emotional expression of caregivers as social reference for approach-avoidance	▪ seek to change affect of another by direct contact
18 months-2 years	▪ engage in pretend ▪ understand physical relation between a person's line of sight and their behaviour ▪ understand goal-directed action ▪ understand mental world by conceptualizing internal states as being directed at objects (understands desires)	▪ understand link between desires, outcomes, and emotions ▪ predict that receipt of broken toy will make child unhappy	▪ Use words *happy, sad, mad, scared* ▪ change doll's affect by bringing suitable object
3 years	▪ understand that other people see the world differently from themselves ▪ understand that imaginary objects are different from real objects ▪ understand that people's actions can be determined by their desires, intentions, and thoughts ▪ understand that perceptual activity (seeing, being told) is in some way connected to knowing ▪ words like *remember, know,* and *think* appear in spontaneous speech	▪ match emotion words happy, sad, mad, afraid to faces ▪ know that comforting is right and hurting is wrong ▪ recognise there can be a variety of reasons for an emotional response ▪ ask for reasons for emotional reactions ▪ predict receipt of toy that is not what was desired will result in negative affect	▪ talk about causes and consequences of emotions (e.g., "Santa will be happy if I pee in the potty.") ▪ use object and "friend" to change affect

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Age	Theory of Mind	Recognising	Using and Manipulating Emotions
4-5 years	▪ conceptualise internal states as representing states in the world (understand desires and beliefs) ▪ recognise that different perceptual viewpoints can lead persons to different interpretations ▪ understand how access to information by seeing or hearing is causally related to knowledge and how knowledge and belief can be causally related to actions in the world (beliefs cause people to act in certain ways)	▪ know the situation that will provoke primary emotions (match emotion word to picture)	▪ object and friend used to comfort baby, to make father happy ▪ can describe a personal situation in which they were happy, sad, mad, scared, surprised
6-8 years	▪ make appropriate judgments of situations in which one knows, remembers, forgets, or guesses	▪ can offer appropriate situations for emotions like jealousy, worry, pride, shame, guilt ▪ understand concept or personal responsibility and role of social standards ▪ understand that one can have first one emotion and then second emotion in response to a situation	▪ use words *proud, jealous, worried* ▪ can intentionally use facial expressions to mislead
8-10 years	▪ understanding or strategies to hide deceit and to detect deceit	▪ understand that one can have tow concurrent emotions of opposite type in response to a situation	▪ use of words *relieve* and *disappointed* emerge at preadolescence

Ref: Communication Disorders with Children with Psychiatric & Behavioural Disorders. 1999 School Aged Series. DianaRogers-Adkinson & Penny Griffith, Singular Publishing Group Inc.

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Summary of symbolic play development.

Age	Props	Themes	Organization	Roles	Language Use in Play
by 18 months	uses one realistic object at a time	familiar everyday activities in which child is active participant (e.g., eating, sleeping)	Short, isolated pretend actions	autosymbolic pretend (e.g., child feeds self pretend food)	Language used to get and maintain toys and seek assistance operating toys (e.g., "baby," "mine," "help")
By 22 months	Uses two realistic objects at a time	Familiar everyday activities that caregivers do (e.g., cooking, reading)	Combines two related toys or performs actions on two people (e.g., uses spoon to eat from plate; feeds mother, then doll)	Child acts on dolls and others (e.g., feeds doll or caregiver)	Usus word combinations to comment on toy or action; uses word for intents, needs, feelings ("want that," "mad," "hungry")
By 24 months	Uses several realistic objectives		Multischeme combinations of steps (e.g., put doll in tub, apply soap, take doll out and dry)		Talks to doll briefly; describes some of the doll's actions (e.g., "baby sleeping"); uses phrases and markers for *–ing* and plurals/possessives
By 30 months	Common but less frequently experienced or especially traumatic experiences (e.g., shopping, doctor)		Emerging limited doll actions (e.g., doll cries)		Talking to doll and commenting on doll's actions increase in frequency; uses
By 3 years		Observed, but not personally experienced activities (e.g., police, fire fighter); compensatory play-re-enacts experienced events, but modifies original outcomes	Temporal sequences of multischeme events (e.g., prepare food, set table, eat food, clear table, wash dishes)	Child talks to doll in response to doll's actions (e.g., "don't cry now," "I'll get you a cookie"); brief complementary role play with peers (e.g., mother and child; doctor and patient)	Use complete sentences with past tense and future aspect; children may comment on what they have just completed or what they will do next (e.g., "Dolly ate the cake." "I'm gonna wash dishes."
By 3 1/2 years	Miniature props, small figures, and object substitutions			Attributes emotions and desires to dolls; reciprocal role taking with dolls (child treats doll as partner – talks for doll and as caregiver)	Use dialogue for dolls and metalinguistic markers (e.g., "he said"); use words to refer to emotions and thoughts
By 4 years	Imaginary props (language and gesture help set the scene)	Familiar fantasy themes (e.g., Batman, Wonder Woman, Cinderella); violent themes common	Planned play events with cause-effect sequences (e.g., child decides to play a birthday party and gathers necessary props and assigns roles)	Child or doll has multiple roles (mother, wife, doctor; firefighter, husband, father); child can handle two or more dolls in complementary rolls (dolls are doctor and patient); attributes thoughts and plans to doll	Use language to plan and narrate the story line; use of connecting words *so, because, but* - effect
By 6 years	Language and gesture can carry the play without props	Create novel and fantasy characters and plots	Multiple planned sequences (plans for self and other players)	More than one role per doll (doll is mother, wife, doctor)	Elaboration of planning and narrative story line; uses sentences with temporal markers, *then, when, while, before, first, next*

Source: Patterson, J., & Westby, C. (1994). The development of play. In W. Haynes & B. Shulman (Eds.), *Communicative development; Foundations, processes, and clinical application.* Englewood Cliffs, NJ: Prentice-Hall.

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Infancy (0-1½ Years)

Developmental Themes

The following theorists postulate differing ideas regarding infant development.

Regulation (Brazelton); Organization (Brazelton); Reciprocity (Sandler); Attachment (Bowlby); Attunement (Stern); Synchrony, Symmetry, Contingency, and Entrainment (Brazelton and Cramer); Basic trust vs. Mistrust (Erikson); Separation and Individuation (Mahler); Temperament (Chess & Thomas).

You are encouraged to consider the contributions of these theorists and how their ideas contribute to current understanding of infant mental health. Although this age group is often seen through Early Intervention Services and specialist infant mental health clinics, understanding these foundations of emotional development is important in making sense of the later years for children and adolescence.

Hazards to Infant Development

- Physical Hazards
- Intrauterine insults (e.g. sub nutrition, eclampsia, exposure to toxins or infectious diseases)
- Neonatal disease or disorder
- Congenital defects
- Accidents
- Infectious diseases in infancy
- Sub nutrition (up to 12-18 months)
- Sensory defects (e.g. deafness)
- Psychosocial Hazards
- Neglect, abuse, abandonment
- Lack or loss of a consistent caregiver
- Insensitive, unresponsive, or inconsistent care (e.g. due to maternal depression)
- Multiple caregivers
- Infant Emotional and Behavioural Difficulties
- Excessive crying and irritability
- Insomnia
- Digestive disturbance
- Non-organic failure to thrive ("deprivation dwarfism")
- Rumination
- Infant "depression", hospitalism, and anaclitic depression
- Excessive separation anxiety
- Failure to attach
- Failure to respond to social interactions

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Fears in Infancy

Early Infancy (0-6 months) – Sensory abilities dominate infant's adaptation and sources of fear are based around:

- Intense stimuli
- Loss of support
- Loud noises

Late Infancy (6-12 months) – Sensorimotor schema are developed, cause and effect understandings are beginning and object constancy is forming. Fears are based around :

- Strangers and
- Separation

Motor and Sensory Skill Development

O months

- Turns head to one side when lying on stomach
- Legs make crawling movements when place on stomach
- Holds a ring in a reflex grasp
- Can focus on objects 9 inches away
- Can distinguish mother's voice
- Can distinguish sweet, sour and salt tastes

3 months

- Sits with support
- Pushes hear and shoulders up when lying on stomach
- Grasps a rattle and reaches with 2 hands
- Breast fed children can distinguish their mother's odour
- Shows interest in faces
- Depth Perception emerges

6 months

- Sits briefly unaided
- Rolls from back to stomach
- Transfers cube between hands

9 months

- Walks holding furniture
- Crawls
- Sits alone
- Picks up button with thumb and forefinger

12 months

- Walks unaided
- Into everything
- Holds crayon and makes mark

18 months

- Climbs stairs
- Throws a ball into a box
- Builds a tower with 3 cubes

Needs for Sleep in Infancy

- 1 week old - 16.5 hrs
- 6 months old - 14.5 hrs
- 12 months old - 13.75 hrs

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Early childhood (1 ½ to 5 yrs)

Developmental Themes

- Increasing physical independence and autonomy.
- The child must adjust to authority, and deal with love and hate.
- Acquisition of self-image (adequacy, inferiority, difference, self-worth, lovability) and the extension of trust in others.
- Increasing ability to take directions, be obedient, and interact with peers.
- Symbolic representations (e.g. in play) develop along with language and early conceptualisation.,
- Core gender identity (Am I a he or a she?) and then gender role identity (How should I behave as a girl or a boy?) emerge.

Motor and Sensory Skill Development

2 years

- Runs
- Walks backwards
- Puts square peg in square hole
- Builds tower with 6 cubes.

3 years

- Can stand on one foot for 5 seconds
- Pedals a tricycle
- Draws a circle
- Climbs stairs using alternate feet

4 years

- Hops on one foot
- Buttons clothes
- Draws a square

5 years

- Hops on both feet
- Ties shoelaces
- Draws triangle

6 years

- Copies diamond

7 years

- Can learn new motor skills like throwing, riding a bicycle

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Cognitive Development

Information Processing: Cognition & Memory

By 2 years, the child uses toys to represent real objects and events, exhibiting deferred imitation, graphic imagery, and the semiotic function (the ability to use one object or event to stand for another). The pre-operational stage (1.5-6 years) follows the sensorimotor stage (0-1.5 years).

From 2-4 years, language facilitates symbolic reasoning. However, preoperational thinking is preconceptual (i.e. dominated by perception), one-dimensional, pre-temporal, egocentric, anthropocentric, animistic, and mechanistic rather than inductive or deductive.

From 4-6 years the child decentres, becoming able to take into account another person's spatial and emotional perspective. Early seriation (e.g. big, bigger, biggest) and classification become possible, as the child moves toward the stage of concrete operations (7-11 years).

Emotional and Behavioural Problems in Early Childhood

- Examples of common behaviour problems are tantrums, breath-holding, refusal to eat, food fads, resistance to toilet training or going to bed, nightmares, night terrors, unwillingness to sleep alone, excessive fears, separation anxiety, and social inhibition.
- Abuse and neglect syndromes. Cross-generational transfer of abuse and neglect may occur. The infant who is failing to thrive “falls off the growth curve”. The signs and symptoms of physical or sexual abuse are often first recognized in the emergency room. Reporting is mandated if abuse is suspected.
- Childhood depression. This was once thought not possible, but now is more often diagnosed through sadness, social withdrawal, regression, somatic complaints, developmental arrest. Commonly follows loss or trauma.
- Oppositional-defiant behaviour.
- Excessive aggression and disorganised attachment foreshadow later conduct problems.
- Symptom disorders (e.g. enuresis, sleep disorder, tics)
- Anxiety disorders (e.g. school avoidance).
- Developmental delay (e.g. language, muscular coordination).
- Autism, other forms of pervasive developmental disorder, and mental retardation.

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Fears in Early Childhood

Toddler Years (2-4yrs) sees the development of pre-operational thinking, with the child having the capacity to imagine, but the inability to distinguish fantasy from reality. Fears are around:

- Imaginary creatures
- Potential burglars
- The dark

Disorders include:

- Separation anxiety
- Selective mutism

Early Childhood (5-7 yrs) is when concrete operational thinking develops, with the child having the ability to think in concrete logical terms. Fears are around:

- Natural disasters (fire, flood, thunder)
- Injury
- Animals
- Media based fears

Disorders include:

- Animal phobia
- Blood phobia

Sexual Development in Infancy and Early Childhood (0-5 yrs)

- Children at this age have intense curiosity about nearly everything, including their bodies, and are often happier with no clothes on
- Sexual self-stimulation, or masturbation, normally begins during infancy and continues throughout development as both self soothing and an exciting behavior
- In addition to their own bodies, children of these ages and also curious about other's bodies. Their curiosity may lead them to try to look at or touch other's genitalia. This is exploratory looking and touching, typically accompanied by giggling and amusement rather than behavior of a coercive nature
- When clear limits are set, preschoolers take redirection easily

Needs for Sleep in Early Childhood

- 2 years - 13 hours
- 3 years - 12 hours
- 4 years - 11.5 hours

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Middle Childhood (6-11 Years)

Here the child learns to master the more formal skills of life:

- relating with peers according to rules
- progressing from free play to play that may be elaborately structured by rules and may demand formal teamwork, such as football, and baseball
- mastering social studies, reading, arithmetic. Homework is a necessity, and the need for self-discipline increases yearly. The child who, because of his successive and successful resolutions of earlier psychosocial crisis, is trusting, autonomous, and full of initiative will learn easily enough to be industrious. However, the mistrusting child will doubt the future. The shame - and guilt-filled child will experience defeat and inferiority.

During the school years, children face challenges concerning the development of an identity or a sense of self-achievement, family relationships, peer relationships and school. Children develop a sense of self, acquire a belief in self-constancy and in relatively permanent psychological traits, and learn to distinguish their thoughts and feelings from those of others.

This is a time where children begin to focus on developing a sense of industry and achievement. During the school years, children shift their achievement orientation from an exclusive focus on learning or task orientation to a performance orientation that includes others' responses to their achievements.

Emotional Development

The shift towards concrete logic and symbolic memory helps the child to bind tension, plan ahead, and learn from others.

Fears and tantrums decrease. Feelings of sadness or misery begin to increase in prevalence after 10 years, but grief is more short-lived in children than in adolescents. Childhood depression may be expressed in the form of disobedience, aggressiveness, hyperactivity, somatic symptoms, or school failure ("depressive equivalents"). Low self-esteem and lack of mastery experiences may render the child vulnerable to later stresses.

Children become increasingly able to recognize others' emotions from vocalization and facial expression, more aware of the connotations of social situations, and better able to use emotional concepts (e.g. "friendly", "happy").

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Emotional and Behavioural Problems of Middle Childhood

Children with the following conditions may present to CYMHS for assessment and treatment. Some examples include:

- Learning difficulties
- Oppositional behaviour
- Attention deficit and hyperactivity
- Aggression
- Withdrawal from peers
- Conduct problems
- Separation anxiety and school refusal
- Hypochondriasis
- Sphincter control problems
- Psychosomatic problems
- Obsessive-compulsive disorder
- Sexual identity disorder
- Mood disorders

Need for Sleep in Middle Childhood

- 6 years - 10.75 hours
- 8 years - 10.25 hours
- 10 years - 9.75 hours

Fears in Middle Childhood

Here, esteem centres on academic and athletic performance in school. Fears are around:

- Poor academic performance
- Poor athletic performance

Disorders see here include:

- Exam anxiety
- School phobia

Sexual Development in Middle Childhood

- School aged children explore their bodies
- Begin to seek information about sex and look for books and diagrams that explain their own organs and functions
- Curiosity about sexuality at this age takes the form of playing games such as 'I'll show you mine if you show me yours'
- Boys at this age compare penis size
- Children at this age become interested in sex words and dirty jokes
- Limited interest in the opposite sex may be evident
- Interest in children's own and others' bodies continues at this time, particularly if changes in their bodies begin to occur
- Feelings of needing privacy emerge at this stage
- Needs for Sleep in Middle Childhood
- Needs for Sleep in Middle Childhood

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Adolescence (12- 20 Years)

Biological/Physical Development

Puberty - Task: Coming to terms with your own body

During successful early adolescence, mature time perspective is developed; the young person acquires self-certainty as opposed to self-consciousness and self-doubt. Adolescents come to experiment with different - usually constructive - roles rather than adopting a "negative identity" (such as delinquency).

The adolescent actually anticipates achievement, and achieves, rather than being "paralysed" by feelings of inferiority or by an inadequate time perspective. In later adolescence, clear sexual identity - manhood or womanhood - is established. The adolescent seeks leadership (someone to inspire them), and gradually develops a set of ideals (socially congruent and desirable, in the case of the successful adolescent).

They do not yet have to "play for keeps," but can experiment, trying various roles, and thus hopefully find the one most suitable for them

Puberty can bring about feelings of embarrassment, uncertainty, and awkwardness. Changes in the body are embarrassing, confusing, and may become totally out of control. Body image becomes the focus of their lives, and self-consciousness results. Part of this self-consciousness relates to how the adolescent relates to parents. . Adolescents hide their bodies from their parents, expect more privacy, and usually reduce the amount of physical affection shown towards their parents.

Fortunately for most adolescents, they are all going through it at the same time! This helps young people adjust to the changes in their bodies more easily. Studies have shown that it takes approximately 4.5 years from the start to finish of puberty. Puberty for girls can start as young as seven or eight, and for boys as young as nine or ten. Or, some youth do not experience puberty until their mid teens. Early, or late puberty is known to cause a larger level of distress and some problems for youth.

Body image is known to be a large factor affecting both male and female's self-esteem. Puberty, and change of body is therefore bound to affect the way youth feel about themselves.

For Girls

Girls who experience early puberty have been shown to have lower self-esteem. This is seen to be because puberty brings a change in fat composition and distribution. Girls put on weight with puberty. This weight change usually follows a preliminary growth spurt, which means that the earlier the puberty, usually, the shorter the adolescent.

Additionally, early puberty means girls must cope with teasing from their peers, and curiosity about their sexuality. This often leads to confidence loss, and confusion, as young girls deal with issues of sexuality long before they are psychologically equipped to deal with them. Sexuality becomes something dirty and unwanted, again, causing girls to feel dirty and different.

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Today's ideal body image is seen as tall and slim. Therefore, it has been shown recently that girls experiencing late puberty usually have a high self-esteem. They have experienced a growth spurt which has been uninhibited by puberty, and they have not experienced the weight gain which comes with puberty.

For Boys

While girls have poor experiences with early puberty, and better experience with late puberty, for boys it is the other way around.

Boys experience an increase in muscle density, a growth spurt as part of puberty, and a change in voice which, when it comes early, boosts self esteem and confidence. Early puberty means extra strength, which young men are happy to have over their peers. Late puberty means boys can be teased for being "wimps", or "sissies", with their high pitched voices, long, lanky frames, and no muscle.

The onset of puberty sparks the onset of the adolescent's interest in themselves and their place in the world around them. The change in body parallels a change in role. They are now becoming sexual beings, capable of creating life, of performing adult roles. Along with the change in body then, comes a change in mind.

At the beginning of adolescence, say the last year of primary school, the young adolescent thinks in concrete terms. That is, they don't think much about the future, but live very much in the here and now. Their major influences are usually teachers, parents, and other significant adults. At this stage, these kids have little idea of themselves as separate from the significant people around them.

If you asked them to list five personal qualities about themselves, they are more likely to tell you the colour of their hair and eyes, rather than any sort of abstract concepts like responsibility. They usually mimic the values and attitudes of their parents without much thought.

This soon changes. The adolescent becomes more able to think in abstract terms. They begin to reason and plan. They have a clearer sense of the future, and their need to prepare for it. They begin to realise that they can, and will have an impact on their world and those around them.

The adolescent's Role models shift from parents and teachers, to peers. They begin dating. Most importantly, they begin to question themselves and form an idea of who they are, separate from their family. Because this is a new style of thinking, and a new perspective, the adolescent copes by thinking in black and white terms. Things are either very right, or very wrong. Additionally, this self-focus leads to a strong egocentric perspective. That is, the adolescent becomes engrossed in themselves as very unique from those around them. They are likely to believe that they are more knowledgeable, and more important than others around them. Youth become very intolerant of others points of view, because they are a threat to their own fragile way of thinking.

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For these reasons, youth are more likely to identify with their peers, because their peers have similar attitudes to their own. All others become outdated and wrong. Youth are very likely to set up an identity in direct opposition to their parents. This is because they need the strong contrast to define their own sense of self.

Some believe that this strong sense of importance and uniqueness is a factor in youth suicide, that the young person believes they can somehow punish the world by suicide.

The search for identity never ends. It is usually expected that the end of adolescence will see a more moderate thinker. The adolescent becomes more confident with his own sense of self, that he can tolerate and even appreciate others' attitudes. Other values and ideals are no longer seen as a threat, and he does not need to defend against them so strongly - by total rejection.

Sexual Development in Adolescence

- Masturbation continues during pre-adolescence
- Some preadolescents engage in sexual activity with peers, including kissing and fondling
- Pre-adoescents may imitate sexual behaviours that they have seen or heard about. While most of these experiences are with the opposite sex, pre-adoescents may engage in sexual activities with their own gender. Such sexual activity with their own gender does not necessarily indicate homosexuality
- During adolescence sex becomes more prominent in the young person's awareness
- They may experience powerful feelings of sexual attraction and erotic feelings
- They develop a clearer sense of their own gender identity and sexual orientation
- A developing link between sexuality and puberty where there is an increase in sex drive because of hormonal changes
- Awareness of the link between sexuality and pregnancy and the seriousness of possible implications of sexual activity
- Development of secondary sex characteristics that serve as basis for sexual attraction and identifies that the person is no longer physically a child
- New social meaning is linked with sexual behaviour – awareness of being accepted or rejected
- Body image and self esteem are strongly linked with a sense of being comfortable with one's own body

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Need for Sleep in Adolescence

- 12 years - 9.25 hours
- 14 years - 9.00 hours
- 16 years - 8.50 hours

Independence

Task: Achieve independence from family

- Learn responsibility
- Experimentation

The primary task of adolescence is to achieve emotional and financial independence from their parents. Puberty, the development of a strong sense of self, and establishing relationships with peers, are all steps towards the final goal of independence.

The adolescent begins to spend less and less time at home, as their need for security gradually becomes less and less. Sort of like a gradual removal before the real thing. (Can be likened to early attachment). As they grow, youth experience a change in limits, and more freedom. They experiment with this freedom, establishing their own means for self control and decision making. They begin to learn things for themselves, and parents have to let them do it. They take risks, and enjoy adult activities they have previously been very curious about - alcohol, drugs, smoking, sex.

Because these things are a new experience for them, adolescents can again become very self-conscious. They become very concerned about being treated like a child, and sensitive to criticism, or to people telling them they are too young to be doing things.

The drive towards independence is not straightforward for either youth, or their parents. On the one hand, the adolescent faces the loss of all that was safe and secure in their dependent relationship with their parents. On the other hand, the lure of adulthood and adult activities is very strong. The adolescent can become ambivalent, and swing between dependent and independent behaviour. For parents, they too face the loss of the parent child-relationship, and come to terms with a parent-adult relationship. They have to squash their strong urge to protect their child, while they watch them take risks, make mistakes, and move away.

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Social Development

Task: Learn to relate to, and rely on people of the same age (peers)

Prepare for intimate relations

As already mentioned, increased peer relations provide support for the adolescents' growing sense of identity. This does not mean that parental influence is totally lost. The adolescent simply has input from both parents and friends. They will use different influences in different situations. There are some situations which only parents can prepare their children for. Parents can often feel jealous of the amount of influence they see friends having over their child. They may also see their children receiving the wrong direction from their friends. Sometimes, this can lead to parents trying to exert more control over their children than is needed or wanted. This will lead to conflict, and parents are unwittingly setting themselves up in competition with peers. Because of the adolescents black and white thinking, this could lead to many conflicts, as the adolescent will feel that he has to choose either one or the other.

Planning for the Future

Adolescents' reliance on peers is a further step towards independence. Dating, and sexual

relationships develop - first on a superficial level with experimentations, then, as identity becomes more fixed, adolescence move toward more intimate relations. These early relationships are important learning experiences for the youth who may one day seek to marry and start a family.

Planning for the future is a difficult task for adolescents today. They are faced with a poor unemployment market for their age and level of experience. More and more jobs require further education, and less manual trades are available.

In some cases, youth have extremely ambitious, unrealistic goals for their future, and parents, in their need to protect, try to soften these plans to avoid disappointment. Some adolescents on the other hand, appear to have no concept of the future whatsoever, and make no plans. Parents again become anxious as they envisage a future for their child on the dole. This may prompt parents to push their child to do their homework, get a part time job etc. Both these scenarios are likely to lead to conflict.

For most adolescents, the future is clearly in their minds, and knowledge of the current employment market can cause a great deal of stress at school. The need to get into university is higher, as is the competition. Also, performance at school is a concrete marker for self esteem, and for some people, like body image, academic performance makes up a great deal of their sense of self worth/esteem.

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Adolescent Suicide

- Attempts peak in 15 to 25-year-old group.
- Multiple motives can be involved in suicidal behaviour (e.g. cry for help, need for revenge, frustrated anger, major depressive disorder)
- The Suicide and Self-harm module discusses this area in detail.

Adolescent onset psychiatric disorders

- Eating disorder (anorexia nervosa, bulimia).
- Alcohol and drug abuse.
- Schizophrenia
- Depression and suicide.
- Post traumatic stress disorder.
- Dissociative disorder.
- Psychological problems complicating physical disorder (e.g. diabetes, epilepsy, asthma, CF, CP)

Common Problems in Adolescence

The following list serves to guide you understand the turmoil and potential problems that adolescents and families endure.

- Adolescent treating home as a boarding house
- Adolescent not wanting to be involved in family activities
- Adolescent being very moody
- Adolescent behaving inconsistently - swinging from adult to childlike behaviour
- Adolescent will not be told anything - becomes angry at advice given by parents
- Adolescent frequently testing limits
- Adolescent attempting to deliberately provoke and shock parents
- Adolescent desperately needing to be like other kids
- Adolescent experimenting with adult behaviour - smoking, drinking, swearing
- Adolescent withdraws from the parents - refusing to talk to them or discuss their problems
- Adolescent engages in risk taking behaviour, which may involve minor law breaking
- Some adolescents run away from home
- Adolescent becomes very defiant
- Adolescent often very critical and rejecting of parents
- Adolescent directly challenges parental authority
- Adolescent's use of the telephone
- Adolescent excessively demanding of material things
- Adolescent only sees his own point of view and rigidly defends it
- Adolescent will be continually pushing the parents for greater freedom/autonomy
- Adolescent wants to move out of home

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Strategies to Avoid when Dealing with Children and Adolescents

- Trying to treat the adolescent like a child or telling them what they 'should' do
- Not giving the adolescent increasing responsibility
- Trying to protect the adolescent by stopping them from making mistakes
- Doing everything for the adolescent
- Ridiculing or teasing the adolescent for wanting to be like other kids
- Trying to nag the adolescent into what you want them to do
- Having rules that you cannot enforce
- Making promises you cannot keep
- Having rigid rules to which there are no exceptions, and having harsh punishments attached to rule breaking
- Attempting to avoid conflict by not setting any rules - children will get the impression that you don't care
- Letting the child play the parents off against each other
- Having the parents directly contradict each other/undermine each other in front of the child
- Never admitting that you are wrong, or you don't know certain things
- Trying to convince the child about your point of view - not allowing the adolescent to hold different opinions and viewpoints.

Helpful Strategies

1. Communication

- try to be ready to discuss issues rationally, without becoming emotional
- listen with respect to their opinions and views
- try to have two way conversations rather than "lectures"
- use "I" statements, rather than "you" statements
- talk when the child is ready, not when you want them to be

2. Rules/Limits

- work out a few clear rules with your teenager
- work out the consequences if the rules are broken - with your teenager
- be detailed and clear about what you expect from each other and why
- don't be surprised when your rules are tested
- rules need to be reviewed as the teenager is able to resume more responsibility
- needing regular review discussions
- Remember that praise and encouragement are more effective that punishment and criticism. If rules are broken, some penalty is OK when it has been discussed beforehand. If rules are adhered to, the teenager is showing you responsibility and growth, which needs to be rewarded with praise, and the opportunity for more responsibility

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3. Self responsibility

- encourage children to do things for themselves, make their own decisions and mistakes
- respect a child's right to privacy
- don't insist that teenagers take part in all family activities
- In times of crisis, provide support and understanding - lecturing can come later

4. Values

- let the adolescent know your values, ideas, goals and hopes
- listen to theirs
- don't try to improve your values - become "self righteous"
- don't get into emotional battles over differences of opinion - keep discussions rational and reality based
- facts, information and experience are more powerful arguments than moralising and emotion

5. Parent's Rights

- be clear about your own rights - which your child should respect
- make sure you pursue your own interests
- support one another in your jobs as parents - plan joint approaches
- expect children to help you out with younger siblings and household chores
- don't become a servant to your child, expect them to be able to look after themselves, and have some interests of your own.

6. Understanding

- remember what your own childhood was like
- try not to feel rejected, or not as important as peers - remember your child is learning and experimenting, and they have to do this away from you - they will come back
- focus on your child's successes as they progress down the path towards their independence

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Summary

The stages of development can be seen as a “psychosocial crisis” which arises and demands resolution before the next stage can be satisfactorily negotiated.

Understanding the normal and abnormal development assists with assessment, diagnostic reasoning, treatment planning and development of the therapeutic relationship. Human development proceeds via the acquisition of structures and functions in biological, psychological and social domains.

Emotional and Behavioural Problems in **Early Childhood** include: Abuse and neglect syndromes, childhood depression, oppositional-defiant behaviour, excessive aggression and disorganised attachment, symptom disorders, anxiety disorders, developmental delay, autism, other forms of pervasive developmental disorder, and mental retardation.

Emotional and Behavioural Problems of **Middle Childhood** include: Learning difficulties, Oppositional behaviour, Attention deficit and hyperactivity, Aggression, Withdrawal from peers, Conduct problems, Separation anxiety and school refusal, Hypochondriasis, Sphincter control problems, Psychosomatic problems, Obsessive-compulsive disorder, Sexual identity disorder, Mood disorders.

Common problems associated with **Adolescence** include: Eating disorders (anorexia nervosa, bulimia)., Alcohol and drug abuse, Schizophrenia, Depression and suicide, Post traumatic stress disorder, Dissociative disorder, Psychological problems complicating physical disorder (e.g. diabetes, epilepsy, asthma, cystic fibrosis, cerebral palsy).

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Reflection Questions

Unit 1.1

Summarise the key developmental issues for infants and middle childhood.

What considerations should be taken into account when setting up the therapy room for assessment or treatment of a child under 12?

What do you consider are the main developmental tasks that an adolescent is likely to be confronted with?

What adolescent behaviours in particular evoke annoyance in adults?

If you were to analyse these behaviours, what do you think they mean?

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You are working with parents to be more understanding of their adolescent's development. What key developmental issues would you discuss to improve knowledge, understanding and promote attitudinal change?

_____

_____

_____

What are some of the helpful things to consider when working with adolescents?

_____

_____

_____

Does your clinical area have educational literature/fact sheets for parents explaining child and adolescent developmental issues?

_____

Discuss an experience in working with a current or past adolescent client that relates to your learning on this unit.

_____

_____

_____

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Unit 1.1

Foundation Concepts for child and youth practice

Record of Learning and Resources

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Record of Learning
Unit 1.1 Foundation Concepts for child and youth mental health practice

The following activities are suggestions for assessing your learning from this unit. They may be used as a self assessment tool or be reviewed with your team leader or supervisor.

1. Watch DVD 1 on Foundation Concepts for CYMHS
2. Study the Associated Learning Materials and complete the Reflection Questions.
3. Study the Additional Learning Materials and complete the Reflection Questions.
4. Review the answers and discuss issues that may arise with your supervisor or team leader.
5. Review the Associated Learning Materials that relate to common disorders seen at CYMHS and choose 2 disorders to study more thoroughly. Choose ones that may relate to your current caseload. See if there is an opportunity for you to present your learning at a peer meeting, supervision or team professional development meeting.
6. During supervision, review one of your current clients from each of the following developmental stages – early childhood, middle childhood and adolescence, focusing on:
    - Identifying the developmental period the client is currently in, moving out of or moving into
    - Determining whether the presenting problems for the client reflect common issues for that age and stage
    - Review whether information or education about relating to a young person of that age would support parental understanding and communication with the young person
    - Review the therapeutic approach you used (or are using) with each client and explain why you have chosen to implement that from a developmental perspective. Describe your clinical reasoning.
    - Identify possibilities for improving practice using the knowledge you have gained from this unit.
7. Complete the following Record of Learning on the following page:

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Record of Learning

Unit 1.1 – Foundation Concepts for Child and Youth Mental Health Practice

Clinician Name _____

Record of Learning	Date achieved	Signed
Explains and demonstrates the application of the Bio-psycho-socio-cultural model in clinical practice		
Can describe a developmental trajectory and stable influences over time		
Can identify in supervision and practice, the potential systems impacting on a young person at any point in time		
Demonstrates in client presentations during supervision, an understanding and knowledge of developmental stages in childhood and adolescence		
Identifies the main challenges facing young people at each developmental stage		
Explains the common mental health disorders that clients present with and can categorize these as externalizing or internalizing disorders		
Gives concrete examples during supervision of how engagement and therapeutic alliance may be enhanced with improved knowledge of client's developmental needs.		
Ensures that adequate literature is available at the CYMHS clinic in the form of fact sheets or resources for parents and clients on developmental stages and challenges		
Tailors the therapy room to suit client developmental needs		
Chooses therapeutic activities to match clients interests and developmental needs		

Additional Supervisor/ Team Leader feedback and comments:

_____

_____

Signed _____

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Unit 1.1 Foundation Concepts for Child and Youth Mental Health Practice

Resource List:

Family Sensitive Practice:

FaST (Family Sensitive Training) Video Series, (1997) Project managed by Jeff Young, Written by Jeff Young & Nancy Black, Directed by Nancy Black & Produced by Mark Harris, Media Production Unit, La Trobe University.

Get Together FaST Workbooks, (1997-1998) Written by Jeff Young, for a State-wide training and service development initiative funded by the Department of Human Services and developed by The Bouverie Centre, Victoria, Melbourne.

Farhall, J et al. (1998) Training to Enhance Partnerships Between Mental Health Professionals and Family Caregivers: A Comparative Study. Psychiatric Services, Vol. 49, No. 11, 1488 – 1490.

Farhall, J et al. (1999) Formal Evaluation of the Get Together Fa.S.T. Initiative. Unpublished. (Available from The Bouverie Centre).

Young, J., Rycroft, P, Bailey, G. (In press) Family Grief and Mental Health: A Systemic, Contextual and Compassionate Analysis, Submitted to Australian and New Zealand Journal of Family Therapy.

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Congratulations and well done for completing this unit of learning. We hope it has been useful and interesting.

Please now complete and return the evaluation/ feedback forms. There is a form for you as the clinician and one for your supervisor to complete. Both of these forms are found in the section 'Evaluation/ Feedback Forms at end of this package.

Thank you

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