treating psychopathology. Some psychiatrists may train in the psychotherapies and some are trained to conduct research, but remain uniquely qualified to use biological treatments.

By the time a psychologist is instructed to carry out a medico-legal assessment, significant developments would normally have occurred within the family, with the involvement of the local authority, preliminary parenting assessments having been undertaken and possibly a range of services provided to the family to assist the parents in their role of parenting. Similarly, where private law proceedings involving contact and residence disputes arise, by the time a psychologist is instructed there could have already been a significant breakdown of trust between the parents and the children involved could possibly have been exposed to conflict and the battle between the parents. The instruction to a clinical psychologist in both private and public law proceedings would range from assessment of the emotional and psychological functioning of the child to the personality structure of the parents and their ability to parent their children. The psychologist is also required to assess the emotional well-being of the child and determine any emotional harm associated with neglect, physical abuse, non-accidental injuries, sexual abuse and fabricated or induced illnesses that may be present in the child. The assessments of the parents could involve cognitive assessment, fully emotional and psychological assessment and to determine whether there are personality or psychological disorders. Assessments of attachment between parents and children as well as sibling attachments are also often requested.

Emotional abuse and neglect is intrinsically linked to the abuser-child relationship, and thus skills in undertaking assessment of the family system and relationships would be essential. This would involve the assessment of the parents' emotional and psychological functioning to highlight factors which are contributing to the harm and the neglect the affected children may be experiencing. An aspect of psychological assessments, which is unique to the psychologist, is the carrying out of psychological tests. This requires the psychologist to be in a position to use quantitative and qualitative psychometric testing. The psychologist would need to have knowledge of the reliability, validation and statistical underpinning of these tests in order to interpret the results. In broad terms, the psychologist's skills and expertise are based on scientific foundations and supported by empirical studies.

It is central to the assessment of children to determine whether they have suffered or are likely to suffer significant harm. The Children Act 1989 uses the term *significant harm,* which is directly related to child abuse and neglect and the impact that this has on the child. Significant harm is the harm to and/or impairment of the child's physical or mental health as well as impairment of physical, intellectual, behavioural, emotional and social development which is attributed to the lack of adequate parental care. In proceedings relating to children, the paramount consideration of the law is the welfare of the child and the clinical psychologist, who is engaged as an expert witness, must also adopt this priority. To assess *significant harm*, comprehensive evaluation of the family

would need to take place including the assessment of the child, the attachments and relationships it has, and of the parents individually in order to determine their psychological and personality functioning. Thus, the input of the psychologist is holistic and includes assessment of current and future risk, potential for change, likely timescales for any treatment to be successful and whether or not treatment in any given instance is indicated and, if so, of what kind.

1.2 FAMILY ASSESSMENTS FOR THE COURT

When undertaking family assessment, a sound and extensive knowledge of adult mental health and child psychology, personality and psychopathology are essential requirements for the clinical psychologist involved. An understanding of the psychological consequences and impact of abuse in all its forms would be necessary in determining how this may make an impact on interpersonal, social and emotional functioning as well as the cognitive functioning of the child. Interpersonal difficulties could relate to attachment disorders, while social and emotional impairment may be associated with anxiety states, depressive disorders, conduct disorders and possible substance misuse. Cognitive impairment could be related to developmental difficulties and under-achievement. Abuse and traumatic experiences could lead to psychiatric disorders, suicidal behaviour and aggression. The long term effects of childhood sexual abuse could have significant implications for interpersonal relationships in the future and the development of psychopathology and psychological disorders associated with depressive illness, eating disorders, self-harm, suicide, anxiety states and substance misuse.

When assessing the emotional and psychological well-being of children, the psychologist would be required to make recommendations with regard to treatment and management of the situation in order to reduce the emotional harm which had been experienced previously, and to prevent further harm from occurring. A range of therapeutic interventions, including family therapy, unstructured and structured play therapy, cognitive behavioural therapy and family therapy are widely used in these situations.

The psychological assessment would involve an extensive study of the child and family, with information derived from a broad base of data relating to the background history and derived also from clinical observation. This would include reviewing and gaining a thorough understanding of the background history from the documentation provided as well as from carrying out interviews with the persons involved such as the parents, foster carers, grandparents, siblings and the child or children involved. Clinical interviews would also be carried out on the persons identified in the letter of instructions as needing to be psychologically assessed. Subject to the nature of the instruction, and the needs of the case, observation of contact, interaction and attachment styles between parents and children would be a valuable way of noting prominent family dynamics and gaining insight into attachment styles and behaviours. Psychometric assessment with the purpose of exploring

- The parent's ability and motivation to stimulate their children in order to promote learning, intellectual development and cognitive growth. This would include facilitating the child's cognitive development by ensuring school attendance.
- The parents' ability to provide appropriate and consistent guidance and boundaries which would enable the child to regulate its own emotional state; the ability to demonstrate and to model appropriate social behaviour and pro-social behaviours.
- The parent's ability to provide a problem solving strategy which is effective, rather than by means which are abusive or negative.

When assessing parenting capacity and ability, various variables or risk factors that affect the parenting process and the parenting behaviours would need to be considered and explored. These would include any learning disabilities or concerns relating to the cognitive capacity of the parents. The mental health and the presence of maladaptive personality functioning would have a bearing on the parenting provided. Domestic violence, substance abuse and alcohol misuse are factors that have a direct bearing on the parenting ability and would have far reaching implications for the emotional well-being of children where this is a feature. Parenting assessment would also need to consider the past parenting experiences of the individual parents, which would highlight capacity for empathy, attachment experiences and whether there has been any developmental arrest associated with rejection feelings and experiences, inadequate parenting, impoverished attachments, dysfunctional mother-child relationships and disturbed family dynamics. Developmental arrest leads to unmet needs during vulnerable developmental phases in formative years and leads to neurological and psychological impairment. It also would account for developmental and emotional delays, which results in the individual remaining vulnerable to stress, remaining stuck in developmental stages of risk taking and showing impaired capacity to achieve internal stability.

3.2 PARENTAL CAPACITY

Parenting competence in the face of a child with complex needs or a difficult temperament may remain intact if the parents' own needs for support are met and also if the parents' own capacities are relatively high. When making an assessment of parenting capacity, a consideration of the relationship between the partners within the course of the parenting assessment would be essential, as this is an important factor which influences overall parental responses as well as indicating the protective mechanisms in play in the parenting situation.

Where there are concerns in parental capacity, change and prognosis for change would depend upon the motivation to change, in that there is acceptance of responsibility of harm and acceptance that parenting behaviour has to change. This would also included real commitment to meet the needs of the child by committing to local resources to improve parenting skills, and the commitment to improve their own psychological well-being. Improvement of parental

capacity would also be dependent upon personal flexibility, emotional strength to follow through with therapeutic interventions and the maintenance of positive working relationships with child care professionals.

The ability to engage in sensitive parenting care is crucial for parental capacity. This involves the parent being able to read the child's signals and emotional state and having emotional regulation capacity, as well as the capacity to prioritise the needs of the child over and above their own needs, interests and feelings.

Poor emotional regulation and poor empathy skills are two of the most important components of psychological difficulties from the point of view of increasing risk. Without adequate empathy it would be impossible to engage in sensitive parenting where it is necessary to be able to tune appropriately into a child's emotional state. Additionally, without adequate emotional regulation, parents would have difficulty in giving priority to the needs of, or to respond to, the child in a way that regulates the child's own emotional state.

Positive parenting capacity and positive prognostic indicators, which would support a positive outcome, would be evident where there has been no history of domestic violence, no history of substance and alcohol abuse and misuse, no recent history of violent and offending behaviour and no indications of marital discord.

3.3 PARENTING STYLES

Assessments of parenting styles are concerned with the approaches parents adopt in their management of and control of their children. In particular, the extent to which the parents show control, emotional warmth, acceptance and involvement in regard to the children are studied. It is essential for a parent to strike a balance between being demanding and demonstrating responsiveness; when this is achieved, it reflects a child-centred approach being taken by the parent. Where there is non-demanding parenting behaviour in addition to lack of parental control, this could reflect inconsistent parenting strategies, resulting in the child's ability for self-regulation possibly being under-developed; it may also lead to high levels of impulsivity being suffered by the child. Neglectful parenting occurs when the parent takes on an undemanding and unresponsive approach to the problems that may arise. In such a case the parents would not be equipping the child with the capacity to develop the ability for self-regulation. This feature is characteristic of homes where there is lack of monitoring or supervision and where emotionally deficient parenting exists. Problematic outcomes include children with impulsivity, low levels of academic achievement and poor self-esteem.

The approach and style of parenting would depend on the parent's capacity for emotional warmth and nurture, the nature of discipline use, communication style and the levels of expectation and control that the parent asserts. Whilst there are various patterns of parenting, parents would generally combine

examiner should be able to accept a given score as being a true indicator of the characteristic being assessed. The test reliability is expressed as a correlation co-efficient (R=0.00 to 1.00). The closer it is to 1.00, the greater the reliability of the test. Measures of test reliability allow us to estimate the accuracy, which is an important consideration when carrying out an in-depth individual assessment on which a psychologist may well be basing important decisions. An essential characteristic of reliability when the term is used in this context is that test results should be capable of replication on repeat testing within an acceptable range of scores.

4.3 VALIDITY

Validity is concerned with what the test score is actually measuring. Understanding the concept of validities is critical to competent test use. Face validity is the global impression that the test appears to be reasonable and that it seems to be measuring what it says it is measuring. Content validity reflects whether the behaviour demonstrates a representative sample of behaviours to be exhibited in a desired performance domain. Concurrent validity is where test scores correlate with an external criterion that is currently available, that is, at the time of testing, while predict validity is where the test score is correlated with an external criterion that may become available in the future. A simple example of the concept of reliability and validity may be given in the form of a thermometer. It is a valid instrument for the measurement of temperature but its reliability depends on whether or not it is in working order.

4.4 NORMS

Scores obtained in tests are typically converted into 'standard' form to facilitate interpretation. This may be carried out by using tables of norms, or by references to criteria and scores. Norms refer to the range of scores obtained on a given test by the standardisation sample. The purpose of norms is to allow the test to compare an individual score with a score obtained by comparable individuals.

4.5 ETHICAL STANDARDS AND INTERPRETATION

The most important area concerning ethical standards is that involving test selection. The selection of tests with adequate norms, reliability and validity for diagnostic purposes is the clinician's ethical responsibility. The examiner must thoroughly understand the research literature for the tests used. A second ethical consideration relates to test security. This means that an examiner must safeguard the questions and the answers for many tests and inventories. Only those who administer, score and interpret the test should have access to such material. Without test scrutiny the validity of test scores would obviously be reduced.

4.6 COMPETENCY TO USE PSYCHOLOGICAL TESTS

In order to carry out psychometric assessments the PTC have set standards that an individual must be able to:

> 'demonstrate knowledge and understanding of psychometric principles underlying test construction, knowledge of the type of tests that are available, when it is appropriate to use them, and to be able to administer, score and interpret tests in order to provide accurate and meaningful feedback to others.' (PTC, *Psychological Testing; Users Guide*).

The International Test Commission (ITC) 2000, has stated that:

> 'the competent test user will use the test appropriately, professionally and in an ethical manner, paying due regard to the needs and rights of those involved in the testing process, the reasons for testing, and the broad context in which the testing takes place'.

When making use of psychometric tests, techniques and questionnaires that have their basis in research and used by competent and appropriately qualified individuals, they lead to judgments that are likely to be more valid than judgments made by other means. It is however essential those administering psychometric tests should be appropriately trained. Although there exists in the UK a training qualification system developed by the British Psychological Society, it is not uncommon for tests to be used by people who are not adequately trained to use them. Personality questionnaires in particular, require considerable experience and the possibility of misinterpretation or inappropriate interpretation of results is a concern.

4.7 EVIDENCE TO COURT AND LAWYERS

In 2004, the BPS issued a 'Statement on the Conduct of Psychologists providing expert psychometric evidence to the courts and lawyers' in association with the PTC. It is strongly advocated that whilst psychologists have a duty to the court, they also need to consider their obligation to the profession and the ethical standards required of those employing psychometric instruments. Obligations include ensuring that experts' opinions provided do not exaggerate the attributes of the tests, and that psychologists do not go beyond their competency in making comment. However, psychologists should at all times uphold the confidential nature of test material. Many tests are invalidated by prior knowledge on the part of the subject of the specific content of tests and their objectives. Thus, psychologists who use tests are required to respect the confidentiality of test materials and to avoid release of the test materials into the public domain (*Conduct of Psychologists*, BPS, 2004).

The Psychological Association in its *Statement of the Disclosure of Test Data 1996* makes the following points:

in a certain way. It also looks at the family strengths, family resources and the available agency services. This information can then be used to determine whether the child is safe, what professional support is needed to keep the child safe and under what circumstances a child should be removed from the family (Calder 2002).

According to Calder (2002) risk assessment is the systematic collection of information to identify if and what risks are involved and the likelihood of their future occurrence/prediction and whether there is the need of further work, and what form this should take. It would also predict the escalation or potential risks and concerns.

In order to establish the presence or absence of historical risk factors, it is necessary to take a detailed history, review medical and criminal records and examine all past and current interpersonal relationships. All sources of risk need to be considered, thus in addition to violence and aggression, other sources of risk need to be explored, such as neglect, substance misuse, direct harm from either parent and mental health. The experiences of the child or children living with domestic violence needs to be assessed, as this depends on the frequency and severity of the violence, the extent of the child's exposure to it, resilience factors and whether the child has experienced other forms of maltreatment.

Risk assessments are carried out to identify whether it is possible to reduce or manage risk, and thus bring different parenting arrangements within the range of possibility. Risks could be managed by court orders, monitoring by child protection services, alcohol and drug treatment, mental health treatment and victim support. Psychological treatments for children and parents, parenting programmes and domestic violence perpetrator programmes are also essential in reducing risks in the face of aggression, violence or impulsive behaviours.

In determining what approach is to be used, an in-depth assessment of risk is essential. Such assessments should be based on an analysis of empirically derived risk indicators derived from multiple sources of information about the client's background. This would involve exploring with the client 'static factors' such as his or her past history and patterns of behaviours in the past, as well as 'dynamic' factors such as current presentation. This would involve exploration of drug and alcohol use, nature of relationships, day-to-day coping strategies, levels of stress and approach in the face of conflicts and frustrations (Kercher et al 2010).

Whilst findings of fact or convictions for violence or abuse is crucial, especially where there are competing accounts by the parties, the context in which violent or abuse incidents have taken place needs to be carefully considered. It is essential to establish whether the risk behaviours make up a pattern of behaviour as opposed to it be an isolated incident. This would require an in-depth assessment of past and current patterns of behaviours within relationships and in the face of stress and pressure.

To undertake risk assessments, the psychologist would need to have a good knowledge of research, risk assessment techniques and an understanding of the nature and dynamics of domestic violence and conflict on children and spousal conflict. Familiarity and training in the use and interpretation of the psychometric assessment tools used is essential. Some examples of risk assessment tools used to carry out risk assessments related to violence, aggression and impulsivity, are the Spousal Assault Risk Assessment Guide (SARA), Assessing Risk for Violence (version 2) (HCR-20), Sexual Violence Risk 20 (SVR-20), Psychopathy Checklist – Revised (PCL-R) and the State – Trait Anger Expression Inventory-Second Edition (STAXI-2). Details of these are set out in Appendix 2.

According to Kercher et al (2010), risk assessment is a continuous process; therefore any parenting arrangement after domestic violence would identify specific goals for the perpetrator of violence to achieve before progressing further with the plan. The expert witness can also contribute to this by specifying clear behavioural goals and indicators of what changes should be looked for in a treatment programme before risk can be considered to have reduced to an acceptable level.

4.15 SUMMARY

Psychological testing is generally used as a study of samples of behaviour under controlled conditions and, thus, psychological tests do not reveal anything that could not be revealed in the clinical interview and/or through observation of the patient over a period of time. Therefore psychological testing can be regarded as a short, quick and effective way of creating conditions under which a particular behaviour will occur rather than waiting for these to occur spontaneously in time. Projective testing can tap personality dynamics, which reveal changes that the individual subject experiences and, thus, within a brief period of time, can uncover underlying personality dynamics that might otherwise take a busy clinician months to spot.

Psychological testing forms an important component of the tools used by clinical psychologists in litigation. Psychologists are of particular assistance to the court as they are in the unique position to apply reliable and valid psychometric tests and measures, which are relevant to the legal issues before the court. Areas that can be addressed to assist the court include cognitive functioning, neurological status, personality, and areas of clinical concern, anger, risk of violence, sexual problems, emotional impairment and various legal competencies.

In childcare cases the psychometric assessments and evaluations look at the capabilities of the parents and the needs of the children, and an arrangement may then be recommended which, ideally, would make the best use of each parent's strengths. Psychological testing improves the objectivity of these evaluations, helps to look beyond the deception which may be practised by individuals in cases involving an adversarial aspect and may help to elicit

capacities, along with personal background experiences that have an impact upon an individual's functioning. In risk assessments, particular attention would need to be paid to the person's intellectual functioning, their personality functioning, relationship styles and approaches to problem solving and stress management. Other areas to be assessed would include:

- background experiences and whether there had been any abuse in own childhood;
- problems in current functioning;
- parenting knowledge and expectations;
- perception of the child;
- attitudes towards discipline;
- characteristics of the child;
- social network and support;
- cultural issues.

5.8 DOMESTIC VIOLENCE

Witnessing family violence is generally considered to be a form of psychologically abusive behaviour. Witnessing family violence, especially one's mother being battered by one's father, is clearly abusive and has been related to subsequent psychological disturbances (Briere, 1992).

Family violence, or domestic violence, usually refers to the physical assault of children and women by male relatives, usually a father and husband/partner. In these situations, a man uses violence to control his partner and children, often in the belief that violence is a male prerogative or that his victims are responsible for his behaviour. Whilst women may also be perpetrators of family violence, they are usually 'fighting back' against a physically abusive partner, and it is unusual for violent women to inflict the same scale of harm as violent men. A child witnessing family violence and domestic violence is at risk of behavioural and emotional difficulties, learning difficulties and long-term developmental problems. Such violence is also associated with aggressive language and behaviour as well as restlessness, anxiety and depression.

Even when children are not direct targets of violence in the home, they can be significantly harmed by witnessing its occurrence or be affected by the emotional distress of the parents. This would be in addition to the lack of emotional availability due the parent's distress or depression following an assault and the anticipatory anxiety by the child as to when this could happen again. Children who live in situations of family violence can suffer immediate physical harm as well as experience short- and long-term emotional, behavioural and developmental problems, including post-traumatic stress disorder. Children who witness family violence suffer the same consequences as those who are directly abused. In other words, a child who witnesses intimate partner violence is experiencing a form of child abuse.

5.9 CHILD SEXUAL ABUSE

The 'Working together to safeguard children' guide defines child sexual abuse as forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Adult males do not solely perpetrate sexual abuse. Women can also commit acts of sexual abuse, as can other children.

A person may sexually abuse a child using threats and physical force, but sexual abuse often involves subtle forms of manipulation, in which the child is coerced into believing that the activity is an expression of love, or that the child brought the abuse upon themselves. Whilst all children are vulnerable to sexual abuse, girls are more likely to be sexually abused than boys. Disabled children are up to seven times more likely to be abused than their non-disabled peers (Briggs 2006). Disclosure is limited; it is estimated that only 10% of child sexual abuse experiences are ever reported to the police, a doctor, or a health agency (Flemming 1997).

Across all community-based studies, most abusers are male and related to the child (Flemming 1997) and most adults who sexually abuse children are not mentally ill and do not meet the diagnostic criteria for 'paedophilia'.

Sexually abused children may be affected in a variety of ways:

- direct physical harm caused by sexual abuse;
- withdrawn, unhappy and suicidal behaviour;
- self-harm and suicidality;
- aggressive and violent behaviour;
- bedwetting, soiling, sleep problems, nightmares;
- eating problems, eg anorexia nervosa and bulimia nervosa;
- mood swings;
- detachment;
- pains for no medical reason;
- sexual behaviour, language, or knowledge too advanced for their age;
- risk taking behaviours during adolescence including multiple sexual relationships;
- mental ill health, substance abuse and alcohol misuse.

(7) Where anatomically correct dolls or drawings were used in the assessment, the account given by the child was consistent with the formal assessment undertaken.

(8) Medical evidence was seen to be consistent with the child's disclosure.

(9) The account given by the child correlates with the history of allegations and events corroborated by witnesses.

Following initial disclosure and assessment, if it had been considered that the child's account has credibility, action needs to be taken in order to protect the child. Where the alleged abuser lives outside of the child's home, or in the case of sibling abuse, the parents need to be able to put protective measures in place. Where the parents do not accept the disclosure, some level of family intervention would need to be carried out to determine whether the parents would be able to protect the child against further harm taking place. If the child had made a disclosure concerning a parental figure living within the home, the child returning to the situation may find it intimidating and in all likelihood this may result in the child retracting its statement. The abuse could continue and the child may well be unlikely to make further allegations owing to the threat of violence and the child will also continue to feel unsafe because of the apparent ineffectiveness of the professionals to protect it after the disclosures and statements it had made. It would, however, be acceptable for the child to return to the home environment if the non-abusing parent believes the child and agrees to protect it and the abuser leaves the home.

Assessment and clinical interviewing of children as part of a medico-legal or clinical assessment should be focused upon the following:

(1) To assess the impact of the abuse on the child.

(2) To assess any abnormal behavioural patterns and the trauma-related dynamics of sexual traumatisation, stigmatisation, betrayal and powerlessness.

(3) To assess the child's perception of risk and the protective factors within its family.

(4) An account to be obtained of the child's perception of the non-abusing parent's capacity to be protective.

(5) To establish the ways in which the child has coped with the abuse and its personal strengths and resources, particularly its capacity for assertiveness and the possession of self-protective skills (A Carr, 1999).

7.3 ASSESSMENT CHILD INTERVIEWS

In addition to talking in a one-to-one situation with the child, the use of play, sand play, drawing and using anatomically correct dolls are useful aids to interviewing. It is recommended that the child be interviewed alone as the presence of a parent could inhibit the child and there could also be an element of fear of repercussions present from what the child could come to say. The pace of the interview should always be in line with the child's pace, its abilities

in coping with the interview and the level of anxiety that is aroused in the child. There has been much research on the use of anatomically correct dolls in this situation. The most significant feature that has been discovered is that children who have not been sexually abused inspect and touch sexual body parts but do not enact sexual activities such as oral, anal or genital intercourse with the dolls. Anatomically correct dolls do not lead, when used, to undue distress or traumatisation suffered by the child and this approach provides a useful way into communication with the child and also allows the child to talk about difficult experiences. This serves as a medium through which to communicate about sexually abusive acts committed on the child.

It is only after the child has given a spontaneous general account of the abuse that information about specific details should be obtained. Specific areas to be covered would include:

(1) The location of the abuse.

(2) The frequency and duration of the abuse.

(3) The use of violence or threats.

(4) The presence of other people during the abuse.

(5) The use of drugs or alcohol by the perpetrator or the child.

(6) Whether photographs or recordings of the abuse were made.

(7) The child's psychological reactions to the abuse.

In addition to the psychological assessment of the child a full physical and medical forensic examination of the child should be conducted as part of a comprehensive assessment following guidelines for good practice. Individual interviews with non-abusing parents should be conducted to assess their capacity to protect the child in the future.

Additionally, clinical interview and assessment of the child should be focused upon the following:

- to assess the impact of the abuse on the child;
- to assess any abnormal behavioural patterns and the trauma-related dynamics of sexual traumatisation, stigmatisation, betrayal and powerlessness;
- to assess the child's perception of risk and protective factors within their family;
- an account of the child's perception of the non-abusing parent's capacity to be protective;
- to establish the ways in which the child has coped with the abuse and her personal strengths and resources, particularly assertiveness and self-protective skills (Carr A, 1999).

This contact program would need to be monitored and the children's guardian could be the person best placed to support the family and monitor the progress. Furthermore, individual therapy to address the impasse and unresolved issues experienced by the alienating parent would need to take place. It is, however, essential in these circumstances that the guardian has the support of the court behind such a program. Owing to the level of resistance for contact by the alienating parent, clear and unambiguous sanctions must stand behind any court orders and directions made, as compliance at this stage would in all likelihood be motivated only by fear. The ultimate sanction is a change of residence. However, other sanctions such as fines and loss of liberty could be used to motivate the parent to co-operate for contact to be reinstated. If the alienating behaviour continues despite the education, post-divorce counselling and impasse resolution therapy, it could only be concluded that this parent does not have the capacity to foster a relationship with the other parent. At that stage the issue for the court is the determination of whether the residential parent has sufficient parenting capacity to outweigh the very serious harm it could be inflicting on the child by the behaviour shown to the other parent.

8.3 PSYCHOLOGICAL IMPACT OF PARENTAL ALIENATION

Children who experience high degrees of conflict as between their parents during divorce show more emotional difficulty than those whose parents are better able to resolve their difficulties. Children whose parents are in conflict are more likely to feel trapped, and children who feel caught are more likely to experience depression, anxiety, and, to a lesser degree, participate also in deviant behaviour. A parent who attempts to alienate the child from the other parent is considered to be perpetrating a form of emotional abuse, in that such alienation could not only produce lifelong alienation from a loving parent, but lifelong psychiatric disturbance in the child. The ultimate emotional state of an alienated child is that its behaviour could become fully enmeshed with the alienating parent's behaviour and incorporates the alienating parent's hatreds, emotions and desires with regard to the non-resident parent. In some of these cases, the enmeshment is so complete that it would cause the child to suffer an emotional breakdown of devastating proportions if residence were to be awarded to the, in its eyes, hated target parent. According to Ward & Harvey (2003) in these cases the child's sense of self is totally dependent on the relationship it has with the alienating parent, and a loss of that relationship would mean destruction of the self. Certainly, attempts to switch residence would be fought against and undermined by the child, using tactics including attempts to run away.

In the process of parental alienation it is not uncommon for the alienating parent to make false allegations and accusations of abuse. The empirical literature has referred to this as 'Sexual Allegations in Divorce Syndrome' (SAIDS), highlighting the use of sexual abuse allegations as a weapon to prevent contact from taking place. Other weapons could include accusations of threats of or actual domestic violence, physical abuse of the child, emotional abuse of the child, mental illness on the part of the non-resident parent,

alcoholism/drug abuse and homosexuality. Caution should however always be expressed that even when such allegations are made in the context of high conflict litigation that these accusations should be taken very seriously and fully investigated to determine their truth. The clinical literature suggests that the emotional harm to a child who is induced into making false allegations of sexual abuse is of a similar degree to the emotional harm that is experienced from actual sexual abuse.

A significant indicator of parental alienation is where the child has had a positive relationship with the now non-residential parent, and the deterioration in the child's behaviour had occurred following his departure from the family home. It has been seen that children do not naturally lose interest in or become distant from their non-residential parent simply by virtue of the fact of absence of that parent. By the nature of the alienation processes the child is placed in a situation involving divided loyalty and conflict, believing it needs to choose which parent to be loyal to. Furthermore, due to the level of conflict and hostility between the parents, alienated children become overly alert to the nuances of emotion and tend to keep the peace by joining the alienating parent in the negative emotions shown towards the alienated parent.

8.4 DIVIDED LOYALTY CONFLICT

An emotionally harmful outcome for children who have been alienated from a parent is the development of a divided loyalty conflict, where the child has lost the range of normal feelings a child would naturally have for a parent. The child gets to the point where it associates all that is positive with the resident parent and all that is bad and wrong with the non-resident parent, including extended family. Such responses strongly reflect making use of splitting as a way of relating to family members. This is a concern, not only because it is a maladaptive defence mechanism, but emotionally harmful for a young child having been placed in the position of such conflict and anxiety, as to necessitate the development of such a defensive structure. The child has needed to develop defence mechanisms and coping strategies in order to deal with mixed feelings, confusion, conflicts and divided loyalty binds. Splitting enables the child to maintain self-worth and to reduce anxiety. However, since it involves a distortion of reality, idealising one person and devaluation of another, it is maladaptive in nature.

Splitting is a primitive defence where negative and positive impulses are split off and 'unintegrated' or disconnected. Splitting creates instability in relationships, because one person is idealised and the other devalued, depending on whether the child's needs are gratified or frustrated. The person who is being idealised could change in other settings when needs are frustrated, and then the same person is devalued, leading to chaotic and unstable relationship patterns, identity diffusion, the creation of a 'false self' and mood disturbances. Additionally from a psychodynamic point of view, for the child to view a parent as 'a bad person', the self of the child is also viewed to be bad; however, by viewing the self as all bad cannot be endured, so the switch is made to the other

psychopathology of a personality disorder is seen to result from rigid personality traits and patterns. A personality disorder would arise when some distortions of the personality develop early in life and persist as part of a person's style, and characterise the way in which he copes with and in his environment, how he defends himself against real or imagined threats, and his personal competence or integrity. Persons with personality disorder may never consider or admit they may have something abnormal or intrusive, thus may never come to suffer feelings of anxiety once these traits become established. The change occurs in childhood resulting in a distortion of personality and the sufferers may come to see things with compensatory changes made by them to offset the distortion. Cameron and Rychlak (1985) note that:

> 'personality disorders suffer from more severe disturbances in that they are distorted strategies in living that enable the person to achieve a stable level of functioning with this distortion included. There is a distortion of personality style that more or less permanently alleviates anxiety.'

After extensive research and clinical experience, Kaplan & Sadock (1981) highlighted that the most outstanding characteristics of all personality disorders includes:

(1) an inflexible and maladaptive response to stress;
(2) a disability in occupation and relationships that is generally more serious and pervasive; and that
(3) the personality disorder almost always occurred in response to a social context.

The literature highlights those with personality disorders as being individuals who constantly fail to see themselves as others do, and also lack meaningful empathy (Leaff, 1981). However, it is important to recognise that persons who have a personality disorder are not out of contact with reality. They do demonstrate non-specific manifestations of ego-weakness, namely lack of anxiety tolerance and lack of impulse control. Furthermore, they experience difficulties associated with shallowness of emotional reactions as well as significant difficulty in or capacity for forming deep and enduring interpersonal relationships (Leaff 1981).

It is widely documented that growing up in a disruptive environment may impair a child's development and his or her sense of self. The disruption can also impede the social development required for satisfactory peer relationships necessary for adequate latency-age (adolescence to adulthood) functioning. The primary difficulties are associated with role confusion, lack of identity and a lack of capacity for intimacy.

Difficulties encountered during the adolescent period of individuals diagnosed with personality disorders held similarities with features such as:

(1) Hostility expressed in subtle ways towards the parent by the child.
(2) Onset of antisocial and disruptive behaviour.

(3) Repeated disciplinary problems, expulsions from school and truancy.
(4) Poor motivation, failures and keeping late hours.
(5) Frequent fights, alcohol and drug use, and recklessness in their behaviour.

11.3 PSYCHODYNAMICS OF MALADAPTIVE PERSONALITY

Looking at the development of personality maladaptive patterns and their dynamics, Ogata et al (1990) found in his studies and within the literature that these patients experience more conflict and less cohesion with their family during their adolescent years, and concluded that adolescent periods spawned problems for the family at a time when the identity and the individualities of an individual became salient features. Personality dysfunction, in particular borderline personalities, 'experience significant peer related problems in school especially during high school years, further underscoring possible difficulties with identity and affectional relationships' and reported feeling left out and isolated in their adolescent years (p 99).

From the research studies it appears that personality disordered patients recall family experiences as a combination of traumatic early years, emotionally or psychologically unavailable parents and family conflict. All of the above reflect a non-nurturing and unstable environment where the pattern of emotional neglect characterises personality-forming maladaptive experiences.

Persons who go on to develop personality disorders might have experienced trauma at an age when they would have been particularly vulnerable (between the ages of 5 and 10). Defence mechanisms employed by children at this age to deal with prolonged distress include denial, splitting and repression. Unmet needs during vulnerable developmental phases in early formative years have a direct impact on development of an immature ego which is incapable of resistance along with other vulnerabilities which lead to the development of these defences (Ogata et al, 1990; Stone, 1990; Leaff, 1980).

The developmental consideration of pathological personality development leads to the observation of developmental failure, particularly in disturbed family relationships, inadequate parenting received and dysfunctional mother/child relationships with repeated instances of children feeling rejected in their childhood. This developmental failure underscores the psychodynamics of personality disorders.

Past childhood experiences of personality disorders are also characterised by neglect and deprivation in childhood. This leads to repetitive and continual trauma arising from chronic disturbance in family structures and relationships. As a consequence, this results in object hunger (seeking for emotional needs to be met) and affective instability. This constant seeking of needs to be met and affective instability represents a child searching for the parenting it never had. This dynamic would be evident and replicated in future relationships and interactions and is reflective of personality dysfunction (van Rooyen, 1993).

the patient gradually becomes desensitised to the old response of fear and learns to react with feelings of relaxation.

(7) **Validity testing.** Patients are asked to test the validity of the automatic thoughts and schemas they encounter. The therapist may ask the patient to defend or produce evidence that a schema is true. If the patient is unable to meet the challenge, the faulty nature of the schema is exposed.

CBT generally lasts about 12 weeks and is mainly conducted individually but is also offered as a group therapy. There is evidence that there are beneficial effects of CBT for patients with anxiety and mood disorders, panic disorder, obsessive-compulsive disorder, post-traumatic stress syndrome and social phobia.

Cognitive Analytic Therapy (CAT)

Cognitive Analytic therapy is an approach of psychological treatment that incorporates understanding from cognitive psychotherapies and from the psychodynamic approaches into one integrated and effective therapy. It is described as a collaborative programme of looking at the way the person thinks, feels and acts, maintaining the focus on individual needs and therapeutic goals. CAT therapists would either have core training as psychotherapists and psychologists, or they would need to have undertaken an accredited two-year training in Cognitive Analytic Therapy.

CAT differs from psychoanalytic therapy in that its focus is on description of the patients' current problem psychological functioning rather than interpretation. Transference and counter-transference are used in the session, but this is only to define current relationship and problem procedures. CAT differs from CBT, as this approach is rooted in cultural and social process rather than using a standard information-processing model that characterises the CBT approach. CAT is therefore both interpersonal and intra psychic, not one or the other.

CAT offers a way of thinking about oneself differently and exploring difficulties: where they originated, how they affect everyday life relating to relationships, work, parenting and social functioning. This therapy helps the person get to a point of finding new ways of addressing concerns, rather than being entrenched in learned patterns of behaviour.

Cognitive analytic therapy (CAT) is time limited and could last between 16 and 24 sessions, although could progress to a year depending on the concerns. This approach is helpful to wide ranges of concerns, from mood and anxiety disorders to borderline personality disorders. This approach is effective in addressing patterns of stress, substance abuse and patterns of discordant relationships.

Psychodynamic psychotherapy

Psychodynamic psychotherapy is a form of psychotherapy used by qualified psychotherapists or clinical psychologists who are trained in this approach to treat patients who have a range of mild to moderate chronic life problems. It is related to a specific body of theories about the relationships between conscious and unconscious mental processes, and should not be used as a synonym for psychotherapy in general.

'Psychodynamic' refers to a view of human personality that results from interactions between conscious and unconscious factors. The purpose of all forms of psychodynamic treatment is to bring unconscious mental material and processes into full consciousness so that the patient can gain more control over his or her life.

Classical psychoanalysis is the least commonly practised form of psychodynamic therapy because of its demands on the patient's time, as well as on his or her emotional and financial resources. This treatment approach focuses on the formation of an intense relationship between the therapist and patient, which is analysed and discussed in order to deepen the patient's insight into his or her problems.

Psychodynamic psychotherapy is a modified form of psychoanalysis based on the same theoretical principles as psychoanalysis, but is less intense and less concerned with major changes in the patient's character structure. The focus in treatment is usually on the patient's current life situation and the way problems relate to early conflicts and feelings. The psychodynamic psychotherapy approach helps a person look inside him or herself to discover and understand emotional conflicts that may be contributing to emotional problems. The therapist helps the client 'uncover' unconscious motivations, unresolved problems from childhood and early patterns of behaviour to resolve issues and to become aware of how those motivations could influence present actions and feelings.

Not all patients benefit from psychodynamic treatment. Rather, it is indicated where the client has the capacity to relate well enough to form an effective working relationship with the therapist. The client would also need to have at least average intelligence and be psychologically minded. It is important for the person to have an ability to tolerate frustration, sadness, and other painful emotions as well as the capacity to distinguish between reality and fantasy. Problem areas and disorders best suited for psychodynamic psychotherapy would include depression, personality impairment, neurotic conflicts, and chronic relationship problems.

In psychodynamic psychotherapy, the therapist does not tell the patient how to solve problems; rather the focus of treatment is the exploration of the patient's mind and habitual thought patterns. Such therapy is non-directed and

develops control over urination, whist secondary enuresis is described when the problem has developed after the child had initially become continent for a period of time.

Encopresis refers to difficulty controlling defecation after the age of 3 or 4 years. By this age most normal children would have achieved bowel control and continual soiling after the age of 4 could suggest a deviation from normal development. The diagnostic criteria for encopresis would include repeated voluntary or involuntary passage of faeces of normal or near-normal consistency in a place not appropriate for the purpose. In an individual's own cultural setting, at least, one such event a week would occur after the age of 4, and the occurrence is not found to be due to any physical disorder.

Both enuresis and encopresis could have a negative impact on children's social, educational and personal development. These children often experience anxiety, low self-worth and lowered mood associated with the response of their peers, exclusion from school and generally from feeling different and ostracised. Children with encopresis often develop conflicting and clashing interactions with parental figures. Enuresis and encopresis are considered in some cases to involve hereditary factors. However, there are strong links between high levels of stress, which interferes with development and maintenance of bladder and bowel control, and these conditions, particularly with secondary enuresis and encopresis. When assessing and managing enuresis and encopresis evaluation is made also of the emotional functioning, family relations and levels of stress the child is experiencing. Before any conclusions are reached as to the possible emotional causes of these disorders, all physiological causes will need to be excluded. It is often the case that a combination of underlying causes is at play.

With enuresis, underlying emotional conflicts, small bladder capacity and failure to learn an adequate response to the sensation of a full bladder are cited as the most usual explanations for the condition. There are, however, no causes of these urinary problems, which have been established conclusively. In childcare proceedings, enuresis is a common feature and at times is observed to be an external indicator of emotional distress experienced by the child. In certain situations, such as when a child is exposed to conflict and violence in the home, or when having to make adjustments when placed in foster care or when placed in a situation of conflict, the child's behaviour may often be accompanied by periods of secondary enuresis.

Effective methods for bladder control and treatment programmes for encopresis would include behavioural procedures and behavioural modification programmes such as night-time awakening, practice of retention control and a reduced fluid intake. Medication has been found to be extremely useful and effective with enuresis, as has the alarm-based programmes such as the bell and pad. A vital element of treatment would include a psycho-educational component to assist parents and children to understand the physiological dynamics of these conditions. The parents' approach should be such that they are reassuring and assist to reduce the child's anxiety surrounding the wetting

or soiling. Breaking the cycle of conflict with encopretic children is essential. Owing to the frustrating nature of these conditions, the parents would also require support and reassurance. For encopresis, family based approaches have been found more useful in conjunction with medical care involving laxatives and increased intake of dietary fibre. Behavioural therapy and techniques involving the maintenance of toilet routines, rewarding the child for engaging in such routines and the learning of sphincter control are included in the family work and psycho-education.

13.3 CHILDHOOD FEARS

General childhood fears are, of course, common and most normal children display specific age-related fears at one time or another. The fears could take the form of concrete stimuli such as fear of animals or strangers, to somewhat more abstract situations such as fear of getting lost, or being kidnapped and of death. Childhood fears are primarily learned experiences from past events, stimuli and experience of situations and events in the child's environment. The child's life experiences could at times have resulted in the association of a normal situation with a feared response. This could be developed through the means of classical conditioning, where fear responses in a young child are associated with a feared response within a neutral situation. Additionally, fear could also develop when a child observes other individuals who show evidence of fear; children generally pick up on the anxieties and fears of others in this way. Most childhood fears are transient in nature and spontaneously decline or resolve with increasing age, settling without any form of intervention. Mild fears are therefore viewed as being a normal part of childhood rather than as a pathological condition. Typical childhood fears in certain age groups could be, for example, loud, sudden noises and loss of support could elicit fear in infants between 0–6 months of age. Between 6 and 9 months of age fear of strangers is fairly typical, and in the first year of life, separation, injury and the toilet could be the basis of common fears involving these situations. Children at the age of 2 typically fear imaginary creatures, death and robbers, while at the age of 3 the most common fears have been found to be the fear of dogs and of being alone. In the fourth year fear of the dark is typical. Then, between the ages of 6 and 12, school, injury, incidents or disasters involving a national dimension, death and social situations cause fear, whilst between the ages of 13 and 18, fear of social situations and of injury are common phenomena while natural disasters, sexual situations and injury are normal fears for adolescents of 19 years or older.

As mild childhood fears are common and disappear spontaneously with age, formal treatment would not be indicated, unless the fear is causing specific levels of distress to the child. Where therapeutic intervention is required procedures such as modelling are effective in dealing with normal fears as well as phobias. It is important to consider that there is a significant distinction to be made between fear and phobias, as phobic disorders would require therapeutic intervention. Fear is essentially a normal response to some object or source of danger, whereas phobias are excessive fears beyond voluntary control and are

experience difficulties with concentration and attention, which may have implications for academic progress as well as for social development.

Signs and symptoms of generalised anxiety include the following:

- worries about things before they happen;
- constant worries or concerns about family, school, friends, or activities;
- restlessness;
- difficulty concentrating;
- irritability;
- sleep disturbance;
- easily fatigued.

The most effective treatment approach for anxiety is cognitive behavioural therapy for children, which includes education about the nature of anxiety; ways to identify, evaluate, and change anxious thoughts; and training in relaxation strategies is indicated. Children are taught to learn to recognise the physiological symptoms of anxiety as well as leaning to make use of positive 'self-talk' rather than negative self-talk. Parental involvement is essential, so as to learn strategies of providing reinforcement, providing rewards for children's success and learning to implement and practice the skills with their children.

14.3.3 Panic disorder

When a child is extremely anxious and experiences recurrent or unmanageable panic attacks of acute intensity, the diagnosis of panic disorder could be made. In childhood, panic disorders commonly result in some degree of agoraphobia, in particular where the child fears leaving the safety of home in case a panic attack occurs in a public setting. Consequently, a typical consequence could be the increased withdrawal and avoidance of going out, with implications with regard to the social, interpersonal, educational and emotional growth and development of the child. Signs and symptoms include intense fearfulness, palpitations, shortness of breath, shakiness, fear of dying and a sense of unreality.

14.3.4 Obsessive-compulsive disorder (OCD)

This condition involves recurrent obsessional thoughts and compulsive acts that are extremely time consuming for the child to deal with and create great levels of distress. The child makes use of rituals or obsessive thoughts to reduce anxiety associated with the obsession. A vicious cycle of anxiety is experienced as the rituals and obsessions lead the child to maladaptive and dysfunctional behaviour and responses, which in itself increases internalised anxiety. The compulsions and obsessions are then increased with the primary purpose being to reduce the increase of anxiety and distress experienced. Typical obsessions and compulsions are related to compulsive hand washing due to obsessions

with germs and cleanliness, or compulsions to order and count items, behaviour which is underlined by feelings being out of control.

Children with OCD often have accompanying features of depression, eating disorders, ADHD or other anxiety disorders. The symptoms tend to vary, with periods of increased intensity from time to time. The child's behaviour may take various forms, such as:

- indications of frequent washing such as raw, chapped hands; high rate of soap and towel use; increase in laundry;
- sudden drop in test grades;
- constant doing and redoing of homework in an attempt to be perfect;
- reworking of written work;
- persistent fear of illness;
- long time spent in preparing for bed or getting ready for school;
- continual fear that something terrible will happen to self or family;
- collecting things others might discard.

Common obsessions with children include fear of germs, the need for order, sexual or aggressive thoughts and fear of harm of self or family members. Common compulsions include excessive hand washing, touching, counting and repetitive rituals as well as checking drawers and locks. The recommended treatment for OCD is cognitive behavioral therapy for children and exposure therapy to assist the children learn the basic CBT tools for recognising anxious thoughts, developing coping mechanisms and managing the physical symptoms of anxiety.

14.3.5 School refusal behaviour and school phobia

School phobia is seen in children with a fear and avoidance particularly relating to the school environment. It is often found that children who have this anxiety relating to school attendance do not have similar anxieties associated with interaction with their peers or going into situations away from school. Anxiety and phobia associated with school tends to lead to the avoidance of the school environment and the experience of fear in that setting. The irrational nature of school phobia creates high levels of stress and distress within families and typically may come to have an impact on all members of the household. The underlying fear could be related to separation from caregivers, fear of travelling or eating in public, bullying at school, fear of using the school toilets, avoidance of changing for gym and anxieties related to interacting with other children. The child will often present with physical symptoms such as headaches or stomach aches on school days, with relief of symptoms when permission is given to remain at home.

Children are more likely to develop difficulties after separation or divorce if there have been previous serious difficulties in the parent/child relationship prior to the separation. This could in particular be related to insecure attachments, inconsistent discipline and where there has been permissive or neglectful parenting before. Furthermore, exposure to chronic family problems, marital discord, and/or domestic violence prior to separation could have an impact on post separation adjustment. Early life stressors experienced by a child such as abuse or bereavement could also have an impact on the child's subsequent capacity to deal with stress following parental separation. On the other hand, positive prognostic indicators are related to having experienced a stable parenting environment before the divorce and separation and the children having had a history of positive physical and psychological adjustment in the past.

It is also the case that ongoing conflict following separation and/or divorce could have a significant impact on the child's emotional, social and psychological functioning. Ongoing parental acrimony and the using of children as weapons in their battle, in particular, could lead to alienation and a source of significant emotional harm.

A comprehensive review of over 200 research reports revealed the following:

(1) Although short-term distress at the time of separation is common, this usually fades with time and long-term adverse outcomes typically apply only to a minority of children experiencing the separation of their parents.

(2) However, these children have roughly twice the probability of experiencing specific poor outcomes in the long term compared with those in intact families.

Children of separated families have a higher probability of:

(1) being in poverty and poor housing;

(2) being poorer when they are adults;

(3) behavioural problems;

(4) performing less well in school;

(5) needing medical treatment;

(6) leaving school/home when young;

(7) becoming sexually active, pregnant, or a parent at an early age;

(8) experiencing depressive symptoms, high levels of smoking and drinking, and drug use during adolescence and adulthood.

Factors affecting outcomes include:

(9) financial hardship can limit educational achievement;

(10) family conflict before, during and after separation can contribute to behavioural problems;

(11) parental ability to recover from distress of separation affects children's ability to adjust;

(12) multiple changes in family structure increase the probability of poor outcomes;

(13) good quality contact with the non-resident parent can improve outcomes.

If recent trends continue, more than a third of new marriages will end within 20 years and four out of ten will ultimately end in divorce. More than one in four children will experience parental divorce by age 16. Divorce rates in England and Wales (but not Scotland or Northern Ireland) are among the highest in Europe, although considerably less than in the United States (where most research has been carried out).

15.2 CHILDREN'S EXPERIENCE OF PARENTAL SEPARATION

Interviews with children around the time of separation have shown that most wish their parents had stayed together and hope they will get back together. They are likely, in the short term, to experience unhappiness, low self-esteem, problems with behaviour and friendships, and loss of contact with a significant part of their extended family. However, good continuing communication and contact between children and both parents is known to be especially important in assisting children to adapt. The immediate distress surrounding parental separation usually fades with time and most children settle into a pattern of normal development. Nevertheless, studies have found that there is a greater probability of poor outcomes for children from separated families than others – and that these can be observed many years after separation, even in adulthood.

Children of separated families:

(1) tend to grow up in households with lower incomes, poorer housing and greater financial hardship than intact families (especially those headed by lone mothers);

(2) tend to achieve less in socio-economic terms when they become adult than children from intact families;

(3) are at increased risk of behavioural problems, including bedwetting, withdrawn behaviour, aggression, delinquency and other antisocial behaviour;

(4) tend to perform less well in school and to gain fewer educational qualifications;

(5) are more likely to be admitted to hospital following accidents, to have more reported health problems and to visit their family doctor;

(6) are more likely to leave school and home when young and more likely at an early age to: become sexually active, form a cohabiting partnership; become pregnant; become a parent; and give birth outside marriage;

(7) tend to report more depressive symptoms and higher levels of smoking, drinking and other drug use during adolescence and adulthood.

Although the differences in outcomes are clear, it cannot be assumed that parental separation is their underlying cause. The complexity of factors that

17.2 ASSESSING CHILDREN WITH ADHD

When assessing children with ADHD, information needs to be drawn from behavioural ratings of the child's behaviour made by the parents and teachers, interviews with parents, teachers and the child, as well as direct observation of the child in behaviour performing tasks, in the classroom and/or in the home environment. ADHD is particularly serious as a condition because the core difficulties of inattention, over activity and impulsivity result in a wide range of secondary academic, relationship and social problems. Additional difficulties may lead to poor attainment in school, whilst impulsivity and aggression could lead to greater difficulties in relationships and social involvement.

The DSM-5 diagnostic criteria for ADHD requires a range of symptoms of inattention, hyperactivity and impulsivity that have persisted for at least 6 months, to the degree that it is maladaptive and inconsistent with developmental levels. Some of the hyperactive, impulsive and/or inattentive symptoms would need to have caused impairment and would have been present prior to the age of 12, and the impairment would need to be evident in at least two settings such as school and home. There must have also been clear evidence of clinically significant impairment in social, academic and/or occupational functioning for the diagnostic criteria to be met.

ADHD is a behavioural disorder with three major symptoms:

- Inattention – The child may have difficulty sustaining attention, listening, and attending to detail. Organisation and study skills may be poor, and the child may be distractible and forgetful.
- Impulsivity – The child may blurt out answers, often interrupt or intrude, or have difficulty waiting in school and in play situations. These characteristics frequently impede social relationships.
- Hyperactivity – The child may seem to be in constant motion, fidget or squirm, often run or climb, talk excessively.

Children with a diagnosis of ADHD also present with associated features such as low frustration tolerance, temper outbursts, bossiness, stubbornness and excessive insistence on requests being met. These children may also present with emotional lability, demoralisation, and suffer rejection by their peers. Additionally, poor self-esteem and poor academic achievement are common amongst these children. Family conflict and conflict with authority figures is commonly found, with family relationships being characterised by resentment and the individual's symptoms may be disruptive to the extent which leaves people to believe their troublesome behaviour is wilful. The consequent family discord and negative parent/child interactions could in turn result in increased emotional problems for the child. Others often interpret inadequate self-application to tasks that require sustained effort as laziness, with a poor sense of responsibility, or as being oppositional behaviour. However, it needs to be appreciated that these children have fundamental difficulties in these areas

and as a consequence are then left behind academically. It is the case that many secondary difficulties evolve owing to the nature of this disorder.

ADHD is a condition where the symptoms may or may not be present all the time as the presentation is to a large extent, dependent upon the situation. When undertaking an assessment of ADHD, it is essential to obtain information from individuals who are familiar with and have observed the child across different settings. Any assessment would need to include the parents and teachers of the child, if not more than one teacher. There needs to be a multi-input approach to understand behaviours at home and at school, school performance and grades achieved, interactions with peers and siblings as well as other relevant features relating to ADHD.

Additionally when undertaking such an assessment, it is not only the external symptoms and behaviours that need to be considered; an in-depth evaluation of the child's emotional, social and behavioural functioning and home life needs to be carried out, as many children with ADHD have co-occurring problems. The child's parenting experiences would also need to be considered, as this would inform the extent to which the parents are able to understand the child's presentation and the extent to which they would be able to respond to and implement treatment strategies.

The assessment process would need to involve the following:

- parent and child interviews;
- parent- and teacher-completed child behaviour rating scales, such as the Connor rating scales;
- parent self-report measures;
- clinic-based psychological tests;
- review of prior school and medical records;
- individually administered intelligence testing, educational achievement testing, or screening for learning disabilities (only necessary if not completed within the past year);
- a standard paediatric examination or neuro-developmental screening to rule out any unusual medical conditions that might produce ADHD-like symptoms;
- additional assessment procedures may be recommended, including vision and hearing screening, as well as formal speech and language assessment.

17.3 CAUSES OF ADHD

In exploring the causes of ADHD the research indicates a combination of factors including genetic factors, impairment of brain functioning and neurological features as well as social and environmental causes related to the child's failure to learn adequate cognitive behavioural skills. Children with ADHD have been found to suffer from a brain-based biological disorder. They have lower levels of dopamine, a neurotransmitter. In addition, brain-imaging

The revised diagnostic Criteria of Autistic Spectrum Disorder (ASD) is as follows:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
   1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
   2. Deficits in non-verbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and non-verbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and non-verbal communication.
   3. Deficits in developing, maintaining, and understanding relationships, such as imaginative play or in making friends and the absence of interest in peers.

B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history:
   1. Stereotyped or repetitive motor movements, use of objects, or speech (eg simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
   2. Insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal/non-verbal behaviour (eg extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
   3. Highly restricted, fixated interests that are abnormal in intensity or focus (eg strong attachment to or preoccupation with unusual objects, excessively circumscribed or preservative interest).
   4. Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (eg apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make co-morbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Children and adolescents with ASD also have high rates of co-occurring ADHD, anxiety, and other medical and behaviour disorders. Research shows that early diagnosis and appropriate treatments leads to improvements in language, social skills, challenging behaviour, and co-occurring conditions.

20.3 COMMUNICATION DISORDER

The new DSM-5 Communication Disorder includes the previously identified language disorder (the previously named expressive and mixed receptive-expressive language disorders), speech sound disorder (phonological disorder), and childhood-onset fluency disorder (stuttering). Also included in the communication disorder category is the social (pragmatic) communication disorder, which encompasses persistent difficulties in the social uses of verbal and nonverbal communication.

Communication disorder is related to persistent difficulty with verbal and non-verbal communication that cannot be explained by low cognitive ability. This disorder limits effective communication, social relationships, academic achievements, or occupational performance. The diagnostic criteria for Communication disorder are as follows:

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:
   1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
   2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on the playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
   3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.
   4. Difficulties understanding, what is not explicitly stated (eg making inferences) and non-literal or ambiguous meanings of language (eg idioms, humour, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains or word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

would normally occur immediately after or soon after the trauma and are usually dramatic, including the recurrent sense that one is re-experiencing or reliving the actual traumatic event along with a general lack of responsiveness to the present environment and a variety of other psychological disturbances.

Anyone who has experienced or witnessed any life-threatening or highly traumatic event may be vulnerable to PTSD. Witnesses to or victims of violent crime, such as rape, domestic violence, kidnapping, armed robbery or assault, could be susceptible to PTSD. Symptoms vary but often involve reliving the ordeal in the form of flashbacks, distressing memories, nightmares or frightening thoughts, especially when exposed to something reminiscent of the trauma. Emotional numbness, feeling detached from other people, sleep disturbances, depression, anxiety, guilt, irritability or angry outbursts are not unusual among PTSD sufferers. Symptoms typically begin within a few hours or days of the traumatic event, and PTSD is diagnosed when symptoms last more than 1 month.

PTSD represents a failure of the body to extinguish or contain the normal sympathetic nervous system response to stress. The failure is associated with the nature and the severity of the exposure to stress or trauma. It is normal that when exposed to traumatic stress, there is an immediate fear response: the body initiates the natural biological reaction that helps us assess the level of danger and organise an appropriate response, what is known as the 'fight or flight' instinctual survival response to stress. The limbic system in the brain, which is associated with emotion, motivation, behaviour and various involuntary actions, is a part of this natural instinctive survival response. It is known that one part of the limbic system, the amygdala, switches on the neuro-chemical and neuro-anatomical circuitry of fear by activating the 'Startle Response', the parasympathetic and sympathetic nervous system response and the hypothalamic-pituitary-adrenal (the rush of adrenalin) response to stress. Importantly the hippocampus, another part of the limbic system, is involved in helping to terminate these 'fight or flight' responses. Eventually the adrenal gland releases cortisol to contain the body's response to stress.

In individuals with PTSD, it has been found there is only a slight rise in cortisol in the immediate aftermath of the trauma and greater sympathetic nervous system arousal (increased heart rate), which suggests that the initial fear response had not been contained.

When an individual's sympathetic nervous system remains aroused after trauma, there is a release of neuro-chemicals in the brain (dopamine, nor-epinephrine and epinephrine). These neuro-chemicals aid memories being formed and, if cortisol fails to adequately shut them down, the traumatic memories become inappropriately remembered. As a result every little thing has a chance of reminding the person of the traumatic event, evident through being easily startled, hyper-aroused, experiencing jumpy and anxious recall, which in turn activates the stress responsive system ('fight or flight' mechanism). This results in irrational thoughts, behaviours and feelings, anxiety and alteration of

mood thoughts and feelings. It is not unusual for persons struggling with PTSD to attempt to cope with stress or fear by using defensive strategies related to avoidance, emotional blocking or withdrawal.

Thus in essence, with PTSD the interplay between cortisol and neuro-chemicals is unbalanced, in that there is too little cortisol and too many neuro-chemicals, which results in the anxious recall not being shut down. The normal way of dealing with the fear response, ie 'fight or flight' has been interfered with. In the face of any reminders this leads to distress, which activates the Stress Response System. This in turn results in increased arousal, which manifests in the typical PTSD symptoms such as irrational thought, fight or flight reactions, increased arousal, re-experiencing symptoms and depressed mood.

23.4.1 Core symptoms of PTSD

The symptoms involved with **re-experiencing** the event could be associated with having upsetting thoughts or images about the traumatic event that come into the person's mind when he does not want them there, having bad dreams or nightmares about the traumatic event and/or reliving the traumatic event, and acting or feeling as if it was happening all over again. Additionally, it is found that the individual suffering from this condition feels emotionally upset when reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc) and also may experience physical symptoms when he is reminded of the traumatic event in some way (for example, by breaking out in a sweat, feeling the heart beating fast).

Avoidant symptoms would involve the person trying not to think about, talk about, or have feelings about the traumatic event, trying to avoid activities, people or places that remind the person of the traumatic event and not being able to remember later some important aspect of the traumatic event. Furthermore, the person could come to have much less interest or participate much less frequently in activities that had previously been important and pleasurable to him, feels distant or cut off from people around him and also feels emotionally numb (for example, being unable to cry or unable to have loving feelings).

Arousal symptoms are also associated with having trouble falling or staying asleep, feeling irritable or having fits of anger and/or having trouble concentrating (for example, drifting in and out of conversations, losing track of the plot of a story or situation on television, forgetting what has been read). Arousal symptoms involving being overly alert (for example, checking to see who is around one, being uncomfortable with one's back to a door, etc) and being jumpy or easily startled (for example, when someone walks up behind one) are also common. There could also be aggressive, reckless or self-destructive behaviours.

From the psychological point of view, there are two main categories of depressive disorders, major depressive disorder and dysthymic disorder. **Major depressive disorders** are characterised by a moderate to severe episode of depressive illness lasting 2 or more weeks. Individuals experiencing this disorder may have, among other symptoms, trouble sleeping, have a loss of interest in activity that they previously undertook without difficulty and which might have given them pleasure, experience changes in their weight, have difficulty concentrating, feel worthless and may have a preoccupation with death or suicide.

While major depressive episodes may be acute, **dysthymic disorders** are characterised by ongoing depression that lasts 2 or more years. A mild to moderate depression of dysthymic disorder may rise and fall in intensity, alternating with some periods of normal non-depressed mood, for up to 2 months in duration. This can also occur in bipolar disorder, which is an affective mental illness that is characterised by radical emotional changes and mood swings from manic highs to depressive lows. The majority of those suffering from bipolar illness experience an alternation between episodes of manic and depressive illness. An understanding of the constellation of symptoms displayed is needed in diagnosing depression disorders.

26.2 CAUSES OF DEPRESSION

In exploring the causes of depression, it is known that there are usually no clearly identifiable causative factors for any particular type of depression. Biological and environmental factors are at play, resulting in levels of imbalance of certain neurotransmitters, which are the chemicals in the brain that transmit messages between nerve cells, external factors or environmental influences such as one's upbringing, may also play a significant role. For example, individuals who have been abused and/or neglected throughout their childhood and adolescence have been shown to have patterns of low self-esteem, negative thinking and varying degrees of depression. Furthermore, external stressors and significant life changes such as physical disorders, death of a loved one, divorce, loss of employment and similar life events can result in adjustment disorders where a depressed mood could be a key symptom. It is clear that the brain is the focus of all mood changes, whether these be pathological or not, and that the effects of environmental changes also come to be mediated by the brain.

26.3 ASSESSMENT OF DEPRESSION

In assessing clients suffering from depression, a clear understanding of the types of depression, clinical presentations and the diagnostic criteria is essential. An in-depth clinical interview needs to be undertaken, which could be assisted by using self-reporting or self-rating questionnaires such as the Beck Depression Inventory–Second Edition (BDI-II) or similar self-rating scales for depression. For a diagnosis of major depressive episodes to be made, the person would need to experience some or most of the following symptoms which include

irritability, change in weight, insomnia or hyper-somnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to work or to concentrate or indecisiveness and recurrent thoughts of death, and suicidal thoughts and/or suicide attempts. It is not uncommon for dysthymic disorder to occur in the presence of other psychiatric and physical disorders. To meet the diagnostic criteria these symptoms would need to have been experienced on a daily basis for a period of 2 or more years, with depression features. Thus, the distinctions between these different types of depression need to be well understood.

When approaching the understanding of depression from a *psychodynamic* or *psychological* framework, central to mood disorders is the concept of loss and guilt, together with a deep-seated sense of insecurity and impaired self-image. These dynamics can be traced to early life experiences, for example a child who grows up in an atmosphere of parent rejection, double standards, eco-centric mothers and inadequate parenting develops a self-image which is characterised by uncertainty, anxiousness and depression. When this person is confronted with requirements, demands, frustrations or challenges in later life, his self-confidence will fail him due to the intrinsic experience of insecurity. A traumatic experience will have a great effect on a child who has grown up in an emotionally impoverished situation. Furthermore helplessness and dependency is central to a depressive person, which leads to aggression. The mere fact that he or she becomes aggressive against those who the person is dependent upon, makes them feel more guilty, increasing feelings of frustration, negativity and directing negative feelings inward. From the psychodynamic perspective, aggression turned inward or suppressed, presents clinically as depression.

The impact that depression has on a person depends upon the person's perceptions based on their life experiences. From this perspective, having experienced loss in the past, the depressed individual will perceive his world as if further losses were probable and thus selectively focus on negative features in his environment. Hence, as a result, a pattern of engaging in depressive thoughts and cognitions, as well as reinforcing unrewarding behaviour patterns, leads to an entrenched depressed mood and negativity. Negative thoughts about the self and their world are reflected in negative cognitions. Depressed persons would describe themselves in negative terms, value themselves as worthless and be critical of their achievements and situation in life. With negative self-evaluation and low self-esteem, goes guilt about lack of achievement or letting others down. Guilt is associated with the belief that a person should be punished, hence directing negative feelings inwards in a form of self-punishment, resulting in suicidal and self-destructive thoughts and feelings. It is possible that patients who have extreme negative thoughts about their self and their world, could also develop delusional thoughts and beliefs.

Due to losses, guilt and negativity the individual is left with lowered mood associated with feelings of sadness, loneliness, loss of pleasure, despair and desperation. Their behaviour could be characterised by reduced or ineffective activity levels and failure to engage in activities. As a consequence of this