**Screening, Assessment and Classifying of Disorders**

**Introduction**

*Psychologists and Clinical psychologists have approached the assessment of abnormal behavior from many different vantage points. While some have viewed abnormal behaviors as physical illnesses or diseases, whose specific causes need to be identified and treatments or interventions administered, others have looked into the complex natural play of the factors responsible of the behaviors. This complex web of cultural, social, psychological and economic forces which appear to shape all human behaviors (normal or not) have engaged these people into an unending tasks of assessment, evaluation and classification. This lecture provides a discussion of issues involved in observation, assessing, describing and classifying the many forms that deviant behaviors can take in children. The lecture also projects to possible effects of deviant behaviors which are not intervened with as the child grows into adolescence phase.*

**Erikson’s Model-Maladaptations and Malignancies (Negative Outcomes)**

Erikson developed clear ideas and terminology-notably 'Maladaptations' and 'Malignancies' - to represent the negative outcomes arising from an unhelpful experience through each of the crisis stages that a developing child goes through.

In crude modern terms these negative outcomes might be referred to as 'baggage', which although somewhat unscientific, is actually a very apt metaphor, since people tend to carry with them through life the psychological outcomes of previously unhelpful experiences. Psychoanalysis, the particular therapeutic science from which Erikson approached these issues, is a way to help people understand where the baggage came from, and thereby assist the process of dumping it.

To an extent these negative outcomes can also arise from repeating or revisiting a crisis, or more realistically the essential aspects of a crisis, since we don't actually regress to a younger age, instead we revisit the experiences and feelings associated with earlier life.

The chart given here below laid out the **crisis** in the centre to aid appreciation that 'maladaptations' develop from tending towards the extreme of the first ('positive') disposition in each crisis, and 'malignancies' develop from tending towards the extreme of the second ('negative') disposition in each crisis.

For example, tending towards the extreme of “Trust”-(positive) would be Maladaptation and tending towards extreme of “Mistrust”-(negative) would be Malignancy. A maladaptation could be seen as 'too much of a good thing'. A malignancy could be seen as not enough. In his later writings malignancies were also referred to as 'antipathies'.

### Let us study these Maladaptations and Malignancies

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| **Maladaptation** | **Crisis** | **Malignancy** |
| Sensory Distortion  (later Sensory Maladjustment) | Trust v Mistrust | Withdrawal |
| Impulsivity (later Shameless Willfulness) | Autonomy v Shame /Doubt | Compulsion |
| Ruthlessness | Initiative v Guilt | Inhibition |
| Narrow Virtuosity | Industry v Inferiority | Inertia |
| Fanaticism | Identity v Role Confusion | Repudiation |
| Promiscuity | Intimacy v Isolation | Exclusivity |
| Over-extension | Generativity v Stagnation | Rejectivity |
| Presumption | Integrity v Despair | Disdain |

Erikson was careful to choose words for the maladaptations and malignancies which convey a lot of meaning and are very symbolic of the emotional outcomes that are relevant to each stage of devlopment.

In each case the maladaptation or malignancy corresponds to an extreme extension of the relevant crisis disposition (for example, 'Withdrawal' results from an extreme extension of 'Mistrust'). Thinking about this, helps to understand what these outcomes entail, and interestingly helps to identify the traits in people - or oneself - when you encounter the behavioral tendency concerned. Malignancies and maladaptations can manifest in various ways. Here are examples, using more modern and common language, to help understand and interpret the meaning and possible attitudes, tendencies, behaviors, etc., within the various malignancies and malapdations. In each case the examples can manifest as more extreme mental difficulties, in which case the terms would be more extreme too. These examples are open to additional interpretation and are intended to be a guide, not scientific certainties. Neither do these examples suggest that anyone experiencing any of these behavioral tendencies is suffering from mental problems. Erikson never established any absolute measurement of emotional difficulty or tendency as to be defined as a malignancy or maladaptation. In truth each of us is subject to emotional feelings and extremes of various sorts, and it is always a matter of opinion as to what actually constitutes a problem. All people possess a degree of maladaptation or malignancy from each crisis experience. Not to do so would not be human, since none of us is perfect. It's always a question of degree. It's also a matter of understanding our weaknesses, maybe understanding where they come from too, and thereby better understanding how we might become stronger, more productive and happier.

### Maladaptations and Malignancies-Examples and Interpretations

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| --- | --- | --- | --- | --- |
| **examples** | **maladaptation** | **Crisis** | **malignancy** | **Examples** |
| unrealistic, spoilt, deluded | Sensory Distortion | Trust v Mistrust | Withdrawal | neurotic, depressive, afraid |
| reckless, inconsi-derate, thoughtless | Impulsivity | Autonomy v Shame/Doubt | Compulsion | anal, constrained, self-limiting |
| exploitative, uncaring, dispassionate | Ruthlessness | Initiative v Guilt | Inhibition | risk-averse, unadventurous |
| workaholic, obsessive specialist | Narrow Virtuosity | Industry v Inferiority | Inertia | lazy, apathetic, purposeless |
| self-important, extremist | Fanaticism | Identity v Role Confusion | Repudiation | socially disconnected, cut-off |
| sexually needy, vulnerable | Promiscuity | Intimacy v Isolation | Exclusivity | loner, cold, self-contained |
| do-gooder, busy-body, meddling | Overextension | Generativity v Stagnation | Rejectivity | disinterested, cynical |
| conceited, pompous, arrogant | Presumption | Integrity v Despair | Disdain | miserable, unful-filled, blaming |

***Erikson's terminology***

This section explains how some of the model's terminology altered as Erikson developed his theory, and is not crucial to understanding the model at a simple level.

Erikson was continually refining and re-evaluating his psychosocial theory, and he encouraged his readers and followers to do likewise. This developmental approach enabled the useful extension of the model to its current format. Some of what is summarized here did not initially appear clearly in Childhood and Society in 1950, which marked the establishment of the basic theory, not its completion. Several aspects of Erikson's theory were clarified in subsequent books decades later, including work focusing on old age by Joan Erikson, Erik's wife and collaborator, notably in the 1996 revised edition of The Life Cycle Completed: A Review.

The Eriksons' refinements also involved alterations - some would say complications - to the terminology, which (although presumably aiming for scientific precision) do not necessarily aid understanding, especially at a basic working level.

For clarity therefore this page sticks mostly with Erikson's original 1950 and other commonly used terminology. Basic Trust v Basic Mistrust (1950) is however shortened here to Trust v Mistrust, and Ego Integrity (1950) is shortened to Integrity, because these seem to be more consistent Erikson preferences. The terms used on this page are perfectly adequate, and perhaps easier too, for grasping what the theory means and making use of it.

Thorough psychological assessment helps greatly to evaluate the impacts of psychological factors, such as stress, depression and trauma, have on the individual affected. For example, a child or an individual who have had some traumatizing event such as an accident may look healed after the treatment and discharge from the hospital, but even though the test results may indicate recovery, the brain may not have recovered fully from the trauma. Assessments such as this are conducted by clinical psychologist and neuropsychologists to assist in the description of the client’s problem and to develop effective intervention plans.

In assessment of abnormal behaviors the psychologists various techniques according to the case at hand. From a long time ago, psychologists use the pragmatic approach to characterize abnormal behavior or the principal diagnostic and classification system of mental disorders. Lately came the Diagnostic and Statistical Manual of Mental Disorders (DSM). All these general issues provided a context for consideration f the basic techniques to be employed by practicing clinicians. Procedures employed include interviews, formal testing, inventories and observations ( Rabin,1981, Turner and Hersen, 1984, Anastasi,1987).

Note that a single disorder can have multiple components, each of which requires intervention. The success of a multimodal approach in such cases is well documented and its use advocated by many practicing clinicians

**Classification of Behavior Disorders in Children**

Using these areas we can classify important disorders seen in children as follow:

1. Developmental disorders
2. Neurotic disorders
3. Habit disorders
4. Sleep and eating disorders
5. Psychiatric aspects of the handicaps
6. Drug addiction and antisocial behavioral disorders

It is important to note that when such behavior disorders are in children, the family of the affected child also gets affected and parents show:-

* distress and feelings of rejection
* depression, guilt, shame or anger
* over-indulgence
* social problems
* marital disharmony (in some)
* dissatisfaction about medical and social services(even when one is normal)

June 2011, La Trobe University approved an Article ob Behavioral Disorders in Children that contained some of the following disorders some of which can be classified as Developmental, Habit or any other type.

Since all young children can be naughty, defiant and impulsive from time to time, which is perfectly normal, some have extremely difficult and challenging behaviors that are outside the norm for their age.

The most common disruptive behavior disorders include oppositional defiant disorder, conduct disorder and attention deficit hyperactivity disorder. These three behavioral disorders share some common symptoms, so diagnosis can be difficult and time consuming. A child or adolescent may have two disorders at the same time. Other exacerbating factors can include emotional problems, mood disorders, family difficulties and substance abuse.

In America, around one in ten children under the age of 12 years are thought to have oppositional defiant disorder (ODD), with boys outnumbering girls by two to one. Some of the typical behaviors of a child with ODD include:

* Easily angered, annoyed or irritated
* Frequenttemper tantrums
* Argues frequently with adults, particularly the most familiar adults in their lives, such as parents
* Refuses to obey rules
* Seems to deliberately try to annoy or aggravate others
* Low self-esteem
* Low frustration threshold
* Seeks to blame others for any misfortunes or misdeeds.

Children with conduct disorder (CD) are often judged as ‘bad kids’ because of their delinquent behavior and refusal to accept rules. In some developed countries around five per cent of 10 year olds are thought to have CD, with boys outnumbering girls by four to one. Around one-third of children with CD also have attention deficit hyperactivity disorder (ADHD).   
Some of the typical behaviors of a child with CD may include:

* Frequent refusal to obey parents or other authority figures
* Repeated truancy
* Tendency to use drugs, including cigarettes and alcohol, at a very early age
* Lack of empathy for others
* Being aggressive to animals and other people or showing sadistic behaviors including bullying and physical or sexual abuse
* Keenness to start physical fights
* Using weapons in physical fights
* Frequent lying
* Criminal behavior such as stealing, deliberately lighting fires, breaking into houses and vandalism
* A tendency to run away from home
* Suicidal tendencies – although these are more rare

In US around two to five per cent of children are thought to have attention deficit hyperactivity disorder (ADHD), with boys outnumbering girls by three to one. The characteristics of ADHD can include:

* **Inattention** – difficulty concentrating, forgetting instructions, moving from one task to another without completing anything.
* **Impulsivity** – talking over the top of others, having a ‘short fuse’, being accident-prone.
* **Over-activity** – constant restlessness and fidgeting.

**The question** that needs our concerted effort to find the answer is: Are the statistics mentioned in this article also apply to developing countries like Kenya, Senegal, Somalia, Ethiopia, etc.?

**Diagnosis of Children’s Behavioral Disorders**

Disruptive behavioral disorders are complicated and may include many different factors working in combination. For example, a child who exhibits the delinquent behaviors of CD may also have ADHD, anxiety, depression, a drug use problem and a difficult home life.   
Diagnosis methods may include:

* Diagnosis by a specialist service, which may include a paediatrician, psychologist or child psychiatrist
* In-depth interviews with the parents, child and teachers
* Behavior check lists or standardized questionnaires.
* A diagnosis is made if the child’s behavior meets the criteria for disruptive behavior disorders in the *Diagnostic and Statistical Manual of Mental Disorders* from the American Psychiatric Association. It is important to rule out acute stressors that might be disrupting the child’s behavior. For example, a sick parent or victimizing by other children might be responsible for sudden changes in a child’s typical behavior and these factors have to be considered initially. Untreated children with behavioral disorders may grow up to be dysfunctional adults. Generally, the earlier the intervention, the better the outcome is likely to be.   
  A large study in the United States, conducted for the National Institute of Mental Health and the Office of School Education Programs, showed that carefully designed medication management and behavioral treatment for ADHD improved all measures of behavior in school and at home.   
  **Treatment** is usually multifaceted and depends on the particular disorder and factors contributing to it, but may include:
* **Parental education** – for example, teaching parents how to communicate with and manage their children.
* **Functional family therapy** – the entire family is helped to improve communication and problem-solving skills.
* **Cognitive behavioral therapy** – to help the child to control their thoughts and behavior.
* **Social training** – the child is taught important social skills, such as how to have a conversation or play cooperatively with others.
* **Anger management** – the child is taught how to recognize the signs of their growing frustration and given a range of coping skills designed to defuse their anger and aggressive behavior. Relaxation techniques and stress management skills are also taught.
* **Support for associated problems** – for example, a child with a learning difficulty will benefit from professional support.
* **Encouragement** – many children with behavioral disorders experience repeated failures at school and in their interactions with others. Encouraging the child to excel in their particular talents (such as sport) can help to build self-esteem.
* **Medication** – to help control impulsive behaviors.

***Diagnostic Evaluation of Depression:*** The first step to getting appropriate treatment, for depression or any emotional problem, is a complete psychological evaluation to determine whether you have a depressive illness, and if so, what type of depression. Consultation with a psychologist will include a review of your physical health history. Some medications as well as some medical conditions can cause symptoms of depression, so your psychologist will ask your family physician to rule out these possibilities if other physical symptoms are evident.

However, physicians often focus only on the physical aspects of depression, and may prescribe medication without referring you for psychological treatment or evaluation.  If you experience the symptoms of depression, as described on this website, you should talk to a psychologist, to assess whether psychological treatment is indicated, even if it not suggested by your physician. As a general rule, you should never take antidepressant medication alone, without also beginning psychotherapy, or at least seeing a psychologist for an evaluation.

A good psychological diagnostic evaluation will include a complete history of your symptoms, i.e., when they started, how long they have lasted, how severe they are, whether you've had them before and, if so, whether you were treated and what treatment you received. Your psychologist should ask you about alcohol and drug use, and if you have had thoughts about death or suicide. Further, a history should include questions about whether other family members have had depression and if treated, what treatments they may have received and which were effective. Lastly, the psychological diagnostic evaluation will include a mental status examination to assess the full range of psychological symptoms and problems. This will help identify any other psychological problems that might be present, and will help determine the most appropriate treatment for you. Treatment choice will depend on the outcome of the evaluation. Most people do well with psychotherapy, but some require treatment with antidepressants in addition to psychotherapy. Medication can allow you to gain relatively quick symptom relief, if you are experiencing severe and disabling symptoms. However, medication does not "cure" the depression, it only treats the symptoms. If you are depressed, you need psychotherapy to help you to learn more effective ways to deal with life's problems and to change the negative thoughts and attitudes that have caused you to develop depression**.**

**References**

* S.V. Kale, (2000)*. Child Psychology and Child Guidance, -6th.Edition*
* Robert M. Berns, (2004). *Child, Family School and Community- Socialization and Support*
* S.K. Mangal, (1987**).** *Abnormal Psychology,* *(revised Edition)*
* R.G.Meyer & P.Salmon, (1984) *Abnormal Psychology, (2nd. Edition)*