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THE ROLE OF INTERDISCIPLINARY TEAM IN PSYCHOLOGICAL ASSESSMENT AND PREVENTION OF INFANCY AND CHILDHOOD DISORDERS

Rodica Gabriela ENACHE[1]

Abstract: *The researcher shows that children can have some problems related to school beginning, when they might experience feelings such as anxiety, sleep deprivation or school phobia. Purpose of study: To identify the differences between the opinion of parents, teachers and school counsellors toward the behaviours of children with age between 5-10, screening emotional and behavioural disorders in children. Research methods: Interviews with parents, teachers and school counsellors, Child Symptom Inventory-4 (CSI-4) Ages 5 to 12 Years (Sprafkin, Gadow, Salisbury, Schneider, & Loney, 2002). Results and conclusions: Having analysed only the scale for them, we have found significant differences: scale A2: HD Hyperactivity disorder, scale B Oppositional Defiant Disorder, scale D Generalized Anxiety Disorder, scale I Social Phobia.*

Key words: *psychological assessment, children, interdisciplinary team.*

1. Theoretical Framework

1.1. Children-parents Relations. Psychological Implications related to Beginning School Experience

All children pass through predictable stages of growth and development. The school age period is usually the first time that children are making some independent judgments, and this may create some conflicts with parents. Children are asked to compete with peers and perform for adults resulting in increased anxiety and tension for the child. The school ager changes so much during these year, that it is often difficult for parents to keep up. Unlike the infant or toddler, whose progress is marked by new abilities and skills (ability to sit up to roll over, ability to speak a full sentence), the development of the school ager is more subtle. Progress may in fact be marked by mood swings, what the child enjoys on one occasion may not be acceptable or another. This may precipitate crises in the family.

Brofenbrenner (1979) talked about children growing up in the capitalism society. He shows that the macrosystem is composed in part of basic institutional patterns, including economic patterns, and ideologies, including values. A child developing in a very

[1] Ovidius University Constanța, România, rodicaenache29@yahoo.com

competitive, deregulated capitalist nation would be surrounded at the macrosystem level by an ideology based on the relatively high prioritization of mastery and hierarchy values and the relatively low prioritization of harmony, egalitarian, and intellectual autonomy values.

Such institutional patterns and ideologies would wend their way from the broad macrosystem level to influence the exosystems and microsystems that more directly impinge upon the child. Unfortunately, prioritization of the values consistent with capitalism is unlikely to bode well for children's well-being, as such values crowd out the values that support nurturing and caring for young people. Brofenbrenner (2016) considers that:

- macro-system includes social ideologies and values of cultures and subcultures;
- exo-system refers to system that influence the individual indirectly through micro-system;
- meso-system includes connections between systems and mycrosistems;
- micro-systems contain direct interaction in activities, roles and relations with others and objects;
- techno-subsystem includes: media influences, computers, internet, portable devices, social media, Tv, phone.

In the contemporary society, family time is taken up by work, homework, and shopping. What it means to be parents and children has changed dramatically. Most of the children are latchkey children: school-agers who are without adult supervision for a part of each weekday. The term alludes to the fact that they generally carry a key or wear it around their neck so that they can let themselves into their home after school. Latchkey children have become a prominent consideration because in as many as 90% of families today, both parents work at least part-time outside the home. A major concern is that latchkey children will develop increased loneliness, an increased tendency to have accidents, delinquent behavior and decreased school performance from lack of homework supervision. Research has shown, however, that these problems do not necessarily occur (Williams & Boyce, 1989; Agger, & Shelton, 2016). For those children who can feel safe in their community a short period of independence every day may actually be beneficial, because it encourages problem solving in self-care.

1.2. Psychological Assessment for Identify Disorders of Infancy and Childhood

a) Diagnosing attention; attention deficit hyperactivity disorder

This disorder is characterized by difficulty in focusing attention or engaging in quiet, passive activities, or both. Although is present at birth, diagnosis before age 5 is difficult unless the child shows severe symptoms. Commonly, the child with attention-deficit hyperactivity disorder is referred for evaluation by the school- with the problems reflecting the child's age. Diagnosis of the disorder usually begins by obtaining data from several sources. Parents, teachers and the important persons for the children are interviewed. Complete psychological, medical and neurologic evaluations are performed to rule out other problems. Then the child takes tests that measure impulsiveness, attention and ability to sustain a task.

The DSM-IV groups a selection of symptoms into attention and hyperactivity-impulsivity categories. The diagnosis of attention-deficit hyperactivity disorder is based

on the person demonstrating at least six symptoms from the inattention group or at least six symptoms from the hyperactivity- impulsivity group. The symptoms must have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

- ***Symptoms of inattention***

The child manifesting inattention:

- often fails to give close attention to details or makes careless mistakes in schoolwork or other activities;
- often has difficulty sustaining attention in tasks or play activities;
- often does not seem to listen when spoken to directly;
- often does not follow through on instructions and fails to finish schoolwork (not because of the oppositional behavior or failure to understand instructions);
- often has difficulty organizing tasks and activities;
- often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
- often loses things necessary for tasks and activities (for example toys, school assignments, pencils, books or tools);
- often becomes distracted by extraneous stimuli;
- often demonstrates forgetfulness in daily activities.

- ***Symptoms of hyperactivity- impulsivity*** *(Table 1)*

Symptoms of hyperactivity-impulsivity Table 1

The children manifesting hyperactivity:	**The children manifesting impulsivity**
often fidgets with hands or feet or squirms in seat	often blurts out answers before question have been completed
often leaves seat in classroom or in other situations in which remaining seated is expected	
often runs about or climbs excessively in situations in which remaining seated is expected	often has difficulty awaiting his turn
often has difficulty playing or engaging in leisure activities quietly	
often characterized as "on the go", or often acts as if driven by a motor"	often interrupts or intrudes on others
often talks excessively.	

Some hyperactivity-impulsivity or inattention symptoms that cause impairment are evident before age 7. Some impairment from symptoms is present in two or more settings.

Anxiety related to beginning school experience

Anxiety is a component of most psychological disorders and many organic disorders. Diagnosed anxiety disorders are classified into five basic types:

- phobias;
- generalized anxiety disorder;
- panic disorder;
- obsessive- compulsive disorder;
- posttraumatic stress disorder.

Adjusting to grade school is a big task for a 6 year old. Even if or she attended preschool, this is different. The rules are firmer and the elective feeling ("If he doesn't like it, we'll take him out of it") is gone. Psychologists are in good position to urge parents to discuss the child's progress with the teacher or principal. Parents may have to alter their expectations to conform with the child's ability. If he is not a performing student, no amount of parental pressure can make him one. Indeed, this type of pressure may make him fail by adding to a feeling of inadequacy.

a) Phobias, School phobia

Defined as a persistent and irrational fear of a specific object, activity or situation, a phobia results in a compelling desire to avoid the perceived hazard. The person recognize that this fear is out of the proportion to any actual danger, but can't control it or explain it away. Three types of phobias exist: agoraphobia, the fear of being alone or of open space, social phobia, the fear of embarrassing oneself in public and specific phobia, the fear of a single, specific objects, such as animals or heights. The onset of a social phobia typically is in late childhood or early adolescence, a specific phobia usually begins in childhood. Social phobia is a persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others. The person feels fear that he may act in a way that will be humiliating or embarrassing. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or predisposed panic attack. Children who resist attending school with an authoritarian teacher may manifest psychosomatic or physical signs of illness, such as vomiting, diarrhea, headache or abdominal pain. They wake up on a school day complaining of feeling sick. The cause of the illness is resistance to school, but the manifestation (vomiting, pain is real). The cause of resistance to school must be determined before it can be cured. In many instance it may be fear of separation from the parents (Mansdorf & Lukens, 1987). Because the problem of school phobia is usually only partly the child's, the entire family generally requires counseling to resolve the issue.

b) Tic disorders

Including Tourette syndrome, chronic motor or vocal tic disorder and transient tic disorder, tic disorders are similar pathophysiologically but differ in severity and prognosis. All tic disorders, commonly known simply as tics, are involuntary spasmodic, recurrent and purposeless motor movements or vocalizations. These disorders are classified as motor or vocal and as simple or complex. Simple motor tics include eye blinking, neck jerking, shoulder shrugging, head banging, head turning, tongue protrusion, lip or tongue biting, nail biting, hair pulling and facial grimacing. Some examples of complex motor tics are facial gestures, grooming behaviors, hitting or biting oneself, jumping, hopping, touching, squatting, deep knee bends, retracing steps, twirling when walking, stamping, smelling an object, and imitating the movements of someone who is being observed (echopraxia). Examples of simple vocal tics include coughing, throat clearing, grunting, sniffing, snorting, hissing, clicking, yelping, and barking. Complex vocal tics may involve repeating words out of context; using socially unacceptable words, many of which are obscene (coprolalia); or repeating the last-heard sound, word, or phrase of another person (echolalia).

c) Stress disorders with physical manifestations

In addition to tic disorders, other stress related disorders that produce physical signs in children include shuttering, functional enuresis, functional encopresis, sleepwalking and

sleep terrors. Shuttering is a disorder characterized by abnormalities of speech rhythms with repetitions and hesitations at the beginning of the words, also may involve movements of the respiratory muscles, shoulders and face. Shuttering may be associated with mental dullness, poor social background and a history of birth trauma. This disorder most commonly occurs in children of average or superior intelligence who fear that can't meet the expectations of their families. Related problems may include low self-esteem, tension, anxiety, humiliation and withdrawal from social situations.

d) Sleep deprivation

Like adults, children who do not receive enough sleep can suffer from sleep deprivation. After approximately 4 days without sleep, they show difficulty in concentrating and experience episodes of disorientation and misperception: they are generally irritable and manifest feelings of persecution and marked physical fatigue. If the sleep loss is mainly REM deprivation they mainly show symptoms of irritability and difficulty concentrating.

e) Autistic disorder or other pervasive developmental disorders

A sever, pervasive developmental disorder, autistic disorder is marked by unresponsiveness to social contact, gross deficits in intelligence and language development, ritualistic and compulsive behaviors, restricted capacity for developmentally appropriate activities and interests and bizarre responses to the environment. A diagnostic of autistic disorder is made when the patient meets the criteria set forth in the DSM-IV. At least six of the following characteristics from the social interaction, communication and patterns categories must be present, including characteristics from the social interaction category and one each from the communication and patterns categories:

Social interaction

Qualitative impairment in social interaction as manifested by the least two of the following:

- marked impairment in the use of the multiple nonverbal behaviors, such as eyes-to-eyes gaze, facial expression, body postures and gestures to regulate social interaction;
- failure to develop peer relationships appropriate to developmental level, lack of the spontaneous seeking to share enjoyment, interests or achievements with other people;
- lack of social and emotional reciprocity;
- gross impairment in ability to make peer friendships.

Communication

Qualitative impairment in communication, as manifested by the least one of the following:

- delay in or total lack of, spoken language development;
- an individuals with adequate speech, marked impairment in initiating or sustaining a conversation with others;
- stereotyped and repetitive use of language and idiosyncratic language;
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Patterns

Restricted, repetitive and stereotyped patterns of behavior, interests and activities as manifested by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity of focus;
- apparently inflexible adherence to specific nonfunctional routines or rituals;
- stereotyped and repetitive motor mannerisms;
- persistent preoccupation with parts or objects.

The disturbance is not better accounted for by Rett's syndrome or childhood disintegrative disorder.

2. Research

2.1. Purpose of Study

1) To identify the differences between parents' and teachers' opinions toward the children with emotional and behavioral disorders (aged between 5 and 10).

2.2. Research Methods

a) Interviews with parents, teachers and school counselor

b) Child Symptom Inventory-4 (CSI-4) Ages 5 to 12 Years (Sprafkin, Gadow, Salisbury, Schneider, & Loney, 2002).

The Child Symptom Inventory-4 (CSI-4) is a behavior rating scale that screens for DSM-IV emotional and behavioral disorders in children between 5 and 12 years old. The CSI-4: Parent Checklist contains 97 items that screen for 15 emotional and behavioral disorders, and the CSI-4: Teacher Checklist contains 77 items that screen for 13 emotional and behavioral disorders. The CSI-4 can be scored to derive Symptom Count scores (diagnostic model) or Symptom Severity scores (normative data model). Scoring is quick and easy with user-friendly score sheets. Disorders included: AD/HD, Oppositional Defiant Disorder, Conduct Disorder, Generalized Anxiety Disorder, Social Phobia, Separation Anxiety Disorder, Obsessive-Compulsive Disorder, Specific Phobia, Dysthymic Disorder, Schizophrenia, Major Depressive Disorder, Pervasive Developmental Disorder, Asperger's Disorder, Motor Tics, Vocal Tics.

The CSI-4 is a behavior rating scale whose items correspond to the symptoms of disorders defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994). Results indicated satisfactory internal consistency reliability, test-retest reliability, and temporal stability over a 4-year period for most symptom categories.

2.3. Sample

The sample includes 78 adults (aged between 29-46 years, mothers or fathers of children aged 4 to 10 years), 2 teachers and 1 counselor from Constanța.

2.4. Findings and Results

For the first purpose of study we compare the mean of children score in opinion of parents and teachers and we analyze only the scale for them we have significant difference:

For Scale A2: HD Hyperactivity disorder: average, parents comparative with the teachers considers that children has a high level of hyperactivity. (Mp=6.76, Mt=4.77, t=2.43, p=0.01)

For Scale B Oppositional Defiant Disorder: average, parents comparative with the teachers considers that children has a high level of Oppositional Defiant Disorder (Mp=4.83, Mt=2.62, t=3.25 , $p < 0{,}001$)

For Scale D Generalized Anxiety Disorder: average, parents comparative with the teachers considers that children has a high level of anxiety (Mp=3.23, Mt=2.01, t=3.75 , $p< 0{,}001$).

***For Scale I Social Phobia*:** average parents comparative with the teachers considers that children has a high level of anxiety (Mp=2.54, Mt=1.72, t=2.60, $p < 0.01$).

3. Conclusions

In this paper we analyzed the role of interdisciplinary team in psychological assessment and prevention of infancy and childhood disorders. In order to ease the pain of the child and those around the child (parents, teachers, classmates) intervention in childhood disorders cases is effective when it is multidimensional and multidisciplinary.

Achieving positive outcomes requires the involvement of specialists from different fields. All medical and psychological aspects of the disorder are taken into account in approaching these cases and approaching these case means intervening in the main life environments of the child- family and school. For this intervention to be successful, it is required that a work team is made by: parents, family doctor, psychiatrist or neurologist, clinic psychologist, educational psychologist, teacher/educator/head teacher, the others teachers, special pedagogy specialist teacher, social assistant (Goichman, & Bucur, 2006). Everyone has different responsibilities:

a) The family doctor observes the child from a medical point of view.

b) The psychiatrist and the neurologist assess the child, give the medical diagnostic, prescribe medical treatment and observe the evolution of the case.

c) The clinical/educational psychologist helps assessing the child, gives the psychological diagnostic and recommends psychotherapy.

d) The clinical/educational psychologist guide parents/teachers using cognitive behavioral therapy methods.

There is a great significance in training educational psychologists, guidance counselors and teachers. They should learn to locate, intervene and use the relevant interventions in classroom situations and daily activities. This modern approach is that these children should remain in mainstream classroom and not in special education classroom (while providing conditions that will allow them to adapt. By using the resources of the educational system it is possible to intervene in adequate ways and to positively influence the developmental process of these children.

Behavioral techniques are used to decrease symptoms and increase the child's ability to response. Positive reinforcement, using food and other rewards can enhance language and

social skills. Providing pleasure sensory and motor stimulation encourages appropriate behavior and helps eliminate inappropriate behavior. Effective management requires an interdisciplinary team approach. A primary goal is to develop the patient's strengths as fully as possible. Another major goal is the development of social adaptive skills. Many children with disorders in childhood require special education and training ideally beginning in infancy.

An individualized effective education program can optimize the quality of life for even the profoundly retarded. The parents of a child diagnosed with disorders or mental retardation in childhood need psychological and social support. Not only may be overwhelmed by care taking and financial concerns, but they also may have difficulty accepting and bonding with their child. The children have all the ordinary needs of a normal child plus those created by his disabilities. The child especially needs affection, acceptance, stimulation and prudent, consistent discipline, he is less able to cope if rejected, over protected or forced beyond his abilities. When carrying for a hospitalized retarded patient promote continuity of care by acting as a liaison for parents and other health care professionals involved in his care.

In particular, parents of a severely retarded child need an extensive teaching and this charge planning program including physical care procedures, stress reduction techniques, support service and referral to developmental programs. Request a social services consultation to investigate available community sources.

Other information may be obtained from the address: rodicaenache29@yahoo.com

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