

Identifying and Counseling Tips
For
Kids Behaviors Problems

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Children With Oppositional Defiant Disorder

All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is often a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family, and academic life.

In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include:

- frequent temper tantrums
- excessive arguing with adults
- active defiance and refusal to comply with adult requests and rules
- deliberate attempts to annoy or upset people
- blaming others for his or her mistakes or misbehavior
- often being touchy or easily annoyed by others
- frequent anger and resentment
- mean and hateful talking when upset
- seeking revenge

The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. Five to fifteen percent of all school-age children have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding than the child's siblings from an early age. Biological and environmental factors may have a role.

A child presenting with ODD symptoms should have a comprehensive evaluation. It is important to look for other disorders which may be present; such as, attention-deficit hyperactive disorder (ADHD), learning disabilities, mood disorders (depression, bipolar disorder) and anxiety disorders. It may be difficult to improve the symptoms of ODD without treating the coexisting disorder. Some children with ODD may go on to develop conduct disorder.

Treatment of ODD may include: Parent Training Programs to help manage the child's behavior, Individual Psychotherapy to develop more effective anger management, Family Psychotherapy to improve communication, Cognitive-Behavioral Therapy to assist problem solving and decrease negativity, and Social Skills Training to increase flexibility and improve frustration tolerance with peers. A child with ODD can be very difficult for parents. These parents need support and understanding.

Parents can help their child with ODD in the following ways:

- Always build on the positives, give the child praise and positive reinforcement when he shows flexibility or cooperation.

- Take a time-out or break if you are about to make the conflict with your child worse, not better. This is good modeling for your child. Support your child if he decides to take a time-out to prevent overreacting.
- Pick your battles. Since the child with ODD has trouble avoiding power struggles, prioritize the things you want your child to do. If you give your child a time-out in his room for misbehavior, don't add time for arguing. Say "your time will start when you go to your room."
- Set up reasonable, age appropriate limits with consequences that can be enforced consistently.
- Maintain interests other than your child with ODD, so that managing your child doesn't take all your time and energy. Try to work with and obtain support from the other adults (teachers, coaches, and spouse) dealing with your child.
- Manage your own stress with exercise and relaxation. Use respite care as needed.

Many children with ODD will respond to the positive parenting techniques. Parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat ODD and any coexisting psychiatric condition.

Conduct Disorder

"Conduct disorder" refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill. Many factors may contribute to a child developing conduct disorder, including brain damage, child abuse, genetic vulnerability, school failure, and traumatic life experiences.

Children or adolescents with conduct disorder may exhibit some of the following behaviors:

Aggression to people and animals

- bullies, threatens or intimidates others
- often initiates physical fights
- has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)
- is physically cruel to people or animals
- steals from a victim while confronting them (e.g. assault)
- forces someone into sexual activity

Destruction of Property

- deliberately engaged in fire setting with the intention to cause damage
- deliberately destroys other's property

Deceitfulness, lying, or stealing

- has broken into someone else's building, house, or car
- lies to obtain goods, or favors or to avoid obligations
- steals items without confronting a victim (e.g. shoplifting, but without breaking and entering)

Serious violations of rules

- often stays out at night despite parental objections
- runs away from home
- often truant from school

Children who exhibit these behaviors should receive a comprehensive evaluation. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, and other medical specialties to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention, impulse problems, or those with depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, early treatment offers a child a better chance for considerable improvement and hope for a more successful future.

Children With Learning Disabilities

Parents are often worried when their child has learning problems in school. There are many reasons for school failure, but a common one is a specific learning disability. Children with learning disabilities usually have a normal range of intelligence. They try very hard to follow instructions, concentrate, and "be good" at home and in school. Yet, despite this effort, he or she is not mastering school tasks and falls behind. Learning disabilities affect at least 1 in 10 schoolchildren.

It is believed that learning disabilities are caused by a difficulty with the nervous system that affects receiving, processing, or communicating information. They may also run in families. Some children with learning disabilities are also hyperactive; unable to sit still, easily distracted, and have a short attention span.

Child and adolescent psychiatrists point out that learning disabilities are treatable. If not detected and treated early, however, they can have a tragic "snowballing" effect. For instance, a child who does not learn addition in elementary school cannot understand algebra in high school. The child,

trying very hard to learn, becomes more and more frustrated, and develops emotional problems such as low self-esteem in the face of repeated failure. Some learning disabled children misbehave in school because they would rather be seen as "bad" than "stupid."

Parents should be aware of the most frequent signals of learning disabilities, when a child:

- has difficulty understanding and following instructions.
- has trouble remembering what someone just told him or her.
- fails to master reading, spelling, writing, and/or math skills, and thus fails
- has difficulty distinguishing right from left; difficulty identifying words or a tendency to reverse letters, words, or numbers; (for example, confusing 25 with 52, "b" with "d," or "on" with "no").
- lacks coordination in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- easily loses or misplaces homework, schoolbooks, or other items.
- cannot understand the concept of time; is confused by "yesterday, today, tomorrow."

Such problems deserve a comprehensive evaluation by an expert who can assess all of the different issues affecting the child. A child and adolescent psychiatrist can help coordinate the evaluation, and work with school professionals and others to have the evaluation and educational testing done to clarify if a learning disability exists. This includes talking with the child and family, evaluating their situation, reviewing the educational testing, and consulting with the school. The child and adolescent psychiatrist will then make recommendations on appropriate school placement, the need for special help such as special educational services or speech-language therapy and help parents assist their child in maximizing his or her learning potential. Sometimes individual or family psychotherapy will be recommended. Medication may be prescribed for hyperactivity or distractibility. It is important to strengthen the child's self-confidence, so vital for healthy development, and also help parents and other family members better understand and cope with the realities of living with a child with learning disabilities.

Children Who Can't Pay Attention/ADHD

Parents are distressed when they receive a note from school saying that their child won't listen to the teacher or causes trouble in class. One possible reason for this kind of behavior is Attention Deficit/Hyperactivity Disorder (ADHD).

Even though the child with ADHD often wants to be a good student, the impulsive behavior and difficulty paying attention in class frequently interferes and causes problems. Teachers, parents, and friends know that the child is misbehaving or different but they may not be able to tell exactly what is wrong.

Any child may show inattention, distractibility, impulsivity, or hyperactivity at times, but the child with ADHD shows these symptoms and behaviors more frequently and severely than other children of the same age or developmental level. ADHD occurs in 3-5% of school age children. ADHD must begin before the age of seven and it can continue into adulthood. ADHD runs in families with about 25% of biological parents also having this medical condition.

A child with ADHD often shows some of the following:

- trouble paying attention
- inattention to details and makes careless mistakes
- easily distracted
- loses school supplies, forgets to turn in homework
- trouble finishing class work and homework
- trouble listening
- trouble following multiple adult commands
- blurts out answers
- impatience
- fidgets or squirms
- leaves seat and runs about or climbs excessively
- seems "on the go"
- talks too much and has difficulty playing quietly
- interrupts or intrudes on others

A child presenting with ADHD symptoms should have a comprehensive evaluation. Parents should ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat this medical condition. A child with ADHD may also have other psychiatric disorders such as conduct disorder, anxiety disorder, depressive disorder, or bipolar disorder. These children may also have learning disabilities.

Without proper treatment, the child may fall behind in schoolwork, and friendships may suffer. The child experiences more failure than success and is criticized by teachers and family who do not recognize a health problem.

Research clearly demonstrates that medication can help improve attention, focus, goal directed behavior, and organizational skills. Medications most likely to be helpful include the stimulants (various methylphenidate and amphetamine preparations) and the non-stimulant, atomoxetine. Other medications such as guanfacine, clonidine, and some antidepressants may also be helpful.

Other treatment approaches may include cognitive-behavioral therapy, social skills training, parent education, and modifications to the child's education program. Behavioral therapy can help a child control aggression, modulate social behavior, and be more productive. Cognitive therapy can help a child build self-esteem, reduce negative thoughts, and improve problem-solving skills. Parents can learn management skills such as issuing instructions one-step at a time rather than issuing multiple requests at once. Education modifications can address ADHD symptoms along with any coexisting learning disabilities.

A child who is diagnosed with ADHD and treated appropriately can have a productive and successful life.

Children Who Steal

When a child or teenager steals, parents are naturally concerned. They worry about what caused their child to steal, and they wonder whether their son or daughter is a "juvenile delinquent."

It is normal for a very young child to take something which excites his or her interest. This should not be regarded as stealing until the youngster is old enough, usually three to five years old, to understand that taking something which belongs to another person is wrong. Parents should actively teach their children about property rights and the consideration of others. Parents are also role models. If you come home with stationary or pens from the office or brag about a mistake at the supermarket checkout counter, your lessons about honesty will be a lot harder for your child to understand.

Although they have learned that theft is wrong, older children or teenagers steal for various reasons. A youngster may steal to make things equal if a brother or sister seems to be favored with affection or gifts. Sometimes, a child may steal as a show of bravery to friends, or to give presents to family or friends or to be more accepted by peers. Children may also steal out of a fear of dependency; they don't want to depend on anyone, so they take what they need.

Parents should consider whether the child has stolen out of a need for more attention. In these cases, the child may be expressing anger or trying to "get even" with his or her parents; the stolen object may become a substitute for love or affection. The parents should make an effort to give more recognition to the child as an important family member.

If parents take the proper measures, in most cases the stealing stops as the child grows older. Child and adolescent psychiatrists recommend that when parents find out their child has stolen, they:

- tell the child that stealing is wrong
- help the youngster to pay for or return the stolen object
- make sure that the child does not benefit from the theft in any way
- avoid lecturing, predicting future bad behavior, or saying that they now consider the child to be a thief or a bad person
- make clear that this behavior is totally unacceptable within the family tradition and the community

When the child has paid for or returned the stolen merchandise, the matter should not be brought up again by the parents, so that the child can begin again with a "clean slate."

If stealing is persistent or accompanied by other problem behaviors or symptoms, the stealing may be a sign of more serious problems in the child's emotional development or problems in the family. Children who repeatedly steal may also have difficulty trusting others and forming close relationships. Rather than feeling guilty, they may blame the behavior on others, arguing that, "Since they refuse to give me what I need, I will take it." These children would benefit from an evaluation by a child and adolescent psychiatrist.

In treating a child who steals persistently, a child and adolescent psychiatrist will evaluate the underlying reasons for the child's need to steal, and develop a plan of treatment. Important aspects of treatment are helping the child learn to establish trusting relationships and helping the family to support the child in changing to a more healthy path of development.

Children And Divorce

One out of every two marriages today ends in divorce and many divorcing families include children. Parents who are getting a divorce are frequently worried about the effect the divorce will have on their children. During this difficult period, parents may be preoccupied with their own problems, but continue to be the most important people in their children's lives.

While parents may be devastated or relieved by the divorce, children are invariably frightened and confused by the threat to their security. Some parents feel so hurt or overwhelmed by the divorce that they may turn to the child for comfort or direction. Divorce can be misinterpreted by children unless parents tell them what is happening, how they are involved and not involved and what will happen to them.

Children often believe they have caused the conflict between their mother and father. Many children assume the responsibility for bringing their parents back together, sometimes by sacrificing themselves. Vulnerability to both physical and mental illnesses can originate in the traumatic loss of one or both parents through divorce. With care and attention, however, a family's strengths can be mobilized during a divorce, and children can be helped to deal constructively with the resolution of parental conflict.

Talking to children about a divorce is difficult. The following tips can help both the child and parents with the challenge and stress of these conversations:

- Do not keep it a secret or wait until the last minute.
- Tell your child together.
- Keep things simple and straight-forward.
- Tell them the divorce is not their fault.
- Admit that this will be sad and upsetting for everyone.
- Reassure your child that you both still love them and will always be their parents.
- Do not discuss each other's faults or problems with the child.

Parents should be alert to signs of distress in their child or children. Young children may react to divorce by becoming more aggressive and uncooperative or withdrawing. Older children may feel deep sadness and loss. Their schoolwork may suffer and behavior problems are common. As teenagers and adults, children of divorce can have trouble with their own relationships and experience problems with self-esteem.

Children will do best if they know that their mother and father will still be their parents and remain involved with them even though the marriage is ending and the parents won't live together. Long custody disputes or pressure on a child to "choose" sides can be particularly harmful for the youngster and can add to the damage of the divorce. Research shows that children do best when parents can cooperate on behalf of the child.

Parents' ongoing commitment to the child's well-being is vital. If a child shows signs of distress, the family doctor or pediatrician can refer the parents to a child and adolescent psychiatrist for evaluation and treatment. In addition, the child and adolescent psychiatrist can meet with the parents to help them learn how to make the strain of the divorce easier on the entire family. Psychotherapy for the children of a divorce, and the divorcing parents, can be helpful.

Childrens Threats: When Are They Serious?

Every year there are tragedies in which children shoot and kill individuals after making threats. When this occurs, everyone asks themselves, "How could this happen?" and "Why didn't we take the threat seriously?"

Most threats made by children or adolescents are not carried out. Many such threats are the child's way of talking big or tough, or getting attention. Sometimes these threats are a reaction to a perceived hurt, rejection, or attack.

What threats should be taken seriously?

Examples of potentially dangerous or emergency situations with a child or adolescent include:

- threats or warnings about hurting or killing someone
- threats or warnings about hurting or killing oneself
- threats to run away from home
- threats to damage or destroy property

Child and adolescent psychiatrists and other mental health professionals agree that it is very difficult to predict a child's future behavior with complete accuracy. A person's past behavior, however, is still one of the best predictors of future behavior. For example, a child with a history of violent or assaultive behavior is more likely to carry out his/her threats and be violent.

When is there more risk associated with threats from children and adolescents?

The presence of one or more of the following increases the risk of violent or dangerous behavior:

- past violent or aggressive behavior (including uncontrollable angry outbursts)
- access to guns or other weapons
- bringing a weapon to school
- past suicide attempts or threats
- family history of violent behavior or suicide attempts
- blaming others and/or unwilling to accept responsibility for one's own actions
- recent experience of humiliation, shame, loss, or rejection
- bullying or intimidating peers or younger children
- a pattern of threats
- being a victim of abuse or neglect (physical, sexual, or emotional)
- witnessing abuse or violence in the home
- themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork
- preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and Internet sites
- mental illness, such as depression, mania, psychosis, or bipolar disorder
- use of alcohol or illicit drugs
- disciplinary problems at school or in the community (delinquent behavior)
- past destruction of property or vandalism
- cruelty to animals
- firesetting behavior
- poor peer relationships and/or social isolation
- involvement with cults or gangs
- little or no supervision or support from parents or other caring adult

What should be done if parents or others are concerned?

When a child makes a serious threat it should not be dismissed as just idle talk. Parents, teachers,

or other adults should immediately talk with the child. If it is determined that the child is at risk and the child refuses to talk, is argumentative, responds defensively, or continues to express violent or dangerous thoughts or plans, arrangements should be made for an immediate evaluation by a mental health professional with experience evaluating children and adolescents. Evaluation of any serious threat must be done in the context of the individual child's past behavior, personality, and current stressors. In an emergency situation or if the child or family refuses help, it may be necessary to contact local police for assistance or take the child to the nearest emergency room for evaluation. Children who have made serious threats must be carefully supervised while awaiting professional intervention. Immediate evaluation and appropriate ongoing treatment of youngsters who make serious threats can help the troubled child and reduce the risk of tragedy.

Bipolar Disorder In Children And Teens

Children and teenagers with Bipolar Disorder have manic and/or depressive symptoms. Some may have mostly depression and others a combination of manic and depressive symptoms. Highs may alternate with lows.

Research has improved the ability to diagnose Bipolar Disorder in children and teens. Bipolar Disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children may develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for Bipolar Disorder.

Manic symptoms include:

- severe changes in mood-either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility - the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

Depressive symptoms include:

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia.

Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium and valproic acid, and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the child understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

The diagnosis of Bipolar Disorder in children and teens is complex and involves careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist identify Bipolar Disorder and start treatment.

Children And Lying

Honesty and dishonesty are learned in the home. Parents are often concerned when their child or adolescent lies.

Lying that is probably not a serious problem:

Young children (ages 4-5) often make up stories and tell tall tales. This is normal activity because they enjoy hearing stories and making up stories for fun. These young children may blur the distinction between reality and fantasy.

An older child or adolescent may tell a lie to be self-serving (e.g. avoid doing something or deny responsibility for their actions). Parents should respond to isolated instances of lying by talking with the youngster about the importance of truthfulness, honesty and trust.

Some adolescents discover that lying may be considered acceptable in certain situations such as not telling a boyfriend or girlfriend the real reasons for breaking up because they don't want to hurt their feelings. Other adolescents may lie to protect their privacy or to help them feel psychologically separate and independent from their parents (e.g. denying they sneaked out late at night with friends).

Lying that may indicate emotional problems:

Some children, who know the difference between truthfulness and lying, tell elaborate stories which appear believable. Children or adolescents usually relate these stories with enthusiasm because they receive a lot of attention as they tell the lie.

Other children or adolescents, who otherwise seem responsible, fall into a pattern of repetitive lying. They often feel that lying is the easiest way to deal with the demands of parents, teachers and friends. These children are usually not trying to be bad or malicious but the repetitive pattern of lying becomes a bad habit.

There are also some children and adolescents who are not bothered by lying or taking advantage of others. Other adolescents may frequently use lying to cover up another serious problem. For example, an adolescent with a serious drug or alcohol problem will lie repeatedly to hide the truth about where they have been, who they were with, what they were doing, and where the money went.

What to do if a Child or Adolescent lies:

Parents are the most important role models for their children. When a child or adolescent lies, parents should take some time to have a serious talk and discuss:

- the difference between make believe and reality, lying and telling the truth,
- the importance of honesty at home and in the community, and
- alternatives to lying.

If a child or adolescent develops a pattern of lying which is serious and repetitive, then professional help may be indicated. Evaluation by a child and adolescent psychiatrist would help the child and parents understand the lying behavior and would also provide recommendations for the future.

Stepfamily Problems

With the high incidence of divorce and changing patterns of families in the United States, there are increasing numbers of stepfamilies. New stepfamilies face many challenges. As with any achievement, developing good stepfamily relationships requires a lot of effort. Stepfamily members have each experienced losses and face complicated adjustments to the new family situation.

When a stepfamily is formed, the members have no shared family histories or shared ways of doing things, and they may have very different beliefs. In addition, a child may feel torn between the parent they live with most (more) of the time and their other parent who they visit (e.g. lives somewhere else). Also, newly married couples may not have had much time together to adjust to their new relationship.

The members of the new blended family need to build strong bonds among themselves through:

- acknowledging and mourning their losses
- developing new skills in making decisions as a family
- fostering and strengthening new relationships between: parents, stepparent and stepchild, and stepsiblings
- supporting one another; and
- maintaining and nurturing original parent-child relationships

While facing these issues may be difficult, most stepfamilies do work out their problems. Stepfamilies often use grandparents (or other family), clergy, support groups, and other community-based programs to help with the adjustments.

Parents should consider a psychiatric evaluation for their child when they exhibit strong feelings of being:

- alone dealing with the losses
- torn between two parents or two households
- excluded
- isolated by feelings of guilt and anger
- unsure about what is right
- very uncomfortable with any member of the original family or stepfamily

In addition, if parents observe that the following signs are lasting or persistent, then they should consider a psychiatric evaluation for the child/family:

- child vents/directs anger upon a particular family member or openly resents a stepparent or parent
- one of the parents suffers from great stress and is unable to help with the child's increased need
- a stepparent or parent openly favors one of the children
- discipline of a child is only left to the parent rather than involving both the stepparent and parent
- frequent crying or withdrawal by the child; or
- members of the family derive no enjoyment from usual pleasurable activities (i.e. learning, going to school, working, playing or being with friends and family)

Child and adolescent psychiatrists are trained and skilled at providing comprehensive psychiatric evaluations of both the child and family if serious problems develop.

Most stepfamilies, when given the necessary time to work on developing their own traditions and to form new relationships, can provide emotionally rich and lasting relationships for the adults, and help the children develop the self-esteem and strength to enjoy the challenges of life.

When To Seek Help For Your Child

Parents are usually the first to recognize that their child has a problem with emotions or behavior. Still, the decision to seek professional help can be difficult and painful for a parent. The first step is to gently try to talk to the child. An honest open talk about feelings can often help. Parents may choose to consult with the child's physicians, teachers, members of the clergy, or other adults who know the child well. These steps may resolve the problems for the child and family.

Following are a few signs which may indicate that a child and adolescent psychiatric evaluation will be useful.

YOUNGER CHILDREN

- Marked fall in school performance.
- Poor grades in school despite trying very hard.
- Severe worry or anxiety, as shown by regular refusal to go to school, go to sleep or take part in activities that are normal for the child's age.
- Hyperactivity; fidgeting; constant movement beyond regular playing.
- Persistent nightmares.
- Persistent disobedience or aggression (longer than 6 months) and provocative opposition to authority figures.
- Frequent, unexplainable temper tantrums.

PRE-ADOLESCENTS AND ADOLESCENTS

- Marked change in school performance.
- Inability to cope with problems and daily activities.
- Marked changes in sleeping and/or eating habits.
- Frequent physical complaints.
- Sexual acting out.
- Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping or thoughts of death.
- Abuse of alcohol and/or drugs.
- Intense fear of becoming obese with no relationship to actual body weight, purging food or restricting eating.
- Persistent nightmares.
- Threats of self-harm or harm to others.
- Self-injury or self destructive behavior.
- Frequent outbursts of anger, aggression.
- Threats to run away.
- Aggressive or non-aggressive consistent violation of rights of others; opposition to authority, truancy, thefts, or vandalism.
- Strange thoughts, beliefs, feelings, or unusual behaviors.

If problems persist over an extended period of time and especially if others involved in the child's life are concerned, consultation with a child and adolescent psychiatrist or other clinician specifically trained to work with children may be helpful.

Discipline

Children do not always do what parents want. When a child misbehaves, the parent must decide how to respond. All children need rules and expectations to help them learn appropriate behavior. How does a parent teach a child the rules and, when those rules are broken, what should parents do?

Parents should begin by talking to each other about how they want to handle discipline and establish the rules. It is important to view discipline as **teaching not punishment**. Learning to follow rules keeps a child safe and helps him or her learn the difference between right and wrong.

Once rules have been established, parents should explain to the child that broken rules carry consequences. For example, *Here are the rules. When you follow the rules, this will happen and if you break a rule, this is what will happen.* Parents and the child should decide together what the rewards and consequences will be. Parents should always acknowledge and offer positive reinforcement and support when their child follows the rules. Parents must also follow through with an appropriate consequence when the child breaks a rule. Consistency and predictability are the cornerstones of discipline and praise is the most powerful reinforcer of learning.

Children learn from experience. Having logical consequences for misbehavior helps them learn that they are accountable for their actions, without damaging their self-esteem. If children are fighting over the television, computer or a video game, turn it off. If a child spills milk at the dinner table while fooling around, have the child clean it up. A teenager who stays up too late

may suffer the natural consequences of being tired the next day. Another type of consequence that can be effective is the suspension or delay of a privilege. If a child breaks the rule about where they can go on their bike, take away the bike for a few days. When a child does not do chores, he or she cannot do something special like spend the night with a friend or rent a movie.

There are different styles and approaches to parenting. Research shows that *effective* parents raise well-adjusted children who are more self-reliant, self-controlled, and positively curious than children raised by parents who are punitive, overly strict (authoritarian), or permissive. Effective parents operate on the belief that both the child and the parent have certain rights and that the needs of both are important. Effective parents don't need to use physical force to discipline the child, but are more likely to set clear rules and explain why these rules are important. Effective parents reason with their children and consider the youngsters' points of views even though they may not agree with them.

Tips for effective discipline:

- Trust your child to do the right thing within the limits of your child's age and stage of development.
- Make sure what you ask for is reasonable.
- Speak to your child as you would want to be spoken to if someone were reprimanding you. Don't resort to name-calling, yelling, or disrespect.
- Be clear about what you mean. Be firm and specific.
- Model positive behavior. "Do as I say, not as I do" seldom works.
- Allow for negotiation and flexibility, which can help build your child's social skills.
- Let your child experience the consequences of his behavior.
- Whenever possible, consequences should be delivered immediately, should relate to the rule broken, and be short enough in duration that you can move on again to emphasize the positives.
- Consequences should be fair and appropriate to the situation and the child's age.

Parenting classes and coaching can be helpful in learning to be an effective parent. If parents have serious concerns about continuing problems with their child's behavior, consultation with a child and adolescent psychiatrist or other qualified mental health professional may be helpful.

Normality

Parents are naturally concerned about the health and welfare of their children. Many parents correctly and comfortably see their youngster as normal. However, some parents worry whether their infant, child, or teenager has a problem. These worries can include questions about:

- how the child is developing
- the emotional well-being of the child
- what the child says, thinks, and feels
- how the child acts, for example, eating and sleeping patterns, behavior at school, getting along with family and friends, or coping with stress

Child and adolescent psychiatrists can help parents and families answer these questions about what's normal and what's not. They usually interview the child and ask the parents about the child's previous health and behavior. They may also ask about how the family gets along together.

It is likely that infants, children, and teenagers are normal when, at the appropriate age, they fully participate in and enjoy their:

- learning, school, and/or work
- relationships within the family
- relationships with friends; and
- play

Many parents first discuss their concerns about their child's normality with a family member or friend, or with the child's physician, school counselor or member of the clergy--who may then refer the family to a child and adolescent psychiatrist. He or she listens carefully to the parents and child and sorts out:

- the long-term factors that tend to lead to--or protect against--the child's developing problems
- the short-term factors that set off the child's problem
- the factors causing these problems to persist
- the possible roles of other medical conditions; and
- the contribution of school learning, social and emotional growth to the child's functioning.

Based on the evaluation, the child and adolescent psychiatrist may:

- reassure the parents, explaining how they can enhance normal development;
- suggest an activity or an educational program for the child, and/or education for parents, which will support normal development and effective parenting;
- provide or arrange for brief counseling to help the child and parents with minor developmental problems, stressful life situations or difficulties due to the child's temperament

If the evaluation reveals a psychiatric disorder, the child and adolescent psychiatrist will recommend a specific treatment program.

Parents, better than anyone else, know their child and know what is usual behavior for their child. If you feel your child has a problem, seek professional help. It is a very important first step in knowing for sure whether there is a problem, and if so, what measures will best help your child.

Children And Movies

Watching movies, videos, and DVDs can be a fun activity in which children and adolescents can use their imagination and fantasy. Parents should, however, consider the following issues when planning to watch movies at a theatre or at home:

- Although going to a movie theatre can be exciting, movies can create anxiety for children with loud noises and frightening and upsetting scenes.
- Younger children may have trouble telling the difference between make-believe and reality. They can be upset when a parent figure dies in a movie or frightening things happen to children.
- Some children cannot tolerate the darkness of a movie theatre, even with their parents present.

- Viewing movies with sex, violence, drug abuse, adult themes, and offensive language can have a negative effect on children and adolescents. Many movies are *not* appropriate for children or teenagers.
- Older children and adolescents may copy risky and possibly dangerous things they see in movies.
- Having a TV, VCR, or DVD player in children and adolescents' bedrooms encourages movie watching without adult supervision.
- Movies should not replace child-care or be left on as background noise.
- If parents are unsure whether a movie is appropriate, they should view the movie in private before watching it as a family.

Tips and Recommendations for Parents:

- Discuss upsetting or frightening events seen in a movie.
- Turn the movie off or leave the theater if your child becomes upset or frightened.
- Use the same care and attention to a movie's content when choosing a movie to watch at home for a child or adolescent as you would a movie in the theater.
- Deciding when a teenager can go to a movie without parental supervision depends on the teenagers' maturity and the friends going with your teenager.
- All ages of children should have their movie watching supervised by their parents or adult caretakers.
- Parents can and should be active participants in their children and adolescents' movie watching experiences.

Watching movies together can be a rewarding experience. It can be an opportunity for your child to have fun with family and friends. If your child or adolescent, however, develops strong and persistent emotional reactions or behavior from seeing a movie, then consider having your child evaluated by a qualified mental health professional.

How do we distinguish a psychological disorder from demon possession?

The Bible gives some examples of people being possessed or influenced by demons. From these we can find some symptoms of demonic influence as well as gain insights as to how a demon possesses someone.

Here are some passages:

Matthew 9:32-33; 12:22; 17:18; Mark 5:1-20 (this is a major passage about the demoniac of the Gadarenes); 7:26-30; Luke 4:33-36; Luke 22:3 (Satan possesses Judas); Acts 16:16-18.

In some of these passages the demon possession causes:

1. physical ailments (inability to speak, epileptic symptoms, blindness, etc.);
2. in other cases it causes the individual to do evil (Judas is the main example); in Acts 16:16-18 the spirit apparently gives a slave girl some ability to know things beyond her own learning (a spirit of divination); in the case of the demoniac of the Gadarenes who was possessed by a multitude of demons, he had superhuman strength, cut himself, went around naked, and lived among the tombstones.
3. King Saul, after rebelling against the LORD, was allowed to be troubled by an evil spirit (1 Samuel 16:14-15; 18:10-11; 19:9-10) with the apparent affect of a melancholy mood and an increased desire and readiness to kill David (God's next anointed king of Israel).

Thus, there are a wide variety of possible symptoms of demon possession.

- These include physical impairments,
- personality changes such as major depression or
- uncharacteristic aggression (as with King Saul), masochism, supernatural strength, a disregard for modesty or "normal" social interaction (as with the demoniac of Gadarenes), and perhaps the ability to share information that one has no natural way of knowing (such as with the fortune-telling of the slave girl of Acts 16).

It is important to note that nearly all of these characteristics may have other explanations, so it is important not to label every depressed person or epileptic individual as demon possessed. On the other hand, I think that in our western culture, we probably don't take Satanic involvement in people's lives seriously enough. But what I am saying is that we should not be looking for a demon behind every bush!

In addition to these physical or emotional distinctions, one can also look at **spiritual attributes** as showing demonic influence.

These may include a refusal to forgive (2 Corinthians 2:10-11) and the belief in and spread of false doctrine, especially concerning Jesus Christ and His atoning work (2 Corinthians 11:3-4, 13-15; 1 Timothy 4:1-5; 1 John 4:1-3). 1 Corinthians 12:3 states that no man can say that Jesus is the Lord except by the Holy Spirit. Some use this declaration "Jesus is Lord" as a kind of litmus test, i.e., based upon this verse they believe that demons will not say that Jesus is Lord or Master. As to the accuracy of applying this verse in this way, I cannot judge for certain.

In reviewing the verses in which Jesus healed diseases that were caused by demon possession and those that were not, it is difficult to distinguish between the two for we are not given a list of

characteristics that set them apart from one another. One distinction is that while some people are born blind, dumb, lame, etc., it is never said that any who are sick because of demon possession were born that way. In one case, the epilepsy caused by demon possession could be traced to “childhood” (Mark 9:21) but not to birth.

Concerning the involvement of demons in the lives of Christians, the apostle Peter is an illustration of the fact that a believer can be INFLUENCED by the devil (Matthew 16:23). Some refer to Christians who are under a STRONG demonic influence as being “demonized”, but never is there an example in Scripture of a believer in Christ being POSSESSED by a demon, and most theologians believe that a Christian CANNOT be possessed because he has the Holy Spirit abiding within (2 Corinthians 1:22; 5:5; 1 Corinthians 6:19).

We are not told exactly how one opens himself up for possession. Judas’ case may be representative, he apparently gave an open door to demon possession when he opened his heart to evil (in his case by his greed (John 12:6)). So it may be possible that if one allows his heart to be ruled by some habitual sin...it becomes an invitation for a demon to enter in. Also, from missionary experiences, demon possession can be related to the worship of heathen idols and the possession of occult materials. This seems to fall in line with Scripture that repeatedly relates idol worship with the actual worship of demons (Leviticus 17:7; Deuteronomy 32:17; Psalm 106:37; 1 Corinthians 10:20), so it should not be surprising that involvement with those religions or their practices could lead to demon possession.

Thus, it is my belief based on the above Scriptural passages as seen in the experiences of missionaries that many people open their lives up to demon involvement through the embracing of some sin or through occult involvement (both knowingly and unknowingly); examples may include drug/alcohol abuse and transcendental meditation...as these alter one’s state of consciousness; but can also include the embracing of immorality, rebellion, or bitterness. In our country, we see an increase of Eastern religious teachings under the guise of the new age movement. The present environmental movement is most directly tied to this teaching and is a form of idolatry in that nature is held as a kind of god (very similar to the ancient teaching of pantheism). With this growth of pantheism in our nation, I believe we will see a rise of demon involvement as well.

The determining of whether an mental or physical illness is being caused by demonic influence or by natural causes would perhaps be aided through a study of the background of a person or their closest relatives to find out if there has been involvement in the occult or the embracing of a sinful habit that would serve as an open door for demon involvement in a life. If there has been and the symptoms of the illness date from the time of such involvement, it would seem to indicate a demonic source of the malady.

In summary, from the different Bible passages that relate to demonic involvement.

Here is a possible list of questions that one might be ask concerning someone’s illness:

1. Has the malady come after birth (and cannot be attributed to an accident causing brain trauma or some other clear physiological problem)?
2. Has there been the embracing of a sinful habit or involvement in an eastern religion or occult practice?
3. Are there manifestations that go beyond the natural (superhuman strength, ability to know things not humanly possible to know, demonic voices from the person)?
4. Are there destructive (to one’s self) or violent (to others) manifestations? A “yes” answer to a number of the above questions could indicate a demonic source of the psychological ailment. I say “could” because I do not believe that we know all of the physiological causes for either physical or psychological problems. Let me make one more related point,

all Christians are called upon to “test the spirits” (1 John 4:1-3). The “testing of the spirits” typically involves using biblical doctrine to determine if someone’s spiritual teaching is of God or of Satan but this passage has also been applied by some people to situations involving possible demonic possession by testing people’s response to biblical teachings such as those mentioned in 1 John 4:2-3. I cannot personally vouch for such application as I have never had occasion to do so.

Lastly, a word to the wise, some people develop an unhealthy fascination with the occult and demonic activity. This is ill advised to say the least. If we pursue God with our lives and are clothing ourselves with His armor and relying upon His strength (not our own) (Ephesians 6:10-18), we have nothing to fear from the evil ones, for God rules over all! And if we are going to be involved with direct demonic confrontation, we need to make sure that we are relying upon His strength and resources as mentioned in Ephesians 6:10-18 and not our own. *Adapted from: Got Questions Ministries.*

Basics steps how to counsel people with Personality Disorders?

1. **Get information regarding the symptoms:** Get as much information as you can, ask question of the primary physician; talk to the social worker, have a family consider conference with rehabilitation counselor; go to the library and information; contact community resources.
2. **Distinguish between spiritual and physical symptoms:** If physical symptoms are excessive consider medical treatments know possibly alleviate the symptoms. When you do this, you will immediately know the cause of the spiritual problems – they come from the heart, but you will not know the cause of the physical complaints. The physical complaints may be caused by a body that is wasting away, by sin in the person’s life, or by Satan; or they may be a divine affliction for the purpose of teaching a person to rely on God alone.

It is important initially to distinguish between these two categories (Physical and Spiritual) for two reasons:

1. If we confuse physical for spiritual symptoms, we are liable to hold people morally responsible for physical symptoms
2. If we confuse spiritual for physical symptoms, we are liable to excuse sin or have little hope for spiritual growth when someone has a psychiatric diagnosis.

To make this distinction, all you need are your two questions:

1. Does the Bible command or prohibit this behavior?
2. Can this behavior be best described as a strength or weakness

3. **Address heart issues.** Ministry to those who are in needs starts with compassion. Rom 12:15; 2 Cor 1: 9-11. Compassion, of course, is much more than sympathizing with a person’s pain. Compassion is active. It knows the isolating nature of the suffering.

1. Be alert of Spiritual Warfare.
2. Deal with Obvious Spiritual Problems.

4. **Maximize remaining strengths: correct or minimize weaknesses.**

Reference:

To learn more go to:

1. American Academy of Child and Adolescent Psychiatry (AACAP)

Facts for Families - http://www.aacap.org/cs/root/facts_for_families/facts_for_families