2-SLM-Psychology

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behavior is means to escape from undesirable consequences, then the child is not to be given any opportunity for doing so. Compliance must be made compulsory under such circumstances. Wherein the problem behaviors in children are an indication of boredom or self stimulation, proper scheduling of activities must take place.

It is one thing to identify and understand or analyze a problem behavior in a child and quite another thing to implement the remediation or behavior correction program. For example, one may chose 'ignoring' technique for an attention seeking problem behavior in a child. One may even take courage, will power and resolve to ignore the child every time he 'bangs his head' (the identified attention seeking problem behavior!). However, after a couple of trials, if you begin to feel bad and cannot ignore the child at such critical times your program is bound to fail. The 'weak hearted' mother may go ahead to carry him the next time the child bangs his head. Then, this becomes the reward for the child to continue his problem behavior!

4.5 AUTISM

Autistic disorder refers to a group of behavioral disturbances seen in some children beginning from infancy or early childhood (below three years). Unlike children with mental retardation, kids with autism show an early developmental history of near normal sensory-motor and even language milestones. Thereafter, there is sudden drop, deterioration or regression in development of the child. The two areas of child development that are typically affected are language and social relationships. They show restricted, stereotyped and repetitive interests and activities. The major signs and symptoms of this disorder are:

(i) Difficulty in interacting or playing with other children

(ii) Act as if deaf and do not react to speech or noises

(iii) Show strong resistance to learning new behaviors or skills

(iv) Lack fear about realistic dangers. For example, they may play with fire

(v) Resist changes in routines. A slight change in routine produce disproportionate anxiety

(vi) Prefer to indicate wants by gestures. Speech may or may not be present

(vii) Laughs or giggles for no appropriate reason

(viii) Not cuddly as a baby

(ix) Show marked physical over activity

(x) Poor or no eye to eye contact with others. Persistently look past or turn away from persons in a conversation

(xi) Unusual attachment for inanimate objects like soap case, plastic covers, etc.

(xii) Spin objects especially round ones

(xiii) Repetitive and sustained odd play such as rattling stones in a can

(xiv) Stand offish manner-treat persons as objects rather than as persons

CASE EXAMPLE

Vipin is a six-year-old. The child was brought with complaints of behavior disturbances like lack of sleep, talking to self, etc. These symptoms persisted for three to five months before decreasing on their own. When these symptoms decreased, Vipin showed inclination to learn. When the symptoms reoccurred, his learning worsened. Any amount of reward or punishment did not help in the improvement of the condition. A course of medicines prescribed by the psychiatrist helped to some extent. This is a typical example a child on the autism spectrum disorder.

Impairment in social functioning is seen as inadequate appreciation of social or emotional cues. They lack responses to other people's emotions. They fail to understand the social context and/or body language and expressions of others. Speech and language understanding or expressions are equally impaired. They do not use speech for social communication. As children, they are deficient in make believe play, creativity and use of fantasy in thinking.

It is important once again to realize that autism can exist in children as primary developmental disorder or it may be seen as associated features along with some other primary condition like severe/profound mental retardation. Also note that an occasional flick of the finger or a rare occasion of muttering to oneself, withdrawn social mood or disinterest in play does not necessarily mean a child should be labeled as autism. Such sweeping generalizations and faulty diagnosis have been the cause of havoc in the lives of many children or their parents.

The causes of autism are poorly understood. It is likely that both genetic and environmental causes play a role in development of autism in young children. A number of genes have been associated with autism. Irregularities in brains of persons with autism are reported. Some researchers have found that neurotransmitters or brain chemicals like serotonin or dopamine do not work properly in these persons. Earlier studies thought that faulty parent or child rearing practices could be the cause of autism.

There is no cure for autism. A variety of therapies have been proposed by different disciplines. They range from diet based restrictions, sensory integration therapies, homeopathy, ayurveda, cleansing of toxins or chelation to vitamin supplements. There has been more on the search rather than solutions. By far, applied behavior analysis or behavior therapy is found to be the most effective when targeted on specific symptoms of autism. Further, most professionals agree that behavior therapy is effective if started early. All the participants in behavior therapy program must coordinate and cooperate in their implementation. Stimulant drugs and anti-psychotic medication are sometimes required as supportive rather than primary treatment for autism.

4.6 CHILDHOOD PHOBIAS

Everyone feels anxious and fearful at sometime or other in their lives. This is normal and acceptable. However, there are some persons, especially children, who show chronic social withdrawal from relationships, friends, family and peers. These problems begin during infancy or later childhood. These fears and apprehensions in children are not due to an inherent incapacity in these children as in the case of autism. They are more the result of emotional interferences, felt anxiety, shyness, sadness or the like.

In early infancy, emotional problems may occur as attachment disorders. The infants show conflict between need for safety in the company of primary caregivers and their tendency for exploration of their environments especially as relationships and emotional bonding with others. They show clear preference of closeness with small number of caregivers. They show anxiety, fear, shyness, protest and caution in

relationship with strangers. It is normal for infants to show close attachment to few people alone during 7-12 months. Even after they grow, some children show fear responses in attempting social relationships with others. They show mixed response of approach-avoidance and resist social relationships with others.

In one extreme form of childhood emotional problem, the child may choose not to speak with others at all. This is called 'elective or selective mutism'. This is not to mean that the child lacks language or speech competence. They can speak well. They do so with some people or in some situations. Yet, they are anxious, withdrawn and refuse to speak in some other situations.

Certain fears in children may be restricted to certain times, place, persons or situations. The child understands very well that such situations are not dangerous. Still, when they are exposed to those persons or situations, the child shows fear and anxiety. The specific objects or situations of phobia can include animals (zoophobia), darkness (nyctophobia), sharp objects (acrophobia), water (hydrophobia), enclosed places (claustrophobia), etc. Phobias in children must be distinguished from normal or age appropriate developmental fears. Fear of dark or stranger is common in toddlers. They usually outgrow these fears with or without treatment as they grow old.

Depression is another common problem in some children. It is difficult for many adults to accept that young children can or do have depression. Of course, the symptoms of depression in children are not those in adults. The loss of pleasure in daily activities or suicide thoughts seen or felt in adult depression is not reported in childhood depression. Their depression may

show up as irritability, body complaints, behavior problems, school refusal, and conduct disturbances, violent and destructive behavior.

Children with emotional disorder can also show fears and anxiety about possible or imagined separation from close attachment figures. They have unrealistic preoccupations about possible harm falling on significant attachment figures or that they will leave and never return. They worry about some untoward incidents like the child being kidnapped, lost, killed or admitted to hospital. Owing to this, there might be persistent refusal to go to school because of fear of separation rather than the events at school. They refuse to go to sleep without being accompanied by the major attachment figure at home. They have repeated nightmares about separation. They may have body complaints like aches or pains. There is excess crying, fear, anxiety, misery, tantrums and social withdrawal.

The several body complaints in children with emotional disturbances have no known or identifiable organic basis. The loss of voice, body sensations, disturbances in hearing or vision, paralysis, fits, or any other body symptom will have no body basis. Sometimes, emotional disturbances occur in children following birth of a younger sibling. A mild form of rivalry between siblings is normal and natural. However, when associated with unusual degree of competition for attention from parents, negative feelings, overt hostility, strong reluctance to share, lack of positive regard, and malice, these disturbances become eligible to be diagnosed as sibling rivalry disorder.

The management of emotional disturbances in children requires careful and correct diagnosis of the problem. There are various behavioral

techniques like relaxation training, stress reduction strategies, systematic desensitization, and graded exposure, modeling, guidance and counseling that are needed to treat the child, parents and some times the whole family.

4.7 QUESTIONS

a. Explain the signs and symptoms of Attention Deficit Disorders. .

b. Differentiate between ADD as primary disorder and as associated features for another primary disorder.

c. Highlight the available treatments for ADD.

d. Differentiate between skill and problem behaviors

e. How are problem behaviors acquired in children?

f. Highlight some techniques for management of problem behaviors in children.

g. List the signs and symptoms of autism.

h. Write a note on the causes and cures for autism

i. List some of the emotional disturbances seen in children.

j. Write short notes on:

(i) Attachment Disorders (ii) Sibling Rivalry Disorder

4.8 ANSWERS

a.	4.3	b.	4.3	c.	4.3	d.	4.4
e.	4.4	f.	4.4	g.	4.5	h.	4.5
i.	4.6	j.	4.6				

4.9 KEY WORDS

Attention Deficit Disorder	Autism
Behavior Therapy	Hyperactivity
Phobia	Problem Behavior

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BLOCK IV: PSYCHOLOGICAL TESTING

Unit 5: Aims and Factors Affecting Testing – Developmental Schedules and Intelligence Tests: Importance

5.1 PURPOSE

This unit explains the meaning and definitions of psychological assessment. It differentiates psychological assessment from psychological testing. There are various assumptions, areas and steps in psychological testing. The important areas of psychological testing as applicable for children with developmental disabilities are measurement of intelligence, development and adaptive behaviors. The tests are briefly explained as relevant or applicable to Indian context. The limitations and factors influencing results on psychological tests are given at the end of this unit.

5.2 INTRODUCTION

Assessment is defined as 'systematic collection, organization and interpretation of information about an individual and his situations in order to enable certain predictions about his behavior in new situations' (Sundberg and Taylor, 1962). According to Hammill (1987), assessment is the 'act of acquiring and analyzing information'. Witt et al (1988) view assessment as 'continuous ongoing process involving the systematic collection of many pieces of information'. It is also defined as 'measurement and evaluation of individual skills, capabilities and limitations by gathering and interpreting information about the said person' (Williams, 1988).

5.3 PSYCHOLOGIAL ASSESSMENT AND TESTING

Psychological assessment is different from psychological testing. Testing involves exposing an individual to particular set of questions under

specified and structured conditions in order to obtain a score. According to American Psychological Association (APA), the set of tasks or questions are intended to elicit particular types of behaviors when presented under standard conditions. They yield scores that have observable psychometric properties. For example, .the Gesell Drawing Test makes use of copying of various geometric shapes by children to measure their intelligence. Similarly, another Porteus Maze Test makes use of the child's ability to negotiate and solve paper pencil mazes to discover their mental age and intelligence. There are many ways to carry out psychological assessment of individuals. Psychological testing is one of them. Thus, a psychological test becomes part of the larger process of psychological assessment.

5.4 PURPOSE AND ASSUMPTIONS

The purpose of psychological assessment varies from screening, identification, classification, placement and program planning to certification and research. Irrespective of their stated purpose, all psychological assessments are based on certain assumptions. Some of these important assumptions are:

(i) There are individual differences for any measured behavioral phenomena. No two children or individuals are identical. Even if two children are measured to have the same IQ or mental age, they are entirely different from each other when it comes to a comparison of their behavior strengths and weaknesses.

(ii) Training is compulsory for examiners before they undertake assessment of children with disabilities. The examiner must know which psychological tests are available or which of them is to be

administered for a given child or group of children. The examiner must know how to administer the psychological test/s, score and/or interpret their results.

(iii) Errors are inevitable in any psychological assessment. There can never be 'error free' assessment. Errors may occur because of the examiner, examinee or the testing process. In any case, the source of error must be identified and corrected wherever or whenever they occur.

(iv) A developmental perspective is important during interpretation of test results especially with regard to children. The children being assessed are not static creatures. They are continually changing or developing according to their age or stage in life. Hence, the examiner should know what is appropriate or inappropriate for the developmental level for each child.

(v) Assessment must be carried out in the context of socio cultural and ecological background of the subjects. For example, it is not correct to use a Western test of intelligence to measure children in the Indian context.

5.5 PROCESS

The areas typically assessed during psychological assessment and/or testing include intelligence, adaptive behavior, aptitudes, anxiety and stress, adjustment, attitudes, personality, memory, thinking, creativity, etc. The focus of assessment vary for a given individual or group of persons depending on the stated purpose. The methods used for assessment are observation, case history, interview, and/or psychological testing. Observation involves purposive or methodological examination of something particularly for purpose of gathering facts. It can be objective

or subjective observation. It can be participant or non-participant observation. It can also be formal or non formal observation. Case history is another method of psychological assessment. A case history format typically includes the following details:

- Demographic Details
- Presenting Complaints
- History of Present Illness
- Past History
- Medical & Developmental History
- Family History
- Academic/Occupational History
- Sexual/Marital History
- Diagnostic Formulation
- Impression
- Recommendations

Interviewing involves face to face verbal interactions between the interviewer (person doing the interview) and interviewee (person being interviewed). Interviewing is not casual chatting. There is always a purpose and method to be followed during interviewing. The interviewer must possess or cultivate the following essential qualities:

- **Listening Skills**

  Listening is a part of effective communication. It is much more than hearing. It involves attention and an effort to pay attention to others. It has to be cultivated by the interviewer.

- **Positive Regard**

  This refers to a temper wherein one suspends judgments on or about the actions of other people. We all have this tendency in us to make or give our impressions about others actions-either as 'good', 'bad', silly', 'stupid', and so on. Such judgments color our views on people. With positive regard, one accepts people as they are.

- **Non-judgmental Attitude**

  Closely related to positive regard, this characteristic refers to the temperament of not making sweeping judgments on others or their actions. We seek to understand them more than crying or laughing at them.

- **Non-bias**

  Bias refers to a particular tendency or inclination that prevents unprejudiced consideration of others. It is a prejudice or preconceived notion about some thing or some person. It may be favorable or unfavorable. Nonetheless, it affects the perception of the reality.

- **Unconditional Warmth**

  This refers to the tendency to give love or warmth of feeling in any relationship without laying any pre conditions. The interviewer must view the interviewee as deserving and capable rather than as some one who is incompetent, weak or inconsequential.

- **Resistance**

  This refers to a tendency to oppose or bring to recall events that are painful or those that cause anxiety. The atmosphere during the interview must be cordial and relaxed for the interviewer as well as interviewee.

- **Privacy & Confidentiality**

  This must be assured and ensured during the process of interview. The matters discussed during the clinical interview must not be divulged to others.

- **Respect for Human Dignity,**

  Human dignity should be respected irrespective of caste, creed, religion, gender, race or nationality.

- **Rights & Autonomy of Individual**

  Whether it is children or adults, their personal rights and sense of self decision making must be recognized and respected. Then interviewing process should not become an affront on their rights or personal decision making.

- **Professional Competency**

  The interviewer has a moral responsibility to constantly sharpen his/her own skills. Of course, the development of clinical competency is a continuous and ongoing process. There is no end to it. Nonetheless, the strive should be on to become better and better interviewer.

5.6 PSYCHOLOGICAL TESTING

As explained above, psychological testing is one of the methods of psychological assessment. Any individual shows several thousands of behaviors day after day. It is impossible to observe all these behaviors. Therefore, one has to just sample and observe a handful of them. This is

the idea behind psychological testing. In short, psychological testing is a scientific procedure of sampling behaviors to understand an individual.

There are several psychological tests as there are many behavioral variables that can be measured. In fact, any or every psychological variable can be observed or measured. The areas that are typically tested include intelligence, adaptive behavior, aptitudes, anxiety and stress, adjustment, attitudes, personality, memory, thinking, creativity, etc. For children with disabilities, among many other things, testing of intelligence and adaptive behavior and their developmental status is frequently required. The measurement of intelligence, adaptive behavior and their developmental status is required for diagnosis, certification, educational planning, intervention, parent guidance and counseling, etc.

(a) Intelligence Tests

Some popular tests of intelligence available in our country are Bhatia's Battery of Performance Tests of Intelligence, Ravens, Progressive Matrices, Gessell Drawing Test, Seguin Form Board, Porteus Maze Test, Malin's Intelligence Scale for Indian Children, Binet Kamat Intelligence Scale, etc.

The Seguin Form Board (SFB) consists of a wooden board with ten geometric blocks like plus, hexagon, semi circle, square, oval, triangle, rectangle, star, circle and diamond. These blocks are arranged in a specified order in front of the child. The child is instructed to replace the blocks into the vacant slots as quickly as possible. The quickest time over three attempts is noted and compared against available norms for finding

the mental age and IQ of the child. Speed is the most critical element in this test.

The Bhatia's Battery of Performance Tests of Intelligence consists of five sub tests. In Alexander Pass Along Test, one of its subtests, the subject is required to pass wooden blocks inside a board within certain time limits to solve a problem. In Koh's Block Design Test, the subject is required to use set of colorful wooden cubes to make certain designs within time limits. In Forward Digit Span Test, the subject is told to repeat increasing number of digits or sounds immediately as instructed by the examiner. In Backward Digit Span Test, the subject is told to reverse and repeat the increasing number of digits or sounds immediately as instructed by the examiner. Picture Completion Test, the subject is asked to rearrange the pieces of a jigsaw puzzle. In Pattern Drawing Test, the subject is required to copy geometric designs without overwriting or lifting the pen.

The Binet Kamat Intelligence Scale has at least six sub tests each for every yearly age group of children from 3 to 21 years. For example, at 3 year level, some of the test items are pointing to parts of body, discriminating big and small, naming familiar objects and so on. At 4 year level, some test items are discrimination of shapes, copying a square and so on. The complexity of test items increase with age. A given child is tested to determine the age level till which he can pass all items correctly. This is the mental age of the child.

The Gesell Drawing Test makes use of copying of various geometric shapes by children to measure their intelligence. For example, if a child can copy square, his mental age is 4 years. If he can copy a diamond, his

mental age is 7 years. The Porteus Maze Test makes use of child's ability to negotiate and solve paper pencil mazes to measure their mental age and intelligence.

The administration of tests of intelligence yield mental age (MA) of the child. This is converted into Intelligence Quotient (IQ) by dividing it with chronological age (CA) of the child and using the formula:

IQ: MA/CA x 100

(b) Developmental Schedules

For assessment of intelligence (or more appropriately developmental status) at lower age levels, psychologists use developmental schedules. Some famous developmental schedules used on young children in our country are Gessell Developmental Schedules, Bayley Scales of Infant Development, Developmental Screening Test, NIMH Developmental Assessment Schedule, etc. Some examples of adaptive behavior scales are Vineland Social Maturity Scale, AAMD Adaptive Behavior Scale and others.

Gessell Developmental Schedules cover developmental ages between 0-6 years. Their items cover areas like motor, adaptive behavior, language, personal and social behaviors. The Bayley Scales of Infant Development cover developmental ages between 0-2 ½ years. Its items include areas like cognitive, gross and fine motor, speech and language. The Developmental Screening Test covers age range till 15 years. Although its items cover almost similar areas of child development, it is more relevant to the development assessment of children with communication disorders.

Unlike tests of intelligence that are individually administered on subjects, developmental schedules are completed by observing the infant or toddlers, or asking for relevant information from parents and caregivers. Developmental schedules yield the developmental age (DA) of the child. This is converted into Developmental Quotient (DQ) by dividing it with chronological age (CA) of the child and using the formula:

DQ: DA/CA x 100

(c) Adaptive Behavior Scales

Adaptive behavior refers to 'effectiveness with which an individual meets the standards of personal independence and social responsibility expected of his age and cultural group'. It is the functional ability of the individual for exercising personal independence and social responsibility. Adaptive behavior depends on age, social standards and expectations about the individual. Further, unlike intelligence, adaptive behavior can be trained and modified through experience.

The components of adaptive behavior include self help skills like self help eating, dressing, toilet and grooming, self direction, social and vocational competencies, community orientation, money-time and domestic skills. Some famous adaptive behavior scale used in our country is Vineland Social Maturity Scale, Adaptive Behavior Scale, Madras Developmental Programming System and Behavior Assessment Scales for Indian Children with Mental Retardation.

The Vineland Social Maturity Scale covers age range of birth to 15 years. There are 89 items with 8 domains grouped according to age levels. The

domains are self help general, self help eating, self help dressing, self direction, occupation, communication, locomotion and socialization. The scale is completed by observing the individual or asking for the relevant information from the parents/caregivers.

The Adaptive Behavior Scale comprises of two parts. The first part measures various components of adaptive behavior and second part measures problem behavior or maladaptive behavior. The Madras Developmental Programming System enables assessment of the individual with disabilities for program planning. It has 360 items grouped under 18 domains. The Behavior Assessment Scales for Indian Children with Mental Retardation is divided into two parts. The first part covers assessment of skill behaviors and second part measures problem behaviors.

The measurement of adaptive behavior is deemed compulsory for making the final diagnosis of several developmental disabilities. Adaptive behavior is measured in terms of social age (SA) and social quotient (SQ). The formula for calculation is:

SQ: SA/CA x 100

5.7 STEPS IN PSYCHOLOGICAL TESTING

Irrespective of the nature or type of psychological testing or its stated purpose, it is carried out in the following different but inter-connected steps:

(i) Selection

This step involves selection of appropriate psychological test according to the need and purpose of assessment. Obviously, a test of intelligence meant for children cannot be used for adults or the one that is developed and standardized in West cannot be used on Indian population.

(ii) Administration

Each test carries a manual in which the authors prescribe procedures for its administration. The test instructions, pattern of presentation of test stimuli, arrangement of apparatus, time limits if any, number of trials, etc., are all clearly specified and must be carefully followed.

(iii) Results & Scoring

The test manual also carries with it the procedure for scoring of subjects responses after administration of the test. Some tests have a system of one mark for each pass or zero for failure. Others have negative marking. Some are scored according to speed or time. Others are scored according to level of difficulty in test items.

(iv) Interpretation

Although a difficult and technical task, interpretation of scores and test results depends on the skill and competency of the examiners. A similar or identical result may be interpreted differently by two psychologists depending on their experience and clinical skills.

(v) Report Writing

This is a highly technical task. It involves the procedure of reporting the results and interpretation by the examiner. A psychological report is not

and cannot be like a biochemist or blood test report. It has to take into account several aspects before pronouncing decisions on or about the subject's behavior. The body of a psychological report typically consists of details on reasons for referral, behavioral observation during testing, tests administered, results, impression and recommendations.

5.8 QUESTIONS

a. Define psychological assessment.
b. Differentiate between psychological assessment and psychological testing.
c. Explain the purpose and assumptions underlying psychological assessment.
d. List the headings covered in a typical case history format.
e. Highlight the qualities to be inculcated in an effective interviewer.
f. What are intelligence tests/ Explain with suitable examples.
g. What are developmental schedules? Explain with suitable examples
h. What are adaptive behavior scales? Explain with suitable examples
i. Describe the steps in psychological testing.

5.9 ANSWERS

a.	5.2	b.	5.3	c.	5.4	d.	5.5	e.	5.5
f.	5.6	g.	5.6	h.	5.6		i.	5.7	

5.10 KEY WORDS

Adaptive Behavior Scales	Assessment
Case History	Developmental Schedules
Intelligence Tests	Interviewing
Observation	Testing

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BLOCK IV: ATTITUDES

Unit 6: Attitude of Parents and Client towards Handicap and Rehabilitation Procedures

6.1 PURPOSE

This unit explains the meaning and importance of attitudes in the context of persons with disabilities. Attitudes about one self as well as those that others have about us influence our behaviors. The persons with disabilities run greater risk of developing distorted self attitudes owing to their unique status and the way their environment or people around view them. Rehabilitation professionals must have a clear understanding on the role of attitudes to optimize their interventions for persons with disabilities and impairments.

6.2 INTRODUCTION

Psychologists spend a lot of effort on understanding or studying attitudes. *Attitudes* refer to thoughts, feeling and actions formed about some object, person, or event in a social context. They develop owing to influence of several significant others, such as, parents, teachers, friends and peers. Attitudes reflect thought, feeling and action components of our behaviors towards our self and others. They can be positive or negative. Negative attitudes are reflected as prejudice-an unjustified attitude. For example, one can have an attitude that all mentally ill persons are violent and wicked; or all criminals are evil persons. Faulty attitudes or prejudices can be changed. Social psychologists have developed and perfected techniques for measuring attitudes and opinions

6.3 ATTITUDE: MEANING AND FORMATION

Allport (1935) defined attitude as 'mental and neural state of readiness organized through experience, exerting dynamic influence on the individual responses to all objects and situations with which it is related'. Closely associated with our attitudes are our intentions, beliefs and behaviors towards specific objects or persons. Attitudes are formed on the basis of direct experiences, rewards and/or aversive experiences with the target objects or persons.

The concept of self is central to psychology of attitudes. In general, self refers to the conscious, reflective personality of an individual. At birth or immediately thereafter, infants have no distinction between self and their environment. They experience their world as disconnected, disjointed, disorderly and disorganized. Over time and with daily experiences, order and organization set into their view about themselves and their world around. This is evolution of self. Self concept or self identity is the mental and conceptual awareness about our selves. It is what one thinks about oneself. It is the mental image or perception that one has of oneself. It includes physical, psychological and social qualities about oneself. On the basis of self concept, one develops a self perception, self image and self esteem-in short, attitudes towards oneself!

6.4 DISABILITY AND ATTITUDE

In the context of persons with disabilities, the study of attitudes assumes importance in two ways: attitudes of the person with handicap towards

himself (attitudes towards self) and the attitudes of others towards persons with disability (public attitudes).

(i) Attitude Toward Self

The success or failure experiences of people are related to how they view themselves and their relationships with others. The self concept or attitudes towards self of every person is *learned by experience*. No one is born with self concept. It is shaped and reshaped with perceived experiences with others. This being the case, the experiences of persons with disabilities in our society are by and large negative. Greater the number of their negative or failure experiences, their self evaluations get severely damaged. Self concept can be measured by using questionnaires, interviews or psychological tests. It is usually assessed on the basis of self reports. It takes into account the person's view of self. This is done through rating scales, checklists, Q-sorts and free response methods. This assessment becomes the basis for planning or implementing guidance and counseling for persons with disabilities whose self concept is severely damaged.

Many studies report that the self perception of persons with disabilities is not positive. These individuals view themselves as incompetent, inferior, incapable and inept compared to non-disabled peers. They have lower self esteem. Persons with high self esteem find it easy to handle conflicts, make friends easily, laugh and smile more often. They have optimistic view of the world or life. Persons with low self esteem find it tough to face problems. They are self critical, passive, withdrawn and depressed. They hesitate to try new things, speak negatively about themselves, get frustrated easily, view temporary problems as permanent and are

pessimistic about themselves or their world. Self esteem grows out of ones experiences. It is influenced by how others respond to our behaviors. Supportive and encouraging feedback from others through praise and approval raises ones self esteem. Success and reward experiences during childhood form the basis for development of self esteem. Alternatively, failures and punishments act as deterrents. Home/school experiences, academic success, achievements in sports or accomplishments in arts promote self esteem. In case of persons with disabilities, failure experience, more than their handicap, fuels their lower self esteem.

Low self-esteem leads to wide range of problems, including poor school achievement, criminal and violent behavior. For some, it can lead to behaviors like bullying, teenage pregnancy, smoking, alcohol and drug abuse, school drop-out, depression and even thoughts of suicide. In children, it can lead to poor physical health, problem behaviors and antisocial behaviors. Over exaggeration or inflated self-esteem is equally dangerous. It can lead to adjustment problems, bragging, egotism, arrogance and self-centeredness. Some common signs of low self-esteem are:

- feeling that they must always please other people
- general feelings of not liking themselves
- feelings of unhappiness most of the time
- feeling that their problems are not normal
- feeling that they are to blame for all their problems
- needing constant validation or approval
- not making friends easily or having no friends
- needing to prove that they are better than others

Some suggestions to foster self esteem or overcome low self esteem are:

- Be a role model for high self-esteem. If you have a positive attitude, chances are that people around will have one too.
- Have realistic expectations. Unreasonable goals for oneself or others will set your self for feelings of failure.
- Respect yourself and others' individuality. Their accomplishments should be praised even if they are not in your area of interest, or if their level of academic success, for instance, is generally lower than yours.
- Praise their efforts, even if they are ultimately unsuccessful. Making a great effort should be rewarded even one did not come in "first".
- Be careful when correcting someone's behavior. Constructive criticism is much more useful than pinning someone with a label like "lazy" or "stupid".
- Avoid statements that tend to reflect comparisons of one person with another.

The attitude one carries towards oneself is important determinant of self presentation. Also called 'impression management', this refers to how we portray ourselves in front of others. It is a form of communication. One is communicating a message about oneself. It is about making an image of one self. The communication is both verbal and nonverbal. Persons with disabilities have a greater challenge as compared to their non disabled peers in matters related to self presentation. Their impressions may convey pity, sympathy, tragedy, sloppiness, ridicule, fun, derision, comic, humor

and laughter. The feedback of such expressions from others only adds on to their negative self image and esteem.

(ii) Public Attitudes

Historically, public attitudes towards persons with disabilities have been generally negative. Earlier and even now some people view persons with disabilities as 'curse of god' for all the sins committed by them in a presumed earlier birth. They were feared, misunderstood, joked, ridiculed, disliked, or pitied, sympathized, or rejected. Separate institutions or asylums were built for these people far outside the city. A policy of segregating these people was practiced. Sometimes, they were even used as exhibits for the rich people to view them like animals in a zoo.

Gradually the attitudes of public changed towards more humane considerations for persons with disabilities. It was realized that segregation and separation of these persons worsened their condition. There were reforms and movements to set free these persons from their imprisonment and into the open society. Training, education and rehabilitation programs were started by involving the family and community for improvement of these individuals. Day care centers, half way homes, respite homes, community based rehabilitation centers, night hospitals, self help groups, home based training programs, home schools, sheltered workshops and such other community friendly agencies were opened for the benefit of rehabilitation of the persons with disabilities and impairments. Several social benefits and concessions were given to these persons.

Public attitudes and opinions about disabled play an important role in the success of such programs. Their faulty attitudes and misconceptions need to be corrected from time to time using sensitivity training programs. Some of the common misconceptions in public about persons with disability are:

Sl No.	Misconceptions
1	Disability is the curse of gods
2	Disability is caused due to sins of the person or his family members in their previous birth
3	Mental retardation is same as mental illness
4	Marriage can cure mental retardation
5	Developmental delays in children get improved on their own as they grow up
6	Some disabilities like mental retardation or cerebral palsy can be infectious
7	If pregnant women work or is exposed to persons with disabilities, she is likely to give birth to defective children
8	Children or persons with disabilities cannot be taught anything
9	Persons with disabilities must be separated or segregated from regular society
10	Disability is the result of past karma or deeds in this or previous life
11	It is waste of time to teach persons with disabilities. The same time or even in less time, it is better or easier to do all the things they need to learn
12	All children with disabilities have behavior problems and are difficult to manage

6.5 CHANGING ATTITUDES

It is correctly argued by some experts that most of the problems faced by persons with disabilities are not really owing to their disabilities. Rather, they are the making of the faulty attitudes of non-disabled persons in their society. A simple example will clarify this point. This whole world is made for an individual with average height. The furniture, buildings, switchboards, ready made garments, or in fact, almost everything is

designed and put in place for an assumed person with average height. In these circumstances, a dwarf is a misfit. He has to jump to sit on a chair. He has to leap to reach the bank counter or even switch on a fan or light. This will result in comic or ridicule. If only, the world had been considerate to have short height chair this tragedy could have been averted. The same is the plight of persons with visual or hearing handicap. They have to learn the expressive language of the non disabled. It is questioned why the non-disabled persons cannot be made to adopt the language or expressions of persons with disability. Probably, they could be taught sign language or Braille. Then, there would be very few difficulties and challenges for the persons with disability. This is the essence of the argument of in changing public attitudes in recent times.

The emphasis of contemporary rehabilitation programs is to change attitudinal barriers in the minds of non-disabled as well as decrease/minimize physical barriers for the convenience of persons with disabilities. It is argued and realized that buildings have to be designed or constructed for the convenience of physically challenged. A ramp is more convenient than a flight of steps. Low height toilet seats aid persons afflicted with cerebral palsy. An interactive voice announcement will facilitate the person with visual impairment. A signage will help the person with hearing loss.

To begin with, attitude change programs are aimed at modifying negative labels and harsh or inconsiderate name calling of persons with disabilities. There is a social movement towards removing hurting names like 'deaf, blind, lame, crippled, idiot, imbecile or moron'. These nick names are best avoided. Rather, there is stress on the positive side-calling the person with

disability as being 'differently abled'. There is emphasis on recognizing the ability hidden within a disability!

The society is committed to create better opportunities for persons with disabilities as well as to eliminate barriers in realization of whatever capacities hidden inside each one of them. These days there is discussion on creating 'barrier free environment'. There are movements to promote better quality in the lives of persons with disabilities. Such changes are likely to result in greater empowerment of these persons. Eventually, they are likely to result in changed self attitudes of the affected persons themselves. There are various strategies for changing negative attitudes of general public towards persons with disabilities.

(i) Mass Contact Programs like Disability Detection Camps
(ii) Use of Media like newspapers, television, internet and others
(iii) Campaigns for a Cause by organizing Special Olympics or Runs
(iv) Organizing Self Help Groups of the Affected
(v) Celebrating a Day or Year for Disabled
(vi) Honoring Achievements of Persons with Disabilities
(vii) Lobbying and Formation of Pressure Groups
(viii) Rewarding and Encouraging Inclusion, Integration and Mainstreaming Activities of the Non disabled for the benefit of persons with disabilities. The government offers incentives to schools adopting or implementing the policy of inclusion in their respective institutions.
(ix) Introduction of Legislation and new laws in favor of the persons with disabilities. For example, the Persons with Disabilities (Equal) Opportunities, Protection of Rights and Equal

Participation Act (1995) carry several tenets that protect these persons from social discrimination.

(x) The Government of India has a policy for reservation of jobs in government sector for persons with disabilities. This has proved to be useful in mainstreaming such affected persons by providing them opportunities to work with the non-disabled.

(xi) However, more than any legal sanction and stricture, what must be eventually aimed in civil society is for a genuine change of attitude in the public for or towards persons with disabilities.

6.6 QUESTIONS

a. Define attitude. Differentiate between self and public attitude.

b. Explain the role for self in development of attitudes..

c. Highlight the negative effects of low self esteem.

d. Describer the public attitudes towards disability.

e. What re the common public misconceptions on or about persons with disabilities?

f. Offer suggestions for changing attitudes on or about disability.

6.7 ANSWERS

a. 6.3 b. 6.4 c. 6.4 d. 6.4

e. 6.4 f. 6.5

6.8 KEY WORDS

Attitude	Campaigns	Media
Misconceptions	Opinion	Prejudice
Public Education	Self Esteem	Stereotypes

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BLOCK IV: THERAPEUTICS

Unit 7: Behavior Therapy and Play Therapy

7.1 PURPOSE

This unit explains the meaning and importance of behavior therapy and play therapy in treatment or rehabilitation of children with disabilities. The basis for all behavior change programs is behavior therapy. It involves using certain steps, procedures and techniques for understanding or analysis of each behavior. This is followed by use of the techniques to change or modify them. Desirable or positive behaviors are taught or facilitated. Undesirable or negative behaviors are to be decreased or eliminated. Play therapy involves the use of play as a medium for changing behaviors in children.

7.2 INTRODUCTION

Psychologists specialize in understanding and changing behaviors. Behaviors are observable and measurable actions. All behaviors are learned. Any or all behaviors that are learned can also be unlearned. Behavior therapy involves a set of procedures and techniques that can bring changes in behaviors of individuals. The change can come as teaching of positive behaviors and/or elimination of negative, maladaptive or unwanted behaviors.

7.3 BEHAVIOR THERAPY AND BEHAVIOR MODIFICATION

Many people use the terms behavior therapy and behavior modification synonymously. Others make a distinction between the two. The term behavior therapy was earlier used to refer non-medical techniques for managing deficit or disordered behaviors of persons with mental illness.

On the other hand, behavior modification involves application of learning principles to change behaviors in any individual-normal or abnormal. The change of behaviors can be the in the direction of initiating new desirable behaviors, maintaining the status of an already acquired behavior, increasing their occurrence, and/or reducing the occurrence of undesirable or maladaptive behaviors.

The origins of behavior therapy and behavior modification owes to several experiments carried out by various psychologists on animals like rats, monkeys, pigeons, cats and others. During these experiments, they found that the behaviors of these animals can be manipulated using certain conditions or techniques. Later, they used the same techniques on human beings, especially children, and found that them effective in changing their behaviors too. Children with development al disabilities are no exception to these rules.

7.4 BEHAVIOR ANALYSIS

It was earlier mentioned that behaviors of children can be divided into two types:

a. Skill Behaviors
b. Problem Behaviors

It was also mentioned that all behaviors are learned and can be unlearned. In order to learn (or teach) skill behaviors or unlearn (or unseat) problem behaviors in children, it is important to understand and carry out behavior analysis.

Behavior analysis is simply a procedure of splitting a behavior into small parts. All children learn through small steps. Instead of teaching something as a whole, the behavior can be split into small steps. Each step is then taught one at a time, until the child learns the whole behavior. For example, if a child has to learn to put on a shirt, this task can be cut into several small steps. 'Holding the shirt in one hand-Inserting right arm into right sleeve-Pulling the shirt with other hand-Inserting left arm into left sleeve-Folding the collar' and so on. It is easy for the child to learn each step separately rather than learn all these steps in one go. This is the essence of behavior analysis.

The same kind of behavior analysis can be carried out to undo a problem behavior. For example, if a child has problem behavior of throwing tantrums, this misbehavior can be analyzed by asking these questions. Where, when or with whom does the child throw the tantrum? What happens during the tantrum behavior? What follows the occurrence of the tantrum behavior? The answers to these questions clarify three things. What is happening 'before', 'during' and 'immediately after' the problem behavior. This kind of behavior analysis will tell us the source of problem behavior as well as their techniques for management. Based on the information derived from behavior analysis, a number of techniques are available for changing behaviors in children.

7.5 TECHNIQUES FOR INCREASING/TEACHING SKILL BEHAVIORS

There are several techniques for increasing or teaching new skill behaviors or for maintenance of already learned skill behaviors in children. Some of them are:

(a) Reward Training

Rewards are things or events that happen after a behavior. That thing or event is liked by the child. And, the child would behave again and again to receive that thing or event. Examples of rewards for children are eatables, toys, play materials, or even a simple verbal praise like saying 'Good'. It has been found that children can be taught to behave in certain desirable ways by appropriately arranging the giving of rewards after the occurrence of those behaviors. For example, children who receive clapping of hands for reciting a nursery rhyme are likely to recite them for receiving their liked reward.

There are many rules about what, how, when or how much to reward children. Always reward the child with something which s/he likes and NOT what you think the child might like. There are many ways to find out what rewards a given child would like to receive. You can simply ask the child directly. Or you could ask the parents, caregivers and friends of the child-someone who knows the child very well. Giving the same reward for the same activity each and every time will not work. Or giving too much of reward for a small activity done by the child is not going to help. Always reward only skill behaviors. Never reward a problem behavior. There are many other rules about giving rewards immediately, clearly,

consistently and constantly so that the child also understands those rules. Sometimes group reward techniques may be used when interacting with small groups of children. Story telling, for example, may be common reward for a whole class which finishes an assignment given by the teacher. One can also use dispensing of points for good behaviors and taking away some of those earned points for wrong behaviors. Later, a set of accumulated points can be exchanged for other things or activities liked by the child.

(b) Shaping

This technique involves the procedure of giving rewards for every small step or measure of success the child shows in performance of a learning task. For example, if a child is unable to say 'water' and the closest sound he can make is 'wa-wa', then shaping may be used to change 'wa-wa' through a sequence of utterances like 'wata', 'watah' to 'water'. Similarly, if a child is being taught to kick a ball in specified direction, one may reward initially even if the child stands near the ball. Gradually, you can shape the child's behavior by rewarding when the child gets closer to the ball, pushes the ball with his feet in any direction, kicks the ball in any direction and eventually kicks the ball in specified direction. The steps planned in shaping process must be very simple and easy to achieve. Also, the child should not be rewarded for the lower step after he has progressed and achieved the next higher step towards the target behavior.

(c) Prompting

This procedure involves giving active assistance, guidance, instructions and help for the child to perform a given learning activity. The current level of performance for any given teaching activity can be categorized

either as totally dependent, physical prompts, verbal prompts, cueing and independent. At the beginning of a teaching activity, physical prompts or manual assistance is used. For example, for teaching of body parts to a child, begin by holding the child's hands and assist him to touch and point his nose. Gradually use verbal prompts while you decrease physical prompts. Later, use only verbal or non-verbal cues before fading even that assistance completely.

(d) Chaining

We have seen that children learn better in simple and smaller steps. When these steps are sequential, chaining can be used as a method for teaching specific skill behaviors. There are two approaches to chaining. One can start at the first step and proceed to the last step (forward chaining) or vice versa (backward chaining).

(c) Modeling

Children learn a lot by imitation. They imitate behaviors of persons whom they consider as important. It may be their favorite teacher, parent, film star, friend, etc. Imitation is a powerful tool for teaching children through demonstration. The child must be guided to pay attention to every detail of the model. The model itself should be free from mistakes or blemishes during the performance of the target behavior.

(d) Generalization

Many times children learn a specific behavior in a particular setting. Then they may be required to perform the same behavior in another related setting. For example, a child learns to greet a teacher in classroom. Then the child learns to extend the same greeting to guests who come home. A

child may be taught to point vegetables in picture cards. Later, he must use that knowledge to point our real vegetables laid in front of him. This phenomenon is called generalization. Children with disabilities have problems in generalization.

Suggested Guidelines for Training Deficit Skill Behaviors

Sl. No.	Guidelines
1	Always begin a skill training activity with a clear objective on what to teach
2	The chosen should be such that it is easily achieved or taught in short time
3	Consider the child's age, sex, ability and your available time before choosing the goal
4	Always select a goal which has functional or utility value for the child and others around
5	Check whether the child has the necessary prerequisites for learning the chosen goal.
6	Break the chosen goal into small and convenient parts to make teaching simple
7	Ensure that enough practice sessions are given for the child to learn a given activity
8	Make sure that rewards are given to the child at the end of performance of an activity
9	Make use of appropriate and interesting toys or teaching aids
10	Avoid blaming or criticizing the child for errors during the learning process
11	Don't make any comparisons with other children who are learning or performing well
12	Always scold in private and praise in public
13	Avoid pressurize teaching. The child should not feel stressed to learn
14	Reward nonoccurrence of errors more than punishment of errors
15	Avoid compelling the child to perform when he is bored or tired

7.6 TECHNIQUES FOR DECREASING PROBLEM BEHAVIORS

In a previous section (4.4), the steps in identification and analysis of problem behaviors in children were explained. It was pointed that each problem behavior must be analyzed in terms of the what, where, when, with whom and why of its occurrence. Several functions were explained,

such as, attention seeking, self stimulation, rewards, escape, and skill deficits as being critical in the development of problem behaviors in children. There are several techniques for decreasing problem behaviors in children. Some of them are presented below:

(i) **Ignoring**

This is the technique of first choice for attention seeking problem behaviors. Never pay attention to the occurrence of such problem behaviors. For example, if a child cries or shouts to be lifted or carried around, be careful not to yield to such demands. Avoid begging or bargaining with the child to behave well. Many people commonly use the technique of diverting the attention of a problem child by showing or giving something else. This type of strategy will only indirectly teach the child to misbehave even more to get at least that 'something else'.

(ii) **Time Out**

Simple ignoring of problem behavior may not be effective in case of some children or for management of some problem behaviors. When ignored, some children may attempt to misbehave even more vigorously to get what they demand. They may become physically assaulting and damaging. In such cases, parents and caregivers must be advised on a more powerful technique of behavior management. Time out involves removal of the child from the rewarding situation or removal of the rewarding situation from the child. There are many forms of time out. A simple time out is telling the child to move out temporarily from the sphere of learning or where the activity is going on. A severe form of timeout may involve locking the child temporarily in a separate room. There are several do's

and don'ts about the use of time out. They should be used consistently, immediately and regularly following the target assaulting behaviors.

(iii) Differential Rewards

Differential rewards involve use of rewards for non-occurrence of problem behaviors. Many times we consider using strategies for reduction or elimination of problem behaviors in a child. But, we seldom give thought to rewarding nonoccurrence of problem behaviors. It is important to convey to the child that he or she has not misbehaved and therefore entitled to certain rewards.

(iv) Activity Scheduling

One of the reasons for occurrence of problem behaviors especially in children with disabilities is their lack of adequate stimulation. These children do not have adequate opportunities for learning, Even if they did, rewards are not sufficiently forthcoming. They lack the friends or leisure skills to keep themselves gainfully occupied. Therefore, appropriate activity schedules need to be made. This does not mean keeping them busy or engaged in just about anything or everything. It requires careful choice of activities appropriate for the age and developmental level of the child.

(v) Contingency Contracting

This technique is useful for implementation with older children. This technique involves declaring your expectations to the child about his behavior in clear terms. The conditions for occurrence of the behavior should also be specified. The consequences for performing or not performing the behavior must be clarified. For example, 'If Irfan keeps his belongings on the shelf everyday and not throw them around in the house

after returning from school for every day in a week, he would be rewarded with his favorite ice cream on Sunday!'

7.7 PLAY THERAPY

Play is a voluntary activity engaged for the enjoyment it gives without consideration of the end result. Play is also a medium through which the child is prepared to take up the role of adulthood. For infants and toddlers, play may be simply a medium for expending their surplus energy. There are many types of play observed in children depending on their age or developmental level.

At an infant level, the play activity may simply involve clasping both the fists and banging ones own mouth. At an older level, the toddler may be enthused with a toy or doll play. Play does not always mean purchase of expensive toys for children. Children with special needs have poor opportunities for play with peers. The so called normal children may refuse to accept these children as play partners. This may prompt these children to misbehave.

Play therapy becomes a medium for establishing relationships with children. It takes into account the social environment of the child (peers, family, friends and school) to bring about positive behavior changes in the children. Play therapy can be directive or non directive. In non-directive play therapy, the child decides what to do in a session within safe boundaries. In directive play therapy, the therapist leads the way. Play therapy is particularly effective with children who cannot or do not want to talk about their problems. There are stages in the development of play in children across various ages. It is important to understand and accept them

before planning sessions of play therapy with given age groups of children. The toys used during play must also be age appropriate.

An essential instrument in engaging kids constructively is the use of appropriate toys. Kids vary in the types of play they like to engage according to their physical or mental age levels. Adults are often at a loss about choosing the right kind of toys for their child. Toys need to be safe, simple, sturdy, accessible, durable, non toxic, portable, user friendly, age appropriate and teaching task oriented. They need not necessarily be expensive.

Toys entertain kids. But, they also educate them. Toys should not be given to children as teaching material alone. Once the child discovers the teaching intentions behind the use of a toy, s/he will not like it. None enjoys the feeling of learning as it involves effort, failures and fatigue. The toy based therapy must be free flowing, natural, spontaneous, curiosity provoking, exploratory and inquiring.

7.8 QUESTIONS

a. Define and differentiate behavior therapy and behavior modification..
b. Explain the meaning and significance of behavior analysis.
c. Bring out the significance of rewards in training children.
d. Highlight the techniques for teaching skill behaviors.
e. Highlight the techniques for reducing problem behaviors in children.
f. Discuss the meaning, significance and role of play therapy for children.

7.8 ANSWERS

a. 7.3 b. 7.4 c. 7.5 d. 7.5 e. 7.6 f. 7.7

7.10 KEY WORDS

Activity Scheduling	Behavior Analysis	Ignoring
Behavior Modification	Behavior Therapy	Modeling
Contingency Contract	Generalization	Prompting
Play Therapy	Problem Behavior	Shaping
Punishment	Skill Behavior	Reward
Time Out		

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GLOSSARY

Abstract Thinking:	Thinking characterized by the ability to use concepts and to make and understand generalizations like properties and patterns shared by a variety of specific items or events.
Activity Scheduling:	Timetabling of activities
Adaptive Behavior:	Refers to social competence of the individual in terms of proficiency related to self care, communication, social skills, locomotion and community orientation
Assessment:	Systematic collection, organization and interpretation of information about an individual and his situations in order to enable certain predictions about his behavior in new situations
Attitude:	Refers to the manner, disposition, feeling, thought or action towards a person or thing.
Autism:	A psychological disorder characterized by severe impairments in communication and social behaviors
Behavior Analysis:	A procedure of splitting each behavioral occurrence in terms of what happened before and after its occurrence in order to remedy them.
Behavior Therapy:	This refers to any act, task or program of treatment for a disease or disorder using principles of behavior modification or as those suggested by psychologists called as behaviorists.
Campaign:	An operation or series of operations undertaken to achieve a specific purpose, such as, fund raising campaign.

Case History:	A procedure of assessment wherein details are collected on or about an individual in a prescribed chronological order and related to personal details, past history, developmental history, academic and occupational history, etc.
Cephalocaudal:	Refers to a direction of development seen in infants wherein the head regions develop before the tail end regions
Child Development:	Series of progressive, orderly, sequential and predictable changes in behavior seen in children and spread over time
Chromosome:	Any of several thread like bodies consisting of chromatin that carry the genes. In human species there are 23 pairs of chromosome in each cell
Cognition:	Refers to higher mental processes including sensation, attention, concentration, perception, imagination, thinking, reasoning and problem solving.
Concrete Thinking:	Thinking characterized by a predominance of actual objects and events and the absence of concepts and generalization.
Congenital:	Refers to a condition present at the time of birth-either inherited or caused by environment, especially intrauterine environment
Contingency Contract:	A behavioral technique involving formation of a contract of 'if' and 'then'. 'If' the child performs a said behavior, 'then' he is entitled for a certain reward.
Counseling:	A professional verbal exchanges or interchanges given in directing the judgment and conduct of another person or for resolving personal conflicts and emotional problems.

Diagnosis:	The process of determining by examination he nature and circumstances of a diseased condition. This is usually done through case history, clinical examination, testing and interviewing significant others.
Disorder:	A psychological disorder characterized by short attention span, impulsivity and over activity in behaviors.
Environment:	The aggregate of surroundings including the things, events, persons, condition or influences on a person.
Epilepsy:	A disorder of the nervous system characterized by mild or episodic loss of consciousness, movement of certain parts of the body, passing of urine, etc.
Experimentation:	Refers to the act, process or practice of controlled testing of a phenomenon being investigated carried out with the purpose of discovering something unknown or verifying a statement or principle.
Formal Thinking:	A higher form of abstract thinking characterized by inclusion of mathematical concepts representing forms, designs and signs
Generalization:	Application of learning to real life situations or settings
Growth:	The quantitative changes in terms of size, shape, body build, weight or height in children or adults.
Heredity:	The transmission of genetic characteristics from parents to offspring.
Hormone:	Refers to certain powerful chemical compounds secreted by some internal organs called glands. Each hormone has certain specific functions to perform and have a powerful regulatory effect on the behaviors of an individual.
Hyperactivity:	Over activity

Ignoring:	A behavioral technique for correcting attention seeking behaviors
Intelligence Tests:	Tests or procedures to measure or determine the intelligence of an individual.
Intelligence:	The global capacity of an individual to think rationally, act purposefully and solve problems in life.
Interview:	An assessment technique/procedure involving verbal interactions between two or more individuals in order to elicit information about an individual/s.
Mainstreaming:	Refers to integration of children with special needs into conventional classes and school activities.
Maturation:	Biological unfolding of characteristics in an individual irrespective of the influence of learning or environment.
Media:	Refers to social means of communication such as radio, television, newspapers, and magazines to reach or influence people widely
Mental Retardation:	Refers to a condition of lower than average levels of intelligence in an individual and characterized by deficits in thinking, problem solving and adaptation to ones environment.
Milestones:	Important events in the life span of a child or individual
Misconception:	An erroneous idea or mistaken notion. It involves some misunderstanding or incorrect perception about any issue, person or thing.
Modeling:	A procedure of teaching or learning by observation
Behavior Modification:	See Behavior Therapy
Motor:	In psychology, pertains to muscular movement.

Natal:	Refers to events or happenings surrounding the time of birth
Normalization:	Refers to the efforts to make normal or as close to it as possible
Object Permanence:	Refers to the awareness that objects continue to exist even when they are no longer visible
Objectivity:	A state, quality or attitude of being impersonal, external or uninvolved during the process of study of a phenomenon
Observation:	An act or instance of noticing in a trained and scientific manner
Opinion:	A personal belief, estimate or judgment that rests on ground insufficient to produce complete certainty.
Phobia:	Anxiety or fear evoking circumscribed situation or object outside an individual which are not currently dangerous and yet perceived as so.
Play Therapy:	A form of therapy wherein play is used to remedy behaviors in children.
Post Natal:	Refers to events or happenings after delivery of child or its birth
Prejudice:	An unfavorable opinion, re conceived notion or feeling formed beforehand or without knowledge thought or reason
Prenatal:	Refers to events or happening before delivery of child or its birth
Problem Behavior:	Negative behaviors that cause stress on others; interfere learning or teaching and are age inappropriate or culturally inappropriate for the individual.

Prompting:	A teaching procedure of giving active assistance, guidance, instruction or help as the child learns specific subsets of target behaviors.
Proximo Distal:	Refers to a direction of development seen in infants wherein the central regions develop before the distal regions
Psychology:	The scientific study of human and animal behavior.
Public Education:	This refers to education mandated for or offered to the children of general public by the government. This is done by establishment of government sponsored schools for children of all class, creed or backgrounds. The term public education is also used in the context of educating the public on various issues.
Punishment:	Set of techniques to decrease the occurrence of a behavior
Intelligence Quotient:	Refers to the percentage product of ratio between mental age and chronological ages in older children and adults.
Developmental Quotient:	Refers to the percentage product of ratio between developmental age and chronological ages in a young children
Replication:	Refers to performance of an experiment or procedure more than once under similar conditions to verify if one is deriving the same results
Reward:	Things of pleasurable events that happen after a behavior and which makes that behavior to occur again and again

Developmental Schedules:	Tests or procedure to determine the developmental age/status of a child
Schizophrenia:	An acute or chronic severe mental disorder characterized by abnormal behaviors like sleep disturbances, withdrawal, irrelevant and incoherent speech, false beliefs, seeing things or visions in their actual absence, etc.
Self Esteem:	A realistic respect for or favorable impression about oneself
Sensory Motor:	Pertains to the sense organs as well as muscle movements
Shaping:	A teaching procedure of giving rewards in successive steps for subsets of behaviors approximated correctly towards a teaching objective.
Skill Behavior:	Positive or adaptive behaviors targeted for teaching children
Social Quotient:	Refers to the percentage product of ratio between social age and chronological ages in older children and adults.
Stereotypes:	A simplified or standardized conception or image invested with some special meaning and held in common by members of a group. For example, the stereotype of a mentally ill person as comical is common in many Indian movies
Testing:	A systematic procedure of sampling behaviors to make inferences on or about a person
Therapy:	This refers to any act, task or program of treatment for a disease or disorder. It could be a remedial, rehabilitative or curative process.
Time Out:	A behavioral procedure of controlling problem behaviors in a child by removing the child from a rewarding situation or removing the rewarding situation from the child.

2-SLM-Psychology

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