Psychology for My Child

TOPIC:

Psychology for my child.

WHY:

Psychology is a broad topic, and there are different psychologists who work in different areas. When working with children, psychologists usually are involved in the following ways:

Supporting young people with mental health concerns

Assisting young people to develop strategies to manage challenging behaviour

Assessing children for behaviour, mental health, and cognitive functioning

Working with parents, teachers and other professionals to holistically support the child

Providing training to stakeholdersHOW:Psychologists work in a variety of ways. For example, individual therapy, group therapy, parent support, school support, and assessing and report writing. Therapy usually involves an initial session to

talk about the current concerns and get a background history of the child, then between 6-12 sessions. Sometimes it may be more or less than this.

Who:

The main areas of psychology that work with children are:

- Clinical Psychology – Clinical psychologists support children or young people who may be experiencing psychologically-based distress or dysfunction that is impacting on their home life, schooling, social interaction or access to the community. They also promote well-being and personal development.
- Educational Psychology – Educational psychologists help children or young people who are experiencing problems that hinder their successful learning and participation in school and other activities. These problems can include a range of emotional and social problems or learning difficulties.

KEY TIPS:

- Effective psychology input requires engagement from not only the child, but from the parents (and schools) as well.
- Psychologists aren’t scary! Although they might talk about things that are difficult to talk about, they try to make sessions as relaxed and safe as possible.
- Psychologists understand that parents can often feel anxious, frustrated or overwhelmed with what is happening with their child. This is why psychologists may also do some work with parents to support them in supporting their child.

FURTHER INFORMATION

To find a Psychologist in your area, talk to your GP or visits the Australian Psychology Society here.

Take a look at our best Psychology resources and sites here.

INSAR 2019 – Conference Day 3

Hi everyone, Tim here. I've been in Montreal last week at the International Society of Autism Researchers (INSAR) annual conference. This conference brings autism researchers from around the world together to discuss and share the leading research into the autism spectrum.

Highlights from Day 3:

Transitioning into adulthood

Are healthcare providers ready to transition ASD teens to adulthood:

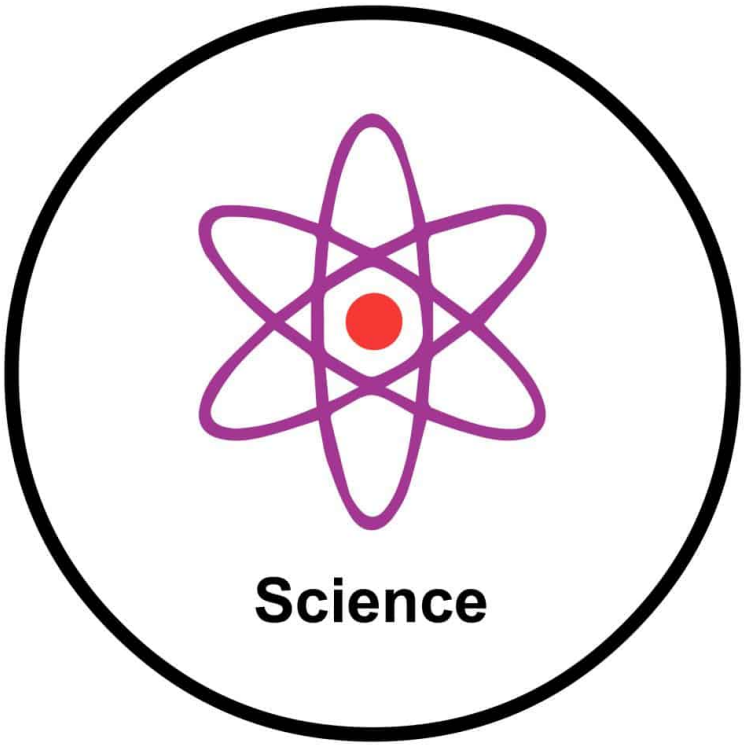
Lisa Croen discussed research into clinical providers in California and their ability to support teens transitioning into adulthood.

Sex differences in health outcomes:

Julie Taylor discussed sex differences in ASD health outcomes,

particularly in transition time points.

You can read more of Julie’s research here.



So much Science and Research over the last 3 days!

Take home message:

Services are often underfunded in supporting ASD teens transitioning to adulthood, and this group is often underserved. Ongoing research is required to provide input to governments and service providers on best practice for transitioning teens.

Also while at INSAR I have discovered so many other great resources, which we have listed below.

- Bostons Children’s Hospital
    - Wonderful stories on going into hospital and what to expect for those who need some preparation. We will be adding this to our resource page for Hospital and Emergency!
- Molehill Mountain

        - This was a new discovery for Look Hear from INSAR, we are yet to test it our selves but it looks awesome!
- Boston Medical Centre
    - This Centre has bucket loads of resources available, and are well thought out and visually pleasing. Also has information helpful for siblings too!
- Autism CRC
    - This is an Australian website that has loads of links to Universities throughout Australia and NZ, as well as lots of programs and resources available (we have done the Secret Agent Society Training and would recommend!!)

Happy Days! We hope you enjoyed our reflections on the INSAR Conference 2019!!

INSAR Conference 2019 – Day 2

Hi everyone, Tim here. I've been in Montreal last week at the International Society of Autism Researchers (INSAR) annual conference. This conference brings autism researchers from around the world together to discuss and share the leading research into the autism spectrum.

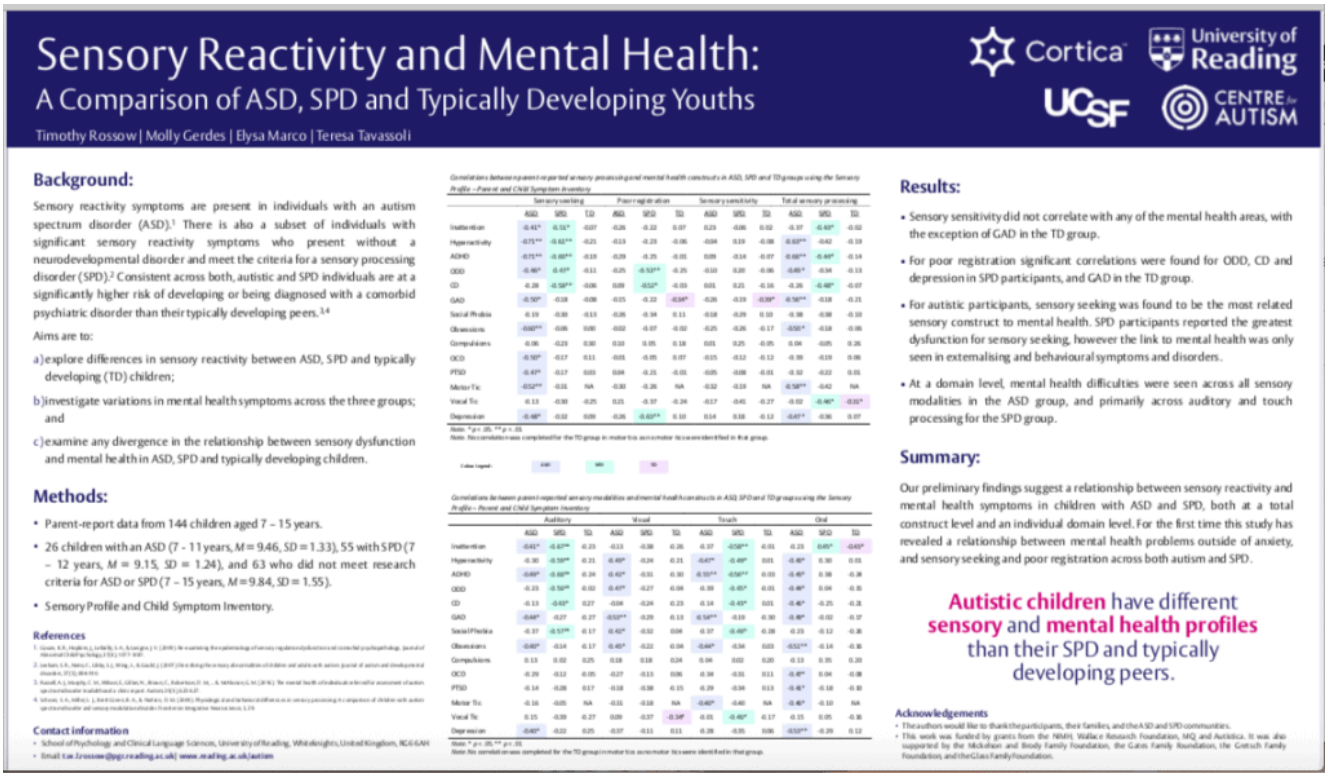
Highlights from Day 2:

Multimodal Measurement of Sensory Processing

Measuring sensory reactivity reliably:

Teresa Tavassoli discussed the difficulties in accurately measuring sensory reactivity in autistic individuals.

I am part of Teresa's team and you can find out more information here.



Sensory Reactivity and Mental Health:
A Comparison of ASD, SPD and Typically Developing Youths

Timothy Rossow | Molly Gerdes | Elysa Marco | Teresa Tavassoli

Cortica · University of Reading · UCSF · Centre for Autism

Background:

Sensory reactivity symptoms are present in individuals with an autism spectrum disorder (ASD).[1] There is also a subset of individuals with significant sensory reactivity symptoms who present without a neurodevelopmental disorder and meet the criteria for a sensory processing disorder (SPD).[2] Consistent across both, autistic and SPD individuals are at a significantly higher risk of developing or being diagnosed with a comorbid psychiatric disorder than their typically developing peers.[3,4]

Aims are to:

a) explore differences in sensory reactivity between ASD, SPD and typically developing (TD) children;

b) investigate variations in mental health symptoms across the three groups; and

c) examine any divergence in the relationship between sensory dysfunction and mental health in ASD, SPD and typically developing children.

Methods:

- Parent-report data from 144 children aged 7 – 15 years.
- 26 children with an ASD (7 - 11 years, *M* = 9.46, *SD* = 1.33), 55 with SPD (7 – 12 years, *M* = 9.15, *SD* = 1.24), and 63 who did not meet research criteria for ASD or SPD (7 – 15 years, *M* = 9.84, *SD* = 1.55).
- Sensory Profile and Child Symptom Inventory.

References

Contact information

- School of Psychology and Clinical Language Sciences, University of Reading, Whiteknights, United Kingdom, RG6 6AH
- Email: t.w.rossow@pgr.reading.ac.uk | www.reading.ac.uk/autism

Correlations between parent-reported sensory processing and mental health constructs in ASD, SPD and TD groups using the Sensory Profile – Parent and Child Symptom Inventory

	Sensory seeking			Poor registration			Sensory sensitivity			Total sensory processing		
	ASD	SPD	TD	ASD	SPD	TD	ASD	SPD	TD	ASD	SPD	TD
Inattention	-0.41*	-0.51*	-0.07	-0.26	-0.22	0.07	0.23	-0.06	0.02	-0.37	-0.49*	-0.02
Hyperactivity	-0.71**	-0.62**	-0.21	-0.13	-0.23	-0.06	-0.04	0.19	-0.08	-0.63**	-0.42	-0.19
ADHD	-0.71**	-0.80**	-0.19	-0.29	-0.25	-0.01	0.09	-0.14	-0.07	-0.66**	-0.66*	-0.14
ODD	-0.46*	-0.49*	-0.11	-0.25	-0.53**	-0.25	-0.10	0.20	-0.06	-0.45*	-0.34	-0.13
CD	-0.28	-0.58**	-0.06	0.09	-0.52*	-0.03	0.01	0.21	-0.16	-0.26	-0.48*	-0.07
GAD	-0.50*	-0.18	-0.08	-0.15	-0.22	-0.04*	-0.26	-0.19	-0.09*	-0.56**	-0.18	-0.21
Social Phobia	-0.19	-0.30	-0.13	-0.26	-0.34	0.11	-0.18	-0.29	0.10	-0.38	-0.38	-0.10
Obsessions	-0.60**	-0.06	0.00	-0.02	-0.07	-0.02	-0.25	-0.26	-0.17	-0.55*	-0.18	-0.06
Compulsions	-0.06	-0.23	0.30	0.10	0.05	0.18	0.01	0.25	-0.05	0.04	-0.05	0.26
OCD	-0.50*	-0.17	0.11	-0.01	-0.05	0.07	-0.15	-0.12	-0.12	-0.39	-0.19	0.06
PTSD	-0.47*	-0.17	0.03	0.04	-0.21	-0.01	-0.05	-0.08	-0.01	-0.32	-0.22	0.01
Motor Tic	-0.52**	-0.31	NA	-0.30	-0.26	NA	-0.32	-0.19	NA	-0.58**	-0.42	NA
Vocal Tic	-0.13	-0.30	-0.25	0.21	-0.37	-0.24	-0.17	-0.41	-0.27	-0.32	-0.46*	-0.31*
Depression	-0.48*	-0.32	0.09	-0.26	-0.67**	0.10	0.14	0.18	-0.12	-0.47*	-0.36	0.07

Note. *p < .05, **p < .01.
Note. No correlation was completed for the TD group in motor tics as no motor tics were identified in that group.

Correlations between parent-reported sensory modalities and mental health constructs in ASD, SPD and TD groups using the Sensory Profile – Parent and Child Symptom Inventory

	Auditory			Visual			Touch			Oral		
	ASD	SPD	TD	ASD	SPD	TD	ASD	SPD	TD	ASD	SPD	TD
Inattention	-0.41*	-0.67**	-0.23	-0.13	-0.38	-0.26	-0.37	-0.58**	-0.01	-0.23	-0.65*	-0.43*
Hyperactivity	-0.30	-0.59**	-0.21	-0.49*	-0.24	-0.21	-0.47*	-0.49*	0.01	-0.40*	-0.30	0.01
ADHD	-0.49*	-0.60**	-0.24	-0.42*	-0.31	-0.30	-0.55**	-0.56**	-0.03	-0.40*	-0.38	-0.28
ODD	-0.23	-0.50**	-0.02	-0.47*	-0.27	-0.04	-0.38	-0.45*	-0.01	-0.40*	-0.04	-0.35
CD	-0.13	-0.40*	0.27	-0.04	-0.24	-0.23	-0.14	-0.43*	0.01	-0.40*	-0.25	-0.31
GAD	-0.44*	-0.27	-0.27	-0.53**	-0.29	-0.13	-0.54**	-0.19	-0.30	-0.40*	-0.02	-0.17
Social Phobia	-0.37	-0.57**	-0.17	-0.42*	-0.32	-0.04	-0.37	-0.49*	-0.08	-0.23	-0.12	-0.36
Obsessions	-0.40*	-0.14	-0.17	-0.45*	-0.22	-0.04	-0.44*	-0.34	0.03	-0.51**	-0.14	-0.36
Compulsions	0.13	0.02	0.25	0.18	0.18	0.24	0.04	0.02	0.20	-0.13	0.35	0.20
OCD	-0.29	-0.12	-0.05	-0.27	-0.13	0.06	-0.34	-0.31	0.11	-0.47*	0.04	-0.38
PTSD	-0.14	-0.28	0.17	-0.18	-0.38	-0.15	-0.29	-0.34	0.13	-0.47*	-0.18	-0.30
Motor Tic	-0.16	-0.05	NA	-0.31	-0.18	NA	-0.40*	-0.40	NA	-0.40*	-0.10	NA
Vocal Tic	0.15	-0.39	-0.27	0.09	-0.37	-0.34*	-0.01	-0.40*	0.17	0.15	0.05	-0.36
Depression	-0.40*	-0.22	0.25	-0.37	-0.11	0.11	-0.28	-0.35	0.06	-0.53**	-0.29	0.12

Note. *p < .05, **p < .01.
Note. No correlation was completed for the TD group in motor tics as no motor tics were identified in that group.

Results:

- Sensory sensitivity did not correlate with any of the mental health areas, with the exception of GAD in the TD group.
- For poor registration significant correlations were found for ODD, CD and depression in SPD participants, and GAD in the TD group.
- For autistic participants, sensory seeking was found to be the most related sensory construct to mental health. SPD participants reported the greatest dysfunction for sensory seeking, however the link to mental health was only seen in externalising and behavioural symptoms and disorders.
- At a domain level, mental health difficulties were seen across all sensory modalities in the ASD group, and primarily across auditory and touch processing for the SPD group.

Summary:

Our preliminary findings suggest a relationship between sensory reactivity and mental health symptoms in children with ASD and SPD, both at a total construct level and an individual domain level. For the first time this study has revealed a relationship between mental health problems outside of anxiety, and sensory seeking and poor registration across both autism and SPD.

Autistic children have different **sensory** and **mental health profiles** than their SPD and typically developing peers.

Acknowledgements

- The authors would like to thank the participants, their families, and the ASD and SPD communities.
- This work was funded by grants from the NIMH, Wallace Research Foundation, MQ, and Autifica. It was also supported by the Mickelson and Brody Family Foundation, the Gates Family Foundation, the Gretsch Family Foundation, and the Glass Family Foundation.

This is my poster! You can find a downloadable version here.

Lessons from psychophysical studies of somatic sensation in autism:

Carissa Cascio spoke about psychophysics, and in particular how tactile perception relates to ASD traits.

You can find our more about Carissa's research here.

Neural habituation of sensory stimuli:

Shula Green described sensory over-responsivity and functional neuroimaging. She discussed differences in neural connectivity to touch and sound processing, particularly over time.

Relating abnormal tactile processing and cortical dysfunction in children with ASD:

Nick Puts continued the discussion on cortical differences in tactile processing in ASD individuals.

Take home message from these sessions:

The assessment of sensory reactivity in autistic individuals requires a multimodal approach that takes into consideration both questionnaire and observational methods. This should include measurement of perception (internal state) and not just reaction (external reaction).

Psychiatric Comorbidities

Adverse childhood experiences:

This talk by Amy Barrett highlighted the large percentage of ASD children who have adverse childhood experiences, including

trauma, and how this is often overlooked in research and in clinical settings.

You can find out more about Amy’s research here.

ASD and suicidal behaviours:

Paul Lipkin advised on his research on suicide behaviours in children and adolescents with autism and their access to medication and interventions. In particular, he looked at exploring factors contributing to suicidal behaviours.

Emotion dysregulation as a risk factor for suicide:

Caitlin Conner outlined her research and showed that increases in emotional dysregulation are correlated with higher reported suicidal ideation.

You can find out more here.

Depressed mood and interpretation of neuroscience data:

Katie Gotham spoke about how depressed mood in autism may obscure our interpretation of neuroscience research data. Analysing mood, anxiety and attention may help interpret research findings more accurately.

Group CBT for ASD and anxiety:

Audrey Blakeley-Smith presented on findings of a trial of group CBT for anxiety in a group of ASD teens with anxiety and intellectual disability.

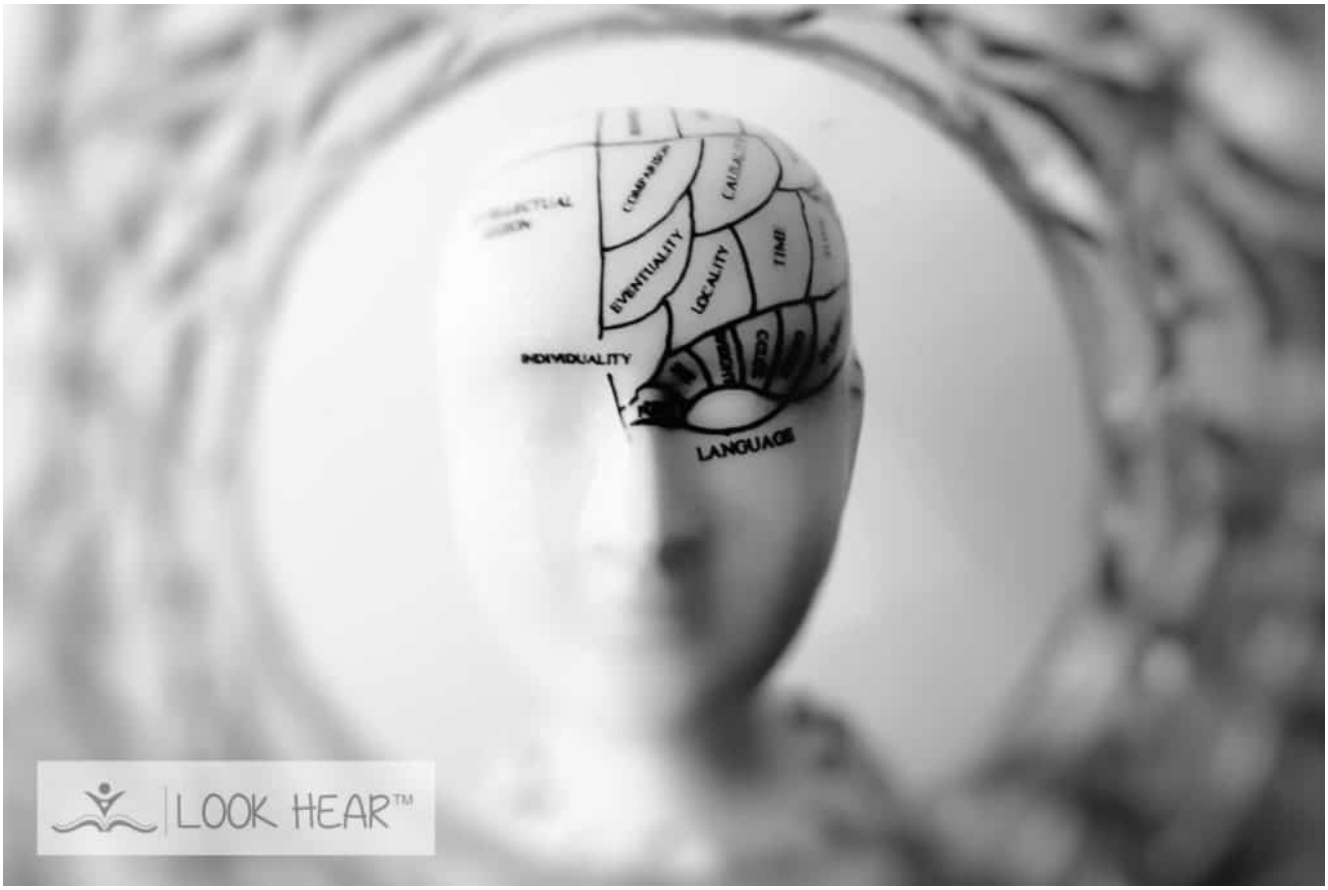
Executive functioning:

Laura Anthony discussed an online executive functioning

intervention – Unstuck. This online program allows for a self-paced, parent led intervention with tips and support.

Take home message:

Whilst research is making strides towards understanding psychopathology in autism, and in particular defining specific vulnerability profiles, there is still a lot to explore. Children with autism are also more likely to mask disorders like anxiety, or not be picked up by standard measures of psychopathology.



If you would like more information or resources, check out our pages on Mental Health or our HUGE Resource Library.

INSAR Conference 2019 – Day 1

Tim shares his reflections and information on the most up to date Autism research fresh from the INSAR Conference 2019!!

Five of the Most Common Questions Clinical Psychologists get asked!

TOPIC:

What are some of the most common questions Clinical Psychologists get asked?

Q: How long will treatment take?

A: Treatment depends on the age of the child, their presentation and type of therapy they are engaging in. Typically therapy would start with 6 sessions, after which there would be a review of the childs' progress. After the review the therapist and family would make further decisions about treatment together.

Further Info:

Talk to your therapist, as this is highly specific to the child and family situation.

Q: What is challenging behaviour?

A: Challenging Behaviour/s are any behaviours that have the potential to cause harm. This could include harm to self, harm to others (including animals), and damage to property. Challenging Behaviour any is behaviour that may also result in the child or young person being excluded from accessing community-based activities. This typically includes education, sporting activities, clubs, and community locations such as

shops.

Further Info:

Talk to your therapist if you are concerned about your child and possible challenging behaviours.

Q: What do you do in your sessions?

A: This again depends on the age of the child, their presentation and type of therapy they are engaging in. This can include therapy involving talking, play, art, and other techniques (however these may require the psychologist to have completed extra and specific training).

Further Info:

Talk to your therapist, as this is highly specific to the child and family situation.

Q: Why do you give parents homework?

A: Often parents will be given homework to reinforce what has been completed in the session/s. This is because the research tells us that when parents implement the suggestions from therapy at home, their children are more likely to make faster gains throughout their treatment. Parents who are engaged with their child's therapy are often more responsive to their child's needs. This means that they are often are more able and likely to identity and respond to problems when they arise. Sometimes therapists will give the parents themselves homework to help them to become more engaged in their child's journey. This may also include being giving tasks to help them identify and respond appropriately to their child's evolving needs.

Further Info:

Talk to your therapist, as it is important that the homework provided to you needs to fit in with what your child's therapist is working on.

Q: What training have you completed?

A: Psychologists in Australia, Europe and the UK have to complete a minimum of 6 years training to become registered

under the protected title of Psychologist. In Australia, this usually includes a four-year undergraduate degree, followed by two-year post graduate study (i.e. a Master's degree, Doctorate degree or supervised practice). In the UK, this usually includes a three-year undergraduate degree and then a three-year Doctorate degree.

Further Info for those interested in becoming a Clinical Psychologist:

APRHA which is the regulating body for Psychologists in Australia

Australian Psychological Society on how to become a Psychologist.

Take a look at our blog post about Being Family Focused!

Bullying – What is the evidence?

BULLYING – WHAT DOES THE EVIDENCE SAY?

Bullying can be defined as a subcategory of interpersonal aggression characteri

zed by intentionality, repetition, and an imbalance of power, often with the el

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Bullying can include direct physical harm (physical bullying), verbal taunts and threats (verbal bullying), exclusion, humiliation, and rumour-spreading (relational or social bullying), and electronic harassment using texts, e-mails, or online mediums (cyberbullying).

Prevalence?

Prevalence rates for bullying vary, however research reveals that between 10% and 33% of school children are victimised, and 5% – 12% of children bully others (Cassidy, 2009; Kessel Schneider, O'Donnell, Stueve, & Coulter, 2012; Perkins, Craig, & Perkins, 2011).

Developmentally, peer bullying is evident as early as preschool, peaking during early high school, then declining towards the end of high school (Currie et al., 2012; Vaillancourt, Trinh, et al., 2010).

The World Health Organisation reports that overall peer victimisation has been decreasing over previous years (Currie et al., 2012), however cyber bullying is increasing (Jones, Mitchell, & Finkelhor, 2013). One reason put forward is that students are often aware of rules prohibiting physical harm to others, but find verbal and social bullying more difficult to identify (Hymel & Swearer, 2015).

Current Research:

Current research reveals that bullies are socially intelligent (Björkqvist, Österman, & Kaukiainen, 2000) and can have considerable status in their peer groups (Vaillancourt et al., 2003). As such, adults may be less able to recognize bullying perpetrated by students who appear to be socially competent,

well-functioning individuals. Interventions should emphasise the interaction of individual vulnerabilities, context effects, and experiences with bullying and victimization. This includes understanding and addressing bullying as a systemic problem (Swearer & Hymel, 2015), and having schools implement school-wide, universal antibullying programs (Bradshaw, 2015).

FURTHER INFO:

Take a look our top resources on Social Skills and Education and Schooling.

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Children with additional

needs accessing hospitals – What does the evidence say?

WHAT DOES THE EVIDENCE SAY? Children with additional needs accessing hospital and emergency departments.

Through each developmental stage, children interpret, comprehend, and process the world in a variety of different ways. Children and adolescents having to be treated in hospital, especially children with additional needs, can find the experience of being poked and prodded by strangers quite confronting. Additionally, it can be developmentally appropriate for children to experience anxiety related to separation or body integrity whilst in hospital. As such there has been a relatively recent push by medical and allied health professionals to take into account the psychological needs of children on an individual and age-appropriate basis. In particular, the need for a calming and minimally disruptive environment that reduces anxiety and allays fear.

Research indicates that in addition to taking into

consideration a child’s age, developmental level and temperament when children are hospitalised, there are a number of other techniques that can be used to promote a minimally disruptive environment. These can include:

· Giving the child developmentally appropriate information regarding the medical procedure

· Encourage children to ask questions

· Developing distraction techniques (i.e. books, iPad apps, etc.)

· Developing relaxation skills (i.e. guided meditation, progressive muscle relaxation, etc.)

· Encouraging positive self-talk through coping statements (i.e. “I am strong”)

· Enhancing parent support

· Swaddling for infants

· Maintaining home routines while in hospital (i.e. wake and sleep times, school work, photos)

· Creating a predictable schedule for the child

· Providing choices for the child so as to create a level of control

· Incorporating consistent play into the child’s day

The available literature indicates that the benefits of professionals taking the time to incorporate these strategies range from decreasing anxiety, decreasing sensations of pain, and decreasing recovery periods.

FURTHER READING

Take a look out some of our resources on accessing the hospital/ ED here.

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