UNIT-9 Problems of Infancy

Learning Outcomes
By the end of this unit the learner will be able to:
✓ Discuss the Problems of Infancy. ✓ Identify the Treatment of Night-Time Fears and Nightmares.

Unit 9

Problems of Infancy

This information is based on bad behaviour disputes, such as oppositional and concentration problems. It will start by taking into account regular growing factors and normal answers of early behavioural disputes, then by describing, for each genre of problem, classification, prevalence, and stability.

Sleep Problems

Where children have sleep conflicts, especially problems such as discomfort and waking up in the middle of the night, parents have attempted over a group of months or years to fix the problem with failure, further family problems may happen that worsen the sleep problems. These problems are: tiredness, parental sadness, problems between parents, weakness in child and parental bonding, and a reduction in the amount and quality of social life.

Discomfort and waking up in the middle of the night are the most common problems, so they will be looked at first. Some people wake up in the middle of the night because of bad dreams, and these will be looked at second. Sleep horrors, sleepwalking, and other things will be looked at next.

Settling and Night-Waking Problems

Problems in falling asleep and waking in up in the middle of the night are usually some of the most common factors leading to problems sleeping among pre-school children.

Psychosocial things to do with comfort problems and waking up in the middle of the night are mum and child bonding problems and maternal worry or depression. When there is a tight mother-infant bond, the mother will leave the child enough time alone when settling or during waking up in the night to give self-soothing abilities to go back to sleep. In cases where a worrying mother-infant bonding has formed, the mother does not leave the child by themselves long enough before sleep or during waking up in the night to create self- soothing attributes.

Many children have problems with sleeping and settling down from birth. Other children create them after some precipitating occurrence or a group of things. Such precipitating things may be psychosocial. They could also be biological as well. Biological factors include serious disease or injury. Stress, especially separation from the mother (usually), or an occurrence that hurts the child or the family like a home robbery, all these are the more likely psychosocial things adding to the growing of settling and waking problems in children who have already created an ineffective sleep pattern. These things might lead to physical discomfort, worry and increased arousal with which the child is not able to function. So the child has problems going to sleep or going back to sleep after being woken up by physical discomfort or bad dreams.

Nightmares

Normally, the child wakes up unexpectedly in an environment of worry from a partially remembered, nightmare. At times, taking a while to fall asleep might happen.

Bad dreams, like other forms of worry, might be consistent by the child and members of the family. The taking-on of a risky emotional set, where the child is highly active and understands both thoughts and actions as threatening, might maintain the regularity of bad dreams. Nightmares might also be maintained by non-caring parent-child levels of attention within which children are not able to express their worries. Such non-caring levels of attention may go from scenes where there is parent-child problems, to those where disregard and physical or sexual abuse are happening.

Night Terrors, Sleepwalking, and Other Things

Night terrors are usually mistaken for nightmares. Nevertheless, there are obvious differences.

With night terrors, the child normally gets startled in bed and screams or gets out of the bed and moves quickly in fear, as if they are trying to get out of something. The child seems very scared and is not responsive to care. With nightmares, the child does not usually scream and they usually react to comforting. When they are waking up from a night terror, there is no in-depth remembrance of a clear dream, whereas this is an appropriate part of a bad dream. Night terrors usually happen in the first third of the sleep time, whereas nightmares normally happen in the second half of the sleep time.

In sleepwalking experiences, which can usually last for around 20 minutes, the child normally leaves the bed, might get changed, and walks unconditionally around the house and cannot wake up. The major risk with sleepwalking is that the child could harm themselves during the scene.

While all of these things might cause worry for the parent or child, the harm coming from head banging and tooth grinding is the major worry to do with this set of circumstances.

In some cases of epilepsy, attacks happen while sleeping, and these might involve movements and speech that can be interpreted wrongly by parents.

Day-Time Sleepiness

A large amount day-time naps in infants and children might happen because of interruption of night-time sleep caused by comfort problems or constant waking up in the night.

Breathing-subjected sleep abnormalities, in which the child is often aroused throughout the night due to breathing problems, is a second accepted aim of naps in children and adults. The ventilation problems might be because of central alveolar hypoventilation or sleep apnoea. With Central Alveolar

Hypoventilation, respiratory hypoventilation gets worse in sleep. However, there are no apnoea spell intervals. With sleep apnoea, the child has experiences 10 seconds or longer in which they stop breathing Normally, episodes of noisy snoring also take place.

Assessment

Upon further investigation of children with sleeping difficulties, it is vital to ask the child and the adult about information of the child's sleep patterns and about the psychosocial information within which these problematic sleep patterns happen, featuring a thought of predisposing, precipitating and keeping things.

Sleep Routines

Questions about sleep patterns and disputes should look at the following:

- Bed-time patterns
- Waking during the night patterns
- Day-time sleeping patterns

Bed-Time Routines

When enquiring about bed-time patterns, it is vital to find things that may encourage the growing of good sleep tendencies and those that might keep a bad sleeping routine.

Find out when the child is last fed and changed before putting to bed, since both hunger and a wet, uncomfortable nappy might stop the child from comforting. Enquire about who puts the child to bed, where and at what time this happens. If this occurs following a set routine, good sleep habits are being fostered. If the time, place and people involved in bed-time routines change erratically, this may be contributing to settling difficulties. Enquire about how adults act while the child is trying to fall asleep and how long this procedure takes. Enquire if the child is allowed to use self-soothing abilities or if the parent holds or feeds the child to relieve the child to sleep. Children who are let to master self-soothing skills aim to create good comforting traits. Where adults allow children to create these abilities, comforting disputes might happen. Long hibernating periods make adults tired and are very stressful.

Night-Waking Routines

Questions about waking up in the night routines should make clear first if bad dreams, night terrors, sleepwalking, sleep articulating, holding, head smashing, bruxism (teeth grinding), ventilation problems, or other things, which contribute to waking up in the night. Questions about when waking happens; how much it happens; the period the child stays awake; and how the comeback to sleep is managed should

also be created. As with looking at bed-time patterns, enquire if the child is allowed to use self-soothing abilities to go back to hibernation or if the parent holds or feeds the child to help the child fall asleep.

Day-Time Sleeping Routines

Day-time naps and playing routines should also be looked at, since day-time naps or inactivity may prevent night-time sleeping. In assessing day-time sleeping routines, the amount of day-time sleeping and circumstances surrounding day-time naps should be explored. In particular, inquiries should be made about the number of naps per day, the times at which they occur, the duration of each nap, whether they were initiated and ended by the child or the parent, and any factors that alter the child's typical pattern.

Sleep Diaries

Facts from assessment questionings may be given with sleep recordings. The sleep recordings kept in may be photocopied and made bigger onto an A3 sheet of paper or card for the parents to complete. It is essential for parents to have a sleep diary all through the course of assessment as well as treatment, as sleep recordings allow improvement or deterioration in sleep disputes to be looked at on a regular basis.

Predisposing Factors

Predisposing biological factors needing special looking at in assessment have perinatal difficulties, allergies, asthma, food intolerance, colic, and difficult behaviour to deal with. All of these things may make it hard for children to use self-soothing patterns to continue their arousal levels.

Precipitating Factors

While some sleeping disputes are there from birth, for others there are easily spotted precipitating things which need careful consideration. Biological factors which might allow the trigger of sleep problems include but are not limited to illnesses, injuries, or development of allergies. Stress, such as going to school, abuse, being harassed/bullied,and divorce of caregivers, are usual psychosocial things that may trigger sleep problems.

Maintaining Factors

Certain repetitive routines of attention between children and adults normally maintain some sleep problems. With lots of comfort problems and waking up in the night, the routine normally involves the adults letting the child to have longer day-time sleeps and not letting the child to have chances for self-soothing in the settling time or following waking up in the night. For the child, there is a continuous routine of getting the attention of the parent in soothing behaviour rather than helping with self-soothing behaviour. For calming down and waking up in the night problems related with bad dreams, parent-child bonds that step up a level rather than trigger the worry which finds emotion in the bad

dream which may keep the sleep disputes. The child's worry may be maintained by continual experiences which suggest a threat to the child's safety or confidence, such as regular bullying or abuse. In other settings, the worry might happen as a section of a reaction to a slight trauma. Where children are not given a care within which to stop worry to do with such trauma, and are willed on to overcome or stop experiencing the hurtful emotions and pictures of the trauma, these things may keep the regularity of bad dreams. With sleep apnoea, airway blocking might keep the breathing related sleep dispute. Night terrors, sleepwalking and other things are most likely kept by the nervous system.

When children have sleep problems, especially settling and night waking problems and adults have tried over a long time to solve the problems with little success, further family problems are created that might add to the sleep problems. Parents become tired. Their space to keep a team-working and happy marital relationship may get worse. Big arguments might happen in the middle of the night as the adults argue over how best to control the child's sleep problems. The worsening in the marital relationship and tiredness might lead to split of the couple's social life and a taking off in the amount and quality of support from people free to each person in the relationship. This lack of care might further stop their mental space to deal with the child's sleep problems.

As sleep problems continue, the quality of parent-child relationships might worsen. This may be from factors to do with other children in the family. When there are other children in the family who have not had sleep problems, parents may think the child with sleep problems is annoying and in contrast, they may think of the sibling without sleeping difficulties as well-behaved. When all children in the family have had sleeping difficulties, the parents' tolerance and mental space for good parent-child relationships may become damaged badly by their persistent sleep loss and tiredness. If there are no brothers or sisters, parents might become especially resentful that their once fun marriage has become prone to arguements as a consequence of the child's sleep problems. They might also come to question their quality as parents in the topic of their continuous inability to fix the child's sleep problems. When mums are pregnant with their second child and their first child continues to have sleep problems, there may be nxiety as the parents contemplte dealing with the continuing sleep problems of the firstborn child and the further needs of the new-born sibling. As with every family disputes, outside paranoia such as those to do with parental work experiences may further break the energy that parents have there to deal with the sleep problems.

Protective Factors and Family Resources

The chance that a sleep-management regime will work is encouraged by a mix of protective things do with the child and the family. It is vital that these be looked at and included in the later process, since it is protective things that normally go as the start for therapeutic change. Easy behaviour to deal with and a hope to fix the sleep dispute are two vital protective things to do with the child as a person.

Parental duties to fixing the dispute, tough parental discipline, safe parent-child bonding, marital success, the availability of social caring, and not much stress are important protective things.

Most parents will have tried a big mix of fixes to their children's sleep disputes before getting a clinical psychologist.

It is important to get a clear, in-depth account of each solution that was carried out, because often, true sleep-management methods have been carried out by parents but are not done for a sufficient amount of time or are done under bad settings. For example, parents who use consistent ignoring of night-time weeping for two nights, while on vacation in a caravan when their child has an ear problem may not help the child develop ways to sleep soundly, because it is an abnormal circumstance for both the child and the parents . However, the same method done for a larger amount of time, at home, when the child is well, may help the child create self-soothing abilities that will help them sleep and be less likely to arise at night. If it is advised that applications that have followed to defeat be attempted again. Such methods must be first talked about and explanations should be given as to why for the failure being answered.

Formulation

Good things from the investigation should be brought together into a conception which starts with a reasoning of the main things of the sleep disputes and then relates these to what causes and keeps these things. Protective things and family things that have consequences for fixing the dispute should also be talked about.

This concept creates the impression that some treatment goals might help for the foundations for making a treatment or plan, which helps control the problem goals might include the reduction in the length of time it takes for the child to settle and helping him to develop self-soothing skills so that he can return to sleep unaided when he awakes at night. A reduction in the length and amount of day-time naps and the giving of chances to improve self-soothing abilities are some methods thought of by the concept for getting these goals. Finally, the concept emphasises the information that if the management concept is to get past it must take into account the adult tiredness, worry and marital problems which has grown around the child's sleeping problems.

For each child, a specially formulated sleep-management programme is needed, since every child is different. These plans are created around the individual's needs. Here are some things that would be included in a programme:

- Step-by-step reduction or elimination of day-time hibernating
- Step-by-step reduction or elimination of pre-sleep feeds or drinks the growing of nice bed-time patterns

- Gradual or sudden movement of bed-time patterns from a time when the child is most common to sleep to an earlier time
- Gradual or sudden revision of chances to use self-soothing abilities while the child is first falling to sleep
- Gradual or sudden provision and opportunities to use self-soothing skills following waking up at night
- Teaching children in self-soothing relaxation abilities reward training and extinction

Reducing Day-Time Sleeping

Day-time naps may cause sleep problems at night. Napping might be put in place by activities that the child enjoys. Naps might have to be cut in half by waking the child after a set time has been reached. Parents find this way hard, because normally the child's day-time sleeping afford the tired parent a chance to nap or spend some time participating in something other than supporting the infant.

Eliminating Pre-Sleep Feeds

When children have big feeds before feeling comfortable, the time gap between these feeds and sleeping may be slowly extended and the duration of the last nappy change is made gradually closer to sleeping time. In settings of waking up in the night where children go back to sleep following feeding, the extent of these feeds may be made smaller step-by-step.

Developing Bed-Time Routines

Nice bed-time routines such as: cleaning, dressing, comforting, hugging a special doll or teddy bear, storytelling and singing, may be put into the pattern so that the child can learn fully what to have at sleeping time.

Reward Training and Extinction

Using a happy-face chart or small treats from a prize box might be used to show the right sleep-related behaviour, such as preparing to go to sleep at a set time; consuming the last drink of the day one hour before bed time; avoiding calling adults to the bedroom after they have said their final good night; and using self-soothing abilities the next night waking rather than going into the adults' bed. Rewarding these actions leads to the likelihood they will happen again and the child will develop the right sleep habits.
Wrong sleep-related behaviours may be used by ignoring them. Therefore, agreeing to begin the bed-time pattern or telling the parent to come to the room after the last decent night might be dismissed, and eventually these wrong habits will rarely recur. If the child understands that getting treats and being reinforced are being used to help them 'become a big girl/boy', and are not looked at as bad

consequences which assume the child as ‘a bad girl/boy’, then the opportunity of team-work and problem solving are highly likely.

The effectiveness of extinction, where children enter the parents’ bed, might be made better if parents act in a way, which sees a lack of emotion to return the child to bed straight away as they go into the parents’ bedroom and ignores being called to the room.

Treatment of Night-Time Fears and Nightmares

The reassurance among children that a bedroom provides a good environment and that nightmare are only thoughts and nothing more is the right way to manage this.

Normally, the fear of night-time and nightmares happen as a section of a wider reaction to a life setting that has concerns to the child’s safety, security or self-esteem. Bed-time fears and bad dreams might increase the child’s effort to progress and get power over harmful aspects of their current life situation.

In some settings, non-violent adults might be taught in listening to what their children are scared of and empathising with them. Parents might also be taught in teaching their children how to calm down to reduce arousal. This best way might be demonstrated by the therapist first and later the adults might be given feedback about their efforts to care for their child’s opening up of fears and to develop calming down and arousal-reduction abilities.

Managing Food Intolerance

Physical discomfort to do with cow’s milk intolerance was spotted as an important thing in causing sleep problems in about 10% of cases at a sleep clinic, and these things resulted in a normality of sleep routines after five weeks when milk related foods were taken out of the children’s diets (Kahn et al., 1989). Soya milk or goat’s milk might be used as differences to cow’s milk in some cases.

Potty-Training Problems

The making of bladder and bowel control happens in a manner in most children in the first few years of life. In the first few months of life the child is lacking control. Slowly, the child will have to develop better control of their bladder and bowels in the evening. This is followed by the making of bowel control in the day. Next, the child understands to control the bladder during the day. Many children by five years of age understand how to control their bladder at night. Most children follow this pattern. Although there is some difference within the group, girls achieve bowel and bladder control at a faster rate than boys. By four years old many children have developed bowel control and by five years of age most children have made bladder control.

Toileting

With toileting, consistent times for going to the toilet need to be recognised. For instance, there might be an agreement that the child will go to the toilet after each morning and evening meal. A programme for adult supervision of this schedule should be agreed. Where children have got a fear of going to the toilet due to previous painful experiences associated with toileting, a desensitisation method might be needed, in which the child is taught to be calm in the presence the fear, which comes in step by step.

With very young children who are extremely scared of sitting on the toilet, going in a nappy might at first can be used as the first reward of passing into a toilet. This is one factor, which can be used in a psychological method and is known as Behaviour Shaping. This is the sorting out of behaviour that is inappropriate and changing it step-by-step.

Accident Management

For school-aged children especially, a pattern for accident management needs to be established. Youths can be assisted by having a hygienic clean-up kit to put in their school bag. This might have inside it: clean underwear, tissues, wet wipes and a plastic bag for storing the soiled underwear.

Diet and Exercise

Where children have constipation issues, eating foods with a high-fibre content and six to eight glasses of water everyday day are essential. Fruit, vegetables, high fibre foods and breakfast cereals should all be an instrumental section of the child's diet and each meal should have a section of food with a high fibre content. Foods that slow down the movement of the bowels, which include, milk-based products, should be consumed from time-to-time. Sweets should be stopped for consumption before meals as they reduce appetite and make it harder for children to consume the high-fibre food, which is essential for decent bowel movement. A dietician may be called out on where advice on the making of a high-fibre diet for a special case that does not react to this simple thing is needed. Lots of daily exercise increases bowel movement and a timetable of such regular activity should be made in cases where children have made a healthy diet. Reward charts might be used to inspire children to stick to a normal diet and exercise patterns.

Biofeedback

With some cases, children might not have the ability to learn to realise when they are about to excrete.

In such cases, biofeedback may be a useful tool to the schedule described here (Olness et al., 1980). There is a large range in the time of effective care for children with encopresis. A good thing to do is regulate series of three or four paediatric arrangements, which are needed to look at the child's physical health and get rid of the mess. It is useful if the psychologist becomes active with the parents and child as early as possible, and the idea is for them to be provided with a first joint consultation with the

paediatrician and psychologist. During this time, the psychologist's major job is to teach the parents and child and sustain a good working alliance. After the first appointment, about six to ten more appointments with the psychologist looking at the bowel-retraining schedule explained above are normally needed. These appointments could be arranged over eighteen months, with first appointments happening on a weekly basis and later appointments happening less and less and less.

Learning and Communication Difficulties

Intellectual Disability

The occurrence of intellectual disability is about 2-3%. Of this bunch, 80% are in the mild section; 12% are in the moderate section; 7% belong to the severe section; and in the most severe category, there is only about 1%. Between 25-50% of cases have important conduct, emotional, or pervasive growing problems; 12-15% have difficulty seeing things; 8-20% have hearing problems; 15-30% have epilepsy; and 20 people in 100,000 have serious challenging behaviour (British Psychological Society, 1994).

Specific Language Delay

A difference might be made between secondary language delay (due to a learning disability, autism, hearing loss or another disability) and specific language delay. Specific language delays may be sub-categorised as expressive delays, which are the highest average and mixed accepted action delays, which are the bluntest. Children with this condition are very rare. With these differences, it is good to describe language problems in context of phonology, semantics, syntax, pragmatics, and fluency.

Phonology

Phonological problems are known as inaccurate speech of certain sounds, usually consonants rather than vowels. The following consonants tend to pose the most difficulties: r, l, f, v and s. Examples are omission, such as "ee" for sleep; substitution, such as berry for very; and bunch cropping, such as ream for cream. Where these phonological difficulties replicate a pre-schooler's problem in the abilities needed for the right pronunciation.

Semantics

With semantic problems, the child has a limited lexicon and so they understand the definition of a small amount of words and can only use a small amount of words to speak with individuals.

Syntax

People, who have difficulties with syntax or grammar, have a limited range of speech and a restricted range of speaking types. By two years old, most children should be using a fairly wide range of words. Children with certain language delays, formed by syntactical problems, are unable to use such a range of words. Later on, they are slow to utilise big sentences, such as 'Where is the ball that I was playing with yesterday'. They will be limited to using simple phrases, like, 'Where is the ball?' Correcting problems are estimated later when reading and spelling problems.

Pragmatics

Difficulties with pragmatics where children are not able to use language and actions within some relationships or environments to get their demands met or get certain communicational goals. Up to the age of two years old, linking gestures with speech is an important pragmatic ability. In pre-schoolers, up to the age of five, vital pragmatic abilities are used to tell flowing longer stories about events that have taken.

Fluency

Stuttering and cluttering are easily spotted fluency difficulties. This includes a fast rate of speech and a constant breakdown in fluency, and this involves repetitions, prolongations, and pauses that mess up the smooth flow of articulation.

Epidemiology

Up to 17% of two-year-olds, 8% of three-year-olds, and 3% of five-year-olds have expressive language delay. The male to female ratio is between 3:1 and 5:1. Most of children with certain language delays will recover by 5 years of age.

Specific Learning Disabilities

Up to 5% of children have specific learning disabilities and of these, reading disabilities are the most likely. Mostly likely, genetic factors plays a vital role in these disorders. Psychosocial things might stay in the secondary conduct and feelings difficulties that normally grow in youths with such disabilities. Psychometric evaluation followed by home-school communication and remedial tuition is the best form of decision.

Learning problems coming from traumatic brain injury usually take into account issues in recalling new things or recalling previously learned things, and are set in the DSM IV and ICD-10 as amnesic disease. Following a traumatic brain injury, children might demonstrate cognitive, attainment, and behavioural problems.

The impact of these problems is affected by biological things, which have to do with the injury. Important biological things for later improvement include: further complications, seizures, comas, and the length of traumatic amnesia. Taking control in cases of traumatic brain injury should have psycho-education, where prognostic facts are provided; periodic reassessment, where recovery is often looked at; and help on the controlling of memory difficulty, seizures, and the emotional and behavioural sequences of traumatic brain injury.

In choosing psychometric tests for usage in the studying of learning and communication issues, the availability of sensible norms and the adequacy of their reliability, validity and user friendliness should considered. In action, using a core test battery, with further tests added as needed, is an especially easy way to manage with the amount of cases needing psychometric viewing of learning and communication difficulties. In looking at any case, the impact of sensorimotor issues and medication things should be considered. Testing processes should be answered at the outset and should be done sensitively – to protect the emotions of both the parents and the children.

Standard testing processes should only be changed if defiantly needs to be to make room the child's unique disabilities. Tests should be precisely scored and feedback given sensitively. Team-work with parents and schools might follow. Early intervention activities for children with intellectual disability, either alone or accompanied by physical disability, have been shown to have an impact on later adjustment, and these activities focus on ability training for the child in conjunction with parent guidance and training.

Autism and Pervasive Developmental Disorders

Autism and other persuasive growing disabilities give big social, communicative and behavioural issues. The early and precise identification, evaluation and management of children with these issues is vital. Working with parents and teachers is vital to good practice in this section. As youngsters move towards adolescence, promoting abilities for independent living, in so far as that is possible within the limits given by the disability, becomes the one objective. The outcome for children with autism is not great. As much as 60% are not able to lead an independent life and only four per cent reach a section where they are seem like normal children.

Treatment

There is no cure for autism. At best, youths with autism may be helped to develop attributes to help partially for their interactive, cognitive and behavioural problems, and parents might be helped to deal with their children better so that youngsters and their families can lead as normal a life as they can.

Comprehensive programmes which exemplify best practice involve the following components:

- Psycho education in which parents are given facts about their child's diagnosis, prognosis, and available advice
- Advice and support in arranging educational placement
- Family-based view to long-term management
- Structured teaching as a vital method for designing learning activities
- Behaviour changing as a vital approach for teaching skills and dealing with challenging behaviour

Psycho Education

The first section in treatment is explaining the diagnosis and making the disorder understandable to parents. The points might be useful in describing autism. Autism is a disorder which is caused by biological things that are not understood very well. Children with autism cannot guess what others are thinking or feeling and so cannot predict their behaviour. They also have a tough wish to keep predictable patterns and to live in an orderly universe. These core hardships make it hard for them to share attention with others and jointly watch an event. They make it hard for autistic children to show warmth towards others, to empathise with others, to communicate effectively, to hold conversations which involve turn taking and respecting the other person's opinion, and to adapt flexibly to changing settings.

Predictability may lead to the growth of rigid routines and habits, which involves repetition. This may also lead to little creativity. People with autism also have a hard time developing a conscience, since this involves thinking of the effect that their actions have on individuals. The hard thing that people with autism have in thinking of what others think means that they may find other people (whom they view as unpredictable) very scary, especially if they disrupt their routines. This may lead to aggression towards others who attempt to change their routines. Usually, this aggression is explained in an extreme way, since the child with autism has a small amount of awareness of the impact the expression of aggression has on individuals. Repetitive self-harm, since it is highly predictable, may be experienced as wanted or as pleasurable.

In the long term, with well-organised teaching and skills teaching and especially if it is done in a predictable setting, youngsters with autism can learn to communicate with others, care for themselves, avoid challenging behaviour, and manage productive work patterns. The amount of independence they gain as adults depends on the level of structured teaching they get as children.

Educational Placement

A vital issue in the treatment of youngsters with autism is whether they should be put in special schools especially for children with autism, or whether they should be put in mainstream schools attended by

children without disabilities and given further support. No comparative data is available on which approach is most effective, so policy and practice decisions on this problem are influenced by ethical and pragmatic accounts.

Ethically, there is widespread agreement whether children with disabilities such as autism should be given every chance to live as normal a life as possible, and for this reason autistic children should be taught in mainstream schools with additional support given. However, it is usually hard to arrange for sufficient support within mainstream schools to be given to allow a child with autism to receive a good education within that context. It is often easier to focus the special educational resources needed for children with autism. Of course, national policy, the views of autism advocacy groups, and the way in which funding from statutory and voluntary sources is allocated all determine the availability of mainstream or centralised special educational placements.

Family-based Approach to Management

The emphasis in good programmes is on a team-working relationship with adults.

It is also acknowledged that parents need support from professionals and parents of other children with autism to help them get through the emotional process associated with adjusting to having a child with this disability.

Skills Training

Children with autism may have a range of problems in learning self-care and academic skills (Bregman and Gerdtz, 1997). In all examples, the syllabus materials should be matched to the child's developmental section. When a child is impaired by a low IQ or lack of language skills, simplified verbal or pictorial interaction methods might be used. Big tasks should be broken down into smaller, more manageable activities that make success more likely. Where children show a lack of initiative, they should be encouraged to choose the learning materials in which they are most interested, and the tasks should be structured so as to maximise success. So if the child is studying a new skill, trials of learning the new, new skill should be interspersed with trials of performing related skills that have already been mastered. Where children show a lack of concentration in studying a new skill, reinforcement should be put together so that it is delivered intermittently, on a variable interval or ratio routine. Nevertheless, when it is delivered, the child should get it straight away, and naturally occurring reinforces rather than contrived reinforces (such as sweets) should be used. Normality of skills learned in one context to lots of contexts is a big problem in the teaching of children with autism. Ideally, children should be encouraged and prompted to practice newly learned abilities in many different settings and are reinforced for doing so, since this maximises the chances of normality occurring.

Communication Training

In the context of speech and interaction, the speech and language syllabus should be driven to the growing level of the child. If there are some language attributes, these may be built upon. But where all linguistic skills are not present, then sign language might first be taught, as this might promote the later development of speech.

Challenging Behaviour

In every case where challenging behaviour is happening, a deep working analysis should first take place. Where challenging behaviours normally happen in response to recognisable environmental stimuli, in some cases, such stimuli may simply be removed. However, in many cases this is not possible because the stimulus is a big part of the child's environment, such as moving from one task to another or from home to school. In these cases, if the child is scared of the stimulus, they may be desensitised to it. If they feel that they are not able to deal with it, they may be coached in coping behaviours, such as, estimating the occurrence of the stimulus, relaxing or distracting themselves when the stimulus is there, and then they may be reinforced for coping with the stimulus.

Further Reading:

- ✓ ***Feeding Problems and Eating Disorders in Children and Adolescents,(1992) By A. Cooper***
- ✓ ***Social and Emotional Development in Infancy and Early Childhood, (2008), edited by Janette B. Benson, Marshall M. Haith***