childpsych PSYCHOLOGY PRACTICE
childpsych LEARNING CENTRE
childpsych:psychology practice and learning centre

childPSYCH News

A newsletter for professionals and parents

We have helped over 5000 children!

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APS Psychologists

We are now consulting in Springfield, Ipswich and Toowoomba!

COGMED

Concentration and Attention Problems?

The cogmed program consists of 25 training sessions of 30-40 minutes each, done over 5 weeks. It is the intensity of this training schedule that is critical to the program's success. The user/family sets the training schedule with the Cogmed Coach, with plenty of flexibility.

Autism Spectrum Disorder

The term "autism" was first put forward in 1911 to describe individual's with schizophrenia. In the 1940's Hans Asperger and Leo Kanner were researching childhood disorders that involved social relationship problems, abnormal language and repetitive interests and behaviours—but without the psychotic features of hallucinations and delusions. They coined the diagnostic labels of Autistic Disorder and Asperger's Disorder. In the last few years, these labels have been replaced by the diagnostic label of Autism Spectrum Disorder (ASD).

ASD is on the rise. There has been a 29% increase in the USA between 2008 and 2010. Not all of this increase can be explained by increased awareness or better diagnostic methods.

Lets first understand some of the core symptoms of ASD.

Some core symptoms

Social communication - The difficulties with social behaviour in ASD children effect many areas. For example, the ability to imitate another person, recognise faces and understand emotional expression, engage in pretend play etc.

Social imitation - Difficulty with spontaneously copying/imitating the motor movements of others has been well documented in children with ASD. The reason for this difficulty has been debated with some researchers arguing problems with the frontal lobe functioning are the cause, and other researchers stating that it is because the ASD child simply doesn't understand how to relate to other people.

"One study found that 50% of children with ASD had an anxiety disorder."

Joint attention - Infants gain an understanding of social information through eye contact and a gesture to show they are sharing a moment. Imagine an infant smiling back at the parent and touching the parents face. For ASD infants, they do not always smile back at the parent or mimic their parents smiles or follow them with their gaze.

Face perception –being able to "read" someone's facial expression is important for social development. Some researchers have shown that ASD children do not pay enough attention to key facial features such as the eyes and nose.

Repetitive behaviours - This symptom is perhaps the most known. It includes behaviours such as hand flapping, lining toys up, insistence on the same routine (e.g. Sitting in the same seat at the table) and restricted interests (e.g. only interested in Trains).

Other disorders that occur with Autism

As autism is considered a neurodevelopmental disorder, the probability that another neurodevelopmental problem is present is high. For example, language problems, learning difficulties and AD/HD all tend to co-occur with autism.

Research has shown that 50% of young children diagnosed with a severe language disorder are later diagnosed with autism. Expressive language problems occur at a higher rate in children with "high functioning autism" (i.e., average intelligence or higher) and in turn have difficulty with writing ("getting ideas on paper") and may have a learning disorder in the area of written expression (Dysgraphia).

Perhaps more concerning, is that there is increasing evidence that anxiety and depression are quite high. One study found that 50% of children with ASD had an anxiety disorder. Social anxiety disorder (social phobia) is one common anxiety disorder we see in our clinic.

Of course the overlap between AD/HD and ASD is also high. Studies have trouble agreeing on the exact rate of occurrence and usually state 33-78% of children with ASD will also be diagnosed with AD/HD. Unfortunately, when AD/HD is also diagnosed, it appears greater oppositional/defiant behaviour is present. It may be that the impulsivity that comes with AD/HD worsens the high anxiety/stress response seen in children with ASD.

Medically, seizures and sleep disturbance is common. There is no specific seizure type associated with ASD but they appear in childhood or adolescence.

Sleep disturbances occur in over 44% of children with ASD. Typically, falling asleep and remaining asleep are the main problems. It appears that children with ASD require less sleep than their peers, but nonetheless require assistance with improving their quality of sleep. Supplements such as Melatonin seem to improve sleep quality.

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Gastro intestinal difficulties

Gastro intestinal (GI) problems certainly occur at a higher rate in children with ASD. The level of anxiety is higher in ASD children with GI issues. In our practice we have been well aware of this link and part of our intervention involves seeking an examination of GI functioning from a medical professional.

Causes of Autism

There are many possible causes of ASD. Complications during pregnancy have been well identified. For example, the mother experiencing high fever whilst pregnant in the first and second trimester results in a two fold increase in risk. Type 2 diabetes in the mother is also a risk factor.

There is no specific gene that appears to cause autism. However, all of the genes appear to effect similar pathways in the brain that bring on the symptoms of Autism.

The link with toxins is still being researched. No studies to date have found a link between vaccines and autism. Researchers did look at the level of mercury in children with ASD but found that this was no greater or lesser than seen in any child.

Diagnosis of Autism

Some of you may have quickly worked out that diagnosis of autism has to be thorough. Not just to arrive at a diagnosis, but to also identify various factors related to the management of autism.

For example, an investigation of gastro intestinal factors should be part of the evaluation from a medical specialist. In addition, cognitive functioning, possible learning disorder and mental health concerns need to be evaluated by a psychologist. Speech pathologists evaluate the language skills but also the ability for the child to use language socially. Initial consideration of autism should start with either a psychologist or paediatric evaluation.

At childpsych we conduct developmental or cognitive assessments, conduct observations of the child as well as conduct diagnostic interviewing procedures to not only diagnose but also begin to develop a management plan. What if after all that we feel Autism is not present? Well, all the information assists us to still determine if another disorder is present and still helps with managing the child.

The assessment process should be more than looking for a diagnosis, it should explain *why* the child is behaving this way and *what* can be done about it!

child and family program™

The child and family program is part of our Community Conscience Program.

The child and family program is designed for families on a low income to access psychology services.

To be eligible for this program, legal guardians must hold in their name a:

1. Low income Health Care Card *OR*
2. Health Care Card *OR*
3. Pension Card **AND**
4. Be referred under the Better Access program (i.e., 10 session Mental Health Treatment Plan)

Contact our office for more information

Methods of identifying learning disorders

What is a learning disorder has been debated, revised, debated and revised over the last 50 years.

Researchers wanted to make a distinction between a learning *difficulty* and a learning *disorder*. The idea being that a learning disorder is unexpected given the learning potential of the child. For example, someone with an intellectual disability is expected to have learning problems so would be described as having " learning difficulties". However, someone of at least average intelligence with learning delays, is unexpected and likely has a learning disorder (e.g. Dyslexia).

As expected, researchers developed the IQ-Discrepancy method where a significant difference between your IQ score and academic test score helped diagnose a learning disorder.

In other words, a mathematical formula was created that involved inserting the IQ score into the equation.

However, over the years research showed that an IQ score really had little to do with learning difficulties.

In response, researchers began to use a " process approach" or "cross battery assessment". This approach identifying what underlying cognitive skills are related to the learning task and then determining if those areas were impaired. For example, phonological processing is related to reading. If the psychologist can show a significant weakness in phonological processing and poor reading skills then a learning disorder can be diagnosed.

But what about the whole learning potential thing? Well even though an IQ score is not used in determining a learning disorder, we still need to be able to show that the student is performing well below their learning potential. The current diagnostic criteria leaves it up to the assessing psychologist to show that the person essentially has Average intellectual ability.

So how do we diagnose a learning disorder? In essence cognitive assessments are used. These are traditionally IQ tests but over the last 10 years there has been a move away from traditional intelligence tests. For example, in our practice we favour the Woodcock Johnson Tests of Cognitive Abilities—3. This cognitive assessment tool assesses a broader range of skills related to literacy and numeracy. Remember how we discussed the need to link underlying cognitive processing problems to learning problems? Well it is important the right cognitive assessment tool is used in this process. Traditional IQ tests only assess limited cognitive skills.

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