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PSYCHOLOGY PRACTICE

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Volume 2, Issue 2

Term 2 2007

childPSYCH News

A newsletter for professionals and parents

Inside this issue:

We have moved!

Special points of interest:

- At *childpsych only* psychologists who are registered teachers will write the report on learning difficulties
- We offer a 5% discount for Health Care Card Holders
- To unsubscribe from this newsletter at any time, either email or call *childpsych*

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Bullying

Feature article by Philip Gosschalk MAPS, Principal Psychologist of *childpsych*

The term "bullying" is used flippantly at times. Bullying is generally defined as "repeated oppression, psychological or physical of a less powerful person or group of persons". The key points are that bullying is *repeated* and represents an *imbalance* of power. This article refers to bullying within the school system by children.

The most common form of bullying is teasing which is experienced by about 11% of boys and girls. In general, bullying seems to be experienced less than once a week by about 30% of children.

Victims of bullying tend to be timid, introverted, have few friends and are less physically strong than others.

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What are the implications of bullying?

Bullying, as it is defined here, has very serious implications. For most victim's, bullying lowers self esteem, isolates the child from their peers and increases absenteeism. Psychologists have long known that self esteem is important in offsetting later mental problems such as depression. We also know that children need to have friendships in order to buffer stress. Ongoing stress can bring on mental health problems in predisposed individuals. In our practice we have seen children so distressed by bullying that they have developed a traumatic reaction. A traumatic reaction can be seen where the child becomes clingy with the parents, has nightmares, avoids discussing or attending school and having a range of sleep problems. Some research suggests that those who have been victimised for a number of years may develop into adults who have difficulty with intimate relationships.

Do victims become bullies?

Some researchers have argued that some victims may redirect their anger at being bullied to another less powerful child than themselves. The issue is complex about victims who become bullies themselves. Socially there are some children who are considered "controversial". This means they are liked by some of their peers but not others. These children may be subjected to bullying by some peers and not others.

What do we know about bullies?

Only a few bullies have been victims themselves. Children who bully tend to be bigger and stronger than average, aggressive, impulsive, low in empathy and low in cooperation. It is more myth that bullies have low self-esteem and have few friends. This is why it is wrong to encourage victims to "fight back" - the victim is likely to end up feeling even less powerful.

The role of the family for bully's

Bully's are more likely to describe their family environment as: not sympathising with them or caring about them, being poorly supportive eof one another, parents who do not take an interest in their future aspirations and are inconsiderate about each other's feelings.

These research findings point out the importance of the family in promoting bullying. Of particular note are families that endorse toughness and dominance who may inadvertently be encouraging bullying in their children.

The role of the family for victim's

It seems that victims may come from family's that are the opposite of bully's. That is, victims may come from families that are overly protective or "wrapped up in each other". These families are sometimes referred to as "enmeshed". Children in these families may grow up feeling afraid of the world, lacking a self confidence and sense of independence.

What is the solution?

The solution requires school's to have clear policies on bullying and families to promote appropriate behaviour among its members. School's are very sensitive to

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Bullying con't

bullying and the vast majority have excellent procedures in place for managing bullying. These responses involve counselling for both the bully and victim as well as clear consequences about how bullying behaviour will be dealt with.

How are serious consequences of bullying managed?

However, there are instances where the victim is so devastated by the bullying that they require specialist psychological treatment. These are the victims of bullying we usually see. As discussed earlier, for these victims their symptoms resemble a traumatic response similar to Post Traumatic Stress Disorder (PTSD). For these victims treatment can take many sessions involving helping them discuss and make sense of what has happened. It often involves "processing" distressing memories using techniques such as guided imagery and relaxation.

When to seek the services of a psychologist

If the victim is exhibiting some of these symptoms then consult a psychologist:

1. Nightmares about being bullied
2. Increased anxiety about the world. For example, fear of going to the toilet alone, being burgled
3. Refusing to talk about being bullied
4. Irritable and sleeplessness
5. Appears to be in a daze

"there are instances where the victim is so devastated by the bullying that they require specialist psychological treatment"

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They're the most important thing in your life and sometimes they need our help

Selective Mutism

By Jean McCausland-Green
Clinical Psychologist with *childpsych*

Selective Mutism refers to the persistent failure of a child to speak in specific social situations where speaking is expected, such as school, day care or with playmates, despite speaking in other situations. Symptoms of Selective Mutism are primarily evident in school or with unfamiliar people as almost all children with Selective Mutism speak freely at home. Selective Mutism interferes with a child's educational and occupational achievement or with socialising. Teasing by other children is common. As might be expected, the children are usually described as being shy, timid, anxious, depressed, withdrawn and fearful. To gain a diagnosis of Selective Mutism a child must be mute for at least one month (but not during the first month of school in which shyness is common).

Age of onset is typically 3-6 years but mutism is not usually recognised until the start of school. It is more common among girls than boys and occurs in less than 1% of the population. However Selective Mutism may be under reported as some parents may attribute their child's symptoms to simple shyness or a problem that will be outgrown. In up to a third of such children, there is a history of speech and language disorders, and three quarters have had behavioural problems in infancy and early childhood.

The cause of Selective Mutism is unknown and it is much more likely to be due to temperament (personality) and anxiety factors.

The assessment of Selective Mutism by a psychologist or other practitioner should involve an interview with parents or other carers, the child and teachers or day-care providers. The assessment will attempt to determine the onset and course of the mutism, a developmental history of the child, medical history, and family history of mental illness.

Treatment of Selective Mutism closely involves parents—a strong emphasis in all our interventions at *childpsych*. A behavioural treatment approach called Cognitive Behaviour Therapy is the most successful with such children. For example, parents are advised on how to manage the child by encouraging the use of all forms of communication (verbal and gestures). The child receives rewards for increased speech or attempts at speech. A programme such as this is usually conducted over a number of sessions and needs to be carefully tailored to the needs of individual children in order to make it not too anxiety provoking.

What is Play Therapy?

Play therapy is an approach to helping children with their problems by using toys and other materials. It is most suited to children under eight years of age and used frequently at *childpsych*.

There are many approaches to play therapy that can be broken down into "directive" and "non-directive". In non-directive play therapy the therapist acts as a facilitator whereas in directive play therapy the therapist will be active during the play, much as children are when playing together. The use of either approach depends on the behaviour of concern. For example, non-directive play therapy seems to be effective at developing self esteem but not resolving issues the child would prefer to avoid discussing. At *childpsych* we generally prefer directive play therapy as it encourages the child to deal with issues they prefer to avoid. For example, if the children are upset about mum and dad separating then we may encourage the child to select toys that represent either parent as well as the therapist and so on. So instead of saying "mum and dad still love you", we would use toys during the game to show how the mother and father toy/characters would care for the toy who represents the child.