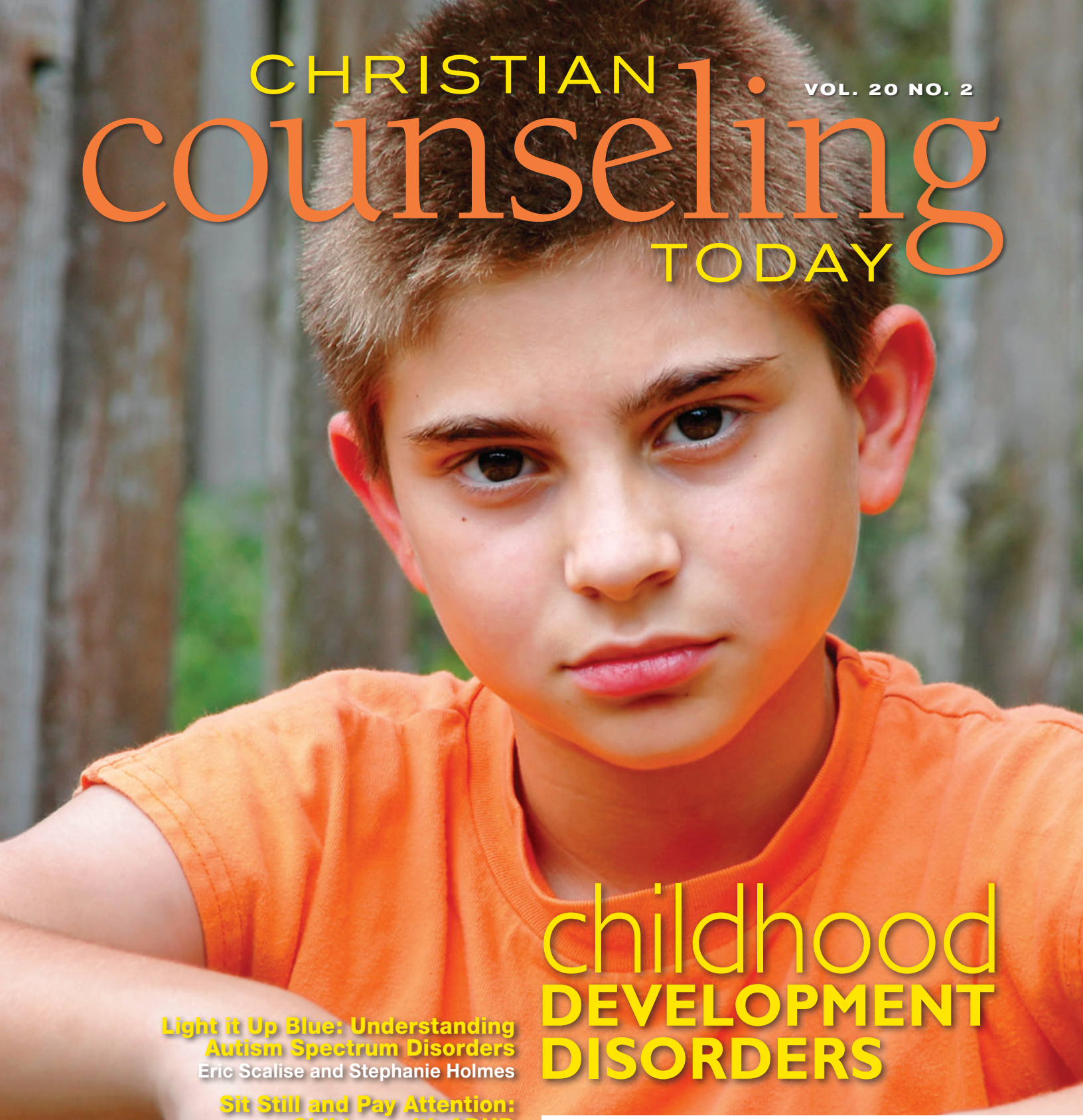
CHRISTIAN counseling TODAY

VOL. 20 NO. 2



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Executive Director, BCPPC

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Understanding and Caring for the Most Vulnerable Among Us

Approximately 25% of all children in the United States will experience at least one significant traumatic event before the age of 16, with 15% of girls and 6% of boys developing symptoms of post-traumatic stress disorder. Unintentional injury remains the leading cause of death among those aged 14 and younger, while nearly 38,000 injuries occur on a daily basis that require medical attention—nearly a half-million emergency room visits annually for traumatic brain injuries. More than 10,000 children are diagnosed with cancer every year, and the most common tumors are brain-related. Each year, somewhere between three to four million reports of childhood abuse and neglect are filed with state and local Child Protective Services (60% of all cases are under the age of 13). Over 800,000 minors are reported missing each year (2,200 times every single day). Minors account for 39% of the homeless population in the United States (almost half of those are under the age of five) and there are an estimated 1.3 million homeless and runaway street kids throughout the country. (Sources: Centers for Disease Control and Prevention, National Institutes of Health, U.S. Department of Health and Human Services, FBI National Crime Information Center, National Coalition for the Homeless)

The above statistics are staggering and can leave most people feeling overwhelmed. Many of these trauma-oriented life experiences can create significant emotional, cognitive, behavioral and relational obstacles that children and their families must face and overcome. However, some problems also arise, not so much as a result of certain incidents being perpetrated upon unsuspecting children, but simply due to complications during pregnancy or because of genetic and birth defects. Nevertheless, with 46 million children under the age of 11 (15% of the total U.S. census), this demographic cannot be summarily dismissed or ignored.

The Scriptures tell us that children are a gift of the Lord (Psalm 127:3). Jesus often blessed them (Matthew 19:13) and said the kingdom of God belongs to such as these (Luke 18:16). God's Word is also full of metaphors and examples of how we are His children and, as such, should walk with and serve Him in obedience and truth. We are to become childlike in our trust and humble ourselves if we want to be considered great in the kingdom of heaven (Matthew 18:2-5). Christ Himself came into the world as a newborn child. Understanding and engaging this population can be challenging and heartrending, as well as dynamic and extremely rewarding. The e-team felt that devoting an entire issue to children was relevant and worthwhile, especially when considering the potential "next generation" impact.

Therapeutic work with children often requires additional training and expertise due to a number of developmental factors that may be present and the need to have sufficient awareness regarding attachment theory, neurobiological considerations, and early life experiences, as well as the various nuances within most family relationships. When it comes to assessment, diagnostic conclusions and treatment interventions, an adept practitioner must be well-versed in systemic processes, behavioral approaches such as play therapy, and have the ability to connect and communicate with children at their level. While it is not necessary for every therapist to be able to complete a full psychological evaluation, the ability to understand the findings and incorporate specific recommendations is critical for effective counseling to take place. Albert Einstein once commented, "Play is the highest form of research."

In this particular issue of *CCT*, contributions cover a broad range of childhood disorders, assessment and diagnosis protocols, and evidenced-based treatment strategies. Cynthia Tobias shares that the ways in which our children need us may change and vary, but the fact they do need us never changes. Several articles include important revisions in the *DSM-5* that released in May 2013. Linda Mintle discusses frequently diagnosed (and misdiagnosed) Attention Deficit Hyperactivity Disorder, while Eric Scalise and Stephanie Holmes provide a timely and comprehensive piece on Autism Spectrum Disorders. Attachment-related disorders, including signs, symptoms, prevalence and treatment options are addressed by Joshua Straub, and the dual elimination problems (enuresis and encopresis) children sometimes wrestle with are covered by Trina Young Greer. On the important topic of intellectual and learning disabilities, child psychologist, Carrie Pagels, gives an overview of the stigmatization minors often face within school and community environments, as well as important educational and treatment considerations parents, teachers and mental health practitioners need to know for competent care. Finally, Steve Warren explores some of the factors that come into play when looking at violence and other behavioral disorders in children.

On one hand, to see the world through a child's eyes is to see the wonder of discovery, the beauty of innocence, and the hope that each day brings with it the promise of a brand-new adventure. On the other hand, to see the world through a child's eyes can also bring the terror of abusive and traumatic events, the loss of innocence, and the fear that each day brings with it a measure of uncertainty, doubt and still another loss.

Beyond the distinctions found in specific disorders, proper assessment and diagnosis is crucial to ensure children receive the right treatments and interventions for ongoing pro-social growth and change. Researcher and clinical supervisor, Gary Sibcy, provides an excellent overview of not only assessment strategies and instruments, but also treatment programs that have been subjected to rigorous research and represent a best practices review. Josephine Olson examines the therapeutic powers of play in promoting healing and resilience in children, and psychiatrist, John Kuhnley, apprises the reader when psychotropic medications are indicated and for what conditions.

On one hand, to see the world through a child's eyes is to see the wonder of discovery, the beauty of innocence, and the hope that each day brings with it the promise of a brand-new adventure. On the other hand, to see the world through a child's eyes can also bring the terror of abusive and traumatic events, the loss of innocence, and the fear that each day brings with it a measure of uncertainty, doubt and still another loss. Yet, it is the incredible power of childlike faith that often captures the heart of a believer and transforms a person into the presence of the Savior—accepting Him for who He is, trusting Him for the things that are not fully understood or seen, and knowing that in Him all things can, and will, work together for what is good. As Christian counselors and caregivers, we must preserve and protect, teach and empower, and bind up and heal those who are the most vulnerable among us.

LIGHT IT UP BLUE

Understanding Autism Spectrum Disorders

WHAT DO MUSIC COMPOSERS AMADEUS MOZART AND LUDWIG VAN BEETHOVEN, ARTISTS MICHELANGELO AND VINCENT VAN GOGH, PHYSICISTS SIR ISAAC NEWTON AND ALBERT EINSTEIN, RENAISSANCE POLYMATH LEONARDO DA VINCI, PRESIDENT THOMAS JEFFERSON, AND MICROSOFT FOUNDER BILL GATES HAVE IN COMMON? All are known or suspected of fitting somewhere on the autism spectrum. As a "spectrum" disorder, autism represents a wide array of symptoms—from mild to severe—that affect individuals differently; however, a common core of indicators influence the neurological development of social skills, empathy, communication, and flexible behavior. This developmental disability also crosses every racial, ethnic and socioeconomic group.

ERIC SCALISE AND STEPHANIE HOLMES

Autism is a label feared by parents, a challenge for educators, the subject of movies and books, often misunderstood, and sometimes caught up in the swirl of emotional controversy. So, what drives the need for greater recognition and has autism reached epidemic proportions? According to research estimates by the Centers for Disease Control and Prevention (CDC), one out of 88 children has been identified with Autism Spectrum Disorder (ASD), with boys (one in 54) about five times more likely to be diagnosed than girls (one in 252).[1] April 2nd of every year is now known as World Autism and Awareness Day, and Light It Up Blue is a global initiative that was created to help get the message out.

Dr. James Coplan, a neurodevelopmental pediatrician from the University of Pennsylvania School of Medicine, maintains the increase is primarily due to changes in diagnostic criteria. He states the way current statistics are reviewed is directly related to the number of children who receive services under the heading of ASD. Prior to 1975, there were few, if any, educational rights for "handicapped" children, so no definitive baseline exists. However, Dr. Martha Herbert, a pediatric neurologist at Harvard Research School of Medicine, believes otherwise. Her team examined the rise in rates as a function of the change in diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III)* to the *DSM-IV*. Yet, broadening of the criteria still accounts for only 400% of the 1,200% increase from the 1980s, leaving a staggering escalation of 800% in the last 25 years not attributable to changes in diagnostic benchmarks.

Much of the debate centers on *incidence* verses *prevalence* rates. Incidence refers to the number of new cases that emerge in the birthrate of a population. Prevalence is the percentage of a population affected by a disease or disorder. To qualify as an ASD epidemic, the incidence based on birthrate must be determined, and this is not known with absolute certainty. Nevertheless, research has clearly shown a significantly higher prevalence of ASD among the present generation, indicating an "explosion of ASD diagnosis," but not necessarily an epidemic.

Signs and Symptoms

Symptoms of ASD vary from person-to-person, generally falling into three categories: social

impairment, communication difficulties and repetitive/stereotyped behaviors. They manifest in a child's early developmental period and impair social, occupational or other areas of functioning. The *DSM-5* criteria include the following (severity is specified according to the need for support):[2]

a. Deficits in social communication and social interaction across multiple contexts
- In social-emotional reciprocity, ranging from an abnormal social approach; to a reduced sharing of interests, emotions or affect; to the failure to initiate or respond to social interactions.
- In nonverbal communication behaviors used for social interaction, ranging from poorly integrated verbal-nonverbal communication; to abnormalities in eye contact and body language; to a total lack of facial expressions and nonverbals.
- In developing, maintaining and understanding relationships, ranging from difficulties in adjusting behavior to fit various social contexts; to difficulties in sharing imaginative play or in making friends; to the absence of interest in peers.

b. Restricted and repetitive patterns of behavior, interests or activities
- Stereotyped or repetitive motor movements, use of objects, or speech (e.g., lining up toys, echolalia, idiosyncratic phrases, etc.).
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal/nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, etc.).
- Highly restricted, fixated interests that are abnormal in focus and intensity.
- Hyper- or hypo-reactivity to sensory input or an unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse responses to specific sounds or textures, excessive smelling/touching of objects, visual fascination with lights or movement, etc.).

In the *DSM-IV*, Asperger's Syndrome (named after pediatrician Hans Asperger) was added to the category of Pervasive Development Disorders and referred to as part of the autism spectrum. Since that time, Asperger's has become a common term in the fields of medicine, psychology, and education. A controversial change in the *DSM-5* is the removal of Asperger's Syndrome as a distinct disorder. The *DSM* revision team decided the term, "autism," was too broad and, hence, was responsible for the increase in autism diagnoses over the past 20 years. The main debate centered on whether "Kanner" or "classical" autism (named after child psychiatrist, Leo Kanner) is clinically significant from Asperger's. In the *DSM-IV* and *DSM-IV-TR*, autism included Classic Autism, Asperger's Syndrome, Childhood Disintegrative Disorder,

Rhett's Syndrome, Tourette's Syndrome, and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), as well as atypical autism.

The Yale School of Medicine analyzed people currently diagnosed with *DSM-IV* criteria and then applied the new *DSM-5* standard on the sample.[3] The updated criteria resulted in 75% of the sample retaining the diagnosis. The majority of the remaining 25% were those previously diagnosed with PDDNOS or Asperger's Syndrome. One major concern for treatment professionals, as well as the parents of a disordered child, is that those who are considered as "higher functioning" may be excluded from the diagnosis and, therefore, much needed services within the educational system.

Dr. Tony Attwood, a world-renowned autism expert, argues that even though the *DSM-5* may exclude Asperger's Syndrome, the ICD-9/ICD-10 (the medical classification system used by the World Health Organization) retained the terminology and distinction. According to Attwood, those with Asperger's (sometimes called Aspies) are usually not diagnosed until the ages of eight to 11 and perhaps later for girls (10–13). The problem lies with the new *DSM-5* criteria where clinical impairment must be noted before the child turns three. Unfortunately, associated symptoms may not be recognized until the child is school age and struggling with psychosocial skill development among peers. Advocates for Asperger's as a separate disorder must wait to see what the impact will be on future diagnoses, treatment interventions and resource availability.

Since Asperger's is a relatively recent term, many went through childhood, adolescence, and early adulthood undiagnosed, especially women who blend into mainstream culture better. More adults are being diagnosed in their late 20s and early 30s today. Asperger's also affects marriage since Aspies grapple with reciprocal conversation and have difficulty showing empathy and love. Studies reveal that 80% of marriages with an Aspie partner end in divorce. There is scant information available on counseling Aspie couples, but traditional marriage counseling tends to be unsuccessful and non-ASD spouses need to be better educated.

Etiological Factors

The exact causes of ASD are not fully understood or universally agreed upon. Possible triggers

Assessing and diagnosing ASD is complex and time-consuming. It can be several years after signs and symptoms first appear before an "official" diagnosis is given. This tendency may have something to do with a lack of awareness on the part of parents, understandable caution over misdiagnosing a child's condition, or concerns regarding a potentially damaging "label."

include genetic/chromosomal abnormalities or syndromes (seen generationally), severe infections that impact the brain (e.g., meningitis, encephalitis, celiac disease), metabolic or neurological factors, and exposure to certain toxins or illness during pregnancy (e.g., rubella, some chemicals). Additional considerations include certain prescription drugs taken during pregnancy, such as valproic acid (brand name – Depakote, a mood-stabilizing drug used to treat epilepsy and migraines), maternal gestational diabetes, bleeding after the first trimester, and premature and/or low weight births in children. Neuroanatomical studies point to a possible link regarding a combination of brain enlargement in some areas and brain reduction in others during pre and early postnatal development. Other studies are beginning to explore the potential connection between ASD and certain comorbid conditions in a person's peripheral nervous, immune and gastrointestinal systems.

There are many who believe childhood vaccines, especially the measles-mumps-rubella (MMR) vaccine, are a primary contributor to ASD. This particular controversy was based on a 1998 article by British physician, Andrew Wakefield. The study was partially retracted in 2004, fully retracted in 2010, and Dr. Wakefield was subsequently stripped of his medical license for unethical conduct related to his research. Following the initial claims made by Dr. Wakefield, several large epidemiological studies were commissioned by the CDC, the American Academy of Pediatrics, the Institute of Medicine, and the U.S. National Academy of Sciences, all of which failed to corroborate the original findings. Nevertheless, some individuals continue to inquire whether or not certain vaccines can "activate" genetic triggers already present, thereby resulting in the development of ASD.

Assessment and Diagnosis

Assessing and diagnosing ASD is complex and time-consuming. It can be several years after signs and symptoms first appear before an "official" diagnosis is given. This tendency may have something to do with a lack of awareness on the part of parents, understandable caution over misdiagnosing a child's condition, or concerns regarding a potentially damaging "label." Screening for ASD is usually comprehensive as there is no single medical test to confirm a diagnosis. Multiple evaluations by healthcare professionals who specialize in developmental disorders are usually necessary (e.g., child psychologists, child psychiatrists, speech pathologists, audiologists, developmental pediatricians, pediatric neurologists, special education teachers). Diagnostic assessments typically include a parental interview; a medical exam, which may incorporate neurological and genetic testing; a hearing test to rule out other audiological problems; and screening for lead poisoning because of its ability to mimic autistic-like symptoms. Other evaluative measures may comprise of speech and language assessments, cognitive testing, adaptive functioning (e.g., the ability to problem solve and demonstrate appropriate social, verbal and nonverbal skills), and sensory-motor assessment.

Interventions and Treatment Protocols

There are various opinions about "curing," or "reversing symptoms" of ASD. Most researchers understand ASD as a lifelong *pervasive* developmental disorder and, therefore, it is usually not discussed in terms of a cure. However, early diagnosis and treatment consistently utilizing a broad range of tailored interventions are believed to be the key. With standard protocols, it is often imperative to have medical supervision (an experienced M.D. or Dr. of Osteopathic Medicine) due to related health risks.

Educational Services: By law, schools are not required to provide assistance absent a current (within three years), formal diagnosis. Once a diagnosis is established, a meeting for special services can be scheduled at the child's school, which then makes him or her eligible for services under the Individuals with Disabilities Education Act (IDEA). Parents need to brace themselves for what may be a tumultuous journey, especially when the student is on the higher functioning end of the spectrum. Many states have an Autism Society or Autism Advocacy groups who understand state/federal laws regarding special services and can help parents navigate the "system."

An Individualized Education Plan (IEP) is developed based on test scores, teacher observations, and professional recommendations. Resources available to children can include small group settings for taking tests/quizzes, extra time to complete assignments, occupational/speech therapy, social skills training, guidance/counseling for anxiety and transition and, in some cases, one-to-one staff support for children who can do the mainstream work, but require behavior assistance. School files typically will not follow into adult life because a diagnostic label for the purpose of educational intervention

ends at 12th grade. However, the correct diagnosis can make a world of difference in resources and tools for a student from grades K–12.

Occupational Therapy: Finding an occupational therapist (OT) outside the school setting who understands and works with ASD children and Sensory Processing Disorder (SPD) is important. Many children struggle with fine motor skills (e.g., holding a pencil, tying shoes, working a zipper), daily living skills, personal space issues, sensory issues, and self-injury. An OT will evaluate and help determine a tailored plan of action.

Physical Therapy: ASD children also struggle with gross motor skills (e.g., sitting in a chair, their walking gait, skipping, running, standing without falling over). Many students have underdeveloped muscle groups that could be strengthened through physical therapy (PT). Available PT options include dance and movement, gymnastic-type skill building, aquatic therapy, Hippotherapy (uses the characteristic movements of a horse to provide sensorimotor input), martial arts, and various types of play therapy. A good PT evaluation can help parents make choices for their children's muscle tone and muscle group development.

Applied Behavioral Analysis (ABA): ABA (a form of behavior modification that excludes hypothetical constructs) can foster basic skills such as looking, listening and imitating, as well as complex skills such as reading, conversing and understanding another person's perspective. It can involve additional cost, but has been clinically shown to improve the behavioral aspects of ASD children.

Social Skills Training: Many children do not grasp social context (e.g., how to read people's body posture or tone, initiate or maintain conversations, initiate play/friendships, or recognize bullying or mean behavior toward them). This is more related to social IQ or etiquette and there are tools parents can incorporate in conjunction with a therapist. Pivotal Response Training for self-management and Developmental, Individual Differences, Relationship-based Approach (DIR, also called "Floortime")™ are two examples.

Cognitive-Behavioral Therapy (CBT): ASD is not a mental disease or disorder, yet is often comorbid with Attention Deficit Disorder, Obsessive Compulsive Disorder, anxiety disorders, emotional dysregulation and other behavioral issues. Children will eventually realize they are "different" than their peers and may need help processing these differences. Individuals often struggle with anxiety and depression (normal markers may be masked) and the upward trend of ASD-related teen suicide has become alarming (60% contemplate suicide by age 13). Having a competent therapist is a valuable asset to families as they navigate educational milestones and new challenges awaiting each transition.

Medical Supervision: Many in the mainstream medical community believe autism is primarily caused by genetic and structural deficits, thereby emphasizing a combination of behavioral therapies and pharmaceutical treatments. Other professionals, however, strongly believe ASD results more from biomedical factors (toxins, immune deficiencies, gastrointestinal inflammation). The Defeat Autism Now (DAN!) project, created by the Autism Research Institute, outlined an approach to treatment called the "DAN! Protocol" based on the biomedical theory. Here, doctors often recommend chelation (removing heavy metals from the body, especially lead, mercury and arsenic), vitamins and supplements, a gluten/casein-free (GFCF) diet and various options of detoxing before considering biomedical treatment.

While ASD remains a complex issue requiring ongoing research, a proactive approach with children and their families is important—letting them know that "different" does not mean defective or less than. The promise of Jeremiah 29:11 is inclusive for all those with Autism Spectrum Disorder: "'For I know the plans I have for you,' declares the Lord, 'plans to prosper you and not to harm you, plans to give you hope and a future'" (NIV). ✠

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Sit Still and Pay Attention CHILDREN WITH ADHD

Every time I go on talk radio in which listeners are able to call in with questions, I inevitable get these two: "Are we overmedicating our children?" and "Why do we have so many children now diagnosed with ADHD (Attention Deficit Hyperactivity Disorder)?" Some callers even question the validity of the diagnosis as a legitimate disorder. They want to know if their children, who seem unable to sit still and pay attention, have ADHD or if they are just being kids who are unnecessarily labeled? With ADHD now a household word, the professional mental health community needs to take responsibility for making sure the right children are being treated and that treatment works, especially when we are working with preschoolers.

ADHD on the Rise

Parents asking questions have reasonable concerns. The Centers for Disease Control and Prevention (CDC) confirm ADHD diagnoses are on the rise and that approximately 4.5 million children under the age of 18 are diagnosed with this disorder, and 2.5 million regularly use stimulant medications.[1] Explanations provided for the growth in numbers are both positive and negative.

First, ADHD is a legitimate diagnosis related to underlying neurological conditions. It is a brain-based biological disorder that can be detected by brain scans and imaging. Chemical differences have been found in the ADHD brain when compared to non ADHD children. Furthermore, current evidence suggests that ADHD has a genetic component, so the question of legitimacy is easily answered. According to the *DSM-5*, ADHD is characterized by a pattern of behavior, which is present in multiple settings (e.g., home and school) that can result in performance issues. Symptoms fall into two primary categories—inattention and hyperactivity/impulsivity—and tend to manifest in behaviors such as failing to pay attention, difficulty in organizing tasks and activities, excessive talking, fidgeting, etc.

In terms of the rising numbers of ADHD children, positive explanations include greater awareness of the condition and better access to competent care. Decades ago, we did not do a good job of identifying children with this disorder. Now, more minors are benefiting from early detection and treatment.

On the negative side, there is evidence to suggest that frequent misdiagnosis does occur. A study by Michigan State University researcher, Todd Elder, posits that almost a million

LINDA MINTLE


When a child enters kindergarten at a younger age than his or her peers, teachers may confuse immaturity for ADHD.

children have been misdiagnosed.[2] Of the many variables Elder and other researchers studied, the child's age when entering school was a key factor in overreporting ADHD.

When a child enters kindergarten at a younger age than his or her peers, teachers may confuse immaturity for ADHD. Elder found that the younger the child was compared to peers, the more likely the diagnosis. Holding back a child one year significantly decreased the probability of a positive determination. Because teachers play a vital role in referrals for mental health services, children who are young for their grade may be more at risk for misdiagnosis.[3] I saw this happen at my own child's school. The age range of kindergartner boys ranged from four to seven-years-old. You can imagine how this age spread impacted maturity levels within the classroom. I noticed the teacher had more concerns about the younger boys in terms of their behavior and ability to stay on task. She repeatedly talked to parents, suggesting they might want their children evaluated for ADHD. Conversely, Elder also noted that the *oldest* child in the classroom could be at risk for *underdiagnosis* because he or she is compared to younger counterparts who are likely to be more immature. Thus, assessing children by using within-grade standards can be a problem when it comes to ADHD diagnoses.[4]

Misdiagnosis and Physical Effects

Misdiagnosis is also troubling because of the potential long-term physical side effects of using certain medications to treat ADHD. When Elder reviewed the literature base looking for existing studies that have investigated the effects of methylphenidate (Ritalin) on children who do *not* have ADHD, he could not find any. This means we are not absolutely sure how commonly prescribed medications impact those with incorrect diagnoses. However, a 2006 study by Biederman and Faraone found that users of extended-release methylphenidate delivery systems had elevated pulse rates and blood pressure throughout

the course of treatment.[5] Because the data does not sort out who is correctly or incorrectly diagnosed, cardiovascular health is a potential issue for both groups using medications.

Another negative physical concern is how ADHD medications affect child growth patterns. The National Institute of Mental Health (NIMH) Multimodal Treatment Study of ADHD examined this issue and found that ADHD medications radically reduce child growth rates.[6] Thus, chronic use of stimulant medications with children who do not have the biological markers of ADHD may result in slow growth, a risk that has to be weighed by parents who decide to use these psychotropic chemicals with their young children, regardless of the diagnosis.

The Cost of Misdiagnosis

Prescription options are expensive and families who use them to treat their children often find they are spending a significant portion of their monthly budget on these medications. Less talked about are the estimated costs that burden so many families when misdiagnosis occurs. Elder estimates that $320 to $500 million is spent annually on ADHD treatments for children who fall into this category.[7] Obviously, teachers, parents and clinicians need to work together to ensure accurate diagnoses. The cost of treatment, combined with the potential side effects of medications, not only concerns parents, but also care providers.

Looking at the Course of Preschool ADHD Treatment

In order to better understand the course of preschool ADHD, researchers at Johns Hopkins University School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Child and Adolescent Psychiatry, formed the Preschool Attention-Deficit/Hyperactivity Disorder Treatment Study (PATS) and decided to follow preschoolers who were diagnosed with ADHD over a period of six years. They wanted to see if those children diagnosed in preschool would have symptoms that persisted into elementary school.

The initial results of the study were published in 2006 and concluded that low doses of medication, closely monitored and taken over the short-term, showed benefits in preschoolers. The later part of the study analyzed the follow-up group and was reported in February 2013 in the *Journal of the American Academy of Child and Adolescent Psychiatry.*

The sample in the follow-up group included a total of 207 children, ages three to five, who were tracked for six years and assessed at ages three, four, and six. The majority of these children received a controlled trial of methylphenidate, plus their parents received training to manage symptoms. Nearly 90% of the children with moderate to severe ADHD continued to show evidence of the diagnosis at the six-year marker despite the interventions. Researchers concluded that ADHD in preschoolers appears to be a relatively stable diagnosis even with medication intervention and parent training.[8]

Since ADHD diagnosed in the preschool years tends to persist throughout childhood, the challenge is to find early, intensive interventions that are effective. More research is needed on the effects of medications on preschoolers over the long-term, as well as the effects of combining different medications. We also need more information regarding which children have individual characteristics that might increase long-term risk of symptoms, and which children have individual characteristics that may reduce symptoms with age. For example, the PAT study found that those children diagnosed with comorbid disorders of oppositional defiant disorder and/or conduct disorders had a 30% higher risk of retaining the ADHD diagnosis at age six. Results also indicated that despite treatment with medication, those children with moderate to severe ADHD did not noticeably improve. Again, effective interventions with this age group are needed, preferably non-pharmocological.

Medication, Diet and Psychological Treatments

With the growing concern about overmedicating children on the minds of so many, preschoolers who are correctly diagnosed do need intervention. So what is being done to provide non-prescription alternatives? One area often mentioned is controlling diet and providing psychological treatments. However, a recent meta-analysis on the evaluation of diet and psychological treatments concluded that medication approaches were better than other treatments studied.

Specifically, the study assessed three dietary interventions: 1) restricted elimination diets, 2) artificial food color exclusions, and 3) free fatty acid supplementation. Psychological treatments included cognitive training, neurofeedback and behavioral interventions. Changes in ADHD symptom severity were measured pre and post treatments. Symptoms were rated by someone close to the child, like a parent, as well as a blinded rater.

Results were interesting because they were impacted by the raters. When both a parent and blinded rater did the assessments, the dietary and psychological interventions showed significant effects. However, when the rater was solely the blinded person, only the free fatty acid supplementation and the artificial food color exclusion made a difference. Based on these results, the researchers wanted to know what would happen if parents added fatty acid supplements to stimulant treatment? A double-blind, placebo-controlled study found no significant differences in the main symptoms of inattention, hyperactivity or impulsive behaviors with this addition.[9] The standardized mean differences for medication treatments in children and adolescents is reported as 0.9; mean differences for the free fatty acid supplementation was 0.16; and for the artificial food color exclusion, 0.42. Thus, medication approaches still produced better mean scores regarding the reduction of ADHD symptoms.[10]

Solar Intensity and ADHD

Perhaps a promising area to explore is solar intensity. Sleep specialists tell us that children with ADHD often have sleep-onset insomnia and a delayed circadian phase. So another group of researchers looked at the relationship between environmental light exposure and ADHD prevalence. What they found was that higher solar intensity was positively correlated with lower ADHD prevalence. Exposing children to intense sunlight during the day and reduced light exposure at night may reduce some ADHD symptoms and act as a protective factor.[11]

Behavior Therapy for Preschoolers

Behavior therapy that includes parent management training is also recommended. The Agency for Healthcare Research and Quality (AHRQ) looked at all the studies on treatment options for preschoolers and recommends parent behavioral interventions.[12] Components from these programs proved to be helpful, including: 1) Triple P (Positive Parenting of Preschoolers)—an evidenced-based program with a multidisciplinary focus, 2) Incredible Years of Parenting Program—a model program recommended by the American Psychological Association for children with conduct problems, 3) Parent-Child Interaction Therapy—an empirically-supported treatment for young children with emotional and behavioral disorders, and 4) New Forest Parenting Program—a program developed specifically for parents of children with ADHD.

In sum, behavior therapy along with medication approaches remain the treatments of choice when it comes to helping preschoolers with moderate to severe ADHD. However, medications appear to be less effective with preschoolers, and methylphenidate hydrochloride (the most commonly prescribed medication) has not been approved for children under the age of six by the FDA. Furthermore, long-term effects of medication use have yet to be determined, thus, supporting the idea that more non-pharmacological interventions are needed with this population. Finally, concerns over misdiagnosis point to the need for extra vigilance regarding the differences between recognizing normative development in childhood from signs of a disorder. ✠

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stigmatized kids

LEARNING AND INTELLECTUAL DISABILITIES

Intellectual disabilities encompass a broad spectrum of cognitive deficits that includes specific learning-related problems and mental retardation or MR (increasingly referred to as general learning or intellectual disability by many advocacy groups to minimize negative connotations with labels). Historically, MR-related issues were viewed primarily in terms of a child's Intelligence Quotient (IQ) with scores under 70, but now include a functional/adaptive skills component. Genetic and congenital factors, pregnancy-related issues (e.g., fetal alcohol syndrome), brain injury and neurodegenerative diseases all represent potential etiologies. The U.S. Department of Education reported nearly six million students who received special education services during the 2003–04 academic year and nearly a half-million were classified as intellectually disabled.[1] Most of these children were considered to be in the mild IQ range (51–70). According to the Centers for Disease Control and Prevention, Down syndrome births increased by 31% from 1979 to 2003, with 12 per 10,000 live births.[2] In some cases, there is no known etiology. It is worth noting that finding more current statistics remains difficult. This reality at least creates the need to explore the ongoing role/effect of abortion on demand over the past several decades. With an increased capacity to test for genetic abnormalities through prenatal diagnostic testing, intellectual disabilities and conditions such as Down syndrome, etc. are more readily detected in utero. Sadly, some women are being counseled to abort their babies or are making the fatal decision on their own.

CARRIE FANCETT PAGELS

Children with learning and intellectual disabilities are often at risk of being stigmatized and demeaned, especially in a society where intelligence is highly valued. Nevertheless, these precious gifts of God are fully capable of going on to live rich and full lives and deserve the opportunity to do so. Parents and family members must learn effective coping strategies, however, and be proactive in building healthy self-esteem and social inclusion. This article discusses common childhood learning disorders, why it is critical to have a proper psychological evaluation, and considerations for counselors serving families with diagnosed children.

Common Childhood Disorders that Interfere with Learning

Attention Deficit Hyperactivity Disorder (ADHD) is a common childhood disorder with roughly one in 10 children diagnosed. While ADHD was once thought to be something most children grew out of, research has not found support for

this conclusion. Many adults whose children have been diagnosed also have the disorder themselves. Counselors may end up giving suggestions for management of an ADHD child to a parent who may not be managing his or her own condition effectively and, consequently, may not be able to implement needed recommendations.

Learning disabilities can occur in many areas related to achievement. A child with a learning disability typically has a significant gap between potential (e.g., intelligence) and performance (e.g., achievement), which is caused by a processing difficulty that is brain-based. Depending on the state in which one lives, guidelines to qualify for special education services can vary. However, that does not mean a child cannot have a diagnosed learning disability such as dyslexia; rather, it means the student does not qualify for services. As a result, other mental health practitioners may end up providing support to the child and his or her parents.

Autism Spectrum Disorder diagnoses, including Asperger's, are also on the rise. The rate of diagnosis of children on the autism spectrum has escalated significantly in recent years (now one in 88 children). Likewise, anxiety and depression can interfere with learning even though they are not learning disorders. They must be considered, however, when determining why a child is having difficulty learning. Cognitive Disability is one of the least prevalent diagnoses. Children with mental impairments will function well below average in all, or almost all, areas of functioning.

Proper Psycho-educational Evaluation is Critical for Treatment and Intervention Planning

If misdiagnosed, there can be a worsening of symptoms or complications, such as wrong medications, inadequate prescribing, inappropriate treatment planning, or a setback in progress.

I interviewed Dr. Mary Burch, Licensed Clinical Psychologist who practices in Virginia. Dr. Burch, like myself, has worked with children and adolescents for more than 25 years. She indicated one of the first things parents want to be assured of in treatment is that something effective can be done for the child/family. The initial diagnosis is key, and counselors, as well as psychologists, must form a comprehensive treatment plan.

Treating symptoms without the correct diagnosis can lead to wrong or inadequate treatment and complications. A counselor should first ensure that other difficulties or disorders are not causing some of the child's learning problems. For instance, has the child had a normal eye exam within the past year? Many problems can be rectified with a proper pair of eyeglasses. Motor delays and fine/gross motor deficits should be referred to an occupational or physical therapist. Similarly, speech and language issues should be addressed by a trained speech pathologist. Finally, a full physical exam by the child's physician should rule out any medical basis for the presenting issues.

Once other etiologies have been addressed and ruled out, a psychological basis for the problem must then be considered. Here are some things to keep in mind:

Experience/Expertise: Counselors need someone with experience and assessment expertise in doing child and adolescent evaluations of their clients. Not all psychologists concentrate their professional practice on testing—many prefer to do therapy. Seek an appropriate referral if necessary. Professional colleagues, and especially physicians, often know who is competent in doing evaluations. Pediatricians will likely not refer a second time to someone who fails to conduct a thorough and timely assessment of their patients.

Communication: Counselors should find someone who will communicate with them effectively and consistently. Dr. Burch commented, "Many clients who had previously been evaluated and then came to me for therapy had never received any feedback regarding assessment results. Reports went to the treatment provider (I assumed they went), but I always provide my own feedback." Parents need to hear results—they need and want to know what is going on with their children.

Accuracy in History: Parents should also be given the report to read and review in the presence of a trained professional to ensure that it is correct—especially regarding the history. This process benefits the counselor if the psychologist is ensuring accuracy. The therapist should also rule out whether the child's problems are caused by a parenting issue. A good family history is critical—for instance, has the parent been diagnosed with a learning issue or received a psychiatric hospitalization? Once this is determined, an evaluation should go forward and a review of school records and an interview with the teacher(s) should take place.

Testing Components

What will a psychologist be assessing? Intellectual functioning with assessment instruments appropriate for the child's age, emotional status and personality, attention and memory, educational achievement, and other processing tests will be given based upon the presenting symptoms and the specific referral questions. Every assessment looks a little different. If educational problems are being considered, you need to ensure the evaluator is covering educational tests in his or her assessment. The following are important evaluation components:

Memory Processing: These tests are critical if the child has attention/retention issues, yet does not have an ADHD diagnosis. The student may be accused of being a daydreamer. He or she may struggle with increased memory demands in transitioning from middle school to high school. Marginalization may occur if the student is gifted, but cannot remember his or her material.

Visual Processing: The child/adolescent should be assessed if there is a suspected difficulty processing visual information, even though a thorough vision exam by a professional shows no vision problems (or if corrective lenses have addressed eyesight). A student with these difficulties may be asked, "Weren't you paying attention? Didn't you see it?" Small visual details can greatly impact mathematic calculations and spelling, for instance.

Auditory Processing: Once hearing is determined to be normal, auditory processing assessment can be done to determine if the child is not able to make sense of what he or she is hearing. This can affect early reading skills, in particular, as well as listening comprehension. A student who performed fine in school through the early grades, yet suddenly has great difficulty in high school, could have issues with listening comprehension. Stigmatization might look something like this: people with auditory processing problems may not be able to tune out background noise. They may tell other students to be quiet—which may negatively impact friendships. In the cafeteria or physical education classes, they may be unable to understand what is being said and need to have information repeated, thus calling attention to themselves and holding other students back.

Listening, Reading and Oral Comprehension: These are frequently unaddressed. Listening comprehension is a learning disability, but because of its relatively low incidence is often overlooked in assessments, particularly in the schools. By high school, a teen who has struggled for years with difficulty comprehending what he or she has heard may end up becoming a fringe student or even a dropout. By the time a student is enrolled primarily in lecture-oriented classes, he or she may have simply given up. If you combine a listening comprehension problem with a fine

Learning disabilities can occur in many areas related to achievement. A child with a learning disability typically has a significant gap between potential (e.g., intelligence) and performance (e.g., achievement), which is caused by a processing difficulty that is brain-based.

motor disorder, then disruptive behavior may occur.

Students with multiple issues, such as Asperger's, often have fine motor delays plus difficulties with auditory processing, resulting in listening comprehension problems. Already stigmatized for their social differences, they will more readily stand out in a class where they cannot comprehend all of the teacher's lectures, much less get it down onto paper. Accommodations may include a note-taker or recordings of classes for the fine motor difficulties. The student may benefit from being asked to give a specific example or make a visual diagram of what the speaker is talking about.

Learning disabilities come in many forms. For example, reading disorders may be in basic word calling ability, reading comprehension, or retention of what is actually read. In the latter case, a diagnosis of ADHD should first be ruled out as the cause of the difficulty in retaining what is read. Dyslexia is a reading disorder with great spillover into writing (especially spelling) and math, especially with word problems in the latter. Writing and math calculation and computation also must take into account other disorders which can affect the ability to concentrate, including medical issues.

Evaluators will usually consider whether there is a problem in one or more stages of information processing:

- **Input:** Is there a problem with vision or visual perception, hearing or auditory perception, or proprioceptive response?
- **Integration:** The information is received, but does not translate in that associated knowledge base.
- **Storage:** Short-term or long-term memory is impeded or not retained.
- **Output:** The knowledge cannot be expressed (e.g., either orally or in writing).

Cognitive impairments have lower incidence rates than learning disabilities. The developmentally delayed or mentally handicapped child will have low functioning in all areas. These children can be particularly stigmatized because they may have no academic area that shines and their adaptive, as well as social, skills will, in general, be lower than those of their peers. Slow learners, or children in the borderline range of intelligence, are often retained and risk being marginalized since they do not qualify for special education services. They will often face a second retention as they move into middle and high school. In this scenario, you may have a 15-year-old in an 8th grade class resulting in social difficulties.

The school district can provide a full psycho-educational evaluation if a multi-disciplinary committee deems it appropriate. Sometimes, however, counselors may direct a parent to pursue a private evaluation versus one offered through the school district, especially if the issues seem more emotional than academic. A clinical psychologist may be more trained and experienced in certain assessments, such as those evaluating psychiatric problems. You may have a child identified with a learning disability, but with underlying psychiatric issues that may be causing the problem. Anxiety, depression, thought disorders, and other issues need to be ruled out.

Some interventions/accommodations (other than special education) include note-takers, books on tape (Learning Ally is new system), testing in isolation, and responding to tests orally rather than through writing. A child on the autism spectrum will need social skills training. Adaptive living skills are also a focus for the cognitively impaired student.

Family needs of parents of children with learning disorders must also be addressed. In a recent online Ezine article, I wrote about parents of special needs children who shared some of their common concerns. Isolation was a significant issue. Counselors need to be aware that the parents of the children they are seeing likely do not have adequate support. Even if they have plenty of family and friends in their local area, they may feel very alone in their struggle to get to the bottom of their child's difficulties. Parents of multiple handicapped children frequently report that other people rarely understand what they are going through. Due to a high rate of abortion when a severe genetic abnormality is identified during pregnancy, these children represent one of the lowest incidence groups

Takeaway

Counselors do not need to know every aspect of working with this population or be specialists in learning difficulties in children. A good axiom is: When in doubt—refer it out. Again, therapists need not understand every nuance of a psychological evaluation and what some of these disorders "look like" in the classroom and at home. Parents of children with learning issues may feel isolated and need support. Children with disabilities and their families may be stigmatized or marginalized by their peers and, likewise, need emotional support and hope that a Christian counselor can provide—along with biblically sound advice. ✠

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acting out or a ticking time bomb?

Dave and Kim lie awake again tonight with fear and confusion about what to do with their eight-year-old son, Sam. His second suspension from school could not have come at a worse time. Dave has an important meeting out of town he cannot miss. After the last "blow-up" over his report card, Sam nearly destroyed his room. **DAVE AND KIM FEEL HOPELESS.**

One of the most referred cases a counselor will face when working with children and adolescents is known as disruptive behavior disorders. These types of disorders can be very difficult to assess because of normal developmental challenges that children have, such as temper tantrums and difficulty with transitions and emotional regulation. Is this just normal developmental struggles, or is there a clinical disorder lurking in the background?

Take, for example, the instance above with eight-year-old Sam. Both mom and dad work, but dad's job keeps him out of town during most weeks, which adds stress for mom. Sam has an older sister who is being treated for Attention Deficit Hyperactivity Disorder (ADHD), and an older brother, the middle child, who does not currently have any symptoms. Mom also had a complicated pregnancy with Sam—from day one, he has had difficulty with hyperactivity and impulsivity. He struggles with regulation, including sleeping and eating patterns. Sam typically has trouble with calming down and often has tantrums and gets frustrated when there is a change of plans or an interruption of the normal schedule. Whenever things do not go his way, he is likely to explode, which has occurred both at home and school. Sam has also been on medication for ADHD to help him focus and decrease hyperactivity. His case is complex, but it is useful to show the many elements of disruptive disorders.

STEVE WARREN


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Disruptive disorders tend to be clustered in three specific conditions: ADHD, Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD). Although there is considerable overlap with indications of comorbidity, these are seen as distinctly diagnosed disorders. A thorough assessment is critical in order to begin seeing results with empirically supported treatments.

Assessment

An accurate evaluation and diagnosis of the defiant disorders grouping and other comorbid conditions include the following assessment tools:

- **Structured Interview:** Diagnostic Interview Schedule for Children & Adolescents – Revised (August, Raswell & Thomas, 1998) and Diagnostic Interview Schedule for Children, Version IV (Jensen et al., 1996)
- **Behavioral Rating Scales:** Behavioral Assessment System for Children – 2 (R.W. Reynolds & Kamphaus 2008), Child Behavioral Checklist, Impairment Rating Score (Achenbauch & McConaughy, 1996)

One complicating factor involved in defiant disorders is the comorbidity of mood disorders. Depression, learning disabilities, and substance use disorders are some of the more common co-occurring disorders. ADHD also tends to be prevalent within ODD and CD, so it is essential to know and treat ADHD, as well as the other disorders.

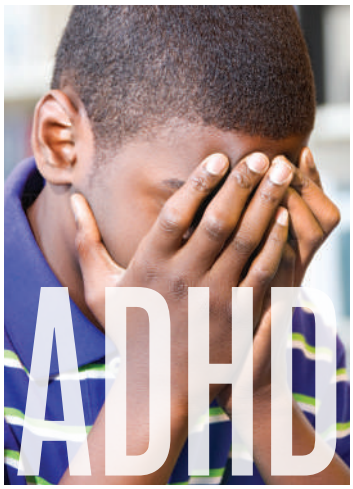
Attention Deficit Hyperactivity Disorder

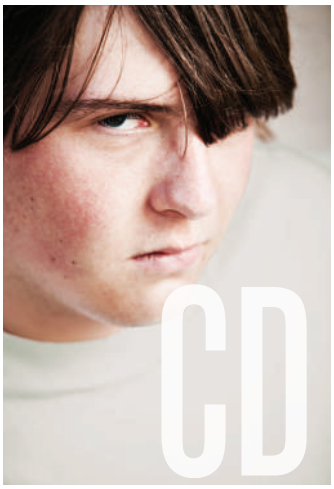
"I can't seem to get through to Derek at school. He can't seem to focus on the task and tends to wander off during group time. He is in real danger of failing."

ADHD is the most common of the neurobehavioral disorders in childhood. According to the recently published 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), it is a persistent pattern of inattention and/or hyperactivity that is more frequent and severe with children at that stage of development. Prevalence among school-aged children is estimated at about 3–7%. The core characteristics of ADHD include:

- Inattention
- Hyperactivity
- Impulsivity

Is this just normal developmental struggles, or is there a clinical disorder lurking in the background?





The causes of ADHD tend to be varied and complex and can be both environmental and genetic. A combination of medication and behavioral interventions may be needed for improvement. Below are a few examples of empirically supported treatments:

- **Pharmaceutical Interventions:** Psychostimulant medications in both short-acting forms (Focalin, Methylin and Ritalin) and long-acting forms (Concerta and Daytrana) can offer effective treatment
- **Behavioral Parent Training:** Patterson's Parent Management training – Oregon Model (Forgatch & Patterson, 2010); Eyberg's Parent-Child Interaction Therapy (Zisser & Eyberg, 2010); and Webster-Stratton's Incredible Years (Webster-Stratton & Reid, 2010)
- **Behavioral Contingency Management in the Classroom:** ADHD Summer Treatment Program (Pelham et al., 2010)

There is a significant overlap between ADHD and the other defiant disorders. Some data suggest that children diagnosed with ADHD have a comorbid ODD, and this increases to 80% for those with ODD who have comorbid ADHD (Green et al., 2002). This makes treating the more impaired ODD and CD cases even more difficult and complex.

Oppositional Defiant Disorder

"This school sucks! I hate you and can't stand this class. I hate middle school. I am sick of homework, and I don't want to be here anymore. I am glad I am suspended so I don't have to see your face anymore. It is your fault anyway."

Oppositional Defiant Disorder is a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior for at least six months in children (APA, 2000). The severity of this disruption has increased and has become more aggressive. This is the disorder most frequently referred to counseling practices for child and adolescent services. The prevalence for ODD is between 2–16% (APA, 2000) and core characteristics include:

- **Negativity:** blaming others for their own mistakes; easily annoyed
- **Hostility:** irritable mood/temper tantrums; anger; resentfulness
- **Defiance:** arguing with adults; active non-compliance with adults; spiteful; vindictive behaviors

The causes for ODD are varied and can include both neurobiological deficits and environmental factors. Children with ODD have executive (cognitive system) skill dysfunction, emotion dysregulation, relationship disturbances, and are highly resistant to traditional parenting practices. Often, treatment approaches focus on the parents, and with good cause, as they tend to have the most interaction with children. One model known as the transactional or reciprocal model (Sameroff, 1995) looks at both the parent and the child and how they interact together. For instance, if a child has difficulty with transitions and frequent outbursts coupled with a highly anxious parent, it could lead to very combustible interactions. Helping parents in a compliance type situation—not only with the child, but also with their own feelings—is key. Below are a couple examples of collaborative treatment:

- Collaborate problem solving developed by Ross Greene et al. (2004) focuses on the parent-child interaction and helping them develop collaborative approaches to address both the parents' and the child's concerns
- Treatment protocols by Russell Barkley (1997) is an approach that works with parents on the development of skills for dealing with behavioral outbursts

Conduct Disorder

"These rules are ridiculous. I am in high school and not a baby anymore. Mom, you can't tell me what to do. I should be able to drink and go out with my friends. So what if I got caught stealing yesterday. It was the school's fault for leaving the computers out!"

The final disruptive disorder that needs to be discussed is the most severe, pertains primarily to adolescents, and is the most difficult to treat. Conduct disorder is described by the *DSM-5* as a

"repetitive persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (APA, 2013, p. 93). In general, the disorder seems to affect between 1–10% of the population, tends to be found mostly in the male population, and has an early onset that is stable across time. The core characteristics involved with CD are as follows:

- Aggressive behavior toward people and animals
- Destruction of property
- Deceitfulness or theft
- Truancy or running away

ADHD and ODD, in some research, are considered to be precursors for conduct problems, with ADHD seen to be significantly comorbid. CD is also frequently comorbid with certain mood disorders, such as major depression, anxiety, and somatization. The following represent common therapeutic models:

- **Multisystemic Therapy:** Uses a variety of interventions at various systems, including family therapy, school consulting, peer group strategies, marital and individual therapy (Schoenwald, Brown & Henggeler, 2000)
- **Multicomponent Interventions:** No single treatment will work in most cases and multiple treatment approaches, such as Parent Management Training and Problem Solving Skills Training, may be necessary

Like any disorder, the sooner one can begin treatment, the better the prognosis. Early effective intervention of behavioral noncompliance can lessen the likelihood of these behaviors continuing into later childhood and adolescence. Parents may not be able or know how to get help. Because these disorders are behavioral in nature, schools, communities, and even churches often place blame on parents for their children's difficulties. In some cases, parental dynamics may play a role, but blaming parents is not helpful in treating these disorders. Parents can also feel guilty for their children's behavior and/or may be dealing with their own disorders, such as depression or anxiety, which makes it that much more difficult to get help. Statements such as, "If these parents would just discipline their kids, they would behave," may cause parents to be ostracized and potentially isolated.

There is a need for the Christian community to come alongside parents of children facing disruptive disorders to provide support and care. The Church is called to "Carry each other's burdens, and in this way you will fulfill the law of Christ" (Galatians 6:2) and offer hope in the midst of desperation. Carrying the burden for these families includes giving them a faith-filled vision of redemption and hope from the Savior. ✠

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LEARNING **DISORDER** OR LEARNING **STYLE?**

A Timeless Perspective

"I think I might be raising a narcissist." The statement came from a dad sitting in a room full of parents of middle school students. Heads were nodding everywhere as he continued. "She's so self-absorbed and thinks her mother and I know absolutely nothing." Another parent raised her hand, "My son has real attention issues—at least in school. He sure can focus on his video games, texting and Facebook friends, but he can't listen for even a couple minutes in class." By now, several more parents were eager to contribute to the discussion. What about eating disorders? How about the uptick in autism? What if your child displays signs of oppositional defiant disorder?

I have to admit, I felt a bit disappointed. My colleague and I were there to talk to parents about how their children can succeed and thrive in school, but the audience already seemed to think their kids were suffering from any number of neurological and learning-oriented disorders. There was an overwhelming sense of loss of control over their circumstances—after all, how can you argue with the symptoms of learning disabilities or mental illness?

We asked everyone to take a deep breath, step back, and start over. Before anyone decides there is something wrong with his or her child, should we not take a look at what is known about individual strengths and needs? And before we accept a label for a child, should we not be aware of how many reasons there might be for a lack of success in school?

CYNTHIA ULRICH TOBIAS

For the next 90 minutes or so, we talked to this concerned group about three things I wish teachers and counselors could tell every parent:

1. Few people want to be analyzed, but everyone wants to be understood—and therein lies a big difference.

No one fits into categories or boxes—and no test exists that can accurately pinpoint exactly what a person "is." We are fearfully and wonderfully made, full of many puzzle pieces of various sizes. When it comes to individual learning strengths and character traits, every person has some portion of almost every piece, and there have never been two people exactly alike since time began. You will never be able to confidently say, "Oh, my child is a _____."

Still, it is good to recognize patterns and identify strengths and learning styles—the inborn strengths in each of us that determine how we learn, remember and make decisions about information gives us a great way to do that. I am not talking about psychological terms or complex mental health issues, but instead about a fundamental framework that helps us understand and appreciate how many ways there are for a person to learn.

This process is something you can discern much more effectively through observation and conversation than you can through a formal test. It is based on two or three solid, empirical research models coupled with your ability and willingness to ask and answer the question, "What's the point?"…

and then find how many ways there might be to get there.

Here are a few facts from just one of those models to get you started:

Auditory learners need to talk. Their lives are filled with words, whether spoken out loud or in their heads. Words, and how they are verbalized, mean a lot. If you want to get the attention of auditory learners, lower and modulate your voice. Stay calm and ask questions—then allow them time to talk to you while you actually listen. They remember best when they can process verbally, and their multiple interruptions may indicate they are getting the point, not just being inattentive.

Visual learners need to see. While it often seems they are simply uncommunicative, it may be largely due to the fact they do not feel the need to talk in order to communicate. There are so many other, more visual, means—pictures, notes, nonverbal language. Sometimes these children are so busy trying to picture what is being said that they forget to respond. If you only judge them by what they verbally communicate, you may not know even half of what they are thinking.

Kinesthetic learners need to move and do. It becomes increasingly difficult for kinesthetic learners to listen while sitting or standing in one place. You might be giving the best advice in the world, but if sitting still is required to hear it, kinesthetic listeners are often left behind in the process. If you want them to keep track of what is being said, keep them moving, even in small ways. What could be considered "hyper" activity may, in fact, diminish considerably when their movements are incorporated into the learning environment.

Regardless of their learning styles, children should understand the need for accountability. We must carefully identify the bottom line and then give them some direction on how to get there.

2. Awareness is half the battle.

It is surprising what a difference it makes when we look at children through the perspective of how different they are from us. As I do live seminars, I have participants compare their learning style profile with those around them. When I ask how many have answers that are different from their neighbors, most hands go up. Then I ask,

No one fits into categories or boxes—and no test exists that can accurately pinpoint exactly what a person "is." We are fearfully and wonderfully made, full of many puzzle pieces of various sizes.

"So which one of you is normal?" The response is usually only sheepish laughter.

There are some questions worth debating: Who gets to decide what's normal? Who decided that in order to be considered attentive you have to sit still and look at the person who is talking to you? Why do so many of us get hired for all the traits that got us in trouble when we were in school? What if we are often medicating our children to conform to classrooms and educational systems that are largely irrelevant after they graduate?

3. How our children need us always changes… the fact that they do need us never changes.

There is no question that younger children need their parents in very different ways than adolescents. However, one discovery I made with my own sons was that they needed me almost more in high school than they did in elementary school. They definitely did not want me to hover over them or interfere, but they counted on my presence and support and wanted me to be involved in their lives. It's true that I don't have the same technological savvy they do, and I certainly have not kept up with all the current trends in fashion, music and video. Nevertheless, I have stayed solidly consistent in my love for them, and they know they can count on me.

Parents need more reminders about how important they are in their children's lives. They need to remember how critical it is to focus on their children's strengths and encourage them to figure out how to use those strengths to cope with difficult and challenging situations. This takes a little time and effort, but moms and dads need to understand that even when medication and professional intervention are necessary, as parents they are still a critical part of their children's success. They cannot simply hand over the well-being of their children to a third party, no matter how professionally trained that person may be. In the end, it is the love and support of a parent that children of any age crave the most.

Conclusion

If a child is diagnosed with a learning disorder, parents should always seek a second opinion. It is important that those who know the child best understand which symptoms are a matter of learning style and which indicate more extreme issues.

When it comes to our children, no matter how much the world changes, no matter how many new cultural trends come and go, no matter what medication or therapy appears and then disappears, there are a few key things a parent can provide that there will never be a substitute for: time spent with them, love shown to them, patience in dealing with them, coping strategies taught to them, encouragement given to them, and prayer with them and on their behalf.

In all cases, we need to urge parents to remember there are no shortcuts when it comes to raising children. There is no doubt children often have different ideas than we do—on almost everything—however; not every behavioral nuance should be labeled as a "disorder." After all, how can you change the world if you are just like everyone else? ✠

CYNTHIA ULRICH TOBIAS, M.ED., *is a best-selling author, featured guest on radio and television, and a popular presenter for businesses, government agencies, churches and schools throughout the United States and around the world. She has a successful background that includes more than 25 years of private practice, eight years of teaching high school, and six years in law enforcement. For more information, visit her at CynthiaTobias.com.*

REACTIVE ATTACHMENT DISORDER & DISINHIBITED SOCIAL ENGAGEMENT DISORDER

One of the most frequently asked questions I receive from counselors, parents and staff in child and adolescent settings is my understanding of, and advice on, Reactive Attachment Disorder (RAD). The growing interest in the understanding of RAD is due, in part, to the numbers of children in foster care placement[1] and children adopted to America from international orphanages.[2] Studies have, indeed, shown significantly higher rates of mental health problems in children within residential care settings as opposed to those not in placements.[3]

However, misperceptions and preconceived notions exist concerning the theoretical and etiological factors with this relatively new disorder. I have also seen confusion in the field, and even among mental health professionals, between the recognized *DSM* diagnosis of RAD and the more generally familiar "attachment disorder," a term child and adolescent researchers use to describe a broader symptomology that combines elements of oppositional defiant disorder, Attention Deficit Hyperactivity Disorder (ADHD), conduct disorder, anxiety disorders and even Post-traumatic Stress Disorder (PTSD).[4] In fact, in older children and adolescents, attachment disturbances may better be accounted for by any of the aforementioned disorders.[5]

I hope to dispel some of these misperceptions and clearly explain RAD and its most recent corresponding diagnosis, disinhibited social engagement disorder.

JOSHUA STRAUB

Changes from *DSM IV-TR* to *DSM-5*

In addition to moving to a brand-new category called "Trauma and Stressor-Related Disorders" (along with disinhibited social engagement disorder, PTSD, acute stress disorder and adjustment disorders), one of the most significant changes of reactive attachment disorder in the recently released *DSM-5*, was the separation of its previously recognized subtypes (inhibited and disinhibited) into two separate disorders.

Signs and Symptoms

Reactive Attachment Disorder now consists primarily of the previously titled inhibited type. It is described as "a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protection, and nurturance."[6] Children with RAD have extreme difficulty self-soothing, being comforted by others, and show minimal, if any, positive emotions. For no apparent reason, they can become irritable, sad, or fearful. The primary diagnostic feature "is absent or grossly underdeveloped attachment between the child and putative caregiving adults."[7]

The disinhibited type is now known as disinhibited social engagement disorder and is different from RAD in that the child's attachments to primary caregivers can range from neglectful to disturbed, but also be secure. The primary diagnostic feature "is a pattern of behavior that involves

The growing interest in the understanding of RAD is due, in part, to the numbers of children in foster care placement and children adopted to America from international orphanages.

culturally inappropriate, overly familiar behavior with relative strangers."[8] These behaviors include having no emotional/psychological filters when approaching unfamiliar adults, excessive people pleasing and affirmation seeking behaviors, indiscriminate emotional and verbal sharing, and being overly affectionate with others.

Attachment, Prevalence and Course

One of the biggest misunderstandings with these two disorders is the confusion with attachment theory. Though a child with RAD most likely has an insecure attachment style, not all children with insecure attachment styles have RAD. In fact, a child could have a secure attachment to a primary caregiver and still be diagnosed with disinhibited social engagement disorder.

Prevalence rates of both disorders are unknown, but rare in clinical settings. Even in the most severe cases of child neglect, prevalence rates are less than 10% for RAD and 20% for disinhibited social engagement disorder.[9] The diagnosis, then, for RAD, in particular, is rare, and most often left for the most extreme cases of harmful insecure attachments.[10] A diagnosis of either disorder should not be given prior to nine months of age to account for the ability of a child to develop selective attachment. Also, since it is unknown whether RAD manifests in older children, the *DSM-5* warns clinicians to use caution when making this diagnosis for those older than five years of age.

On the other hand, disinhibited social engagement disorder does manifest itself through older childhood and into adolescence. However, there is no evidence of this disorder developing in children whose neglect begins after two years of age. This underscores the relation to the child's perhaps anxious attachment style, which is developed in the first two years of life by a caregiver who showed ambivalence toward the child.

Interventions and Treatment Protocols

Since very few empirically-based protocols for RAD exist, treatment consists of interventions found to be effective in addressing disorders with similar symptomology.[11] One of the most controversial interventions is known as "holding therapy." The only reason I mention it here is because it is also referred to as "attachment therapy," and should not be confused with other forms of empirically valid attachment-based treatments. This form of therapy has shown detrimental results in literature, including children death, and has thus been outlawed by some states.

Empirically valid forms of therapy for RAD and disinhibited social engagement disorder include attachment-based family therapy,[12] trauma-focused cognitive behavioral therapy,[13] integrative play therapy,[14] and behavioral management therapy,[15] which utilizes the implementation of 20 minutes of command free time per day between the child and safe attachment figures. ✠

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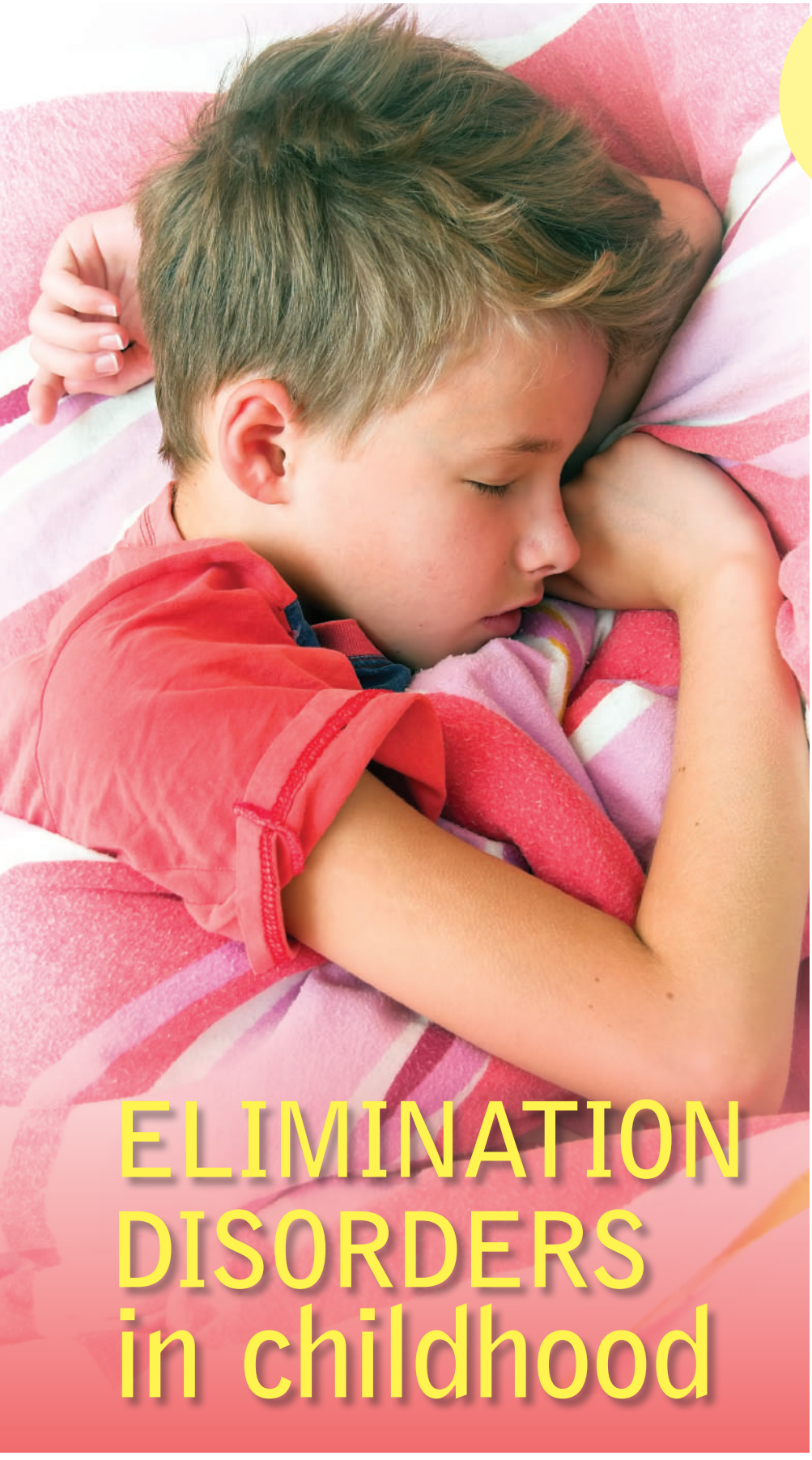

ELIMINATION DISORDERS in childhood

Going to the bathroom may not exist in heaven, but while here on earth, it is a mundane reality—mundane, that is, except for children suffering from elimination disorders. These children often carry associated feelings of shame and embarrassment, accompanied with much anxiety for the child and his or her parents.

Elimination disorders are diagnosed when children eliminate in inappropriate places or times, and in the absence of a physical condition to explain it. The two primary diagnoses classified by the *DSM-5* are Enuresis (wetting) and Encopresis (soiling). Other diagnoses used when full criteria for Enuresis or Encopresis are not met include, "Other Specified Elimination Disorder" and "Unspecified Elimination Disorder."

Enuresis

Enuresis is diagnosed when a child of at least five-years-old exhibits a urination problem (whether intentional or involuntary) that occurs more than once per week for three consecutive months or causes significant distress or impairs the child's functioning. There are three subtypes of Enuresis: Diurnal Only (daytime), Nocturnal Only (nighttime), or both.

Enuresis is more frequent in younger children, with as many as 10% of five-year-olds experiencing a wetting problem. It is less common as children age, with only 1% of 15-year-olds evidencing the problem. When assessing for enuresis, it is important to rule out a physical cause for the wetting. Gaining the parents' perspective regarding the onset and course of the wetting behavior is beneficial. Standardized psychological testing is helpful to evaluate for other problems and comorbid conditions, which may contribute to, or exacerbate, the enuresis (e.g., impulsivity, anger, Attention Deficit Hyperactivity Disorder, depression, anxiety, or trauma).

Etiologies for enuresis are varied, and primarily fall into either psychodynamic theories, biobehavioral causes, or a combination of the two. Older psychodynamic

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theories tended to characterize enuresis with psychopathology (Christophersen & Friman, 2010). A current literature review, however, shows more research support for biobehavioral models. These models list etiological factors from a variety of possibilities including maturational delay, stressful and/or traumatic life events, psychosocial concerns, learning and modeling, genetics, sleep dynamics, or a combination of these factors.

There are several options for treatment of nocturnal enuresis. A well-known behavioral treatment is referred to as the "bell-and-pad" procedure. This protocol was first developed in the 1930s and consists of a urine-sensitive pad that is connected to a buzzer alarm or bell. The pad is placed under the child at bedtime and the alarm sounds to wake the child when he or she begins to urinate. Over time, the child is sensitized to the sensation of having a full bladder. This method boasts a success rate of approximately 75% (Barkoukis, et al., 2008; Christophersen & Friman, 2010). Variations of this method are now available including pajama devices, vibrating alarms for the child, and pagers for parents.

Other behavioral treatments include a combination of psychoeducation, positive reinforcement, arousal training utilizing an alarm, psychotherapy, biofeedback, positive practice, and family encouragement. Some physicians also use drug treatments, but behavioral treatments for enuresis are typically preferred due to fewer side effects and longer lasting impact. Furthermore, controlled trials show better support for alarm-based treatment compared to pharmacological approaches (Christophersen & Friman, 2010; Yarhouse, et al., 2005).

Treatments for diurnal enuresis include psychoeducational methods (e.g., cueing and motivating, teaching Kegel exercises to improve muscle tone, urine alarms/vibrators, and psychotherapy). There is less research on diurnal versus nocturnal enuresis.

Encopresis

Encopresis is diagnosed when a child of at least four years of age exhibits loss of a stool in inappropriate places at least once per month for three consecutive months. The episodes may be involuntary or intentional. Primary encopresis refers to children who have never responded to potty-training, while secondary encopresis applies to children who were toilet-trained at one time, but then resumed soiling. Physiological causes, other than constipation, need to be ruled out before diagnosing encopresis. Prevalence estimates for encopresis range from 1–3%, and the disorder is more common in boys than girls.

There are many theories regarding the causes of encopresis, including coercive potty-training, sexual abuse, trauma, or psychosocial stressors. The comorbid condition most clearly supported in literature is constipation (Christophersen & Friman, 2010). Over 90% of children referred for treatment report constipation. Constipation may be caused from a variety of factors, including diet, medication side effects, emotional stress, or frequent changes in daily routines.

Treatment typically starts with a physician, since the first step is assessment for physical causes. Laxative treatment, suppositories and/or dietary measures may be prescribed to address the constipation. This may take place whether or not organic pathology is found to explain the soiling. If there are no physical explanations for the chronic constipation or soiling, then a psychological assessment is in order. Assessment should include questions regarding the medical history of the child and family, the child's diet, potty-training history, current stressors, the psychosocial environment, and information about the course of the encopresis along with any previous attempts to address the issue.

A recommended first step of therapeutic treatment is parent education to ensure them that their child is most likely not soiling on purpose. Psychotherapy may help address any emotional distress, family pressures, or behavioral issues. If there are other common comorbid conditions (e.g., Oppositional Defiant Disorder, ADHD, anxiety, or Adjustment Disorder), then they should also be included in a treatment plan.

In conclusion, enuresis and encopresis are most often accompanied by shame and embarrassment for children, as well as their parents. Christian counselors can play an important role in educating parents and helping identify and address the root causes. As children overcome these conditions and the associated shame, they are better able to embrace and grow in their God-given nature.

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A BRIEF GUIDE TO EVIDENCE-BASED PRACTICE for children and adolescents

We are in the age of "evidence-based" healthcare, where practitioners are being mandated to use scientifically sound, empirically-supported[1] practice strategies. I have found the vast majority of these treatments can easily transport into clinical practice settings and are accepted well when sensitively and thoughtfully delivered to Christian children and families.

Below, I give a very brief overview of some the best assessment strategies and treatment protocols, as well as a few of the most well-established, empirically-validated treatments available for common childhood disorders.

Assessment Strategies

I encourage clinicians to consider learning how to use a structured diagnostic interview that allows them to systematically cover a wide array of childhood problems and concerns and helps establish a sound clinical diagnosis. *The Diagnostic Interview for Children and Adolescents* can be administered by you as an interviewer or in a computer-driven format. There are versions for both parents and children, which can be obtained from mhs.com.

GARY A. SIBCY II

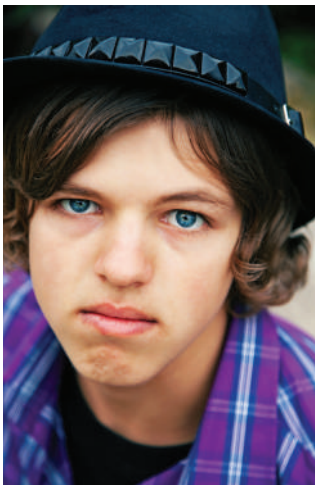
Assessment Instruments

Evidence-based strategies for assessing childhood problems begin with broad, multi-scaled instruments like the *Behavior Assessment System for Children-2* (pearsonassessments.com). This extremely well-validated and reliable device taps into a wide array of symptom areas (anxiety, depression, aggression, attention, hyperactivity, social skills, etc.) and has multiple forms (teacher, parent, child). There is also an observational measure, a comprehensive social and developmental history, and a measure of the quality of the parent-child relationship.

Once a particular problem area is identified, specific scales may be followed up with more directed interview questions to clarify a diagnosis, or you may administer more problem-specific assessment instruments:

- **Disruptive Behavior and ADHD:** Consider Barkley's and Murphy's Disruptive Behavior Rating Scale and Barkley's


Effective and tailored treatments for children and adolescents begin with a comprehensive assessment that incorporates the right instruments and testing protocols. They provide a helpful road map and best-practice orientation that utilizes well-researched programs for optimal results.



Home and School Situations Questionnaires[2]

■ **Anxiety Disorders and OCD:** March's Multidimensional Anxiety Disorders Scale is an excellent instrument because it not only assesses for physical symptoms of anxiety and avoidance behaviors, but also has specific subscales for generalized anxiety, separation anxiety, specific phobias and OCD

■ **Depression:** Children's Depression Inventory-2 assesses both emotional (negative mood/physical symptoms, negative self-esteem) and functional (interpersonal problems, ineffectiveness) aspects of depression in both children and adolescents (ages seven to 17). It is well-normed, validated, and reliable. Although the inventory is hand scored, it is easy to administer, score, and interpret. It also comes in both long and short versions.

Now, let us turn our attention to the myriad of treatment interventions that currently exist.

Disruptive Behavior Disorders

Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are the most common referrals to mental health clinics that treat minors. Consequently, they have also been some of the best-studied treatments conducted in child and adolescent mental health. Of the many interventions, four have the strongest empirical evidence. Three of the four are primarily focused on parental behavior management training and one is a form of cognitive therapy delivered directly to the client. The three parenting programs are:

- Patterson's Parent Management Training based on the Oregon model[3]
- Eyberg's Parent-Child Interaction Therapy[4]
- Webster-Stratton's Incredible Years[5]

Kazdin's Problem-Solving Skills Training[6] is the child-focused approach that combines both cognitive and behavioral strategies to address a number of cognitive skill deficits associated with conduct problems, especially as they relate to aggressive children's tendencies to perceive, approach, and handle interpersonal problems. This approach is often paired with a parent management program like the ones above.

Anxiety Disorders

Anxiety-related diagnoses include generalized anxiety disorder (GAD), separation anxiety disorder and social phobia. Kendall's Coping CAT Cognitive Behavior Treatment for

Childhood Anxiety Disorders[7] is the most well-established treatment for childhood anxiety disorders and is based on principles of cognitive behavioral therapy (CBT). It has also been successfully modified to actively include family/parenting components.[8]

Childhood Obsessive Compulsive Disorder

OCD is treated somewhat differently than other anxiety disorders. The gold-standard treatment[9] for this potentially debilitating disorder is another form of cognitive behavior therapy tailor-made for OCD, developed by John March and his colleagues at Duke University.[10]

Childhood and Adolescent Depression

A number of individual cognitive behavioral programs have been developed that show potential, but no one program has emerged as the most promising, empirically-supported treatment. One evidenced-based CBT approach that is both well-organized and easily accessible is by Kevin Start and his associates.[11]

Several group approaches to CBT have also proven to be effective. Two standouts are: the Penn Prevention Program[12] and the Coping with Depression treatment program[13] (can be downloaded at kpchr.org/research/public/acwd/acwd.html).

Finally, the prominent and utilized individual treatment for adolescent depression is Interpersonal Therapy, specially designed for this client population.[14] Effective and tailored treatments for children and adolescents begin with a comprehensive assessment that incorporates the right instruments and testing protocols. They provide a helpful road map and best-practice orientation that utilizes well-researched programs for optimal results. ✠

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Psychiatric Medications for Children and Adolescents

According to the Centers for Disease Control and Prevention (CDC), one in five young people aged three to 17 suffers from a mental illness. The most common mental illnesses among children and adolescents include Attention Deficit/Hyperactivity Disorder (ADHD) (6.8%), conduct disorders (3.5%), anxiety disorders (3.0%), depression (2.1%), and autism spectrum disorder (ASD) (1.1%). Additionally, many suffer from comorbid conditions, meaning that a single individual may have two or more disorders. Each diagnosis may require different medication strategies.

Psychiatric treatment of children and adolescents requires close attention to medication evaluation and management. These steps involve determining the appropriate medication for a particular patient, ensuring compliance with prescription protocols, and following suitable measures for changing or stopping medications.

Medication evaluation and management are just one part of a patient's comprehensive treatment plan. Other components comprise of a thorough psychiatric evaluation, individual and/or family counseling, and positive lifestyle changes, as well as communication between all members of a treatment team. The treatment team can include, but is not limited to, parents, counselors, educators and other clinicians/professionals (e.g., occupational therapists, social workers, play therapists, nutritionists, etc.)… all dedicated to helping the patient cope with conditions and improve daily functioning.

EDWARD JOHN KUHNLEY

A biopsychosocial evaluation usually consists of interviews with the patient and parents, as well as information from educators and other health-care providers. Physical examination, medical consultations, laboratory tests, and psychological/educational testing may be necessary to determine differential diagnosis (systematic method) and the presence of any underlying comorbid medical and/or psychiatric conditions. Obtaining an accurate clinical picture is necessary to determine specific treatments for each aspect, because medical conditions, psychiatric symptoms, and psychosocial/educational factors can affect each other and the patient. The treatments, likewise, may enhance or interfere with each other, so

it is vital for all members of the team to communicate effectively regarding goals and limitations, including medication. Before prescribing medication, it is necessary to inform both the patient and parents about the expected benefits, as well as any possible side effects, FDA warnings and risk factors. Parents and adolescent patients should also be informed as to the proper use of any prescription.

While some believe medication should only be used as a last resort, children and adolescents in crisis may require psychotropic intervention in order to achieve stability. Once initial stability is established, the treatment team can better formulate a plan involving, but not limited to, counseling, effective coping strategies and special accommodations at home and school. While some patients may be able to reduce or stop medications altogether after a period of time, other conditions require long-term management over the course of many years.

The goal of medication is to reduce or eliminate target symptoms and improve daily functioning. In addressing any potential adverse side effects, a physician may initially prescribe a low dose of the medication and gradually increase the amount over time. Ideally, a patient can be treated with a single medication. However, the presence of comorbid conditions may require more than one medication. Additionally, if side effects from a single medication are intolerable, low doses of two or more medications used in combination may be necessary to achieve the desired result.

One of the biggest problems regarding medication management for children and adolescents is compliance. Medication can be instrumental in coping and recovering, but only if the patient follows through with the medication regime (i.e., the prescribed times during the day, dosages and duration). Many patients, particularly children, are reluctant to take

Medication, while often a necessary element of a patient's comprehensive treatment plan, is not a substitute for positive lifestyle changes and a supportive environment.

medications for a variety of reasons. Some may "cheek" and then covertly discard, rather than swallow, the medicine. For this reason, it is necessary for the clinician to impress upon the patient the importance of taking the medication exactly as prescribed. Noncompliance of medication treatment can lead to uncertainty, the worsening of psychiatric symptoms and unnecessary additional treatments. Members of the treatment team must closely monitor a patient's compliance to ensure optimal results.

Another problem regarding medical management involves changes in a medication's effectiveness over time. A patient may develop a tolerance for a particular medication, meaning the same dose no longer produces the desired effect. As children and adolescents grow (dosages are often tied to body weight), develop, and gain life experience, their response to medication may change. Additionally, lifestyle alterations such as diet, exercise, and changes within the home environment may impact the patient in such a way that medication no longer appears to be effective. Conversely, some patients feel they have recovered and no longer require medication, not realizing how instrumental it is to their continued daily functioning, overall well-being or recovery.

For these reasons, it is essential for the older patient and his or her parents to thoroughly discuss all desired changes in medication with their physician, especially to avoid adverse effects. Withdrawal symptoms can be reduced or eliminated by gradually tapering the dose of a medication over time. The patient may also require additional support during the transition.

At times, a minor receiving psychiatric medication may require other medical treatments, including medications from other healthcare providers. Since medications and treatments may interact with each other, all providers must have full knowledge of the treatment regimen to determine if any adjustments are necessary. Prescribers and pharmacists have access to drug interaction databases to guide recommendations. For example, surgeons and anesthesiologists must know all medications taken by patients preparing for surgery (including dental surgery) and then advise them of necessary changes, including temporary suspension of taking a medication before, during, and/or after surgery.

A number of medications are useful in treating children and adolescents with psychiatric conditions including:

- **Stimulants** such as methylphenidate (Ritalin) and amphetamine, and non-stimulants such as atomoxetine (Strattera), clonidine (Kapvay or Nexiclon), and guanfacine (Tenex) may be helpful for ADHD.
- **Antidepressant medications** are prescribed in the treatment of depression and anxiety disorders (generalized anxiety, school phobias, panic attacks, obsessive-compulsive disorder, post-traumatic stress disorder, and other anxiety disorders), ADHD, bedwetting, and eating disorders. Selective serotonin reuptake inhibitors (SSRIs) include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro), and fluvoxamine (Luvox). However, these medications have also shown to increase suicidal ideation, so they require monitoring. Other medications used less often for anxiety include benzodiazepines (e.g., Ativan, Restoril, Librium, Valium, Xanax, Klonopin, etc.) and buspirone (Buspar).
- **Antipsychotic medications** may be helpful for psychotic symptoms including delusions and hallucinations, disorganized thinking, muscle twitches ("tics") or Tourette's Syndrome, severe aggressive behavior, and possibly severe anxiety.
- **Mood stabilizers and anticonvulsant medications** (valproate, carbamazepine and oxcarbazepine, lithium, and lamotrigine) may be helpful in treating bipolar disorder, severe mood swings, aggressive behavior and impulse control disorders.

Medication, while often a necessary element of a patient's comprehensive treatment plan, is not a substitute for positive lifestyle changes and a supportive environment. Research indicates that medication, when utilized with psychotherapy, produces the best outcomes. Some patients and their parents expect the medication alone to solve their problems, but often it only helps up to a certain point. All patients, especially children, suffering from a mental illness will require additional support to overcome the limitations of their condition and improve their quality of life. ✠

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THE therapeutic powers of play

promoting healing & resilience in children

For well over half a century, play therapy has been recognized as an effective means of treating children who struggle with a variety of difficulties associated with social and developmental deficits and trauma-related symptoms. Play Therapy is defined by the Association for Play Therapy (APT) as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (APT, 2013). This article examines some of the therapeutic gains associated with play therapy and explores the therapist's role in the process.

Play and its Implications on Child Development

Play enhances a child's development on several dimensions. According to a report published by the American Academy of Pediatrics (AAP), play stimulates creativity and imagination, enhances physical growth and agility, and promotes intellectual and emotional stability. Play that occurs naturally is vital to the comprehensive development of the child (Ginbsurg, 2007). In fact, neuroscience research suggests play enhances brain development as neural pathways in the brain are built and fortified (Panksepp, 2005).

Relationship Enhancement

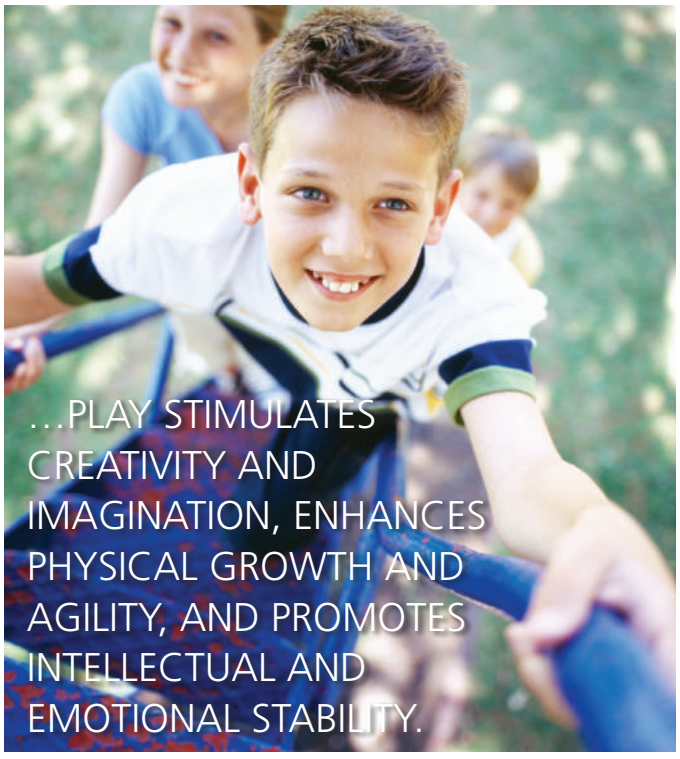
The focus of filial therapy is to assist parents (can also include caregivers) in facilitating non-directive play therapy sessions with their own children.

JOSEPHINE M. OLSON

The therapist assumes the role of teacher, facilitator, and supervisor while modeling skills, first in the play therapy room and then in the home (Ginsberg, 2002). Upon reviewing the research in filial therapy, this therapeutic medium was recognized as significant in increasing "parental acceptance, self-esteem, empathy, [and creating] positive changes in family environment, and the child's adjustment and self-esteem, while decreasing parental stress and the child's behavioral problems" (Rennie & Landreth, 2000).

Expressing and Regulating Emotions

Puppets are frequently incorporated into play therapy sessions. Often, children are able to project their own feelings and ideas onto the puppets during spontaneous role-play, providing them the appropriate distance to explore their emotions. By allowing the puppet to become the "symbolic client," the therapist can engage a child who otherwise would avoid emotional expression (Hall, Kaduson & Schaefer, 2002). The play therapy room serves as a safe environment for children to explore both positive and negative emotions and practice new ways to appropriately manage their affect.


…PLAY STIMULATES CREATIVITY AND IMAGINATION, ENHANCES PHYSICAL GROWTH AND AGILITY, AND PROMOTES INTELLECTUAL AND EMOTIONAL STABILITY.

Children are intrinsically motivated to play...

Coping Skills: The Bereaved Child

Sandplay therapy is a form of play therapy that allows children the sensory experience of manipulating figures to create a subjective world. These figures represent feelings and ideas that the child may or may not experience on a conscious level. Sandplay offers the child opportunities to symbolically portray concepts like grief, and subsequently process feelings associated with the loss (Green & Connolly, 2009). As cited in Green and Connolly (2009), the therapeutic gains associated with sandplay in grieving children are expressions of grief through figures, symbols, and metaphors in protective environments; understanding of the psycho-educational aspects of loss; release of dominant sensations through symbolic play; and the building of a therapeutic alliance to nurture acceptance as the child improves coping skills (Reddy, Files-Hall & Schaefer, 2005).

Social Skills

Social skills are also enhanced as children engage in play. During free play, they are able to assume new identities, participate in creative activities and play out different social scenarios. The play therapy room provides a nonthreatening environment that creates a venue for the child to articulate his or her subjective experiences. The play therapist and child form an alliance that fosters a nurturing relationship. The resulting therapeutic alliance, when maintained appropriately, will stimulate the child's social drive and augment the development of necessary social skills (Ray, 2011).

The Therapeutic Relationship

Virginia Axline, a pioneer in child-centered play therapy, believed the therapeutic relationship was central to promoting change and fostering growth in the child. Axline (1969) developed eight principles to facilitate the therapeutic process. The first and second principles delineate the therapist's demeanor. Axline suggested the therapist must establish a genuine relationship based on unconditional acceptance and understanding of the child. Once positive rapport is established, the child is able to direct the play and attach his or her own personal meaning to the play. The third and fourth principles recognize the importance of permitting the child freedom to explore ideas and feelings; those feelings are then reflected by the therapist, guiding the child toward self-awareness. The fifth and sixth principles assume the child is inherently motivated toward change; the child, when given the proper tools, can direct this process. The seventh principle acknowledges that this process can be a gradual one and the therapist should not impose time constraints. The eighth and final principle speaks to limits and boundaries established by the therapist to encourage awareness of the child's responsibility, further grounding the child to reality (as cited in Van-Fleet, Sywulak & Sniscak, 2010). The efficacy of play therapy can be further enhanced with parental involvement as the ideal number of sessions is delivered (Bratton, Ray, Rhine & Jones, 2005).

The therapeutic gains associated with play therapy are substantial. Children are intrinsically motivated to play and, when nurtured, this process can promote self-exploration, better emotional regulation, more positive social adjustment, and healthy coping skills (Ray 2011). Children are afforded the opportunity to grow and thrive whether participating in a play therapy relationship or engaging in free play. Reviewing the research and recognizing the implication of play is helpful, but little compares to observing the pure delight and contagious laughter of a child immersed in play. ✠

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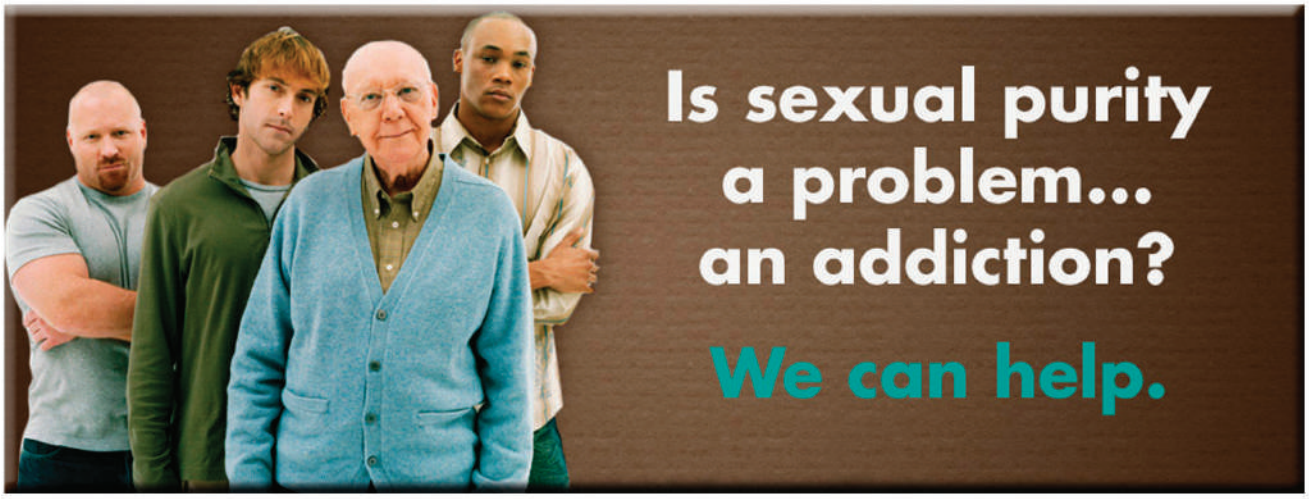

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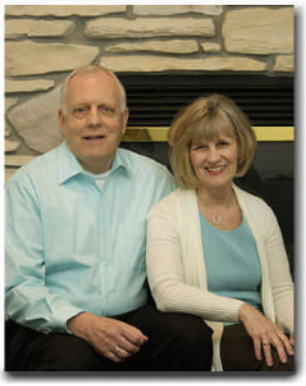

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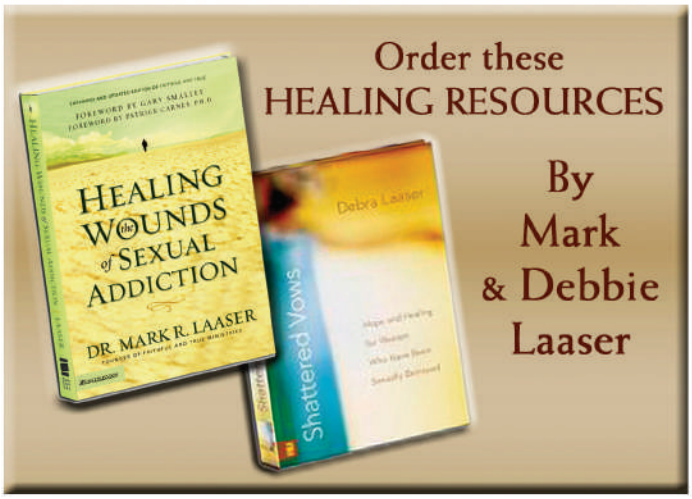

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« H.B. LONDON, JR., D.D.

Aren't They All Our Children?

Recently, my wife, Beverley, and I were seated in a small restaurant when a young family walked in—the mother and father, a five or six-year-old boy, and a baby carriage. Naturally, I thought the carriage held a small infant. However, as they passed our table, I noticed the child was not a baby, but a severely disadvantaged older son who could not care for himself and was totally dependent on someone else for his survival.

The moment was so shocking to me that I could not finish my meal. I literally had to leave the restaurant. I have been thinking of that family ever since. Why? Not so much because of my own discomfort, but for that household whose lives will never be normal as long as that child lives. Yet, I know there are multiplied thousands of homes who love children with disabilities and other challenges, but it does not make their journey any easier or, to be honest, my ability to relate to their circumstances. Yet, the more I think about it, I have to ask myself, "Do these helpless children not belong to all of us?"

They are All Our Children

Some years ago, I read a story told by former Georgia Senator, Sam Nunn, about a little girl who was shot by a sniper during the terrible conflict in Bosnia. A reporter was watching as the girl went down and hurried to assist a man who was holding her. They all loaded into the reporter's car and hurried off to the hospital. As they drove, the frantic man holding the bleeding girl pleaded with the driver to hurry. "The child is still alive," he cried. Then, "The child is still breathing," and now, "Hurry, please, she is getting colder."

When they arrived at the hospital, the little girl had died. As the two men were washing the blood from their hands, the man turned to the reporter and said, "This is terrible for me, for I must go tell her father that his child is dead. He will be heartbroken." The amazed reporter looked at the grieving man and said, "I thought she was your child?" The man looked down wiping his tear-stained face and said, "No, but aren't they all our children?"

I was not there, but it is said that Senator Nunn reminded his listeners, "Yes, they are all our children. They are also God's children as well, and He has entrusted us with their care, not just in Sarajevo, but wherever they may be found." I wonder if we really believe that.

The Secret to Loving the Unlovable

I am not sure this next little verse of song is even politically correct anymore, but can you remember in Sunday school how we used to sing, "Jesus loves the little children, all the children of the world. Red and yellow, black and white, they are precious in His sight, Jesus loves the little children of the world?" And so He does, and so should we… but at times, the responsibility becomes too great, too formidable, too time-consuming and, like it was for me, very intimidating.

If you think about it, the love God has for His children is not conditional. It means, as is said, "All the children of the world"… even if they are unaware of that monumental affection. John's first Epistle is filled with those kinds of reminders:

- *"… We should love one another"* (3:11).
- *"This is how we know what love is: Jesus Christ laid down his life for us.*

And we ought to lay down our lives for our brothers and sisters" (3:16).

- *"Dear children, let us not love with words or speech but with actions and in truth"* (3:18).
- *"Dear friends, let us love one another, for love comes from God… because God is love"* (4:7-8).
- *"Dear friends, since God so loved us, we also ought to love one another"* (4:11).
- *"… God is love. Whoever lives in love lives in God, and God in them… We love because he first loved us"* (4:16, 19).

Truthfully, that is the secret—loving others, even those who seem to be unlovable, because God enables us to do so. In fact, they are all our children because they all belong to God. We do not love when it is convenient… we love because of God's love for us. We just cannot help loving those even when they are unable to love us back.

Who Does God Love the Most?

Here is one last story that illustrates how God loves through others. One Sunday, a very nice-looking family attended the church I pastored in Oregon. The next week, I made a call to their home and was seated in their den with the husband and wife and two beautiful children. It was then that I heard a terrible sound coming from another room. The mother excused herself and returned shortly carrying the most deformed, disabled child I had ever seen.

She laid the child down on the floor in front of her and said, "This is Johnny; he is our third child. We love him more than I can say. He does not know we do, and neither can he love us back, but if you were to ask us which one of our three children we love the most, we would have to say Johnny."

I was taken aback, and I heard myself say, "How can that be?" The mother thought for a moment, stroked the little boy's hair, and responded, "Because he needs us to love him the most." Is that not the way God loves? *"And he has given us this command: 'Anyone who loves God must also love their brother and sister'"* (1 John 4:21). This means anyone and everyone who needs to be loved, and that means *everybody.*

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And a Little Child Shall Lead Them

Parenting can be an adventure full of exquisite joy and run the gambit all the way to fear, grief and great sorrow. I do not think we realize the great vulnerability parenting brings on us until our children arrive, as the impact of such tiny lives is quite profound. It also never goes away no matter how big they get or how far away they end up. We are impacted by their love, joys, successes and accomplishments. We are equally susceptible to their hurts, sorrows, limitations and failures. The only protection from such vulnerabilities is the hardness of the heart for a failure to love.

Our vulnerability and the resulting effect of our children's lives lead to something few ever mention—core principle I believe is one of the integral parts of parenting. We meet these tiny people and feel overwhelmed at all that is required of us. Their basic care rests on our shoulders as they can do nothing for themselves. We must teach and train and shape these little lives. They are stunningly vulnerable and most adults have some sense of how easily we could hurt them. We want them to grow up strong and healthy and wise. We may feel utterly inadequate for the task and are keenly aware of all they will require from milk to education to ethical and spiritual training. We are to be there for them. What is less readily seen, however, is that they are also there for us. We are their training ground and they are ours. We shape them; they shape us. Both sides actually go to "school" simultaneously.

Many years ago, when my firstborn was still quite small, he did something naughty (I no longer remember what it was) that required a time out. I was about six months pregnant. I took him by the hand and led him upstairs to the chair we used. He cried for a bit and then I spoke with him and went back down to the dinner table. He did it again… and again. On my third or so trip down the stairs, I sat down on the landing and said out loud to myself, "Who in the world is actually getting disciplined here?" The light went on. I suddenly realized I was being trained by my Heavenly Father just as much as my son was being trained by his earthly mother. He was learning to obey his mommy. I was learning to teach him over and over with patience and a gentle, but firm, voice (not my natural inclination). If I chose not to bow to the training of my Father, then the training of my son would be out of balance. My son, with all his gifts and precious ways… as well as his struggles, had been sent to me for parenting, teaching and loving. He had also been sent to me so I might learn more of the ways of my Father in heaven and be shaped more into His likeness. How like God to take what we quickly see as a one-way street and make it into a two-way experience! The revelation changed the dialogue in my head—from thinking, "What does my son need to do or learn or be?" to "Father, how would You have me respond? What is the best for my son from Your perspective?" Fortunately, for both of my sons, it made a significant difference in the responses of their mother over the years.

Such thinking is quite unlike our natural responses. We get angry because of what our children did or did not do; we are impatient when they do not/will not learn; we discipline out of our own emotions rather than out of the nature of Christ, and we forget their littleness… their limitations and vulnerability. We want them to do the right thing, the convenient thing, mostly because it will make our lives easier or smoother. We are self-serving in that way, rather than being a servant.

Therapy is, of course, quite similar. Broken, hurting, angry, thrashing, vulnerable people come to us for counseling. We are to be there for them. We are to reflect, empathize, suggest, question and teach so that they might learn and grow and find comfort. Yet once again, our Father is after us and uses their anger, repetitive behaviors or failures, anxiety, irrationality, and deep wounds to call us to bow so that He might shape us into His image no matter what gets thrown at us. Both parenting and therapy invite us to learn the ways of our incarnational God, who put on human flesh and showed us how to walk in love and truth—not only influencing and shaping those around us, but also by being shaped so that in our flesh we carry the fragrance and likeness of Christ into those relationships. ✠

My son... had been sent to me for parenting, teaching and loving. He had also been sent to me so I might learn more of the ways of my Father in heaven and be shaped more into His likeness.

DIANE LANGBERG, PH.D., chairs AACC's Executive Board and is a licensed psychologist with Diane Langberg & Associates in Jenkintown, Pennsylvania. She is also the author of *Counseling Survivors of Sexual Abuse* and *On the Threshold of Hope.*

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« GARY W. MOON, PH.D.

Re-ordering Our Disorder

I sometimes joke about why I became a psychologist, typically saying, "Well, I knew I would be spending much of my adult life in a psychotherapist's office, so I thought I'd put myself in the position of getting to pick the best chair."

The statement is about two parts self-effacing southern humor, but at least one part truth.

It is probably fair to say that almost every condition in the *Diagnostic and Statistical Manual for Mental Disorders (DSM)* exists on a continuum. For example, every normal person has experienced symptoms of depression at some point. If your best friend, spouse, or child dies and you do not experience significant depressive symptoms, something is very wrong. These "symptoms" would be part of normal bereavement, yet very similar to those of major depression, at least for a period of time.

Too much anxiety can be debilitating. A little anxiety can help you perform routine tasks more quickly. Thinking a little outside the box can get you promoted. Thinking way, way outside the box can get you in a pharmacological straightjacket.

I still love the simple definition of what constitutes a mental disorder that I learned over three decades ago. A condition is considered a "disorder" if patterns of thought or behavior exist to such an extent or intensity as to get in the way of normal social, emotional or occupational functioning. The disorder is not in the symptoms, but in what they eventually prevent.

The issue theme for this edition of *CCT* has me musing about my own childhood experiences and which, if any, could have been seen as a disorder by a school psychologist—assuming there had been such things in my rural Georgia elementary school that featured eight grades, eight teachers, and 88 children.

I do know I bailed from youth camp on two separate occasions, and it was not just because I was afraid of the salvation specialists who had been brought in to talk about the possibility of me becoming a rotisserie item in the afterlife. No, it was because I was prone to some pretty intense feelings of homesickness.

I also know I had some toys in my room that were placed on shelves in a very precise order and "just for show," which often was quite a surprise to my more normal friends. When I was dropped off at school by my mom, there were several prayers I had to pray… and in just the right way. So, from this vantage point, there is a pretty good chance I might have qualified for a separation anxiety disorder of childhood with some obsessive-compulsive symptoms thrown in if the *DSM* had contained more pages at that time, and if there had been a psychologist in my county.

I am also fairly certain I should have been diagnosed with a learning disability. I sometimes reverse brag about making the lowest grade in the entire 10th grade on a spelling test—and I think I have already mentioned the rural Georgia part.

I don't mean to be making light of these disorders. At the time, my anxiety and verbal skills—that could not keep within two standard deviations of my math skills—were no laughing matter and, in fact, became my personal dark secrets. To this day, the process of keeping those skeletons in the cupboard may still fuel some deep fear that if people really get to know me, I will be found out to be a fraud.

However, there is also a sense in which I have deep appreciation for these deficits. I think it is precisely my childhood homesickness and attempts to control anxiety by thoughts and actions that have given me a very deep appreciation for the fact that as an unceasing spiritual being, I am actually not from around here. I only feel peaceful to the extent that I am going home (several times a day) to the invisible realm of the here-and-now kingdom and hearing God call my name and tell me how much I am loved. My disorder may be giving me a deeper appreciation for the order of the universe.

The reading and spelling problems have resulted in some things that are just weird. Why would a person who still cannot spell "bycicle," and who found math so easy as to be able to beat a slide rule on most two-digit computations, never take another math class after his freshman year of college? And why would he, instead, make most of his living with words?

Somewhere along the way, I learned that while my brain is like a Kaypro computer, but with an even slower processor and no spell check whatsoever, it has a pretty good color graphics package. If it can absorb the information (preferably through auditory channels), it is easy to turn that information into metaphors and teachable illustrations. The bottom line is I think most abilities having the wattage of a Christmas light are often pretty close to some other abilities that can light up a room. My verbal disability has become a wonderful lesson in humility and trust, and has helped me to believe that God likely has a good sense of humor.

When I first started working as a psychotherapist, I had a fairly simply system for understanding disorder. For a while, I called it the compassion deficit model. I reasoned that human beings were designed to live in Eden, a place that means "delight," and awash with the love and presence of God. If the psyche is seen as an engine, the love of God and others is the needed oil to keep it humming smoothly.

However, to move away from God, to live outside the garden away from love and presence, is painful. Engines without oil experience heat and friction and begin to shut down. A psyche running without love and acceptance experiences pain.

No normal human likes the warning signals of pain. I believe psychic pain most often signals a significant compassion deficit. The pain of compassion deficits can then trigger a person to look for relief from the pain that may be under his or her control. Hurting people often pursue cognitive behavioral "narcotics" to dull the real or perceived absence of love.

My favorite "self-medication" took the forms of perfectionism, workaholism and control. The anxiety over possible rejection or separation caused me to work harder to feel worthy, to be impossible to reject. This has often been both ugly and exhausting. Yet, great beauty can be found in the disorder.

I believe the three most common symptoms of compassion deficits are anger, anxiety and depression, and that the flipside of these "conditions" is love, joy and peace—the first three in the Apostle Paul's listing of the fruit of the Spirit (Galatians 5).

What is my point? It is almost too simple. Within much of the disorder in my life, a clear path back to order can be found. I am drawn to the beauty of picturesque communication, in part because individual letters and words were so baffling and boring. I best know willingness and surrender because I am so prone to willfulness and control. It is precisely my experience of separation and fear that creates within me a powerful drive for union and love.

I am not saying we should celebrate all disorder, not by any means. What I am saying, however, is that we should seek to learn all that disorder may have to teach us about love and life in the invisible kingdom, the new Eden, before we work to make the symptoms go away. ✠

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« MICHAEL R. LYLES, M.D.

When Failure Should Not be an Option

The movie, Apollo 13, was based on a real-life explosion on a lunar spaceflight that threatened the lives of the crew. The mission flight director responded to the crisis by ordering his engineers to "work the problem" and find a solution, as "failure is not an option." In medicine, failure is not just an option, but often a frequent reality. Some patients do not respond to pharmacological treatments or cease to experience any therapeutic benefit after varying amounts of time. This kind of "failure" often depletes patients of their most precious commodity: hope. From this hopeless position, patients can self-medicate, drop out of treatment altogether, lose jobs, ruin relationships, fade spiritually, and have an increased risk for suicide.

The reality is that medication management does not always work in addressing a patient's clinical problems. Sometimes, we do not fully understand the complexities of the diseases that we are attempting to treat or have the appropriate technology to treat even a fairly well-understood problem. Nevertheless, there may be an answer if we "work the problem" adequately, and failure should not be considered as an option. To document what working the problem would look like, we monitored patients over a two-month period who presented with pharmacological scenarios where medications were either not working at all or had ceased being effective. The following is a list of the problems that were "worked" and corrected, resulting in recovery becoming a reality for these patients. It bears repeating: these were real, not theoretical, situations.

■ **Substance Use Disorders:** Using alcohol, cannabis, methamphetamine and cocaine were associated with depression, anxiety and psychosis. Nicotine use can speed up (induce) liver enzymatic clearance (flushing) of some psychiatric medications from the body. Reducing or stopping nicotine increased blood levels and psychotropic performance.

■ **New Medical Problems:** The onset of the following was associated with worsening of a variety of psychiatric symptoms: thyroid disease, low testosterone levels, menopause/perimenopause, diabetes, polycystic ovarian syndrome, anemia and chronic pain syndromes.

■ **Medication Side Effects:** Psychiatric symptoms were temporally associated with starting a variety of medications including: Keppra and Topamax (for epilepsy and seizures), Arimidex and Lupron (for cancer), chronic hepatitis C antivirals, and Prednisone (an immunosuppressant). Several psychostimulants (Attention Deficit Hyperactivity Disorder) and appetite suppressants were also associated with mania.

■ **Medication Interactions:** Oral contraceptives reduced Lamictal (an anticonvulsant) blood levels (enhancing the risk for bipolar depression). Methotrexate (for autoimmune diseases) reduced folic acid levels (enhancing depression). Asthma medications enhanced anxiety as a side effect of Wellbutrin (an antidepressant).

■ **Sleep:** Anything that disrupts normal sleep cycles can have psychiatric consequences. Examples of this include cough/cold medications, sleep apnea, barbiturates (sleeping pills), leaky CPAP (continuous positive airway pressure) masks for sleep apnea, caffeine/energy drinks, jet lag and stimulating nutritional supplements.

■ **Diagnostic Challenges:** In this category, the patient either had multiple psychiatric diagnoses (e.g., depression plus OCD/PTSD/eating disorder, etc.), with one of the other diagnoses not fully addressed, or the wrong primary diagnosis (e.g., Bipolar II instead of major depression).

■ **Drug Issues:** Changing from a brand medication to a generic form or from one generic to another was relevant. Several patients changed to different doctors (due to insurance mandates) who adjusted the dosage of a medication that was working or failed to monitor blood levels with drugs like Lithium. In a few cases, it was indicated to change to a medication with a different mechanism of action (e.g., impacts a different neurotransmitter)—which every patient (and referral source) assumed to be the only intervention needed.

■ **Allergies:** Inflammation is a hot area of study in psychiatry. Hence, it is not surprising that severe allergies to gluten and black mold made the list of fixable problems, due to elevating systemic inflammation.

■ **Diet:** Deficiencies with B and D vitamins were relevant along with the excessive usage of grapefruit (which can affect drug metabolic rates), caffeine and sea salt (which can result in decreased iodine levels from not using iodized table salt and resultant thyroid dysfunction).

■ **Personal Drama:** Patients lied about taking their medications, used expired medications, changed their own dosages or mixed their medications with questionable medications that were obtained abroad via the Internet. Collateral history from family members was critical here in finding the truth.

■ **Therapy:** Medications are contraindicated for many problems. Job losses, relational conflicts, unresolved traumas and spiritual concerns were examples of problems where medications should have failed as a primary and sole treatment.

In summary, this list is not exhaustive, but reflects what was seen during this three-month monitoring period. These examples do reflect the broad categories of concerns that illustrate what "working the problem" should resemble in order to avoid preventable failures in psychopharmacology. ✠

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« JOHN SANDY, J.D.

New HIPAA Omnibus Rule Takeaways for Christian Counselors

The HIPAA Omnibus Rule—published by the U.S. Department of Health and Human Services ("HHS") on January 25, 2013—includes some important modifications of the Health Insurance Portability and Accountability Act's (HIPAA) Privacy, Security and Enforcement Rules, including increased consumer rights and a greater likelihood that data breaches will be reported by covered entities (e.g., solo counselor, group practice, treatment facility, etc.). According to HHS Office of Civil Rights Director, Leon Rodriguez, the Rule sets forth, "… the most sweeping changes to the HIPAA Privacy and Security Rules since they were first implemented."[1] The Rule, which became effective on March 26, 2013, requires compliance by covered entities, generally, by September 23, 2013.

Notable key provisions of the HIPAA Omnibus Rule of interest to licensed Christian counselors who are HIPAA covered entities and must protect client confidentiality are as follows:

Changes to the Notice of Privacy Practices

A covered entity's Notice of Privacy Practices ("NPP") must, in part, include:

- A statement regarding the right of affected individuals to be notified following a data breach.
- A description of the types of uses and disclosures of Protected Health Information ("PHI") that, generally, requires authorization for disclosure (i.e., psychotherapy notes, the use and disclosure of PHI for marketing purposes, and the sale of PHI). The NPP must also make clear that all other uses and disclosures of PHI not described in the NPP will only be made with the individual's authorization.
- A statement regarding an individual's right, generally, to require a covered entity to restrict disclosure of PHI to a health plan if the PHI pertains solely to a healthcare item or service for which the individual, or person other than the health plan, has paid the covered entity in full.

Increased PHI Access by Consumers

If a covered entity maintains PHI electronically in designated record sets, patients can, generally, obtain an electronic copy of such records. PHI must, generally, be provided to an individual in the form and format desired by the individual. If PHI is not readily producible in that form, the covered entity and individual can agree on a readable electronic form and format.

- **Unencrypted E-mail.** The HHS stressed in the comments to the HIPAA Omnibus Rule that a covered entity can send information to an individual in unencrypted e-mail if the individual is notified of the risk involved in such disclosure and still desires to receive PHI in such format. Covered entities are not responsible for unauthorized access of PHI while in transmission to the individual based on the individual's request.
- **Individual Requests for PHI Disclosure and Nondisclosure.** An individual can request that a covered entity transmit a copy of his or her PHI to another person. The request must be in writing and signed by the individual. Also, as noted previously, individuals can, generally, restrict disclosure of their PHI by a covered entity to a health plan for an item or service for which the individual, or person other than the health plan, has paid the covered entity in full.
- **Response Time and Fees.** A covered entity has 30 days to respond to an individual's request for access *to*, or a copy of, his or her PHI. A 30-day extension of time to produce the PHI is also possible. Finally, a reasonable fee can be charged for furnishing a copy of the PHI to an individual.

Direct Business Associate Responsibility for HIPAA Compliance

Business associates are now directly subject to the HIPAA Security Rule and a majority of requirements of the HIPAA Privacy Rule. The HIPAA Omnibus Rule expands the definition of business associate and specifically names certain entities (e.g., subcontractors of business associates and people who provide data transmission services with respect to PHI to a covered entity and require access on a routine basis to PHI).

More Stringent Breach Notification Guidelines

The Omnibus Rule revises the definition of "breach" to make it more probable that a covered entity or business associate will need to report one. Prior law required that a breach need only be reported if it posed a significant risk of financial, reputational or other harm to the individual. Under the final Rule, a presumption is created that the unauthorized acquisition, access, use or disclosure of unsecured PHI is a data

breach unless a covered entity or business associate can demonstrate that there is a low probability that the PHI was compromised. In order to determine if a low probability exists, a covered entity or business associate, as applicable, must conduct a risk assessment based on at least the following factors:

- the nature and extent of the PHI involved
- the unauthorized person who used the PHI or to whom the disclosure was made
- whether the PHI was acquired or viewed
- the extent to which the risk to the PHI has been mitigated

Increased HHS Penalties

Penalties for violation of HIPAA Rules now range from $100 to $50,000 per infringement. There are four violation categories and penalty tiers. Penalties are capped at $1.5 million per calendar year for multiple violations. The Department of Health and Human Services makes clear in the comments to the Omnibus Rule that a covered entity, as well as a business associate, can be liable for the actions of a business associate who is acting as an agent of the covered entity in accordance with agency law.

Recommended Action Steps for Christian Counselors

Licensed Christian counselors who are HIPAA covered entities should take action to assure compliance with HIPAA as a result of the Omnibus Rule. In particular, business associate agreements, Notice of Privacy Practices, and HIPAA policies and procedures must be reviewed and modified as needed. Members of the covered entity's workforce should be educated and trained to comply with new HIPAA requirements. ✠

The information is current as of the date it is written. This article is provided solely for general educational purposes and does not constitute legal advice between an attorney and a client. The law varies in different jurisdictions. Consultation with an attorney is recommended if you desire legal advice.

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Endnote

1 U.S. Department of Health and Human Services (2013). "New Rule Protects Patient Privacy, Secures Health Information." Retrieved May 18, 2013 at hhs.gov/news/press/2013pres/01/20130117b.html.

« HENRY CLOUD, PH.D.

The Leader's "Childhood" Disorders

For some reason, most of us make an innocent mistake when trying to help a "leader." Because of his or her position, we often assume something that might not be true—"adulthood." Keep in mind, just because someone lives in a 40-year-old body, he or she can still have some "parts" that are exactly the same as when they were 10. The difference is that now the person is running a department, team, or an entire organization instead of just cleaning his or her room or walking the dog. Do not let the "adult costume" fool you.

While it is impossible to look at all the ways childhood disorders affect leadership—both in ministry and business—in the space permitted here, we can examine one and give it a new name: "ADHD Leadership."

In my book, *Boundaries for Leaders*, I tell the stories of many organizations and teams that suffer from exactly this condition. Their leaders are managing in ways that create organizational ADHD, and their followers are unable to respond in a balanced way. The reason? It is similar to working with some ADHD children: *their inability to engage the executive functions of the brain.* Here is where you, as a counselor to leaders, can have a significant impact.

Basically, the "executive functions" are the faculties of the brain that allow a person to get anything done. To reach a goal or move something from point "A" to "Z," we need these important neuro-cognitive abilities. Whether the objective is meeting a sales goal, an evangelism effort, or driving the car from your house to a 7-11 store, the brain must do three things in order to make that happen: 1) Attend – It must be able to focus on relevant stimuli and information, 2) Inhibit – It must shut out all distractions, and 3) Working Memory – It must keep everything current, and front and center.

So, in this case, to arrive safely at the 7-11, the brain must "attend" to each necessary step in reaching the goal (the proper lane, oncoming traffic, vehicle speed, the next turn, etc.). You must, likewise, "inhibit" distractions from attending (texting or watching a video while driving, having someone scream at you, etc.). Finally, you must keep a "working memory." In other words, you cannot simply be dropped into the driver's seat out of a time machine because you would probably be clueless on what to do next if you were unaware what just happened. You have to be in a continuous "flow" to get there.

Often, because of the personal issues leaders sometimes wrestle with, they lead themselves and others in ways the brain cannot follow. Their executive functions (attending, inhibiting and working memory) are not engaged well. Therefore, they are not always successful in helping people reach their goals. The reason is because the leader is not able to attend to what is relevant, inhibit what is not, and keep it all current in a working memory without losing focus.

For example, leaders "cast a vision" or have a "goal" they want to accomplish. They are motivated and set to go out and conquer the world… until the next day after the planning retreat. Then, the next "big thing" becomes the

most important project to them. They overwhelm their people with e-mails and "urgencies" that have nothing to do with the "most important" priority they have decided upon. As a result, they lose focus on what is "vital" and "core" and become distracted by the tyranny of the urgent or the attractive, and then have too many things now requiring time, attention and resources. I often tell leaders, "If everything is 'important,' *nothing* is."

When you help one leader with his or her executive functions, you sometimes help thousands and thousands of people. As Bill Hybels, Senior Pastor of Willow Creek Community Church, often says, "When a leader gets better, everybody benefits." When you can help a leader realize he or she is not focused on what has been deemed and communicated as "important," organizational confusion and demoralization is reduced and the "ADHD" of leadership is better mediated. In my experience, leadership train wrecks and mishaps are often caused by the scatteredness, lack of focus, and impulsivity of the leader, which bring their gifts to a standstill. In assisting leaders, help them focus… and stay focused.

Facilitating a leader in staying committed to what he or she has deemed important can add incredible fuel to the counseling, coaching or therapy process. It literally *forces* therapeutic and character issues to come to the forefront; for as you begin to confront the lack of focus, you are bringing up the underlying reasons that drive it: fears of failure, fears of confrontation, the lack of discipline and structure, narcissism, impulsivity and, sometimes, a deep soul searching regarding giftedness and purpose. This lack of focus can be a powerful dynamic, but as long as leaders are allowed to be "all over the map," they never have to face some of those issues.

In *Boundaries for Leaders*, I talk about how many leaders are too obsessed with finding the right "strategy" or "plan," when the real issue is they are not leading people well. Their own lack of boundaries is getting in the way of the results they desire and would be very fulfilling to them. If you can guide them in finding appropriate boundaries, they will have a greater capacity to be fruitful, fulfilled, and able to bring relief to those they lead. ✠

HENRY CLOUD, PH.D., is a clinical psychologist, leadership consultant, and the author of the new release, *Boundaries for Leaders: Results, Relationships, and Being Ridiculously in Charge* (Harper, 2013).

« MARK A. YARHOUSE, PSY.D.

Obsessive-Compulsive Disorder

Family Factors and Treatment Outcomes for OCD

Peris, T.S., Sugar, C.A., Bergman, L., Chang S., Langley, A. & Piacentini, J. (2012). Family Factors Predict Treatment Outcome for Pediatric Obsessive-Compulsive Disorder. *Journal of Consulting and Clinical Psychology*, 80 (2), 255-263. DOI: 10.1037/a0027084.

This was a study that considered various family factors, such as family conflict and parental blame, as possible predictors of treatment outcomes for minor clients diagnosed with obsessive-compulsive disorder (OCD) who were being seen in family-focused cognitive behavioral therapy (FCBT). Participants in the study were drawn from a larger clinical trial that was comparing FCBT to relaxation training and psychoeducation. Forty-nine youth ranging in age from eight to 17 years (average age of 12.4 years; SD = 2.6 years) and their families had been assigned to either FCBT or the relaxation training/psychoeducation material. The FCBT approach involved 12, 90-minute sessions over 14 weeks (60 minutes of individual child treatment and 30 minutes of family treatment with a focus on reducing blame, limit setting, identifying barriers to treatment, and so on).

After controlling for severity of OCD symptoms at the start of treatment, it was reported that families with lower levels of family conflict and parental blame and higher levels of family cohesion at the start of treatment had better treatment outcomes. Families with higher levels of dysfunction at the start of treatment did not do as well. As the researchers observed, "These findings speak to the important role of the family in treatment for childhood OCD, providing preliminary evidence that negative family dynamics may attenuate clinical outcomes" (p. 260).

Christian counselors can benefit from assessing multiple aspects of family functioning prior to providing services. As the researchers conclude, this may help identify both family strengths and weaknesses heading into treatment. Blame, conflict, and cohesion all appear to be important—with family cohesion being especially critical—and could be addressed in the context of providing counseling services.

Attachment-based Interventions and OCD

Rezvan, S., Bahrami, F., Abedi, M., Macieod, C., Doost, H.T.N. & Ghasemi, V. (2013). A Preliminary Study on the Effects of Attachment-based Intervention on Pediatric Obsessive-Compulsive Disorder. *International Journal of Preventive Medicine*, 4 (1), 78-87.

This study examined the efficacy of attachment-based intervention in a

child sample that had been diagnosed with obsessive-compulsive disorder (OCD). Participants in the study were 24 female children ranging in age between 10 and 12 years. The 24 children were then randomly assigned to receive either attachment-based interventions or be in a wait-list control group (to receive intervention later). Twelve youth received the attachment-based treatment over an eight-week period of time (eight, 60-minute sessions with their mothers). There were no differences on various measures of symptom severity between the treatment and control groups at the start of therapy.

The attachment-based intervention focused on a number of areas, including discussing the link between attachment needs and behavioral expression; how mothers respond to their children's attachment needs; role play of emotional needs and responses; and so on. A great deal of emphasis was placed on identifying areas of conflict and training mothers to respond based on attachment needs rather than the mother's own emotional state.

The results were that symptoms of OCD decreased significantly by the end of the eight weeks of attachment-based therapy. These gains were maintained at the four-week follow-up. There was no such improvement among children in the control group.

This study supports other studies that have been conducted that emphasize the importance of family-based interventions. At the same time, it may be the first to examine attachment-based interventions. The researchers argue that future research should consider whether improving the parent-child relationship could "contribute to the prevention of OCD in children" (p. 85).

Whether or not preventative strategies are developed, this study affirms attachment-based interventions with children diagnosed with OCD. Perhaps others will be able to replicate these findings with a larger sample.

Children with Very Early Onset OCD

Nakatani, E., Krebs, G., Micali, N., Turner, C., Heyman, I. & Mataix-Cols, D. (2011). Children with Very Early Onset Obsessive Compulsive Disorder: Clinical Features and Treatment Outcome. *The Journal of Child Psychology and Psychiatry*, 52 (12), 1261-1268. DOI: 10.1111/j.1469-7610.2011.02434.x.

Eriko Nakatani and his colleagues examined early onset obsessive-compulsive disorder (OCD). Literature suggests that those who report early onset OCD tend to have greater symptom severity, greater persistence of symptoms, and are less responsive to intervention. Three hundred sixty-five young people were a part of the study. They were divided into two groups: very early onset of OCD, which refers to before the age of 10, and late onset, which refers to age 10 or later. The researchers also conducted an analysis of a subgroup of those who participated in cognitive-behavioral therapy (CBT) alone or CBT with medication.

The very early onset group was younger at the time of assessment and reported a longer history of OCD. More frequently reported among the very early onset group were comorbid chronic tic disorders (sudden, rapid and nonrhythmic movements) and scores (reported by parents) indicating more total difficulties. The very early onset group was also more likely to have higher levels of repeating and

ordering compulsions. Total difficulties scores were no greater by self-report or teacher-report and the two groups were similar in terms of family history of OCD, symptom severity, depression, and psychosocial disability. Both the very early onset group and the late onset group reported significant reductions in OCD symptoms over the course of intervention via CBT.

Christian counselors may be encouraged to see that, at least in this study, while there may be differences between children with early and late onset OCD, the responsiveness to treatment is not tied to onset. Both groups of children responded "equally well to CBT that is tailored to their developmental level" (p. 1,267). The researchers encourage accurate early detection and intervention of OCD followed by evidence-based interventions.

Predicting Quality of Life in Children with OCD

Palermo, S.D., Bloch, M.H., Craiglow, B., Landeros-Weisenberger, A., Dombrowski, P.A., Panza, K., Smith, M.E., Peterson, B.S. & Leckman, J.F. (2011). Predictors of Early Adulthood Quality of Life in Children with Obsessive-Compulsive Disorder. *Social Psychiatry and Psychiatric Epidemiology*, 46, 291-297. DOI: 10.1007/s00127-010-0194-2.

Sean Palermo and his colleagues conducted a study to identify predictors of quality of life in early adulthood among children diagnosed with obsessive-compulsive disorder (OCD). This was a longitudinal study with completed data from 36 children (out of a possible 61) with OCD. The children were interviewed at a baseline (average age of 12 years) and again in emerging adulthood, at an average age of 21 (nine years later).

Fifteen participants (42%) experienced a remission of OCD symptoms by early adulthood. Another 14 (39%) reported minimal OCD, while five (14%) had moderate OCD and two (6%) had severe OCD. More than half (57%) had no evidence of impaired quality of life in adulthood. Primary hoarding OCD symptoms at initial assessment in childhood predicted lower quality of life in emerging adulthood. Among those whose OCD symptoms did not remit, the greatest impairments were noted in the interpersonal relationships and work/employment domains (though in the mild range, on average).

The researchers see their findings as providing hope for families insofar as children initially diagnosed with OCD were often functioning well in adulthood. This was true even when OCD symptoms did not completely remit. Other comorbid conditions, such as ADHD, tic disorders, and depression did not predict quality of life in emerging adulthood.

Mother-Child Interactions and Childhood OCD

Schlup, B., Farrell, L. & Barrett, P. (2013). Mother-Child Interactions and Childhood OCD: Effects of CBT on Mother and Child Observed Behaviors. *Child & Family Behavior Therapy*, 33 (4), 322-336. DOI: 10.1080/07317107.2011.623920.

Barbara Schlup and her colleagues studied a group-based cognitive behavioral therapy with family focus (CBT-F) for the treatment of children with obsessive-compulsive disorder (OCD). Participants were 44 children and adolescents ranging in age from seven to 17 years (M = 12.05, SD = 2.84) diagnosed with OCD and their mothers. Participants were randomly assigned to either the treatment condition or a wait list control group—25 were in the CBT-F treatment group, while 19 were in the control group. Most participants (80%) met criteria for a secondary diagnosis, including Generalized Anxiety Disorder (34%), Separation Anxiety Disorder (16%), Social Phobia (14%), Specific Phobia (9%), and Major Depression (5%).

The CBT-F intervention consisted of 14 weekly, 90-minute group sessions divided up as follows: 50 minutes of group CBT with children (psychoeducation, anxiety management, graded exposure/response prevention, etc.); 30 minutes of parent skills training (psychoeducation, problem-solving, etc.); and 10 minutes of family review of progress in treatment.

There were no significant differences between the CBT-F treatment group and control group on age, presence of comorbidity, gender, or mother/child behavioral variables; however, there were differences in OCD severity at the beginning of treatment, with the CBT-F participants being less severe pretreatment. For all subsequent analyses, pretreatment symptom severity was entered as a covariate.

Both mother-observed behaviors and child-observed behaviors were overall more positive after CBT-F treatment as compared to the wait list control group. The results suggest that CBT with family involvement "may help to improve mother-child behavioral interactions in families with a child suffering from OCD" (p. 332). Because of design limitations, it is also possible that symptom improvement lead to better family interactions.

Christian counselors are certainly seeing more research on interventions that include family members in the treatment of childhood OCD. There appears to be growing evidence that involving family is helpful, and this study provides some preliminary support for that understanding. ✠

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« CHILDHOOD DEVELOPMENT DISORDERS
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Answer the following questions from this issue of Christian Counseling Today by marking the appropriate circle. Once completed, you may send in this entire page or a photocopy with your payment to the address below. Please do not send cash. The quiz is open-book and you will need a minimum score of 70% to receive a letter of completion.

Acting Out or a Ticking Time Bomb? – Steve Warren

1. The transactional or reciprocal model for treating ODD
   - ○ a. looks at how the school system disciplines opposition
   - ○ b. strictly looks at the biological causes of ODD
   - ○ c. looks at how the parent and child interact together
   - ○ d. looks at early childhood developmental patterns

Elimination Disorders in Childhood – Trina Young Greer

2. Primary encopresis refers to
   - ○ a. children who have never responded to potty training
   - ○ b. a condition existing in primary school age children
   - ○ c. bed wetting that occurs during the day
   - ○ d. soiling clothes that began late in childhood

A Brief Guide to Evidence-based Practice… – Gary Sibcy

3. Sibcy says the gold standard treatment for childhood OCD is
   - ○ a. a form of reality therapy developed by Glasser
   - ○ b. a form of CBT developed by John March at Duke
   - ○ c. the use of thought stopping and reframing techniques
   - ○ d. the reevaluate, resist, replace and redirect technique

Learning Disorder or Learning Style?... – Cynthia Ulrich Tobias

4. According to the author
   - ○ a. if your child is diagnosed with a learning disorder, seek a second opinion
   - ○ b. it is critical to focus on your child's strengths
   - ○ c. as adults, we often get hired for what got us in trouble in school
   - ○ d. all of the above

Light it Up Blue: Understanding Autism Spectrum Disorders – Eric Scalise and Stephanie Holmes

5. By law, schools are not required to provide assistance for autism until
   - ○ a. a formal diagnosis is made
   - ○ b. the child's disruptive behavior becomes intolerable
   - ○ c. a formal request is made in writing by the parents
   - ○ d. all of the above

Psychiatric Medications for Children and Adolescents – Edward John Kuhnley

6. One of the biggest problems regarding medication management for children is
   - ○ a. parents do not want their children on drugs
   - ○ b. compliance by the child
   - ○ c. drugs create unforeseen damaging side effects in children
   - ○ d. children often overdose on their drugs

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder – Joshua Straub

7. One of the most significant changes in the *DSM-5* for RAD is
   - ○ a. it has been recognized as a biological disorder
   - ○ b. it has been moved to an Axis II disorder
   - ○ c. its subtypes are now two separate disorders
   - ○ d. all of the above

Sit Still and Pay Attention: Children with ADHD – Linda Mintle

8. The PATS study concluded that
   - ○ a. symptoms treated early did not persist in later childhood
   - ○ b. despite treatment with medication, children did not improve
   - ○ c. diet was a significant factor in ADHD
   - ○ d. intense sunlight during the day increased ADHD in children

Stigmatized Kids: Learning and Intellectual Disabilities – Carrie Fancett Pagels

9. The author lists which of the following as the "key" for treatment
   - ○ a. the initial diagnosis
   - ○ b. an extensive medical evaluation
   - ○ c. complete psychological testing
   - ○ d. cognitive restructuring

The Therapeutic Powers of Play… – Josephine Olson

10. Sandplay therapy allows children to manipulate figures and
    - ○ a. increase self-worth and self-esteem
    - ○ b. establish close bonds with the therapist
    - ○ c. create a subjective world
    - ○ d. overcome parental alienation

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« TIM CLINTON, ED.D., LPC, LMFT

Awesome-tistic: Parenting an Autistic Child

I am excited to share with you the powerful story of my friends, Randy and Janet Tomlin. They have a lot more to say than I do about raising a special needs child.

On March 24, 1993, Randy and Janet welcomed their first child into the world, a precious little boy named Coy. As a Major League Baseball player, Randy envisioned his son carrying on his dreams. Soon, they began to fear something was gravely wrong; Coy struggled to eat, roll over, and make eye contact. "The doctors put him through every test imaginable, with no answers," Janet shares.

Three years of waiting left Randy and Janet feeling desperate. They began reading about autism and started checking off one behavior after another. "The diagnosis was the first relief, but also the beginning of the unknown," Randy says. "We had to sit there and listen to the experts tell us everything that Coy would never do. It was gut-wrenching."

"Major League Baseball players are not supposed to have any weaknesses," Janet points out. "Here was my husband on posters… on ESPN… and I had given him a child who didn't fit the mold. I felt like a complete failure."

A white, three-inch binder seemed to seal Coy's fate, with page after page describing his grim future. The doctors suggested institutionalized care, predicting a low quality of life. Eighteen years ago, very little was known about autism—it was a mystery even to the specialists.

In a moment they now look back on and see as life-changing, Randy tossed the binder into the garbage when they walked out of the clinic. Janet still remembers his words: "This is our son. God gave him to us, and we are going to raise Coy. Nobody knows the future of our son's life or how God will use him."

"We felt like our lives were over," Janet remembers, but the Tomlins clung to their faith and chose to believe in God's promise "to give [Coy] a hope and a future" (Jeremiah 29:11). As a young couple with two children, Randy and Janet quickly realized their need for support from family and friends. The experts told them, "Coy's best therapy is from you—his family. You are his biggest advocates." Rather than tearing apart their marriage, autism has, in fact, brought the couple closer together.

In considering various treatments, Randy and Janet encourage other parents to be judicious and pursue methods that reduce symptoms and increase the child's abilities and skills. "Don't drive yourself crazy on every diet and therapy. Your children need to know they are more than 'projects' to manage. In many ways, the cure for your autistic child is you."

From their own experience, the Tomlins identify several pitfalls. "It's easy to get stuck feeling sorry for yourself and your child, but you've got to see God's perspective. Coy has strengths and weaknesses—much like other kids. Early on, we decided to capitalize on his strengths and be patient with his challenges."

Photos Compliments of Janet Tomlin

Randy and Janet have been honest with Coy about autism, but they have also worked hard to avoid labeling him. "Don't tell an autistic child who he is," Randy challenges parents. "Yes, Coy is autistic, but he is so much more. Often, I feel like we put these kids on strings and treat them like puppets. Every child—autistic or not—needs to be loved, valued, and understood."

"There are so many stereotypes," the Tomlins share. "Many people believe that these kids are unapproachable and emotionless, but this is just not true." Attunement is the key to healthy relationships here—we must enter into their world, rather than expecting them to come into ours. "Sometimes, with Coy, we have seven different conversations at a time… that's just the way his brain works," Randy laughs. "You have to meet your child where he is in the moment."

Over the years, Coy's parents have taken an active role in advocating for him with teachers, coaches, and even professionals. We tell people, "If you take time to look into Coy's eyes, you will discover an amazing child with personality, laughter, and joy."

Autistic children often get easily overwhelmed and need small steps, prompts, and rewards. For Coy, it quickly became about Skittles®… and baseball. From potty training to social skills, from swimming to baseball, a great deal of patience is required. "Sure, it's frustrating sometimes, and inconvenient, but it's part of parenting our son," the Tomlins point out. "You have to celebrate the little victories… and roll with the punches."

Early on, Randy and Janet admit they really disabled Coy. With the best of intentions, they held him back from rambunctious play for fear he would get hurt. Over time, though, they have learned to trust God and let their son "live"—even if it means broken bones and trips to the doctor. "Only when he is put into real-life situations can he build the necessary coping skills and learn how to interact with others."

The Tomlins encourage parents not to worry about what other people think. "Normal is a setting on the dishwasher," Janet laughs. "There is no perfect child, so don't live in fear. Get over being embarrassed. Go out to restaurants… go on vacation… enjoy life." Obviously, wisdom and preparation are needed, but Randy and Janet encourage families to make memories together and not stay cooped up at home.

While Coy cannot tie his shoes or make a PB&J sandwich, he genuinely loves others. "He inspires me to laugh louder, to trust more, and to be more passionate about life," Randy reflects. Rather than viewing autistic children as "less than," perhaps we would do well to see them as rare gifts from God. Through his tenderness, compassion and joy, Coy has impacted countless people for Christ. He has the unique ability to see past the surface to what really matters.

"Autism has not disabled my son or my family," Randy says. "In fact, it has strengthened us—teaching us that everyone is capable of doing extraordinary things when given love, encouragement and support from family, friends and the community."

"We want Coy to know we love him just the way he is, and we're so proud of him. He is a dreamer, an overcomer, an achiever, a champion. He is awesome-tistic!"

TIM CLINTON, ED.D., LPC, LMFT, is President of AACC, Executive Director of the Center for Counseling and Family Studies/Professor of Counseling and Pastoral Care at Liberty University, and co-founder of Light Counseling, Inc., a clinical practice serving children, adolescents, and adults. He is the author of several books, including *God Attachment* (Howard Books), *The Popular Encyclopedia of Christian Counseling* (Harvest House), and his most recent, *Break Through* (Worthy Publishing).

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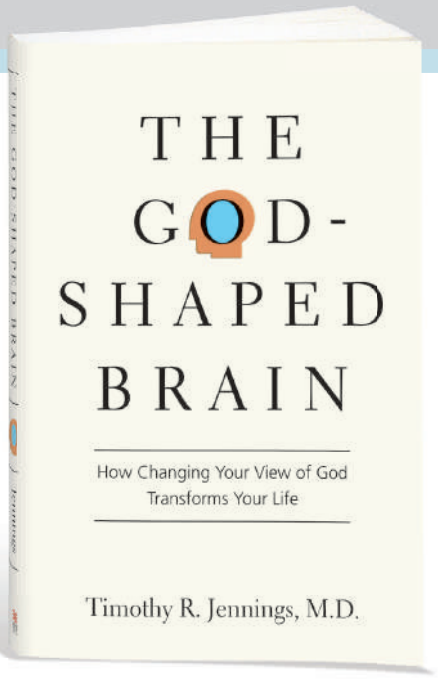

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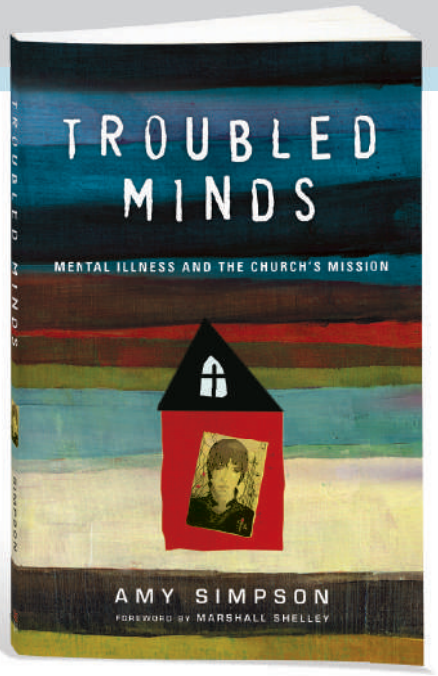

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