

Eighth Edition

Child Psychopathology





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Child Psychopathology, 8th Edition
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Library of Congress Control Number: 2023903594

ISBN: 978-0-357-79658-0

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DSM-5-TR Classifications

Neurodevelopmental Disorders

Intellectual Disabilities

Intellectual Disability (Intellectual Developmental Disorder)/Global Developmental Delay/Unspecified Intellectual Disability (Intellectual Developmental Disorder)

Communication Disorders

Language Disorder/Speech Sound Disorder/Childhood-Onset Fluency Disorder (Stuttering)/Social (Pragmatic) Communication Disorder/Unspecified Communication Disorder

Autism Spectrum Disorder

Autism Spectrum Disorder

Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder/Other Specified Attention-Deficit/Hyperactivity Disorder/Unspecified Attention-Deficit/Hyperactivity Disorder

Specific Learning Disorder

Motor Disorders

Developmental Coordination Disorder/Stereotypic Movement Disorder

Tic Disorders

Tourette's Disorder/Persistent (Chronic) Motor or Vocal Tic Disorder/Provisional Tic Disorder/Other Specified Tic Disorder/Unspecific Tic Disorder

Other Neurodevelopmental Disorders

Other Specified Neurodevelopmental Disorder/Unspecified Neurodevelopmental Disorder

Schizophrenia Spectrum and other Psychotic Disorders

Schizotypal (Personality) Disorder
Delusional Disorder
Brief Psychotic Disorder
Schizophreniform Disorder

Schizophrenia
Schizoaffective Disorder
Substance/Medication-Induced Psychotic Disorder
Psychotic Disorder Due to Another Medical Condition
Catatonia Associated with Another Mental Disorder
Catatonic Disorder due to Another Medical Condition
Unspecified Catatonia
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Bipolar and Related Disorders

Bipolar I Disorder/Bipolar II Disorder/Cyclothymic Disorder/Substance/Medication-Induced Bipolar and Related Disorder/Bipolar and Related Disorder Due to Another Medical Condition/Other Specified Bipolar and Related Disorder/Unspecified Bipolar and Related Disorder

Depressive Disorders

Disruptive Mood Dysregulation Disorder/Major Depressive Disorder/Persistent Depressive Disorder (Dysthymia)/Premenstrual Dysphoric Disorder/Substance/Medication-Induced Depressive Disorder/Depressive Disorder Due to Another Medical Condition/Other Specified Depressive Disorder/Unspecified Depressive Disorder

Anxiety Disorders

Separation Anxiety Disorder/
Selective Mutism/Specific Phobia/
Social Anxiety Disorder (Social Phobia)/Panic Disorder/Panic Attack Specifier/Agoraphobia/
Generalized Anxiety Disorder/
Substance/Medication-Induced

Anxiety Disorder/Anxiety Disorder Due to Another Medical Condition/
Other Specified Anxiety Disorder/
Unspecified Anxiety Disorder

Obsessive-Compulsive and Related Disorders

Obsessive-Compulsive Disorder/
Body Dysmorphic Disorder/
Hoarding Disorder/Trichotillomania (Hair-Pulling Disorder)/Excoriation (Skin-Picking) Disorder/Substance/Medication-Induced Obsessive-Compulsive and Related Disorder/
Obsessive-Compulsive and Related Disorder Due to Another Medical Condition/Other Specified Obsessive-Compulsive and Related Disorder/Unspecified Obsessive-Compulsive and Related Disorder

Trauma- and Stressor-Related Disorders

Reactive Attachment Disorder/
Disinhibited Social Engagement Disorder/Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger)/Acute Stress Disorder/Adjustment Disorders/
Other Specified Trauma- and Stressor-Related Disorder/
Unspecified Trauma- and Stressor-Related Disorder

Dissociative Disorders

Dissociative Identity Disorder/
Dissociative Amnesia/
Depersonalization/Derealization Disorder/Other Specified Dissociative Disorder/Unspecified Dissociative Disorder

Somatic Symptom and Related Disorders

Somatic Symptom Disorder/Illness Anxiety Disorder/Conversion Disorder (Functional Neurological

Symptom Disorder)/Psychological Factors Affecting Other Medical Conditions/Factitious Disorder (includes Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another)/Other Specified Somatic Symptom and Related Disorder/Unspecified Somatic Symptoms and Related Disorder

Feeding and Eating Disorders

Pica/Rumination Disorder/Avoidant/Restrictive Food Intake Disorder/Anorexia Nervosa (Restricting type, Binge-eating/Purging type)/Bulimia Nervosa/Binge-Eating Disorder/Other Specified Feeding or Eating Disorder/Unspecified Feeding or Eating Disorder

Elimination Disorders

Enuresis/Encopresis/Other Specified Elimination Disorder/Unspecified Elimination Disorder

Sleep-Wake Disorders

Insomnia Disorder

Hypersomnolence Disorder/Narcolepsy

Breathing-Related Sleep Disorders

Obstructive Sleep Apnea Hypopnea/Central Sleep Apnea/Sleep-Related Hypoventilation/Circadian Rhythm Sleep-Wake Disorders

Parasomnias

Nonrapid Eye Movement Sleep Arousal Disorders/Nightmare Disorder/Rapid Eye Movement Sleep Behavior Disorder/Restless Legs Syndrome/Substance/Medication-Induced Sleep Disorder/Other Specified Insomnia Disorder/Unspecified Insomnia Disorder/Other Specified Hypersomnolence Disorder/Unspecified Hypersomnolence Disorder/Other Specified Sleep-Wake Disorder/Unspecified Sleep-Wake Disorder

Sexual Dysfunctions

Delayed Ejaculation/Erectile Disorder/Female Orgasmic Disorder/Female Sexual Interest/Arousal Disorder/Genito-Pelvic Pain/Penetration Disorder/Male Hypoactive Sexual Desire Disorder/Premature (Early) Ejaculation/Substance/Medication-Induced Sexual Dysfunction/Other Specified Sexual Dysfunction/Unspecified Sexual Dysfunction

Gender Dysphoria

Gender Dysphoria/Other Specified Gender Dysphoria/Unspecified Gender Dysphoria

Disruptive, Impulse-Control, and Conduct Disorders

Oppositional Defiant Disorder/Intermittent Explosive Disorder/Conduct Disorder/Antisocial Personality Disorder/Pyromania/Kleptomania/Other Specified Disruptive, Impulse-Control, and Conduct Disorder/Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Substance-Related and Addictive Disorders

Substance-Related Disorders

Alcohol-Related Disorders: Alcohol Use Disorder/Alcohol Intoxication/Alcohol Withdrawal/Other Alcohol-Induced Disorders/Unspecified Alcohol-Related Disorder
Caffeine-Related Disorders: Caffeine Intoxication/Caffeine Withdrawal/Other Caffeine-Induced Disorders/Unspecified Caffeine-Related Disorder
Cannabis-Related Disorders: Cannabis Use Disorder/Cannabis Intoxication/Cannabis Withdrawal/Other Cannabis-Induced Disorders/Unspecified Cannabis-Related Disorder
Hallucinogen-Related Disorders: Phencyclidine Use Disorders/Other Hallucinogen Use Disorder/

Phencyclidine Intoxication/Other Hallucinogen Intoxication/Hallucinogen Persisting Perception Disorder/Other Phencyclidine-Induced Disorders/Other Hallucinogen-Induced Disorders/Unspecified Phencyclidine-Related Disorders/Unspecified Hallucinogen-Related Disorders
Inhalant-Related Disorders: Inhalant Use Disorder/Inhalant Intoxication/Other Inhalant-Induced Disorders/Unspecified Inhalant-Related Disorders
Opioid-Related Disorders: Opioid Use Disorder/Opioid Intoxication/Opioid Withdrawal/Other Opioid-Induced Disorders/Unspecified Opioid-Related Disorder
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders: Sedative, Hypnotic, or Anxiolytic Use Disorder/Sedative, Hypnotic, or Anxiolytic Intoxication/Sedative, Hypnotic, or Anxiolytic Withdrawal/Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders/Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder
Stimulant-Related Disorders: Stimulant Use Disorder/Stimulant Intoxication/Stimulant Withdrawal/Other Stimulant-Induced Disorders/Unspecified Stimulant-Related Disorder
Tobacco-Related Disorders: Tobacco Use Disorder/Tobacco Withdrawal/Other Tobacco-Induced Disorders/Unspecified Tobacco-Related Disorder
Other (or Unknown) Substance-Related Disorders: Other (or Unknown) Substance Use Disorder/Other (or Unknown) Substance Intoxication/Other (or Unknown) Substance Withdrawal/Other (or Unknown) Substance-Induced Disorders/Unspecified Other (or Unknown) Substance-Related Disorder
Non-Substance-Related Disorders
Gambling Disorder

Neurocognitive Disorders

Delirium

Major and Mild Neurocognitive Disorders

Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease

Major or Mild Frontotemporal Neurocognitive Disorder

Major or Mild Neurocognitive Disorder with Lewy Bodies

Major or Mild Vascular Neurocognitive Disorder

Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

Substance/Medication-Induced Major or Mild Neurocognitive Disorder

Major or Mild Neurocognitive Disorder Due to HIV Infection

Major or Mild Neurocognitive Disorder Due to Prion Disease

Major or Mild Neurocognitive Disorder Due to Parkinson's Disease

Major or Mild Neurocognitive Disorder Due to Huntington's Disease

Major or Mild Neurocognitive Disorder Due to Another Medical Condition

Major and Mild Neurocognitive Disorders Due to Multiple Etiologies
Unspecified Neurocognitive Disorder

Personality Disorders

Cluster A Personality Disorders

Paranoid Personality Disorder/
Schizoid Personality Disorder/
Schizotypal Personality Disorder

Cluster B Personality Disorders

Antisocial Personality Disorder/
Borderline Personality Disorder/
Histrionic Personality Disorder/
Narcissistic Personality Disorder

Cluster C Personality Disorders

Avoidant Personality Disorder/
Dependent Personality Disorder/
Obsessive-Compulsive Personality Disorder

Other Personality Disorders

Personality Change Due to Another Medical Condition/Other Specified Personality Disorder/Unspecified Personality Disorder

Paraphilic Disorders

Voyeuristic Disorder/Exhibitionist Disorder/Frotteuristic Disorder/
Sexual Masochism Disorder/
Sexual Sadism Disorder/Pedophilic Disorder/Fetishistic Disorder/
Transvestic Disorder/Other Specified Paraphilic Disorder/
Unspecified Paraphilic Disorder

Other Mental Disorders

Other Specified Mental Disorder Due to Another Medical Condition/
Unspecified Mental Disorder Due to Another Medical Condition/
Other Specified Mental Disorder/
Unspecified Mental Disorder

Medication-Induced Movement Disorders and Other Adverse Effects of Medication

Neuroleptic-Induced Parkinsonism/
Other Medication-Induced Parkinsonism/Neuroleptic Malignant Syndrome/Medication-Induced Acute Dystonia/
Medication-Induced Acute Akathisia/Tardive Dyskinesia/
Tardive Dystonia/Tardive Akathisia/
Medication-Induced Postural Tremor/Other Medication-Induced Movement Disorder/Antidepressant Discontinuation Syndrome/Other Adverse Effect of Medication

Other Conditions That May Be a Focus of Clinical Attention

Relational Problems

Problems Related to Family Upbringing
Other Problems Related to Primary Support Group

Abuse and Neglect

Child Maltreatment and Neglect Problems
Adult Maltreatment and Neglect Problems

Educational and Occupational Problems

Educational Problems
Occupational Problems

Housing and Economic Problems

Housing Problems
Economic Problems

Other Problems Related to the Social Environment

Problems Related to Crime or Interaction with the Legal System

Other Health Service Encounters for Counseling and Medical Advice

Problems Related to Other Psychosocial, Personal, and Environment Circumstances

Other Circumstances of Personal History

Problems Related to Access to Medical and Other Health Care
Nonadherence to Medical Treatment

The DSM-5 Task Force judged that these disorders do not currently have sufficient supporting data for inclusion in DSM-5 and therefore require further study. In fact, only a few of these proposed disorders will ultimately meet criteria, and others will be excluded from further consideration. Many of the more interesting disorders are discussed in one or more appropriate chapters.

Attenuated Psychosis Syndrome

Key features include delusions, hallucinations, or disorganized speech that distresses and disables the individual; the symptoms are like psychosis but not extreme enough to be considered a full psychotic disorder.

Depressive Episodes with Short-Duration Hypomania

Key features of this disorder are depressive episodes and episodes resembling hypomanic episodes but having a shorter duration (at least 2 days but below the 4-day minimum for hypomanic episodes).

Caffeine Use Disorder

Key features of this disorder are constant caffeine use and an inability to control use.

Internet Gaming Disorder

Key features of this disorder are the fixation on Internet games and continually playing them, at the expense of school, work, and/or social interactions.

Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure

The key feature is diminished behavioral, cognitive, or adaptive functioning due to prenatal alcohol exposure.

Suicidal Behavior Disorder

Key feature is a suicide attempt within the past 2 years that is not related to confusion or delirium.

Nonsuicidal Self-Injury

Key feature is repeated, yet nonserious, self-inflicted bodily damage. The individual engages in these acts due to interpersonal problems, negative feelings, or uncontrollable and/or intense thoughts about the act of injuring themselves.

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Preface

We are delighted with the momentous success of *Child Psychopathology* (formerly *Abnormal Child Psychology*) leading to the release of this eighth edition. The title was changed to reflect the understanding that the term “abnormal” has become pejorative and stigmatizing, which can then serve as a significant barrier for individuals seeking help for mental health concerns (Samara et al., 2022). Because language plays a role in perception and behaviors in how people are viewed and treated in our society, it is important to take action when using a term is causing the “othering” of individuals affected by mental distress (Hermaszewska, 2022). Therefore, we have changed the title to *Child Psychopathology*.

Over the past 20 years, we have closely connected to the diversity and significance of topics covered by this vibrant and active field, which (in our humble opinion) has established essential core knowledge for students interested in the many diverse areas of psychology that are influenced by typical and atypical developmental processes. To keep pace with this expanding knowledge base, we have reviewed literally thousands of new studies across major and minor areas in this field, resulting in the most up-to-date and comprehensive text on the market.

The positive reception to previous editions of our book and the helpful feedback from students and instructors continues to shape *Child Psychopathology* into a comprehensive yet student-friendly textbook. The eighth edition maintains its focus on the child, not just the disorders, while continuing to keep the text on the cutting edge of scholarly and practical advancements in the field. Because reading textbooks can be demanding, we think you will find that the full color presentation, graphics, and artwork increase your engagement with and enjoyment of the material from the moment you pick up the book.

Changes in diagnostic terminology, modifications, and descriptions are reflected throughout this eighth edition, consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, Text Revision (DSM-5-TR). These changes include the addition of diagnostic entities, and modifications and updated terminology in diagnostic criteria and specifier definitions for relevant diagnoses. For example, significant changes to criterion A for Autism Spectrum Disorder were noted in order to reflect the high diagnostic

threshold. Another example is the diagnosis of intellectual developmental disorder (intellectual disability). It was revised from the DSM-5 diagnosis, and thus, the changes are now reflected in this eighth edition. The term “intellectual developmental disorder” is used to clarify the disorder’s relationship with the World Health Organization’s International Classification of Diseases, eleventh revision (ICD-11) classification system, which uses the term “disorders of intellectual development.” The equivalent term “intellectual disability” is placed in parentheses for continued use.

Also, this edition continues to expand on important new developments over the past few years, such as the coronavirus pandemic and its wide-ranging impact on child and adolescent mental health. There are additional substantial updates and additions in areas such as efficacy of treatments, role of culture/socioeconomic status/race and ethnicity, as well as LGBTQIA+ considerations in mental health.

At the same time, the eighth edition retains the hallmark features that make it one of the most successful texts in courses on child psychopathology, developmental psychopathology, behavior disorders of childhood and adolescence, and child psychology. Among these features are engaging first-person accounts and case histories designed to create powerful links between key topics and the experiences of individual children and their families. The features that follow are also foundational to the text.

Attention to Advances in Child and Adolescent Psychopathology

The past decade has produced extraordinary advances in understanding the special issues pertaining to child and adolescent psychopathology. Today, we have a much better ability to distinguish among different disorders of children and adolescents, as well as increased recognition of common features and underlying mechanisms for these supposedly different disorders. Research advances have given rise to increased recognition of poorly understood or underdetected problems such as intellectual developmental disorders, autism spectrum disorder, communication and specific learning disorders, attention-deficit/hyperactivity disorder, motor

disorders, oppositional and conduct disorders, depressive and bipolar disorders, youth suicide, substance use, anxiety disorders, obsessive–compulsive disorder, trauma- and stressor-related disorders, feeding and eating disorders, and disorders stemming from chronic health problems. Similarly, the field of child psychopathology is now more aware of the ways children’s and adolescents’ psychological disorders are distinguishable from those of adults, and how important it is to maintain a strong developmental perspective in understanding the course of childhood disorders over the life span.¹

In a relatively short time, the study of child and adolescent psychopathology has moved well beyond the individual child and family to consider the roles of community, social, and cultural influences in an integrative and developmentally sensitive manner. Similarly, those of us working in this field are more attuned to the many struggles faced by children and adolescents with psychological disorders and their families, as well as to the demands and costs such concerns place on the mental health, education, medical, and juvenile justice systems.

A Focus on the Child, Not Just the Disorders

We believe that one of the best ways to introduce students to a particular problem of childhood or adolescence is to describe a real child. Clinical descriptions, written in an accessible, engaging fashion, help students understand a child’s problem in context and provide a framework in which to explore the complete nature of the disorder. In each chapter, we introduce case examples of children and adolescents with disorders from our own clinical files and from those of colleagues. We then refer to these children when describing the course of the disorder, which provides the student with a well-rounded picture of the child or adolescent in the context of their family, peers, community, and culture.

In addition to clinical case material, we use extracts, quotes, and photos throughout each chapter to help the student remain focused on the real challenges faced by children with disorders and their families. First-person accounts and case descriptions enrich the reader’s understanding of the daily lives of children and adolescents with problems and allow for a more realistic portrayal of individual strengths and limitations.

¹Note: *Child Psychopathology* (8th ed.) spans the age period from infancy through young adulthood. “Child” often is used as shorthand for this broader age range.

A Comprehensive and Integrative Approach

To reflect the expansion of this field, the causes and effects of various childhood disorders are explained from an integrative perspective that recognizes biological, psychological, social, and emotional influences and their interdependence. This strategy was further guided by a consideration of developmental processes that shape and are shaped by the expression of each disorder. Considering the broader contexts of family, peers, school, community, culture, and society that affect development is also important for understanding child and adolescent disorders; they are a critical feature of this text.

We use both categorical and dimensional approaches in describing disorders because each method offers unique and important definitions and viewpoints. Each topic area is defined using DSM-5-TR criteria accompanied by clinical descriptions, examples, and empirically derived dimensions. The clinical features of each disorder are described in a manner that allows students to gain a firm grasp of the basic dimensions and expression of the disorder across its life span. Since children and adolescents referred for psychological services typically show symptoms that overlap diagnostic categories, each chapter discusses common comorbidities and developmental norms that help inform diagnostic decisions.

Attention to Both Developmental Pathways and Adult Outcomes

To provide balance, we approach each disorder from the perspective of the whole child. Diagnostic criteria are accompanied by added emphasis on the strengths of the individual and on the environmental circumstances that influence the developmental course of each disorder, which is followed from its early beginnings in infancy and childhood through adolescence and into early adulthood. We highlight the special issues pertaining to younger and older age groups and the risk and protective factors affecting developmental pathways. In this manner, we examine developmental continuities and discontinuities and attempt to understand why some children with disorders continue to experience difficulties as adolescents and adults and others do not.

Emphasis on Diversity

The importance of recognizing diversity in understanding and helping children with problems and their families is emphasized throughout. New research continues to inform and increase our understanding of the crucial role that factors such as socioeconomic status (SES), gender identity, sexual orientation, race, ethnicity, and culture play in the identification, expression, prevalence, causes, treatments, and outcomes for child and adolescent problems. To sharpen our emphasis on these factors, Katherine Nguyen Williams, Ph.D., of University of California, San Diego School of Medicine, was brought on as co-author to substantially revise the text with a focused aim to incorporate diversity and culturally relevant information throughout the entire book. She is an expert in diversity and child psychology, and recognized as a Faculty Champion of Diversity at University of California, San Diego. Moreover, we were fortunate to receive input from Sumru Erkut, Ph.D., of Wellesley College, and Khalima Bolden, Ph.D., of University of California, Davis, both experts in diversity and child development. As a result of their input, we examine differences related to SES, gender, race, ethnicity, and culture for each childhood disorder under discussion. In addition, we also recognize the importance of studying distinct groups in their own right as a way of understanding the processes associated with specific problems for each gender, ethnic, or cultural group. While emphasizing new knowledge about diversity issues and childhood disorders, we also caution throughout this text that relatively few studies have examined the attitudes, behaviors, and biological and psychological processes of children and adolescents with disorders across different cultures, and we indicate places where this situation is beginning to change.

Coverage of Trauma- and Stressor-Related Disorders, Child Maltreatment, and Relationship-Based Disorders

A distinguishing feature of this textbook is its expansion and emphasis on several of the more recent and important areas of developmental psychopathology that do not easily fit into a deficits model or a categorical approach. One of these new areas concerns

trauma- and stressor-related disorders, which are now recognized in DSM-5-TR as specific disorders stemming from many forms of tragic events that affect children's development and life course. The eighth edition expands on the role of stressful and traumatic events in children's lives and how such events may be direct or contributing causes to psychological disorders. We discuss the nature of child maltreatment to illustrate how major forms of childhood stress and trauma often stem from unhealthy relationships with significant others. Along with recognition of the importance of biological dispositions in guiding development and behavior, we discuss the strong connection between children's behavior patterns and the availability of a suitable child-rearing environment and how early experience can influence both gene expression and brain development. Students are made aware of how children's overt symptoms can sometimes be adaptive in particular settings or in caregiving relationships that are atypical or abusive and how traditional diagnostic labels may not be helpful.

Integration of Treatment and Prevention

Treatment and prevention approaches are integral parts of understanding a particular disorder. Applying knowledge of the clinical features and developmental courses of childhood disorders to benefit children with these disorders and their families always intrigues students and helps them make greater sense of the material. Therefore, we emphasize current evidence-based approaches to treatment and prevention in each chapter, where such information can be tailored to the particular childhood problem. Consistent with current health system demands for accountability, we discuss best practice guidelines and emphasize interventions for which there is empirical support.

A Flexible, Even More User-Friendly Text

The book is organized into a logical four-part framework to facilitate understanding of the individual disorders and mastery of the material overall. Following the introductory chapters that comprise Part I, the contents can be readily assigned to students in any order that suits student needs and the goals and preferences

of the instructor. The following is an overview of the book's four parts:

- I. Understanding Child Psychopathology (definitions, theories, clinical description, research, assessment, and treatment issues)
- II. Neurodevelopmental Disorders (intellectual developmental disorder, autism spectrum disorder and childhood-onset schizophrenia, communication and specific learning disorders, attention-deficit/hyperactivity disorder)
- III. Behavioral and Emotional Disorders (conduct problems, depressive and bipolar disorders, anxiety and obsessive-compulsive disorders, trauma- and stressor-related disorders)
- IV. Problems Related to Physical and Mental Health (health-related and substance-use disorders, feeding and eating disorders)

The overall length of the text is completely student-centered and manageable without sacrificing academic standards of content and coverage. Dozens of first-person accounts and case histories help students grasp the real-world impact of disorders. Two guides—"Cases by Chapter" and "Cases by Clinical Aspect"—have been provided at the front of the text to help teachers and students navigate the book as easily as possible.

In addition, chapters are consistently organized to help instructors avoid assigning sections of each chapter (e.g., biological causes) that may not appeal to the level of their students or that address particular subtopics that fall outside the parameters of a given course (e.g., childhood-onset schizophrenia or pediatric bipolar disorder). For instructors wanting a more detailed presentation of research findings, supplementary readings can be drawn from the many up-to-date citations of original research.

Related but less critical information that enhances each topic appears in the "A Closer Look" features, so that students can easily recognize that the material is presented to add further insight or examples to the major content areas of the chapter.

Finally, chapters provide many useful pedagogical features to help make students' encounters with and learning of the material an agreeable experience: *key terms* are highlighted and defined where they appear in the text, listed at the chapter's end, and defined in a separate glossary at the back of the book to help students grasp important terminology; DSM-5 tables are provided in addition to general tables to summarize

diagnostic criteria; *bullet points* guide students to key concepts throughout the chapters; and "Objectives" to help students consolidate each chapter's key concepts. In addition to the lists of key terms, students will find a listing of "Section Summaries" and "Section Summary Questions" at the end of each section for easy reference while studying.

For this book, we can highlight that it is aimed at upper-division undergraduate and graduate students who have completed a general or introductory psychology course. We can say that the approachable writing style and numerous examples/learning aids help students comprehend the nuanced topics.

Although *Child Psychopathology*, eighth edition covers complex issues and difficult topics, clear, concise, and understandable language is used throughout.

The text is aimed at upper-division undergraduate students and graduate students. Although it will be helpful if students have completed an introductory psychology or life-span human development course, the text does not assume this background.

Summary of Key Features

- "A Closer Look" features, mentioned earlier, are found throughout the book to draw students into the material and enrich each topic with engaging information. Some examples include: "What Are the Long-Term Criminal Consequences of Child Maltreatment?" "Common Fears in Infancy, Childhood, and Adolescence," and "Did Darwin Have a Panic Disorder?"
- Visual learning aids such as memes, tables, and eye-catching chapter- and section-opening quotes, as well as numerous photos and figures, in full color, illustrate key concepts throughout the text to complement student understanding.
- The authors' in-depth coverage of the role of the normal developmental process in understanding each disorder, as well as their close attention to important socioeconomic and cultural determinants, and outcomes of child and adolescent disorders, promote greater understanding.
- Current findings regarding the reliability and validity of DSM diagnostic criteria for specific disorders are discussed, with attention to issues, features, and disorders that are new to DSM-5-TR.

Notable Content Changes and Updates in the Eighth Edition

Highlights of the content changes and updates to this edition include the following:

- Coverage of the most recent significant developments that have broadly affected child and adolescent mental well-being, such as the coronavirus global pandemic.
- Updated terminology that reflects appropriate language to reduce stigma and pejorative connotations.
- Enriched coverage of socioeconomic and cultural factors in the diagnosis, associated features, and/or interventions for disorders.
- Updated diagnostic criteria as indicated by DSM-5-TR.
- The most current information concerning prevalence, age at onset, and gender distribution for each disorder.
- Clear and concise learning objectives to aid in students' focus, set student expectations, and guide their learning processes for each section.
- Section Summary Questions to reinforce the most important points in each section and provide an aid to learning.
- Updated artwork including the addition of memes. Inclusion of ecological and cognitive theories of child psychopathology (Chapter 1).
- Added coverage of Bronfenbrenner's Ecological Systems Theory (Chapters 1 and 2).
- Inclusion of explanation on mental disorders and violence along with APA Position Statement (Chapter 1)
- Updated prevalence rates for child and adolescent disorders (Chapter 1).
- Updated stressors for children and adolescents, including newer developments on social media use and technology (Chapter 1).
- Role of implicit bias in diagnostic considerations (Chapter 1).
- Inclusion of LGBTQIA+ and the role of stigma in child and adolescent mental health (Chapter 1).
- Inclusion of Adverse Childhood Experiences Study (ACES) data (Chapter 1).
- Added discussion on misinformation and proliferation of mental health information on social media, e.g., TikTok (Chapter 3).
- Inclusion of specific resources for locating evidence-based interventions for child disorders (Chapter 3).
- Discussion of strength-based approach to clinical assessment (Chapter 4).
- Case-conceptualization process in clinical assessment (Chapter 4).
- Role of therapeutic alliance in clinical assessment (Chapter 4).
- Interpreting screening measures from a culturally competent perspective (Chapter 4).
- Expanded discussion on cultural humility (Chapter 4).
- How to interpret varied observations of a child's behavior during evidence-based clinical assessment (Chapter 4).
- Expanded strategies and tips in engaging children and families in clinical assessment (Chapter 4).
- Inclusion of achievement tests in assessment (Chapter 4).
- Reliability and validity of projective tests, and limitations with BIPOC population (Chapter 4).
- Addressing majority cultural perspective and issue of negative stereotypes and biases (Chapter 4).
- Addition of Parent Management Training (Chapter 4).
- Updated information on Intellectual Developmental Disorder (IDD), including Facilitated Communication (FC) (Chapter 5).
- Enhanced discussion on reducing stigmatizing language for IDD (Chapter 5).
- Expanded discussion on socioeconomic factors, including redlining and colonialism, on diagnosing IDD, including historical and sociopolitical context (Chapter 5).
- Inclusion of role of coronavirus pandemic in societal disparities in considering intellectual developmental disability, as well as impact on fetal alcohol spectrum disorders (Chapter 5).
- Enhanced information about time out from reinforcement in behavioral interventions (Chapter 5).
- Updated DSM-5-TR information on Intellectual Developmental Disorder (Chapter 5).
- Addition of identify-first language in autism spectrum disorders (Chapter 6).
- Updated evidence-based assessment information, e.g., ADOS (Chapter 6).

- Inclusion of role of gender variance and gender dysphoria in ASD (Chapter 6).
- Addition of cognitive symptoms in psychosis and schizophrenia (Chapter 6).
- Inclusion of role of ACES and socioeconomic factors in schizophrenia (Chapter 6).
- Updated DSM-5-TR information on Autism Spectrum Disorder and Language Disorder (Chapter 6).
- Enhanced discussion of language disorders and social/school functioning (Chapter 7).
- Discussion of impact of coronavirus pandemic on assessment and interventions for children with communication problems (Chapter 7).
- Addition of information on “twice exceptional” children and adolescents (Chapter 7).
- Research on MRI and imaging on ADHD (Chapter 8).
- Impact of coronavirus pandemic on ADHD symptoms (Chapter 8).
- Inclusion of implicit bias, socioeconomic factors, and environment in ADHD diagnosis (Chapter 8).
- Updated statistics on conduct-related behaviors (Chapter 9).
- Enhance discussion on socioeconomic factors relating to conduct disorder (Chapter 9).
- Updated statistics on social and economic costs of conduct disorder (Chapter 9).
- Inclusion of discussion on epigenetics and externalizing disorders (Chapter 9).
- Updated statistics on child and adolescent depression (Chapter 10).
- Updated DSM-5-TR information on Persistent Depressive Disorder and Major Depressive Disorder (Chapter 10).
- Updated statistics on child and adolescent anxiety, including for LGBTQIA+ youth (Chapter 11).
- Enhanced discussion of socioeconomic factors in anxiety, including structural racism and cultural mistrust (Chapter 11).
- Updated DSM-5-TR information on Social Anxiety Disorder (Chapter 11).
- Inclusion of impact of coronavirus pandemic and trauma in youth (Chapter 12).
- Updated statistics on child abuse (Chapter 12).
- Inclusion of discussion on research on racial trauma, its effects on youth from marginalized backgrounds, and interventions (Chapter 12).
- Updated DSM-5-TR information on trauma (Chapter 12).
- Inclusion of Adverse Childhood Experiences Study (ACES) and its far-reaching impact on health and development of chronic disease and illness (Chapter 13).
- Inclusion of discussion on statistics on socioeconomic and race/ethnicity factors in health disparities (Chapter 13).
- Updated data on socioeconomic and race/ethnicity factors in substance use among children and adolescents, including prevalence rates (Chapter 13).
- Enhanced discussion on substance use on cognitive functioning and neurodevelopment (Chapter 13).
- Inclusion of case study on coronavirus and health conditions (Chapter 13).
- Updated DSM-5-TR information on substance use disorders (Chapter 13).
- Inclusion of transgender youth and risk for substance use disorders (Chapter 13).
- Updated review on psychosocial treatments for eating disorders (Chapter 14).
- Updated epidemiology and prevalence rates for ARFID (Chapter 14).
- Latest research on etiology and treatments for ARFID (Chapter 14).
- Updated prevalence rates for PICA (Chapter 14).
- Inclusion of coronavirus pandemic’s impact on pediatric obesity (Chapter 14).
- Addition of cultural lens for assessment and sequelae for pediatric obesity (Chapter 14).

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Acknowledgments

One of the most rewarding aspects of this project has been the willingness and commitment on the part of many to share their knowledge and abilities. With great pleasure and appreciation, we wish to acknowledge individuals who have in one way or another contributed to its completion, while recognizing that any shortcomings of this book are our responsibility alone.

In Calgary, Alison and Megan Wiigs, as creative and talented a mother-and-daughter team as there is, have contributed enormously to every phase of this project. For their devotion to the project, they have our special gratitude. We also again thank Carlie Montpetit and Camille Popovich for their perceptive and useful feedback from a student perspective and generous help in locating resource material and references. We are also grateful to colleagues who generously provided us with case materials and other information for this and previous editions, including Thomas Achenbach, Ann Marie Albano, Russell Barkley, David Dozois, Scott Henggeler, Giuseppe Iaria, Charlotte Johnston, Alan Kazdin, Philip Kendall, David Kolko, Ivar Lovaas, Margaret McKim, Robert McMahon, Douglas Murdoch, Joel Nigg, Gerald Patterson, John Pearce, William Pelham, John Piacentini, Phyl and Rachel Prout, Jerry Sattler, David Shaffer, Rosemary Tannock, and Fred Weizmann. Many thanks again to Sumru Erkut, Ph.D., Associate Director and Senior Research Scientist at Wellesley College's Wellesley Centers for Women, and Khalima Bolden, Ph.D., licensed psychologist and Assistant Director of Clinical Training for their expert review of this text's previous and current edition focusing on diversity. We extend our special thanks to the many students and psychology interns in our courses and clinical training programs and those from other universities who provided us with helpful feedback on this edition. Dr. Jeff St. Pierre in London, Ontario, deserves special thanks for his devoted attention to improving ways of teaching child psychopathology using our textbook.

The production of a textbook involves many behind-the-scenes individuals who deserve special thanks. Product manager Cazzie Reyes gave her support in launching this eighth edition. Brett Rader,

content manager, contributed valuable assistance from start to finish. The rest of the devoted and talented staff at and associated with Cengage Group, including Sara Greenwood, designer; Shruti Negi, MPS Limited project manager; Fantasia Mejia, product assistant; and Anjali Kambli, Lumina Datamatics project manager, all deserve our thankful recognition for their contributions toward making the eighth edition of this text top quality.

Once again, we wish to thank our families, whose steadfast support and tolerance for the demands and excesses that go into a project such as this were critically important and exceedingly strong. The preparation of this textbook placed a heavy burden of our time away from them, and we are grateful for their unyielding support and encouragement. Eric Mash thanks Heather Henderson Mash, his wife and soul mate, for her love and support, tolerance of the time that a project like this takes away from family life, and her wise advice on many matters relating to this book. David Wolfe thanks his three children, Amy, Annie, and Alex, who were incredible sources of inspiration, information, humor, and photographs. His wife, Barbara Legate, has been a touchstone throughout every edition for her intellectual and emotional support. Katherine Nguyen Williams thanks her family, including her four children, Grant, Cole, Kate, and Paul, for their patience, humor, and support throughout the writing process. She also thanks her parents, Deacon Peter Can Nguyen and Yen Nguyen, for their love and support, as well as their countless delicious chicken curry deliveries on long writing days.

Reviewers

A critical part of writing this textbook involved feedback from students, teachers, and experts. We wish to again acknowledge and thank the reviewers whose detailed comments and insights in previous editions were enormously helpful in shaping the final manuscript of this edition: Daniel M. Bagner, Florida International University; Paul Bartoli, East Stroudsburg University; Debora J. Bell, University of Missouri-Columbia; Greg Berg, San Jose State University; S. Denise Britt, University of Tennessee at Martin; Myra Bundy, Ph.D., Eastern Kentucky University; Kristin Christodulu, University at Albany, State University of New York;

Richard Clements, Indiana University Northwest; Mary Ann Coupland, Sinte Gleska University; David Day, Ryerson University; Tina Du Rocher Schudlich, Western Washington University; Nancy Eldred, San Jose State University; Robert Emery, University of Virginia; Rebecca Ezechukwu, Miami University; Virginia E. Fee, Mississippi State University; Michael Figguccio, PhD, Farmingdale State College; Domenica Favero, Associate Professor of Department of Psychological Science, University of Lynchburg; Brian Fisak, University of North Florida; Paul Florsheim, University of Utah; Gregory Fouts, University of Calgary; Laura Freberg, California Polytechnic State University–San Luis Obispo; Maria Gartstein, Washington State University–Pullman; Elisa Geiss, California State University; Gary Harper, DePaul University; Casey A. Holtz, Wisconsin Lutheran College; Anne-Marie Iselin, Elon University; Yo Jackson, University of Kansas; Christopher Kearney, University of Nevada–Las Vegas; Elizabeth J. Kiel Luebbe, Miami University; Janet Kistner, Florida State University; Bertha Kondrak, Central TX University; Marvin Kumler, Bowling Green State University; June Madsen Clausen, University of San Francisco; Susan K. Marell, St. Thomas Aquinas College; Christine McAuliffe, PhD, Bryant University; Patrick McGrath, Dalhousie University; Kay McIntyre, University of Missouri–St. Louis; Clark McKown, University of California–Berkeley; Robert McMahan, Simon Fraser University; Richard Milich, University of Kentucky; Martin Murphy, University of Akron; Jill Norvilitis, Buffalo State College; Claire Novosad, Southern Connecticut State University; Narina Nunez, University of Wyoming; Stacy Overstreet, Tulane University; Lauren Polvere, Clinton Community College; Michael Roberts, University of Kansas; Donald T. Saposnek, University of California, Santa Cruz; Dana Schneider, M.A., MFT, Sonoma State University; Jeff St. Pierre, Western University; Kristina Todorovic, University of Toledo; Michael Vasey, Ohio State University; Jan Weiner, Hunter College; Robert Weisskirch, California State University–Monterey Bay; Carol K. Whalen, University of California, Irvine; and Eric A. Youngstrom, Ph.D., University of North Carolina.

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Introduction to Psychopathology in Children and Adolescents

You need a whole community to raise a child.

—Toni Morrison (1981)

Chapter Preview

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After centuries of silence, misunderstanding, and outright abuse, children’s mental health concerns and needs now receive greater attention, which corresponds to society’s recent concern about children’s well-being. Fortunately, today more people like you want to understand and address the needs of children and adolescents. Perhaps you have begun to recognize that children’s mental health concerns differ in many ways from those of adults, so you have chosen to take a closer look. Maybe you are planning a career in teaching, counseling, medicine, law, rehabilitation, or psychology—all of which rely somewhat on knowledge of children’s special needs to shape their focus and practice. Whatever your reason is for reading this book, we are pleased to welcome you to an exciting and active field of study, one that we believe will expose you to concepts and issues that will have a profound and lasting influence. Child and adolescent mental health issues have become highly relevant to many of us in our current and future roles as professionals, community members, and parents, and the needs for trained personnel are increasing (McLearn, Knitzer, & Carter, 2007). For the purpose of this book, we will be using the term “mental health” to encompass our emotional, psychological, and social well-being. In recent years, the term “behavioral health” has emerged and is increasingly adopted to refer to the scientific study of the emotions, behaviors and biology relating to a person’s mental well-being, with a nod to the role of brain and biology in psychological well-being. Many professionals use this term interchangeably with “mental health.” Because “behavioral health” has not yet become widespread in its usage, we will use the term “mental health” for the remainder of this book.

In December 2021, the U.S. Surgeon General issued an Advisory to highlight the urgent need to address the youth mental health crisis exposed by the COVID-19 global pandemic. “Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide—and

rates have increased over the past decade,” said Surgeon General Vivek Murthy. “The COVID-19 pandemic further altered their experiences at home, school, and in the community, and the effect on their mental health has been devastating. The future wellbeing of our country depends on how we support and invest in the next generation” (Office of the Surgeon General, 2021). This significant announcement was on the heels of an unprecedented declaration of a national emergency in child and adolescent mental health by three key U.S. organizations, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, and the Children’s Hospital Association (AAP, 2021). After centuries of being ignored, children’s mental health and well-being have finally been highlighted as an issue of paramount concern for the United States and the world. Let’s begin by considering Georgina’s problems, which raise several fundamental questions that guide our current understanding of children’s **psychological disorders**. Ask yourself: Does Georgina’s behavior seem unusual, or are aspects of her behavior normal under certain circumstances?

How would you describe Georgina’s issue? Is it an emotional concern? A learning issue? A developmental disability? Could something in her environment cause these rituals, or is she more likely responding to internal cues we do not know about? Would Georgina’s behavior be viewed differently if she were a different gender, or Black or Latino? Will she continue to display these behaviors and, if so, what can we do to help?

When seeking assistance or advice, parents often ask questions similar to these about their child’s behavior, and understandably they need to know the probable course and outcome. These questions also exemplify the following issues that research studies in child psychopathology seek to address:

- Defining what constitutes psychopathology for children of different ages, sexes, and racial/ethnic and cultural backgrounds from a Western medical perspective
- Identifying the causes and correlates of child psychopathology

Georgina

Counting for Safety

At age 10, Georgina's unusual symptoms had reached the point where her mother needed answers—and fast. Her behavior first became a concern about two years ago, when she started talking about harm befalling herself or her family. Her mother recalled how Georgina would come home from the third grade and complain that “I need to finish stuff but I can't seem to,” and “I know I'm gonna forget something so I have to keep thinking about it.” Her mother expressed her own frustration and worry: “As early as age 5, I remember Georgina would touch and arrange things a certain way, such as brushing her teeth in a certain sequence. Sometimes, I'd notice that she would walk through doorways over and over, and she seemed to need to check and arrange things her way before she could leave a room.” Georgina's mother had spoken to their family doctor about it back then and was told, “It's probably a phase she's going through, like stepping on cracks will break your mother's back. Ignore it and it'll stop.”

But it didn't stop. Georgina developed more elaborate rituals for counting words and objects, primarily in groups of four. She told her mom, “I need to count things out and group them a certain way—only I know the rules how to do it.” When she came to my office, Georgina told me, “When someone says something to me or I read something, I have to count the words in groups of four and then organize these groups into larger and larger groups of four.” She looked at the pile



Alexander Egiziarov/Shutterstock.com

Even at age 5, Georgina's unusual counting ritual was a symptom of her obsessive-compulsive disorder.

of magazines in my office and the books on my shelf and explained, matter-of-factly, that she was counting and grouping these things while we talked! Georgina was constantly terrified of forgetting a passage or objects or being interrupted. She believed that if she could not complete her counting, some horrible tragedy would befall her parents or herself. Nighttime was the worst, she explained, because “I can't go to sleep until my counting is complete, and this can take a long time.” (In fact, it took up to several hours, her mother confirmed.) Understandably, her daytime counting rituals had led to decline in her schoolwork and friendships. Her mother showed me her report cards: Georgina's grades had gone from above average to near failing in several subjects. (Based on Piacentini & Graae, 1997)

- Making predictions about long-term outcomes
- Developing and evaluating methods for treatment and/or prevention

How you choose to describe the behavioral concerns that children show, and what harm or impairments they may lead to, is often the first step toward understanding the nature of their behavioral concerns. As we discuss in Chapter 11, Georgina's symptoms fit the diagnostic criteria for obsessive-compulsive disorder. This diagnostic label, although far from perfect, tells a great deal

about the nature of her disorder, the course it may follow, and the possible treatments.

Georgina's behavioral concerns also illustrate important features that distinguish most child and adolescent disorders:

- **When adults seek services for children, it often is not clear whose “concern” it is.** Children usually enter the mental health system as a result of concerns raised by adults—parents, pediatricians, teachers, or school counselors—and the children themselves may have little choice in the matter.

Children and adolescents do not tend to refer themselves for treatment, which has important implications for how we detect children’s mental health concerns and how we respond to them.

- **Many child and adolescent behaviors of concern involve failure to show expected developmental progress.** The concerning behaviors may be transitory, like most types of bedwetting, or it may be an initial indication of more severe issues ahead, as we see in Georgina’s case. Determining the concerning behavior requires familiarity with the ages and typical stages in child development.
- **Many behaviors of concern shown by children and youths are not entirely atypical.** To some extent, most children and youth commonly exhibit certain behaviors of concern. For instance, worrying from time to time about forgetting things or losing track of thoughts is common; Georgina’s behavior, however, seems to involve more than these usual concerns. Thus, decisions about what to do also require familiarity with known psychological disorders and behaviors of concern.
- **Interventions for children and adolescents often are intended to promote further development, rather than merely to restore a previous level of functioning.** Unlike interventions for most adult disorders, the goal for many children is to boost their abilities and skills, as well as to eliminate distress.

Before we look at today’s definitions of psychopathology in children and adolescents, it is valuable to discover how society’s interests and approaches to these concerning behaviors during previous generations have improved the quality of life and mental health of children and youths. Many children, especially those with special needs, fared poorly in the past because they were forced to work as coal miners, field hands, or beggars. Genuine interest in children’s needs, rights, and care requires a prominent and consistent social sensitivity and awareness that simply did not exist prior to the twentieth century (Aries, 1962). As you read the following historical synopsis, note how the relatively short history of child psychopathology has been strongly influenced by philosophical and societal changes in how adults view and treat children in general (Borstelmann, 1983; V. French, 1977). ■

1.1 Historical Views and Breakthroughs

Learning Objectives

- Summarize the perspective of “childhood” before the 18th century.
- Describe John Locke’s view of children
- Define behaviorism.
- Describe how behaviorism affected the way children were treated.

Childhood, after all, is the first precious coin that poverty steals from a child.

—Anthony Horowitz (2011)

We must recognize children as valuable, independent of any other purpose, to help them develop their lives and competencies. Although this view of children should seem self-evident to us today, valuing children as persons in their own right—and providing medical, educational, and psychological resources to encourage their progress—has not been a priority of previous societies. Early writings suggest that children were considered servants of the state in the city-states of early Greece. Ancient Greek and Roman societies believed that any person—young or old—with a physical or mental handicap, disability, or deformity was an economic burden and a social embarrassment, and thus was to be scorned, abandoned, or put to death (V. French, 1977).

Prior to the eighteenth century, children’s mental health concerns—unlike adult disorders—were seldom mentioned in professional or other forms of communication amongst Western scientific and medical societies. Some of the earliest Western historical interest in child psychopathology surfaced near the end of the eighteenth century. The Christian Church used its strong influence to attribute children’s unusual or disturbing behaviors to their inherently uncivilized and provocative nature (Kanner, 1962). In fact, during this period, nonreligious explanations for disordered behavior in children were rarely given serious consideration because possession by the devil and similar forces of evil was the only explanation anyone needed (Rie, 1971). No one was eager to challenge this view, given that they too could be seen as possessed and dealt with accordingly.

Sadly, during the seventeenth and eighteenth centuries, as many as two-thirds of children died before their fifth birthday, often because there were no antibiotics

or similar medications to treat deadly diseases (Zelizer, 1994). Many children were treated harshly or indifferently by their parents. Cruel acts ranging from extreme parental indifference and neglect to physical and sexual abuse of children went unnoticed or were considered an adult's right in the education or disciplining of a child (Radbill, 1968). For many generations, the implied view of society that children are the exclusive property and responsibility of their parents was unchallenged by any countermovement to seek more humane treatment for children. A parent's prerogative to enforce child obedience, for example, was formalized by Massachusetts' Stubborn Child Act of 1654, which permitted parents to put "stubborn" children to death for misbehaving. (Fortunately, no one met this ultimate fate.) Into the mid-1800s, specific laws allowed children with severe developmental disabilities to be kept in cages and cellars (Donohue, Hersen, & Ammerman, 2000).

The Emergence of Social Conscience

It is easier to build strong children than to fix broken men.

—Attributed to Frederick Douglass

Fortunately, the situation gradually improved for children and youths throughout the nineteenth century and progressed significantly during the latter part of the twentieth century. With the acuity of hindsight, we now know that before any real change occurs, it requires a philosophy of humane understanding in how society recognizes and addresses the special needs of some of its members. In addition to humane beliefs, each society must develop ways and means to recognize and protect the rights of individuals, especially children, in the broadest sense (UN Convention on the Rights of the Child, 1989). An overview of some of these major developments provides important background for understanding today's approaches to children's mental health concerns.

In Western society, an inkling of the prerequisites for a social conscience first occurred during the seventeenth century, when both a philosophy of humane care and institutions of social protection began to take root. One individual at the forefront of these changes was John Locke (1632–1704), a noted English philosopher and physician who influenced present-day attitudes and practices of childbirth and child rearing. Locke believed in individual rights, and he expressed the novel opinion that children should be raised with thought and care instead of indifference and harsh treatment. Rather than seeing children as uncivilized tyrants, he saw them as emotionally sensitive beings

who should be treated with kindness and understanding and given proper educational opportunities (Illick, 1974). In his words, "the only fence* against the world is a thorough knowledge of it."

Then, at the turn of the nineteenth century, one of the first documented efforts to work with a special child was undertaken by Jean Marc Itard (1774–1838). A Closer Look 1.1 explains how Itard treated Victor (discovered living in the woods outside Paris) for his severe developmental delays rather than sending him to an asylum. Symbolically, this undertaking launched a new era of a helping orientation toward special children, which initially focused on the care, treatment, and training of the people then unfortunately termed "mental defectives."

As the influence of Locke and others fostered the expansion of universal education throughout Europe and North America during the latter half of the nineteenth century, children unable to handle the demands of school became a visible and troubling group. Psychologists such as Leta Stetter Hollingworth (1886–1939) argued that many of these children were actually suffering from emotional and behavioral issues primarily due to inept treatment by adults and lack of appropriate intellectual challenge (Benjamin & Shields, 1990). This view led to an important and basic distinction between persons with intellectual disability and those with mental health concerns, although this distinction was far from clear at the time. Essentially, local governments needed to know who was responsible for helping children whose cognitive development appeared normal but who showed serious behavioral health concerns. The only guidance they had previously had in distinguishing children with intellectual deficits from children with behavioral health concerns was derived from religious views of immoral behavior: children who had normal cognitive abilities but who were disturbed were thought to suffer from "moral insanity," which implied a disturbance in personality or character (Pritchard, 1837). Benjamin Rush (1745–1813), a pioneer in psychiatry, argued that children were incapable of true adult-like insanity, because the immaturity of their developing brains prevented them from retaining the mental events that caused insanity (Rie, 1971). Consequently, the term *moral insanity* grew in acceptance as a means of accounting for nonintellectual forms of child psychopathology.

The implications of this basic distinction created a brief yet significant burst of optimism among professionals. Societal interest in the plight and welfare of

*Archaic use, meaning "defense."

1.1 A Closer Look

Victor of Aveyron

Victor, often referred to as the “wild boy of Aveyron,” was discovered in France by hunters when he was about 11 or 12 years old, having lived alone in the woods presumably all of his life. Jean Marc Itard, a young physician at the time, believed the boy was “mentally arrested” because of social and educational neglect, and set about demonstrating whether such delays could be reversed. Victor—who initially was mute, walked on all fours, drank water while lying flat on the ground, and bit and scratched—became the object of popular attention as rumors spread that he had been raised by animals. He was dirty, nonverbal, incapable of attention, and insensitive to basic sensations of hot and cold. Despite the child’s appearance and behavior, Itard believed that environmental stimulation could humanize him. Itard’s account of his efforts poignantly reveals the optimism, frustration, anger, hope, and despair that he experienced in working with this special child.

Itard used a variety of methods to bring Victor to an awareness of his sensory experiences: hot baths, massages, tickling, emotional excitement, even electric shocks. After five years of training by Dr. Itard, Victor had learned to identify objects, identify letters of the alphabet, comprehend many words, and apply names to objects and parts of objects. Victor also showed a preference for social life over the isolation of the wild. Despite his achievements, Itard felt his efforts had failed because his goals of socializing the boy to make him “normal” were



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never reached. Nevertheless, the case of Victor was a landmark in the effort to assist children with special needs. For the first time an adult had tried to really understand—to feel and know—the mind and emotions of a special child, and had proved that a child with severe impairments could improve through appropriate training. This deep investment on the part of an individual in the needs and feelings of another person’s child remains a key aspect of the helping orientation to this day.

children with mental health concerns began to rise in conjunction with two important influences. First, with advances in general medicine, physiology, and neurology, the “moral insanity” view of psychological disorders was replaced by the organic disease model, which emphasized more humane forms of treatment. This advancement was furthered by advocates such as U.S. journalist and columnist Dorothea Dix (1802–1887), who in the mid-nineteenth century established 32 humane mental hospitals for the treatment of troubled youths previously relegated to cellars and cages (Achenbach, 1982). Second, the growing influence of the philosophies of Locke and others led to the view that children needed moral guidance and support. With these changing views came an increased concern

for moral education, compulsory education, and improved health practices. These early efforts to assist children provided the foundation for evolving views of child psychopathology as the result of combinations of biological, environmental, psychological, and cultural influences.

Early Biological Attributions

The successful treatment of infectious diseases during the latter part of the nineteenth century strengthened the emerging belief that illness and disease, including mental illness, were biological problems. However, early attempts at biological explanations for child psychopathology were highly biased in favor of the

1.2 A Closer Look

Masturbatory Insanity

Today, most parents hardly balk at discovering their child engaging in some form of self-stimulation—it is considered a usual part of self-discovery and pleasant-sensation seeking. Such tolerance was not always the case. In fact, children’s masturbation is historically significant because it was the first “disorder” unique to children and adolescents (Rie, 1971). Just over a 100 years ago, *masturbatory insanity* was a form of mental illness and, in keeping with the contemporaneous view that such problems resided within the individual, it was believed to be a very worrisome problem (Rie, 1971; Szasz, 1970).

By the eighteenth century, society’s objections to masturbation originated from religious views that were augmented by the growing influence of science (Rie, 1971; Szasz, 1970). Moral convictions regarding the wrongfulness of masturbation led to a physiological explanation with severe medical ramifications, based on pseudoscientific papers such as *Onania, or the Heinous*

Sin of Self-Pollution (circa 1710) (Szasz, 1970). The medical view of masturbation focused initially on adverse effects on physical health, but by the mid-nineteenth century the dominant thought shifted to a focus on the presumed negative effects on mental health and nervous system functioning. With amazing speed, masturbation became the most frequently mentioned “cause” of psychopathology in children.

Interest in masturbatory insanity gradually waned toward the end of the nineteenth century, but the argument remained tenable as psychoanalytic theory gained acceptance. Eventually, the notion of masturbatory insanity gave way to the concept of neurosis. It was not until much later in the twentieth century that the misguided and illusory belief in a relationship between masturbation and mental illness was dispelled. Let this example remind us of the importance of scientific skepticism in confirming or disconfirming new theories and explanations for psychopathology.

cause being the person’s fault. The public generally distrusted and scorned anyone who appeared “mad” or “possessed by the devil” or similar evil forces. A Closer Look 1.2 describes “masturbatory insanity,” a good illustration of how such thinking can lead to an explanation of psychopathology without consideration of objective scientific findings and the base rate of masturbation in the general population. The notion of masturbatory insanity also illustrates how the prevailing political and social climates influence definitions of child psychopathology, which is as true today as it was in the past. Views on masturbation evolved from the moral judgment that it was a sin of the flesh, to the medical opinion that it was harmful to one’s physical health, to the psychiatric assertion that sexual overindulgence caused insanity.

In contrast to the public’s general ignorance and avoidance of issues concerning persons with mental disorders, which continued during the late nineteenth century, the mental hygiene movement provides a benchmark of changing attitudes toward children and adults with psychopathology. In 1909, Clifford Beers, a layperson who had recovered from a severe psychosis, spearheaded efforts to change the plight of others also afflicted. Believing that psychopathology was a form

of disease, he criticized society’s ignorance and indifference and sought to prevent psychopathology by raising the standards of care and disseminating reliable information (M. Levine & Levine, 1992). As a result, detection and intervention methods began to flourish, based on a more tempered—yet still quite frightened and ill-informed—view of afflicted individuals.

Unfortunately, because this paradigm was based on a biological disease model, intervention was limited to persons with the most visible and prominent disorders, such as severe psychoses or severe intellectual disability. Although developmental explanations were a part of this early view of psychopathology, they were quite narrow. The development of the disease was considered progressive and irreversible, tied to the development of the child only in that it manifested itself differently as the child grew, but remained impervious to other influences such as treatment or learning. All one could do was to prevent the most extreme manifestations by strict punishment and to protect those not affected.

Sadly, this early educational and humane model for assisting persons with psychopathology soon reverted to a custodial model during the early part of the twentieth century. Once again, attitudes toward

anyone with mental health concerns or intellectual disabilities turned from cautious optimism to dire pessimism, hostility, and disdain. Particularly, children, youths, and adults with intellectual disability were blamed for crimes and social ills during the ensuing alarmist period (Achenbach, 1982). Rather than viewing knowledge as a form of protection, as Locke had argued, society returned to the view that psychopathology and intellectual disability were diseases that could spread if left unchecked. For the next two decades, many U.S. communities opted to segregate or institutionalize people with mental disabilities and to prevent them from procreating (eugenics). We will return to these important developments in our discussion of the history of intellectual disability in Chapter 5.

Early Psychological Attributions

To conceptualize and understand child psychopathology, biological influences must be balanced with important developmental and cultural factors, including the family, peer group, school, neighborhood, community, etc. Of course, this perception was not always the case. The long-standing, medically based view that psychopathology is a disorder or disease residing within the person unfortunately led to neglect of the essential role of a person's surroundings, context, and relations, and of the interactions among these variables.

The recognition of psychological influences emerged early in the twentieth century, when attention was drawn to the importance of major psychological disorders and to formulating a taxonomy (classification) of illnesses. Such recognition allowed researchers to organize and categorize ways of differentiating among various psychological issues, resulting in some semblance of understanding and control. At the same time, there was concern that attempts to recognize the wide range of mental health needs of children and adults could easily backfire and lead to the neglect of persons with more severe disorders. This shift in perspective and increase in knowledge also prompted the development of diagnostic categories and new criminal offenses, the expansion of descriptions of atypical behavior, and the addition of more comprehensive monitoring procedures for identified individuals (Costello & Angold, 2006). Two major theoretical paradigms helped shape these emerging psychological and environmental influences: psychoanalytic theory and behaviorism. We'll limit our discussion here to their historical importance, but additional content concerning their contemporary

influence appears in the Chapter 2 discussion of theories and causes.

Psychoanalytic Theory

In Sigmund Freud's day, near the beginning of the twentieth century, many child psychiatrists and psychologists had grown pessimistic about their ability to treat children's psychopathology other than with custodial or palliative care. Freud was one of the first to reject such pessimism and raise new possibilities for treatment as the roots of these disorders were traced to early childhood (Fonagy, Target, & Gergely, 2006). Although he believed that individuals have inborn drives and predispositions that strongly affect their development, he also believed that experiences play a necessary role in psychopathology. For perhaps the first time, the course of psychiatric disorders was not viewed as inevitable; children and adults could be helped if provided with the proper environment, therapy, or both.

Psychoanalytic theory significantly influenced advances in our ways of thinking about the causes and treatment of psychiatric disorders. Perhaps the most important of these advances from the perspective of child psychopathology was that Freud was also the first to give meaning to the concept of psychiatric disorder by linking it to childhood experiences (Rilling, 2000). His radical theory incorporated developmental concepts into an understanding of psychopathology at a time when early childhood development was virtually ignored by mainstream child psychiatry and psychology spheres. Rather than focusing on singular, specific causes (a hallmark of the disease model in vogue at the time), psychoanalytic theory emphasized that personality and mental health outcomes had multiple roots. Outcomes depended to a large degree on the interaction of developmental and situational processes that change over time in unique ways (Fonagy et al., 2006). In effect, Freud's writings shifted the view from one of children as innocent or insignificant to one of human beings in turmoil, struggling to achieve control over biological needs and to make themselves acceptable to society through the microcosm of the family (Freud, 1909/1953).

Contributions based on Freud's theory continued to expand throughout the early part of the twentieth century, as clinicians and theorists broke from some of his earlier teachings and brought new insights to the field. His daughter, Anna Freud (1895–1982), was instrumental in expanding his ideas to understanding children, in particular by noting how children's symptoms

were related more to developmental stages than were those of adults. Anna Freud's contemporary, Melanie Klein (1882–1960), also took an interest in the meaning of children's play, arguing that all actions could be interpreted in terms of unconscious fantasy. The work of both women made possible the analysis of younger children and the recognition of nonverbal communication for patients of all ages (Mason, 2003).

In recent years, psychoanalytic theory's approach to child psychopathology has had less influence on clinical practice and teaching, largely because of the popularity of the phenomenological (descriptive) approach to psychopathology (Costello & Angold, 2006). Nevertheless, it is important to remember that current **nosologies** (the efforts to classify psychiatric disorders into descriptive categories) are essentially nondevelopmental in their approaches. Rather than attempting, as the Freudian approach does, to describe the development of the disease in the context of the development of the individual, nosologies such as those in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022) attempt to find common denominators that describe the manifestations of a disorder at any age (Achenbach & Rescorla, 2006). Despite valid criticism and a lack of empirical validation of the content of psychoanalytic theory and its many derivatives, the idea of emphasizing the interconnection between children's typical and atypical development retains considerable attraction as a model for understanding child psychopathology.

Behaviorism

The development of evidence-based treatments for children, youths, and families can be traced to the rise of behaviorism in the early 1900s, as reflected in Pavlov's experimental research that established the foundations for classical conditioning, and in the classic studies on the conditioning and elimination of children's fears (Jones, 1924; J. B. Watson & Rayner, 1920). Initially, John Watson (1878–1958), the “Father of Behaviorism,” intended to explain Freud's concepts in more scientific terms, based on the new learning theory of classical conditioning.

Ironically, Watson was perhaps more psychoanalytically inspired by Freud's theories than he intended. As he attempted to explain terms such as *unconscious* and *transference* using the language of conditioned emotional responses (and thereby discredit Freud's theory of emotions), he in fact pioneered the scientific

investigation of some of Freud's ideas (Rilling, 2000). A Closer Look 1.3 highlights some of Watson's scientific ambitions and his famous study with Little Albert, as well as some of the controversy surrounding his career.

Watson is known for his theory of emotions, which he extrapolated from typical to atypical behavior. His infamous words exemplify the faith some early researchers—and the public—placed in laboratory-based research on learning and behavior: “Give me a dozen healthy infants . . . and I'll guarantee to take any one at random and train him to become any type of specialist I might select—doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and race of his ancestors” (J. B. Watson, 1925, p. 82).

Beyond the work in their lab, the Watson household must have been an interesting place. Consider the following contrasting views and advice on raising children from one of America's first “child experts” and his wife:

John Watson (1925): Never hug and kiss them, never let them sit in your lap. If you must, kiss them once on the forehead when they say goodnight. Shake hands with them in the morning.

Rosalie Rayner Watson (1930): I cannot restrain my affection for the children completely. . . . I like being merry and gay and having the giggles. The behaviorists think giggling is a sign of maladjustment, so when the children want to giggle I have to keep a straight face or rush them off to their rooms.

This example and the study of Little Albert illustrate the importance of keeping in perspective any new advances and insights that at first may seem like panaceas for age-old problems. As any soiled veteran of parenting would attest, no child-rearing shortcuts or uniform solutions guide us in dealing with children's behavioral issues—raising children is part skill, part wisdom, and part luck. Nonetheless, families, communities, and societal and cultural values play a strong role in determining how successful current child-rearing philosophies are at benefiting children.

Ecological and Cognitive Theories

Watson's work propelled the field of psychology forward in other ways, specifically spurring psychological researchers to understand the underlying link of condition. Here we begin to see the rise of cognitive developmental theories such as that of Piaget and Vygotsky.