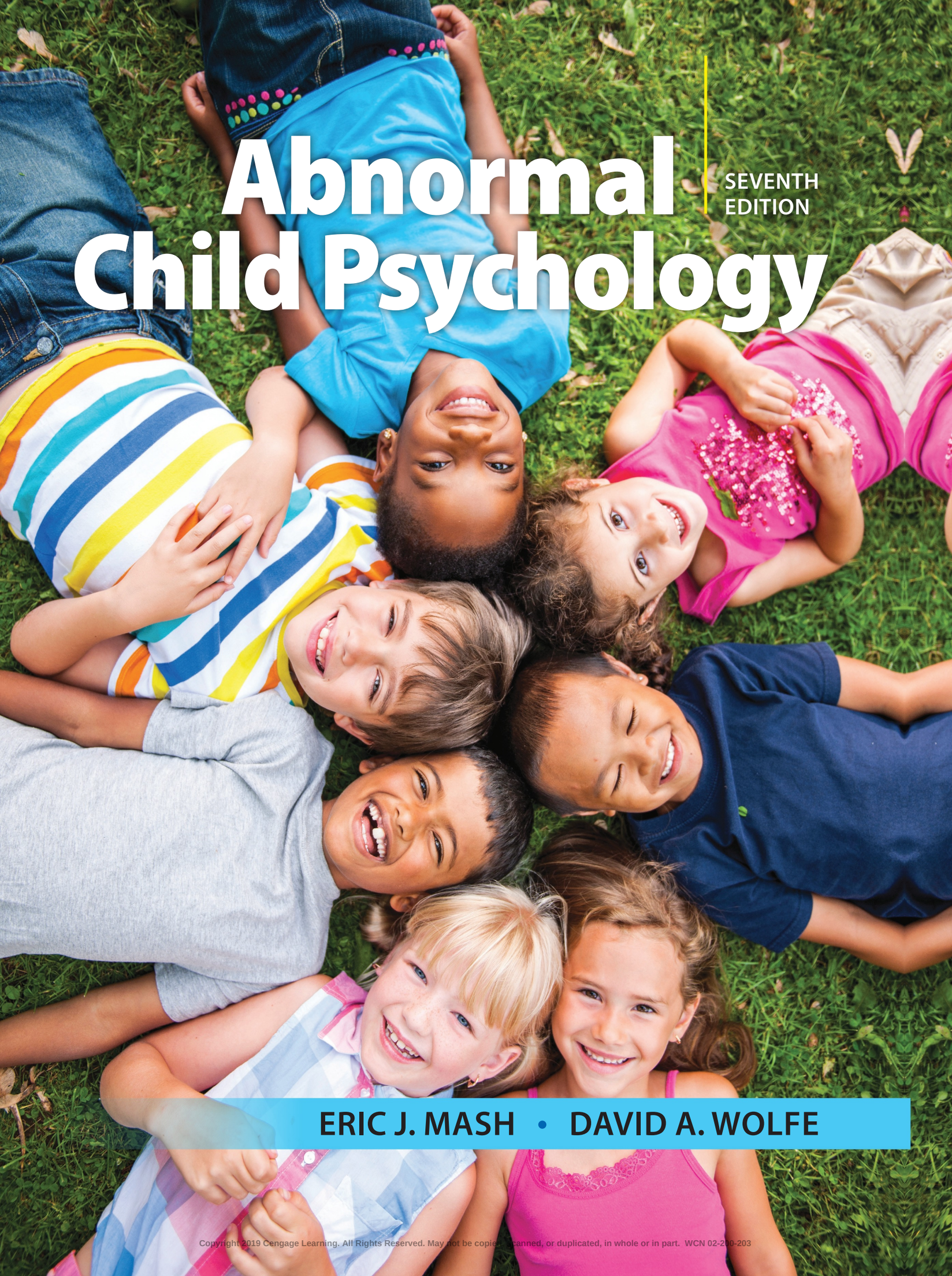
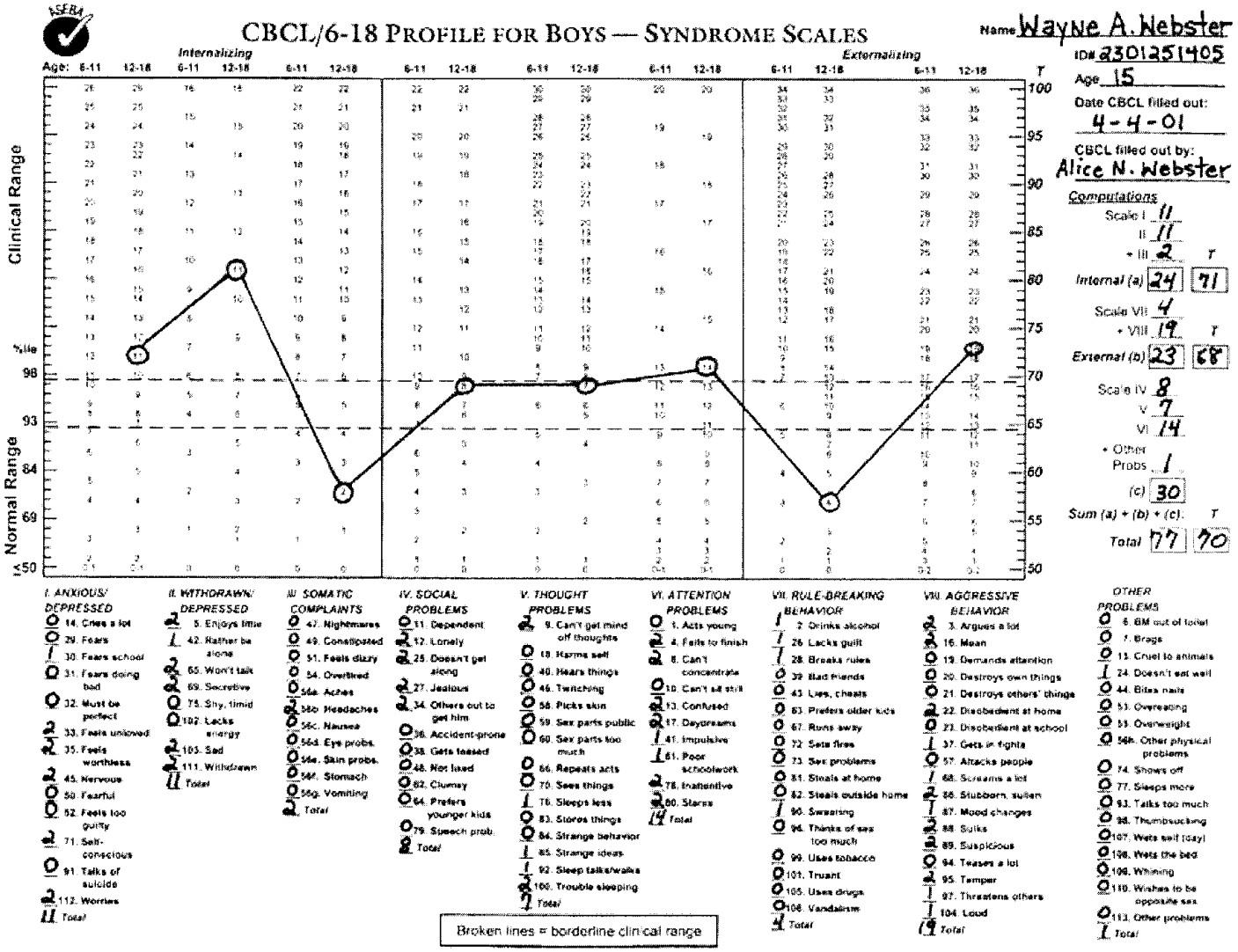


Abnormal Child Psychology

SEVENTH EDITION

ERIC J. MASH • DAVID A. WOLFE

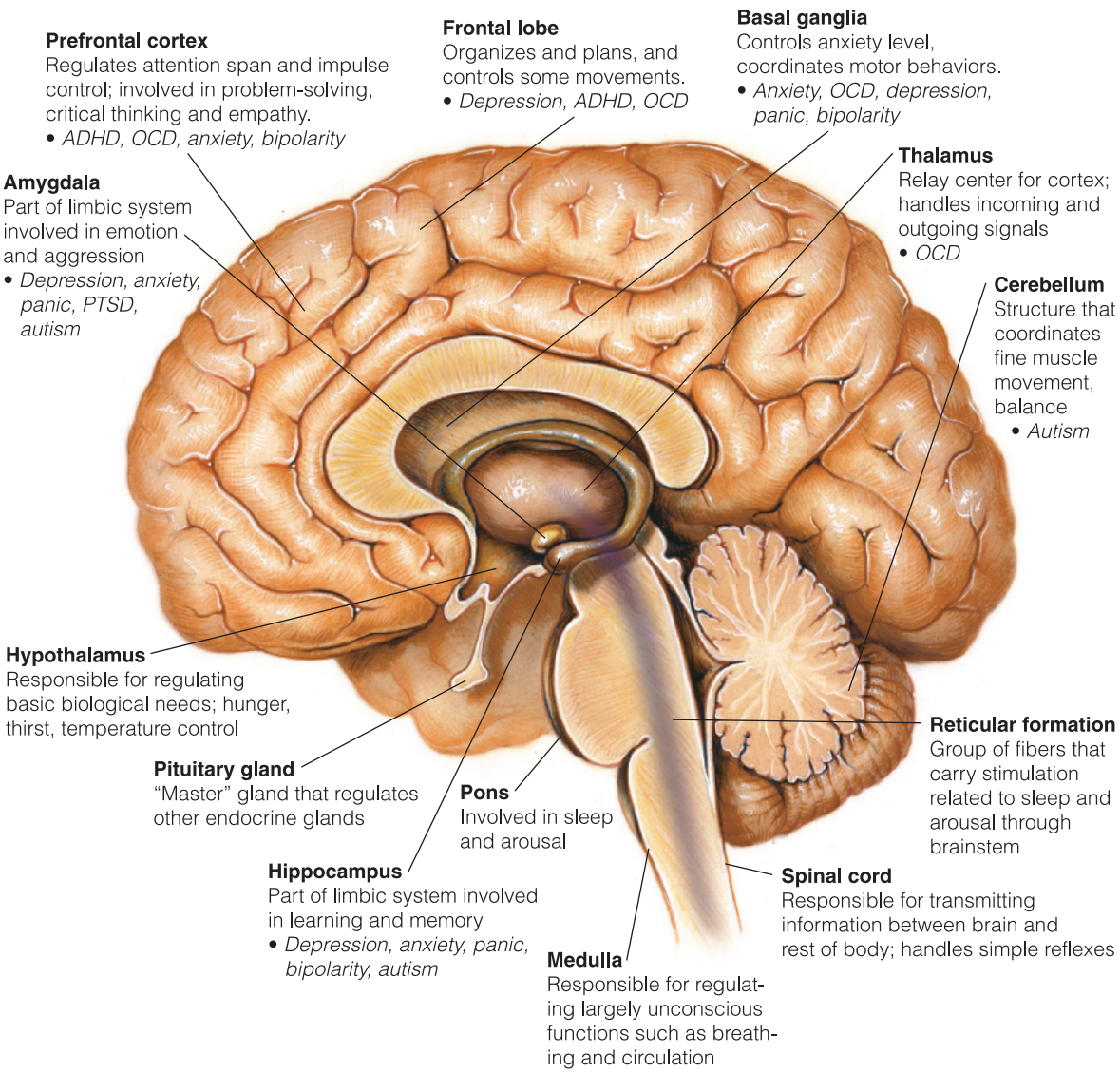
Profile from Child Behavior Checklist (CBCL): Syndrome Scales



Hand-scored Syndrome Profile from CBCL completed for Wayne Webster by his mother.
From Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA school-age forms & profiles: An integrated system of multi-informant assessment*. Burlington VT: ASEBA, p. 23.

The Human Brain and Possible Areas Linked to Mental Disorders in Children

The human brain does not reach full cognitive and emotional maturity until a person reaches his or her 30s.



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Abnormal Child Psychology

SEVENTH EDITION

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Brief Contents

Contents

PART 4

Problems Related to Physical and Mental Health

Cases by Chapter

Cases by Clinical Aspect

Diagnosis

Causes

Comorbidity

Developmental Pathways

Risk and Protective Factors

Gender

Treatment

Intervention and Prevention

Preface

We are delighted with the momentous success of *Abnormal Child Psychology*, leading to the release of this seventh edition. 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 normal and abnormal 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 *Abnormal Child Psychology* into a comprehensive yet student-friendly textbook. The seventh 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.

Major changes in diagnostic terminology and criteria are reflected in the organization and content of the seventh edition, consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5). For example, chapters on specific disorders are organized developmentally, beginning with Neurodevelopmental Disorders (i.e., intellectual disability, autism spectrum disorder, communication and specific learning disorders, and attention-deficit/hyperactivity disorder). A separate chapter on Trauma- and Stressor-Related Disorders is included to reflect the DSM-5 consensus that such disorders are distinct from other behavioral and emotional disorders. Also, this edition continues to expand on important new developments over the past few years. Recent findings on diagnosis, prevalence, causes, subtypes, comorbidity, developmental pathways, risk and protective factors, gender, ethnicity, evidence-based treatments, and early intervention and prevention are noted throughout. A recent upsurge of research into the role of genes and gene–environment interactions (G×E) as well as new studies of brain structure, functioning, and connectivity have contributed enormously to our understanding of the childhood disorders covered in this book.

At the same time, the seventh edition retains the hallmark features that make it one of the most successful texts in courses on child psychopathology, abnormal child and adolescent psychology, developmental psychopathology, atypical development, and behavior disorders of childhood and adolescence. 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 ABNORMAL CHILD AND ADOLESCENT PSYCHOLOGY

The past decade has produced extraordinary advances in understanding the special issues pertaining to abnormal child and adolescent psychology. 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 disabilities, autism spectrum disorder, communication and specific learning disorders, attention-deficit/hyperactivity disorder, motor disorders, oppositional and conduct disorders, depressive and bipolar disorders, teen suicide and substance abuse, 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 abnormal child psychology 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 abnormal child and adolescent psychology 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

[1]*Note: Abnormal Child Psychology* (7th ed.) spans the age period from infancy through young adulthood. "Child" often is used as shorthand for this broader age range.

struggles faced by children and adolescents with psychological disorders and their families, as well as to the demands and costs such problems 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 his or her 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.

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 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 problems 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, 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, we were fortunate to receive input from Sumru Erkut, Ph.D., of Wellesley College, an expert in diversity and abnormal child development. As a result of Dr. Erkut's input, we examine differences related to SES, gender, race, ethnicity, and culture for each childhood problem 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 mental disorders and problems 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 as specific disorders stemming from many forms of tragic events that affect children's development and life course. The seventh 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 problems and their families always intrigues students and helps them make greater sense of the material. Therefore, we emphasize current 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 Abnormal Child Psychology (definitions, theories, clinical description, research, assessment, and treatment issues)
II. Neurodevelopmental Disorders (intellectual disability, 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 interim "Section Summaries" help students consolidate each chapter's key concepts. In addition to the lists of key terms, students will find a listing of "Section Summaries" at the end of each chapter for easy reference while studying.

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 cartoons, 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 sex differences in the expression, 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.

NOTABLE CONTENT CHANGES AND UPDATES IN THE SEVENTH EDITION

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

- The most current information concerning prevalence, age at onset, and gender distribution for each disorder, including a discussion of issues surrounding the reported increase in the prevalence of autism spectrum disorder.
- Enriched coverage of gender and culture, including exciting new findings related to the expression, development, and adolescent outcomes for girls with attention-deficit/hyperactivity disorder (ADHD), conduct problems, and anxiety and mood disorders and for children from different ethnic and cultural groups.
- The most recent theories about developmental pathways for different disorders, including the childhood precursors of eating disorders.
- Integrative developmental frameworks for ADHD, conduct problems, anxiety disorders, depressive disorders, autism spectrum disorder, and child maltreatment.
- Exciting new findings on the interplay between early experience and brain development, including how early stressors, such as abuse, alter the brain systems associated with regulating stress and how they place the child at risk for developing later problems, such as anxiety or mood disorders.
- Recent genetic discoveries regarding neurodevelopmental disorders such as autism spectrum disorder, ADHD, and specific learning and communication disorders.
- Findings from neuroimaging studies of ADHD, autism spectrum disorder, anxiety, and depression that illuminate neurobiological causes.
- New information on family factors in externalizing and internalizing disorders, and on developmental disabilities.
- New findings on different presentation types, dimensions, and specifiers for disorders such as ADHD, oppositional defiant disorder, and conduct disorders.
- Recent findings on the development of precursors of psychopathy in young people.
- Recent findings on patterns of use and misuse of medications for treating ADHD and childhood depression.
- New definitions of intellectual disabilities and adaptive behavior.
- Current findings from neuroimaging studies showing the harmful effects of abuse and neglect and similar forms of stress and trauma on neurocognitive development.
- Discussion of the DSM-5 categories Reactive Attachment Disorder (RAD) and Disinihibited Social Engagement Disorder (DSED).
- The most recent follow-up findings from groundbreaking early intervention and prevention programs, such as early interventions for children with autism spectrum disorder, Fast Track for conduct disorders, and the Multimodal Treatment Study for Children with ADHD.
- An enhanced focus on evidence-based assessment and treatments including:
  - Advances in early identification and new treatments for autism spectrum disorder (Chapter 6)

- Descriptions of new/revised communication and learning disorders, such as social (pragmatic) communication disorder
- Behavior therapy, psychopharmacological, and combined treatments for ADHD (Chapter 8)
- Parent management training, problem-solving skills training, and multisystemic therapy for oppositional and conduct disorders (Chapter 9)
- Cognitive–behavioral therapy and interpersonal therapy for depression (Chapter 10)
- Cognitive–behavioral therapy, exposure, and modeling for anxiety disorders (Chapter 11)
- Treatment for child and adolescence substance-abuse problems (Chapter 13)
- Treatment outcome studies with anorexia and bulimia (Chapter 14)

- Added coverage on important, contemporary topics including:
  - Presentation types of disorders such as the predominantly inattentive presentation of ADHD and new findings on emotional impulsivity (Chapter 8)
  - Temperament and personality disorders (Chapters 2 and 4)
  - Emergent approaches to diagnosis such as the Research Domain Criteria (RDoC) initiative (Chapter 4)
  - Different symptom clusters for oppositional defiant disorder (Chapter 9)
  - Parenting styles (Chapters 2, 9, 10, 11, and 12)
  - The stigma of mental illness (Chapters 1 and 4)
  - The interplay between research findings in abnormal child psychology and public policy implications throughout the book
- Coverage of many significant reports from the Surgeon General, the World Health Organization, and others that will shape the future of research and practice in children's mental health (Chapters 1 and 2)

MINDTAP FOR MASH AND WOLFE'S *ABNORMAL CHILD PSYCHOLOGY*

MindTap is a personalized teaching experience with relevant assignments that guide students to analyze, apply, and improve thinking, allowing you to measure skills and outcomes with ease.

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- Promote Better Outcomes: Empower instructors and motivate students with analytics and reports that provide a snapshot of class progress, time in course, engagement, and completion rates.

In addition to the benefits of the platform, MindTap for Mash and Wolfe's *Abnormal Child Psychology* includes the following learning path:

- START. Students begin their personalized learning plan for each chapter with Mastery Training, powered by Cerego. This app helps students retain knowledge as they progress through each chapter, and pass each test!
- READ. Students read the chapter next. After each major section, students answer the Check Your Understanding mini-quiz questions. These section quizzes help students know what they just read before progressing to the next major section.
- WATCH. Students watch videos, which are followed by thought-provoking questions related to both the chapter that they just read and the video content. Each video features real people with real disorders, including attention deficit/hyperactivity disorder (ADHD), autism spectrum disorder, learning disorders, intellectual disability, and more.
- REVIEW. After students read the chapter and understand and know what they've read, it's time to review and take the Chapter Quiz.

A COMPREHENSIVE TEACHING AND LEARNING PACKAGE

Abnormal Child Psychology, seventh edition, is accompanied by an array of supplements developed to facilitate both the instructors' and the students' best possible experience, inside as well as outside the classroom. Cengage Learning invites you to take full advantage of the teaching and learning tools available to you and has prepared the following descriptions of each.

Online Instructor's Manual

The Instructor's Manual, fully aligned with *Abnormal Child Psychology*, seventh edtion, consists of:

- Discussion Questions
- Helpful Websites

- Helpful Videos, DVDs, and Films
- Helpful YouTube Videos
- Handouts
- Chapter Summaries, Learning Objectives, Chapter Outlines, and Chapter Key Terms and Concepts

Online Microsoft PowerPoint Lecture Outlines

Lecture outlines, both handy and accessible, are a great starting point for helping instructors prepare for and present to the class.

Cognero

Cengage Learning Testing Powered by Cognero is a flexible, online system that allows you to author, edit, and manage test bank content from multiple Cengage Learning solutions, create multiple test versions in an instant, and deliver tests from your Learning Management System (LMS), your classroom, or wherever you want.

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.

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Eric J. Mash
David A. Wolfe

1

Introduction to Normal and Abnormal Behavior in Children and Adolescents

Mankind owes to the child the best it has to give.

—UN Convention on the Rights of the Child (1989)

CHAPTER PREVIEW

AFTER CENTURIES OF SILENCE, misunderstanding, and outright abuse, children's mental health problems 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 problems 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 are becoming 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).

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 abnormal, or are aspects of her behavior normal under certain circumstances?

How would you describe Georgina's problem? Is it an emotional problem? A learning problem? A developmental disability? Could something in her environment cause these strange 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 boy, or African American or Hispanic? Will she continue to display these behaviors and, if so, what can we do to help?

GEORGINA

Counting for Safety

At age 10, Georgina's strange 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 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)

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

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 abnormal child psychology seek to address:

- Defining what constitutes normal and abnormal behavior for children of different ages, sexes, and ethnic and cultural backgrounds
- Identifying the causes and correlates of abnormal child behavior
- Making predictions about long-term outcomes
- Developing and evaluating methods for treatment and/or prevention

How you choose to describe the problems that children show, and what harm or impairments such problems may lead to, is often the first step toward understanding the nature of their problems. 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 problems also illustrate important features that distinguish most child and adolescent disorders:

- *When adults seek services for children, it often is not clear whose "problem" 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 do not refer themselves for treatment. This has important implications for how we detect children's problems and how we respond to them.
- *Many child and adolescent problems involve failure to show expected developmental progress.* The problem may be transitory, like most types of bedwetting, or it may be an initial indication of more severe problems ahead, as we see in Georgina's case. Determining the problem requires familiarity with normal, as well as abnormal, development.
- *Many problem behaviors shown by children and youths are not entirely abnormal.* To some extent, most children and youth commonly exhibit certain problem behaviors. 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 normal concerns. Thus, decisions about what to do also require familiarity with known psychological disorders and troublesome problem behaviors.
- *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 abnormal behavior in children and adolescents, it is valuable to discover how society's interests and approaches to these problems 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. Concern for 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 abnormal child psychology has been strongly influenced by philosophical and societal changes in how adults view and treat children in general (Borstelmann, 1983; V. French, 1977).

HISTORICAL VIEWS AND BREAKTHROUGHS

These were feverish, melancholy times; I cannot remember to have raised my head or seen the moon or any of the heavenly bodies; my eyes were turned downward to the broad lamplit streets and to where the trees of the garden rustled together all night in undecipherable blackness . . .

—Robert Louis Stevenson, describing memories of childhood illness and depression (quoted in Calder, 1980)

We must recognize children as valuable, independent of any other purpose, to help them develop normal 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 problems—unlike adult disorders—were seldom

mentioned in professional or other forms of communication. Some of the earliest historical interest in abnormal child behavior surfaced near the end of the eighteenth century. The 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. However, until very recent changes in laws and attitudes, children (along with women, members of minority groups, and persons with special needs) were often the last to benefit from society's prosperity and were the primary victims of its shortcomings. 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 issues.

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 [archaic use, meaning "defense"] 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 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 Hollingworth (1886–1939) argued that many mentally defective children were actually suffering from emotional and behavioral problems 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 ("imbeciles") and those with psychiatric or mental disorders ("lunatics"), 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 emotional or behavioral problems. The only guidance they had previously had in distinguishing children with intellectual deficits from children with behavioral and emotional problems was derived from religious views of immoral

A CLOSER LOOK 1.1

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 retardation 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 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.

Mary Evans Picture Library/Alamy Stock Photo

Source: From A History of the Care and Study of the Mentally Retarded, by L. Kanner, 1964, p. 15. Courtesy of Charles C Thomas, Publisher, Springfield, Illinois.

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 abnormal child behavior.

The implications of this basic distinction created a brief yet significant burst of optimism among professionals. Concern for the plight and welfare of children with mental and behavioral disturbances 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 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 abnormal child behavior as the result of combinations of biological, environmental, psychological, and cultural influences.

A CLOSER LOOK 1.2

Masturbatory Insanity

Today, most parents hardly balk at discovering their child engaging in some form of self-stimulation—it is considered a normal 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 hundred 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 abnormal behavior.

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 deviant or abnormal behavior were highly biased in favor of the 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 abnormal behavior 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 mental disorders. 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 mental disorders were a form of disease, he criticized society's ignorance and indifference and sought to prevent mental disease 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 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 mental disorders soon reverted to a custodial model during the early part of the twentieth century. Once again, attitudes toward anyone with mental 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 mental illness and retardation were diseases that could spread if left unchecked. For the next two decades, many 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 (formerly known as mental retardation) in Chapter 5.

Early Psychological Attributions

To conceptualize and understand abnormal child psychology, biological influences must be balanced with important developmental and cultural factors, including the family, peer group, and school. Of course, this perception was not always the case. The long-standing, medically based view that abnormal behavior 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 problems, 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 deviant 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 mental disorders 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 mental 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 mental disorders. Perhaps the most important of these advances from the perspective of abnormal child psychology was that Freud was the first to give meaning to the concept of mental 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. 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 abnormal child psychology 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; American Psychiatric Association, 2013) 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 normal and abnormal development retains considerable attraction as a model for abnormal child psychology.

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 normal to abnormal 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 problems—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.

Evolving Forms of Treatment

Compared with the times that followed, the period from 1930 to 1950 was a quiet time for research and treatment in abnormal child psychology. A few reports in the 1930s described the behavioral treatment of isolated problems such as bed-wetting (O. H. Mowrer & Mowrer, 1938), stuttering (Dunlap, 1932), and fears (F. B. Holmes, 1936). Other than these reports, psychodynamic approaches were the dominant form of treatment during this period. As a carryover from the 1800s, most children with intellectual or mental disorders were still institutionalized. This practice had come under mounting criticism by the late 1940s, when studies by René Spitz raised serious questions about the harmful impact of institutional life on children's growth and development (R. Spitz, 1945). He discovered that infants raised in institutions without adult physical contact and stimulation developed severe physical and emotional problems. Efforts were undertaken to close institutions and place dependent and difficult children in foster family homes or group homes. Within a 20-year period, from 1945 to 1965, there was a rapid decline in the number of children in institutions, while the number of children in foster family homes and group homes increased.

During the 1950s and early 1960s, behavior therapy emerged as a systematic approach to the treatment of child and family disorders. The therapy was originally

A CLOSER LOOK 1.3

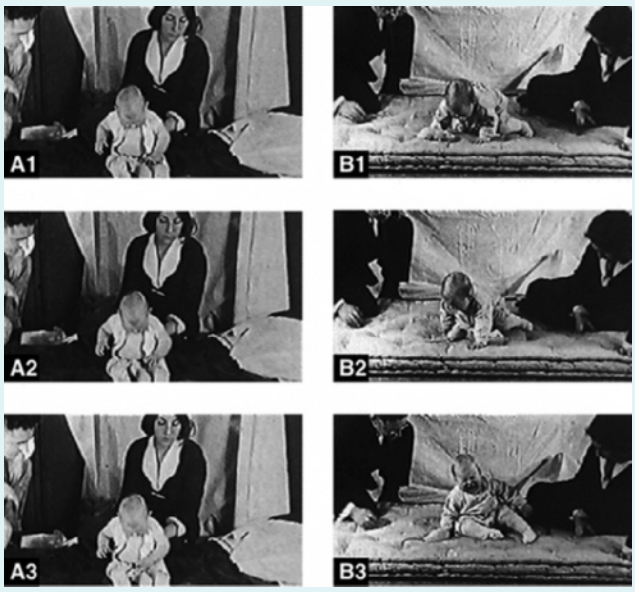
Little Albert, Big Fears, and Sex in Advertising

Most of us are familiar with the story of Little Albert and his fear of white rats and other white furry objects, thanks to the work of John Watson and his graduate assistant (and then wife) Rosalie Rayner. However, understanding the times and background of John Watson helps put these pioneering efforts into a broader historical perspective, and highlights the limited concern for ethics in research that existed in his day.

Watson's fascination with and life dedication to the study of fears may have stemmed from his own acknowledged fear of the dark, which afflicted him throughout his adult life. His career break arrived when he was given an opportunity to create a research laboratory at Johns Hopkins University for the study of child development. Instead of conditioning rats, he could now use humans to test his emerging theories of fear conditioning. However, at that time the only source of human subjects was persons whose rights were considered insignificant or who had less than adequate power to protect themselves, such as orphans, mental patients, and prisoners. Just as he had studied rats in their cages, Watson now studied babies in their cribs.

Clearly, his method of obtaining research subjects and experimenting with them would be considered highly unethical today. To demonstrate how fear might be conditioned in a baby, Watson and Rayner set out to condition fear in an 11-month-old orphan baby they named Albert B., who was given a small white rat to touch, toward which he showed no fear. After this warm-up, every time the infant reached to touch the rat, Watson would strike a steel bar with a hammer. After repeated attempts to touch the rat brought on the same shocking sounds, "the infant jumped violently, fell forward and began to whimper." The process was repeated intermittently, enough times that eventually Albert B. would break down and cry, desperately trying to crawl away, whenever he saw the rat. Watson and Rayner had successfully conditioned the child to fear rats. They then conditioned him to fear rabbits, dogs, fur coats, and—believe it or not—Santa Claus masks (Karier, 1986).

It is disconcerting that Albert B. moved away before any deconditioning was attempted, resulting in decades of speculation as to his identity and the strange set of fears he might have suffered. In 2009, a team of psychologists tracked down Little Albert's identity and fate: he was identified as Douglas Merritte, whose mother worked at the campus hospital and was paid $1 for her baby's research participation. Sadly, the team discovered that Douglas died at age 6 of acquired hydrocephalus (Beck, Levinson, & Irons, 2009).



Source: Neurobiology of Pavlovian Fear Conditioning Annual Review of Neuroscience Vol. 24: 897–931, by Stephen Maren; Annual Review of Neuroscience ©2011 Annual Reviews. All rights reserved.

It is ironic, moreover, that Watson went on to develop a career in advertising after he was ousted from the university (presumably as a result of concerns over his extramarital relationship with his graduate student; Benjamin et al., 2007). His brand of behaviorism, with its emphasis on the prediction and control of human behavior, met with unqualified success on Madison Avenue. As he explained, "No matter what it is, like the good naturalist you are, you must never lose sight of your experimental animal—the consumer." We can thank John B. Watson for advertising's dramatic shift in the 1930s toward creating images around any given product that exploited whenever possible the sexual desires of both men and women.

Source: Based on Karier, 1986.

based on operant and classical conditioning principles established through laboratory work with animals. In their early form, these laboratory-based techniques to modify undesirable behaviors and shape adaptive abilities stood in stark contrast to the dominant psychoanalytic approaches, which stressed resolution of internal conflicts and unconscious motives. Behavior therapy focused initially on children with intellectual disability or severe disturbances. Psychoanalytic practices for these children were perceived as ineffective or inappropriate. Much of this early work took place in institutions or classroom settings that were thought to provide the kind of environmental control needed to change behavior effectively. Since that time, behavior therapy has continued to expand in scope, and has emerged as a prominent form of therapy for a wide range of children's disorders (Kazdin, 2016; Ollendick, King, & Chorpita, 2006; Weisz & Kazdin, 2010).