Abnormal Child and Adolescent Psychology

DSM-5 Update

EIGHTH EDITION

Rita Wicks-Nelson • Allen C. Israel

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If you're wondering why you should buy this new edition of *Abnormal Child and Adolescent Psychology*, here are nine good reasons.

1. **DSM-5.** This revised edition incorporates the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).
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8. **Special consideration is given to issues of high social interest,** such as terrorism and war, poverty, child maltreatment, substance use, and bullying and victimization.

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Eighth Edition

Abnormal Child and Adolescent Psychology with DSM-V Updates

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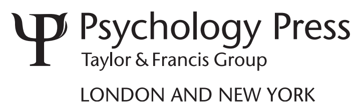

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To Leonard C. Nelson
and The Poulos,
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To Sara and Daniel—ACI

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PREFACE

In roughly one hundred years, the study of young people has moved from relative ignorance to considerable knowledge about human development in general and disordered behavior more specifically. The last few decades arguably have witnessed unprecedented progress in understanding the problems of children and adolescents and how they and their families might be assisted. Of course, there is much yet to be learned and the needs of youth are considerable, so the study of young people is an especially worthwhile enterprise. We hope that this text makes clear the challenge and excitement of the endeavor.

Now in its updated eighth edition, *Abnormal Child and Adolescent Psychology* has enjoyed enormous success. It has been gratifying for us to know that it continues to make a substantial contribution to the field. At the inception of this text (initially entitled "Behavior Disorders of Children"), relatively few comprehensive books were available in the field. Just as important was the need for a text that emphasized certain themes that we considered critical to the study of problems of youth. These themes have stood the test of time, have evolved, and have become more widely and subtly recognized as essential. Indeed, their early incorporation into the text undoubtedly accounts in part for its ongoing success.

THEME 1: DEVELOPMENTAL PSYCHOPATHOLOGY

At the heart of the text is the partnership of the developmental psychopathology perspective and the more traditional (usual) clinical/disorder approach. The latter underscores description of the symptoms, causes, and treatments of disorders of young people. The developmental psychopathology perspective assumes that problems of youth must be viewed within a developmental context. The developmental psychopathology perspective is articulated in early chapters of the book and guides discussion of specific disorders in subsequent chapters.

A primary assumption of developmental psychopathology is the belief that normal and disturbed behavior are related and are best viewed as occurring along a dynamic pathway of growth and experience, with connections to the past and to the future. This proposition is reflected in the text in several ways. Consideration is given to the timing and processes of normal development and how these may go awry in psychopathology. We also take seriously the assumption that behavioral development cannot be readily parsed by age, and thus we employ a broad time frame for discussing psychological problems in childhood and adolescence. Understanding these problems is enhanced by anchoring them in the early years of life and linking them to outcomes in adulthood.

THEME 2: MULTIPLE TRANSACTIONAL INFLUENCES

A second theme woven throughout the text is the view that behavioral problems result from transactions among variables. With few—if any—exceptions, behavior stems from multiple influences and their continuous interactions. Biological structure and function, genetic transmission, cognition, emotion, social interaction, and numerous aspects of the immediate and broader environment play complex roles in generating and maintaining psychological and behavioral functioning. Developmental psychopathologists are committed to the difficult task of understanding and integrating these multiple influences—efforts that are addressed throughout the text.

THEME 3: THE INDIVIDUAL IN CONTEXT

Following from this, a third theme emphasizes that the problems of the young are intricately tied to the social and cultural contexts in which they experience life. Children and adolescents are embedded in a circle of social and environmental influences involving family, peer, school, neighborhood, societal, and cultural circumstances. At any one time, youths bring their personal attributes to these circumstances, are affected by them, and in turn, influence other people and situations. Meaningful analysis of psychological problems thus requires that the individual be considered in developmental context. Such aspects as family interactions, friendships, gender, educational opportunity, poverty, ethnicity and race, and cultural values all come into play.

THEME 4: THE EMPIRICAL APPROACH

A fourth major theme is a bias toward the empirical approach. Prudent and insightful thinking is required in both figuring out the puzzles of behavioral problems and applying acquired knowledge. We believe that empirical approaches and the theoretical frameworks that rely on scientific method provide the best avenue for understanding the complexity of human behavior. Research findings thus are a central component of the book and inform our understanding of the problems experienced by youth and how the lives of young people might be improved.

THEME 5: THE PERSON AT THE CENTER

Concern for the optimal development of the child or adolescent is given important emphasis throughout this text. While there is no doubt that empirical studies further our understanding of development, it is helpful to examine problems from a more personal viewpoint. Thus, by also viewing problems through the lens of the experience of troubled youths and their families, students better come to understand how psychopathology is manifested, what needs a youth may have, how intervention can help a child, and a plethora of other factors. The many case descriptions in the text are vital in bringing forth the personal. So also are the several other individual accounts, quotations, and photographs. Real-life is singularly captured by the hyperactive child who realizes that he is considered a "bad boy," the sister who believes she has become a better person through caring for her intellectually challenged brother, and the parents who report being "jolted" by a TV description of a youth whose problems were similar to those of their undiagnosed child.

ORGANIZATION OF THE TEXT

As a relatively comprehensive introduction to the field, *Abnormal Child and Adolescent Psychology* includes theoretical and methodological foundations of the field and devotes most discussion to specific problems of youth—that is, to the characteristics, epidemiology, developmental course, etiology, assessment, treatment, and prevention of psychopathology. Although we have not formally divided the chapters into broader sections, they are conceptualized as three units.

UNIT I, consisting of Chapters 1 through 5, presents the foundation for subsequent discussion. A broad overview of the field is presented, including basic concepts, historical context, developmental influences, theoretical perspectives, research methodology, classification and diagnosis, assessment, prevention, and treatment approaches. These chapters draw heavily on the psychological literature and also recognize the multidisciplinary nature of the study and treatment of youth. We assume that readers have some background in psychology, but we have made an effort to serve those with relatively limited background or experience.

UNIT II, consisting of Chapters 6 through 14, addresses major disorders. There is considerable organizational consistency across these chapters. For most disorders, classification, clinical description, epidemiology, developmental course, etiology, assessment, and prevention/treatment are discussed in that order. At the same time, flexible organization is a guiding principle so that the complexity inherent in specific chapter topics is not sacrificed.

- Chapter 6 (anxiety and related disorders) and Chapter 7 (mood disorders) focus on internalizing disorders.
- Chapter 8 (conduct problems) and Chapter 9 (attention-deficit hyperactivity disorder) discuss externalizing disorders.
- Specific and pervasive developmental problems are presented in Chapter 10 (language and learning disorders), Chapter 11 (intellectual disability), and Chapter 12 (autism spectrum disorder and schizophrenia).
- Chapter 13 (basic physical functions) and Chapter 14 (medical conditions) focus on health- and medical-related problems.

UNIT III consists of Chapter 15, which rounds out and extends what has gone before. The chapter examines evolving concerns regarding the development of youth. The focus is on selected critical family issues, mental health services, and briefly on youth living in countries other than the United States.

CONTENT: HIGHLIGHTS AND UPDATES

It almost goes without saying that the study of the psychopathology of youth, as it catapults ahead, must include judicious consideration of recent research and issues. Such consideration is reflected by the provision of new information throughout the text. The updated content not only points to new findings and issues but, importantly, it also confirms or extends

previous findings in various ways. Moreover, in reviewing new information we have been especially sensitive to topics that are currently of high interest and concern. The following are notable instances of highlighted and updated topics.

- This edition of the text captures the heightened interest in how best to classify and diagnose psychological problems. It includes diagnostic criteria and information from the most recent version of the DSM (DSM-5) and gives appreciable attention to how the dimensional approach has informed and is likely to continue to inform developments in the classification of psychopathology of youth.
- The substantial progress in understanding the causes of psychopathology is exemplified across chapters. Special attention is given to etiological models of problem behavior.
- Similarly, increased and updated consideration is given to neurological findings, particularly those from brain imaging studies.
- Consonant with advances in the field, genetic processes and new findings that implicate gene effects and their interaction with the environment receive greater attention.
- Receiving particular attention are the complex roles of the family and peers within the transaction of multiple influences on the development of problems in children and adolescents.
- The developmental course and outcome of major disorders continues to have high priority.
- Attention is given to the role of sex/gender in psychopathology—both to differences in prevalence, symptoms, and outcome as well as to factors that may underlie them.
- Continued and increased attention is given to the various roles of culture, ethnicity, and race in psychopathology. An example is how cultural considerations may influence assessment and treatment.
- Notable progress being made in the prevention of disorder is reflected in new findings and extended discussion. Early intervention efforts—such as for reading disability and autism—can be viewed as merging prevention and treatment.
- Examples of specific individual and family treatments are generously interwoven throughout the chapters, with an emphasis on evidence-based intervention. To take an example, the latest findings from the most comprehensive multimodal treatment of ADHD are examined.
- Increased attention is also given to efforts to improve accessibility of evidence-based treatments, to how such treatments can be disseminated from research to "real-world" settings, and to the role that technology may play in these efforts.
- We continue to give particular consideration to problems that recently have been reported to have increased in prevalence—such as bipolar disorder, autism, and obesity. Discussion includes potential reasons for rising prevalence and, for some disorders, whether the apparent increase actually exists.
- Similar consideration is given to specific problems that remain or have become of high societal interest—such as terrorism and war, poverty, child maltreatment, substance use, and bullying/victimization.
- Also updated and/or expanded is discussion of issues that have been or still are particularly controversial. These include debates over inappropriate or excessive use of medication in children, discredited claims of a link between vaccines and autism, and the effects of attendance of children with intellectual disability in regular rather than special education classrooms.

FEATURES: SOME OLD, SOME NEW

As will be obvious to users of the previous edition, we have retained the basic organization of the chapters, which appears to work well. Similarly, specific features of the book continue to emphasize for students a person-oriented, applied perspective. The text is rich in case descriptions and in accounts of assessment and treatment. An additional feature, the Accents, allows for detailed discussion of particular topics of interest, for example, fetal alcohol syndrome, infant mental health, ADHD in African American boys, and stigma linked to the term "mental retardation." Further, the text continues to be rich in illustrations—graphs, tables, photos, drawings—without an excessiveness that can be confusing to readers.

Other features of the text are especially aimed at facilitating student learning. Included in this edition is Looking Forward, which focuses students' attention at the beginning of each chapter on the central issues to be addressed. Looking Forward roughly follows the organization of the chapter and sets the stage for the overview at the chapter's end, referred to as Overview/Looking Back. In addition, important or new terms in each chapter appear in bold in the text and also are listed as Key Terms at the conclusion of the chapter. Finally, several supplementary teaching and learning materials, described in the following section, add to the value of *Abnormal Child and Adolescent Psychology* for both students and instructors.

SUPPLEMENTARY TEACHING AND LEARNING MATERIALS

Please visit the companion website at www.routledge.com/9780133766981

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Rita Wicks-Nelson

Allen C. Israel

CHAPTER 1

Introduction

LOOKING FORWARD

After reading this chapter, you should be able to discuss:

- How psychological disorders are defined and identified
- Prevalence of psychological disorders
- The relationship between developmental level and psychological disorders
- The relationship between gender and psychological disorders
- Historical influences on understanding psychological disorders
- Current study and practice of abnormal child and adolescent psychology

To be young is to bounce balls as high as the heavens, gobble up fairytales, walk tightropes without falling, love friends with glee, and peer at the wondrous future.

To be young is to feel ignorant and useless, to be alone and unlovable, to ride the waves of ups and downs and unending insecurities.

The early years of life have long been described in extremes of emotions, behaviors, and encounters. In fact, most individuals who look back on their own youth admit not only to some of the extremes—but also to a sizable portion of more moderate experiences. And they frequently view their youth as a special time of growth and opportunity. It is against this backdrop that we embark on the study of the psychological problems of childhood and adolescence.

This book is written for those who ask questions about and have concerns regarding less-than-optimal development of youth. It addresses definitions, characteristics, origins, development, diagnosis, prevention, and

amelioration of maladaptive functioning. We anticipate, and hope, that you will find this field of study as satisfying as we do. It is an area of study that encompasses both humanitarian concerns for young people and scientific intrigue.

The last decades have been a particularly promising time to study behavioral and psychological disturbance. The current need for increased understanding, prevention, and treatment is substantial, and is recognized in many parts of the world. At the same time, research into the development of youth continues to grow by leaps and bounds, with contributions from many disciplines. As is usually true in science, increased knowledge and improved methods have led to new questions and paradoxes. This combination of new understandings, new questions, and new avenues of inquiry gives both promise and enthusiasm to the study of the problems of young people.

DEFINING AND IDENTIFYING ABNORMALITY

Behavioral repertoires come in endless varieties, and many kinds of disorders are discussed in this text (see Accent: "Some Faces of Problem Behavior"). Various labels have been applied to such problems: abnormal behavior, behavioral disturbance, emotional disorder, psychological deficit, mental illness, psychopathology, maladaptive behavior, developmental disorder, and so forth. Moreover, systems have been constructed to categorize problems and to offer guidelines to professionals for identifying abnormality. Underlying this effort are complex issues in defining and distinguishing psychopathology.

The criteria for abnormality are primarily based on how a person is acting or what a person is saying and only rarely include a specific known marker for disorder. Of course, most of us would agree that problems are evident when individuals do not acquire speech, are unable to feed themselves, or see and hear things that others do not. But less dramatic instances are harder to judge and a fine line can exist between what is considered disordered and what is normal. Young people of specific ages display behaviors that may or may not be considered signs of disturbance, such as noncompliance with parental rules, social withdrawal, high activity level, fearfulness, sadness, and delayed reading skills. Thus, we must ask, "When do we consider behaviors abnormal?" and "How can we distinguish everyday problems from more serious indications of psychopathology?" There are no simple answers to these questions, but it is informative to consider several factors that enter into judgments about psychological or behavioral disturbances.

ACCENT
Some Faces of Problem Behavior

Four-year-old **Joey** had been kicked out of preschool, where he had sat on the floor and stared, refused to talk, and hit any child who touched him. If the teacher insisted that he participate in activities, he screamed, cried, and banged his arms and legs on the floor. Similar behaviors occurred at home. Joey rarely talked or showed emotion, and he slept fitfully, banged his head against the wall, and rocked back and forth. (Adapted from Morgan, 1999, pp. 3–4)

Lakeshia had always been considered a slow learner but these difficulties had sometimes been beneath the "radar screen" of her teachers, perhaps in part because she was quiet and well-behaved. She repeated second grade and had a tutor, but by the time she was in fifth grade, Lakeshia was failing all her subjects. An evaluation indicated low-average to borderline overall intelligence and ratings of attention and learning problems in the clinically borderline range. (Adapted from Hathaway, Dooling-Litfin, & Edwards, 2006, pp. 402–405)

Nine-year-old **Juan** was referred by his teacher due to classroom behavior problems. He was fidgety, did not pay attention, usually did not answer questions, and bothered classmates when they were working. Juan, who spoke mostly Spanish at home, exhibited above-average cognitive ability and average academic skills. His mother reported that he was easily distracted and had difficulty completing homework, but she felt that Juan's behavior was consistent with that of children whom she observed growing up in Mexico. (Adapted from DuPaul et al., 2010, p. 555)

Anne had begun to worship Satan and noted that praying to Satan brought her relief from distress. Anne had dyed her hair black, dusted her face with white powder, and looked like a character in a vampire story rather than a 14-year-old. Anne reported that she had difficulty falling asleep because she worried about her grades and her parents' divorce, for which she believed she was partly responsible. She found it hard to concentrate in school, was irritable, and had lost weight. She had no energy, no longer enjoyed activities with friends, and spent most of her time in her room. Anne denied any intent or plan for suicide, involvement with cults, or drug use. (Adapted from Morgan, 1999, pp. 35–37)

Atypical and Harmful Behavior

Psychological problems frequently are viewed as atypical, odd, or abnormal—all of which imply that they deviate from the average. Indeed, "ab" means "away" or "from," whereas "normal" refers to the average or standard. However, being atypical in itself hardly defines psychopathology. People who display exceptionally high intelligence and social competence are generally considered fortunate, and their "oddness" is looked upon with favor. The deviations we are considering are assumed to be harmful in some way to the individual. The American Psychiatric Association (2013), for example, defines disorder as a syndrome of clinically significant behavioral, cognitive, or emotional disturbances that reflect dysfunction in underlying mental processes, and that is associated with distress or disability in important areas of functioning.

Abnormality or psychopathology is viewed as interfering with adaptation, that is, with individuals fitting the circumstances of their lives. Psychopathology hinders or prevents the young person from negotiating developmental tasks, whether acquiring language skills, emotional control, or satisfactory social relationships. Disorder may be viewed as residing *within* the individual. Alternatively, it can be regarded as the individual's reactions to circumstances—with the interface of the person with other people or environmental conditions. The latter, more appropriate, perspective emphasizes that behavior is inextricably linked with the larger world in which it is embedded.

Developmental Standards

Age, as an index of developmental level, is always important in judging behavior, but it is especially important for children and adolescents because they change so rapidly. Judgments about behavior rely on **developmental norms,** which describe the typical rates of growth, sequences of growth, and forms of physical skills, language, cognition, emotion, and social behavior. These serve as developmental standards from which to evaluate the possibility that "something is wrong."

Behavior can be judged as anomalous relative to these norms in a number of ways, as indicated in Table 1.1. Delayed development, or failure to keep up with typical developmental change, indicates that something is awry. Children sometimes may achieve developmental norms and then regress, or return, to behavior typically seen in younger individuals.

Several other signs are noteworthy. These include atypical frequency, intensity, or duration of behavior, as well as the display of behavior in inappropriate situations. It is not unusual for a child to display fear, for example, but fearfulness may be a problem if it occurs excessively, is

TABLE 1.1 Behavioral Indicators of Disorder

Developmental delay
Developmental regression or deterioration
Extremely high or low frequency of behavior
Extremely high or low intensity of behavior
Behavioral difficulty persisting over time
Behavior inappropriate to the situation
Abrupt changes in behavior
Several problem behaviors
Behavior qualitatively different from normal

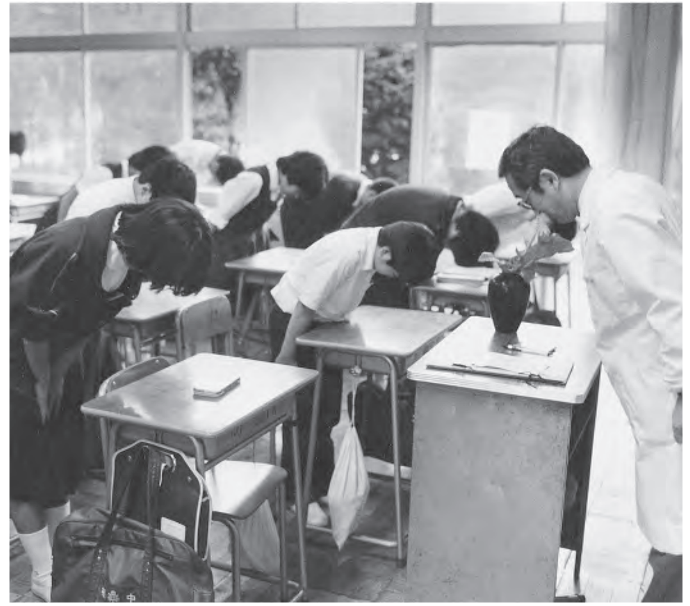
extremely intense, does not weaken over time, or is shown in harmless situations. Concern might also be expressed for the youth whose behavior abruptly changes, as when an outgoing adolescent turns solitary, or when a child displays several questionable behaviors. All of these indications of disturbance are quantitative differences from developmental norms.

Yet another manifestation that may signal the need for help is behavior that appears qualitatively different from the norm. That is, the behavior—or the sequence in which it develops—is not seen in normal growth. For instance, most children are socially responsive to their caretakers soon after birth, but children diagnosed as autistic display atypical unresponsive behaviors, such as lack of normal eye contact. Qualitatively different behaviors frequently indicate a pervasive problem in development.

Culture and Ethnicity

The term **culture** encompasses the idea that groups of people are organized in specific ways, live in specific environmental niches, and share specific attitudes, beliefs, values, practices, and behavioral standards. Culture is a way of life that is transmitted from generation to generation. It is unsurprising, then, that although many disorders are found across cultures—that is, they are universal—there are some cross-cultural differences. Rates of disorders have been found to vary and disorders may be expressed in subtly different ways (Canino & Alegria, 2008; Rutter, 2011). An example of the latter is anxiety disorder; it appears to be universal but is expressed more through bodily symptoms in Asian and Latino groups than in European Americans (Serafica & Vargas, 2006). Whether any disorder is specific to a single culture and not found otherwise is less clear.

Cultural analyses describe the many ways in which cultures shape normal and abnormal development and also conceptualize, explain, and treat psychopathology. **Cultural norms** have broad influence on expectations,



The behavior that is expected of or considered appropriate for a child varies across cultures.

judgments, and beliefs about the behavior of youth. Children in the United States, for example, are expected to show less self-control and less deference to adults than children in some other parts of the world (Weisz et al., 1995). Weisz and his colleagues found that teachers in Thailand reported more conduct problems among their students than teachers in the United States, but trained observers reported just the opposite for the two student groups. The researchers suggested that Thai teachers may hold students to a more demanding behavioral standard—and thus see more problems and more readily label them.

The different ways in which problem behaviors may be explained and treated were shown in an investigation in which mothers of North African and Middle Eastern background living in Israel were interviewed about their children who were developmentally delayed (Stahl, 1991). Almost half of the mothers gave magic-religious causes for the condition. They believed in demons entering the body, an Evil Eye, and punishment from God. These mothers accordingly relied on magic-religious treatments such as burning a piece of cloth belonging to the person who cast the Evil Eye, praying, or getting help from a rabbi. Their behaviors were in keeping with the cultural beliefs of their native countries.

The above findings suggest the need to consider ethnicity or race when assessing various aspects of abnormality. **Ethnicity** denotes common customs, values, language, or traits that are associated with national origin or geographic area. **Race,** a distinction based on physical characteristics, can also be associated with shared customs, values, and the like. Ethnic or racial groups embedded within a heterogeneous society may show different rates of psychopathology, express psychopathology somewhat differently, and hold beliefs and standards different from those of the dominant cultural group (Anderson & Mayes, 2010). Even when parenting behaviors are similar in dominant and ethnic groups, the effects on offspring may be dissimilar due to the different values held by these groups (Eichelsheim et al., 2010).

An example of ethnic difference in the United States is provided by comparisons between European American and Asian American parents concerning the achievement behavior of their children (Ly, 2008). In general, compared to European American parents, Asian American parents assign greater importance to the child's effort—for example, in academic success—than to the child's ability. However, there are relatively few cultural comparisons of families with children with disability. As part of one such study, parents were asked to rate the success of their intellectually disabled children's performance on a task and also rate the degree to which performance was due to ability and effort. The Asian American parents viewed their children as less successful (real differences did not exist), held lower expectations for future success, and attributed performance to lower ability and lower effort (Figure 1.1). They also reported different emotional reactions to their children's performance. Although this study had limitations (e.g., families were volunteers), it demonstrates the need for sensitivity to possible ethnic/racial differences in the study of psychopathology of young people.

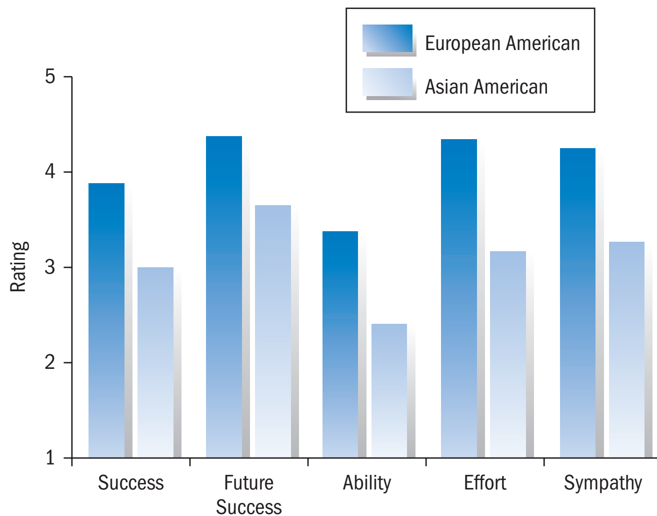


FIGURE 1.1 Parent ratings of their child's task performance. *Adapted from Ly, 2008.*

Other Standards: Gender and Situations

Expectations based on gender also contribute to defining problem behavior. **Gender norms** significantly influence development; they affect emotions, behaviors, opportunities, and choices. In most societies, males are expected to be relatively more aggressive, dominant, active, and adventurous, while females are expected to be more passive, dependent, quiet, sensitive, and emotional. These gender stereotypes play a role in judgments about normality. We would probably be less inclined to worry about the hypersensitive, shy girl and the excessively dominant boy than about their opposite-sex counterparts.

Judgments of deviance or normality of behavior also take into account **situational norms**—what is expected in specific settings or social situations. Energetic running may be quite acceptable on a playground but not allowed in a library. Norms for social interaction can be quite subtle; for example, how a statement is voiced can either compliment or insult another person. Individuals in all cultures are expected to learn what is acceptable and to act in certain ways in certain situations, given their age and gender. When they do not, their competence or societal adjustment may be questioned.

The Role of Others

Youth, especially young children, hardly ever refer themselves for clinical evaluation, thereby declaring a problem. The identification and labeling of a problem is more likely to occur when others become concerned—for example, when parents worry about their child's social isolation or when a teacher is troubled about a child's inability to learn.

Referral of youth to mental health professionals thus may have as much or more to do with the characteristics of parents, teachers, or family physicians as with the young people themselves (Costello & Angold, 1995; Verhulst & van der Ende, 1997). Indeed, disagreement often exists among adults as to whether a child or adolescent "has a problem." This may in part be due to different adults being exposed to different child behaviors but adult attitudes, sensitivity, tolerance, and ability to cope all play a role in identifying disorders.

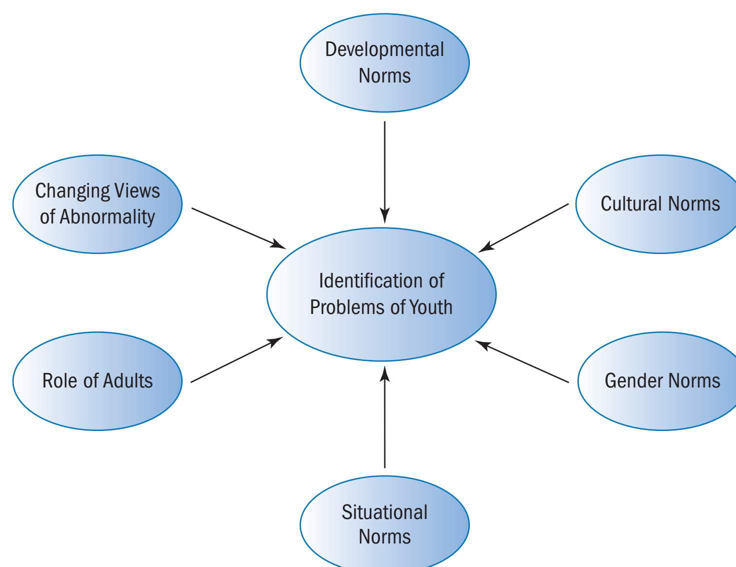


FIGURE 1.2 Several factors enter into judgments about normality and abnormality.

Changing Views of Abnormality

Finally, judgments about abnormality are not set in stone. Examples abound. In the 1800s, masturbation was considered a sign of disturbance or a behavior that could cause insanity (Rie, 1971). Nail biting was once seen as a sign of degeneration (Anthony, 1970). Excessive intellectual activity in young women was believed by some to lead to mental problems (Silk et al., 2000). Today these views are not given credence.

Many factors undoubtedly contribute to change in judgments about abnormality. Enhanced knowledge and theoretical modifications have played a role. So has transition in cultural beliefs and values. For example, eating disorders, once found almost exclusively in Western societies, have increased worldwide in the past decades, perhaps due to wider adoption of the modern Western preference for slender body size (Harkness & Super, 2000).

In summary, psychopathology cannot simply be defined as an entity carried around within a person. It is most appropriately viewed as a judgment that a person's behavior, emotion, or thinking is atypical, dysfunctional, and harmful in some way—a judgment involving knowledge about development, cultural and ethnic influences, social norms, and the people making the judgment.

HOW COMMON ARE PSYCHOLOGICAL PROBLEMS?

The prevalence of behavioral or psychological disorder suggests the extent to which prevention, treatment, and research are needed. However, frequency depends on several factors, most importantly how a disorder is defined and the criteria set for identification. Rates of disorder can vary with the measures used and whether parents, teachers, or youth themselves are the source of information. Characteristics of the population examined—regarding, for example, age, gender, and clinic versus community populations—can make a difference in prevalence.

Given such complexity, considerable disparity is found in rates of problems. An extensive summary of studies reported from 1985 to 2000, which included several countries, showed that the prevalence of disorders in youths ages 4 to 18 years ranged from 5.4 to 35.5% (Fombonne, 2002). Recent U.S. surveys of major emotional and conduct disorders in children and adolescents indicate rates of about 13 to 22% (Merikangas et al., 2010a; 2010b). The American Psychological Association (2007) cited 10% of youth as having a serious mental health problem and another 10% as having mild to moderate problems. Many of the youths reported as having a problem are identified as displaying symptoms of more than one disorder. In addition, there is evidence that by young adulthood, most individuals have experienced some type of mental problem at some time (Copeland et al., 2011).

Although research of prevalence has highlighted the age range from childhood through adolescence, problems in preschoolers appear to approximate the rates observed in older children (Egger & Angold, 2006). Moreover, a population-based study of 18-month-olds in Denmark found that 16 to 18% exhibited diagnosed disturbances, most commonly of emotion, behavior, and regulatory problems such as in feeding and sleeping (Skovgaard et al., 2007). The problems of preschoolers and infants appear quite similar to those of older children, although developmental differences are noteworthy. During the last few decades, the field of infant mental health has emerged as a multidimensional effort to better understand and enhance the development of very young children (Zeanah & Zeanah, 2009). (See Accent: "Infant Mental Health.")

Concern has been expressed that societal change during the last several decades has resulted in an increased risk of disorders for the young. Some change and its cause are obvious; for example, medical advances have increased the survival of infants born prematurely or with physical problems, and these infants have relatively high rates of behavioral and learning difficulties. However, due to variations across studies and methodological issues, it has been difficult to draw overall conclusions about such historical or so-called **secular trends.**

As examples of this work, we look at two studies of adolescents. Sweeting, Young, & West (2009) collected data in 1987, 1999, and 2006 on 15-year-olds from the same area in Scotland. Each cohort completed the same self-report measure of psychological stress. Substantial increases in stress were reported by girls from 1987 to 1999 and by both girls and boys from 1999 to 2006. Searching for explanations of the data, the investigators then looked at key social changes during this time period, which were categorized as economic, family, education, and values and lifestyle (Sweeting et al., 2010). The role of the family and education were highlighted as plausible contributors to the secular changes. Worries, arguments with parents, and school disengagement were especially cited by the adolescents.

Collishaw and colleagues (2010) compared 16- to 17-year-olds living in England in 1986 and in 2006 on several measures. Increases in emotional problems were reported for 2006, especially for girls. For boys, parent-rated difficulties showed a rise whereas boys themselves reported little change except for an elevation of frequent

ACCENT
Infant Mental Health

Despite long interest in very early occurring problems, the idea that infants could have mental health problems had been puzzling to and even resisted by some individuals. Perhaps the notion of innocent infancy seemed mismatched to maladjustment, stigma, and mental illness. Or perhaps infant mental health problems were thought impossible as long as infants were viewed as having limited emotional and cognitive capacity (Tronick & Beeghly, 2011).

Increased understanding of the very early years of life has notably contributed to interest in and acceptance of the idea of infant mental health. The age range considered by those studying infant mental health has expanded in recent years (Egger & Emde, 2011; Zeanah & Zeanah, 2009). In pediatrics—the medical specialty focusing on children—"infant" typically refers to the first year of life. In the mental health field, birth to 3 years was initially taken as the span of interest; this age range has been extended to age 5 or so. In many respects, we can expect continuities between the mental health of very young and older children, but some aspects of infant mental health, if not unique, are sufficiently different to merit special comment. Here, we note four of these.

First, concern for infants historically has emphasized the importance of the infant–child relationship and how the development of very young children strongly depends on the caregiving context (Zeanah & Zeanah, 2009). Early descriptions of infant mental health appeared in case reports of infant symptoms originating from emotional deprivation in orphanages, disturbances in infant–child attachment, and rearing by parents with psychological disorder (Egger & Emde, 2011). The child's relationship with caregivers remains important in the field.

Second, of particular concern is the need for reliable and valid criteria for identifying and categorizing mental health problems for very young children (Egger & Emde, 2011). Methods and systems used with older children are largely viewed as insufficiently sensitive to developmental differences, and those currently used for infants as requiring improvement.

Third, the role of primary health care practitioners is noteworthy. Most all infants/toddlers are seen by general physicians, pediatricians, or various other health care providers as part of "well-child" visits (Zeanah & Gleason, 2009). These practitioners frequently are the first professionals to hear about feeding and sleep problems, delayed motor or language milestones, and behavioral difficulties. It is thus imperative that they have general knowledge of infant mental health principles and practices, including screenings for symptoms, and a good working relationship with families and mental health professionals.

Fourth, prevention of disorder is inherent in infant mental health. The relief of symptoms is critical, of course, but because infants change so rapidly, high priority must be given to their future development. In addition, research shows that early prevention is especially effective. Thus, treatment goes hand in hand with prevention of future difficulties, and there is a call for efforts to support policies and programs that promote the well-being of infants and very young children (Nelson & Mann, 2010).

depression/anxiety (Figure 1.3). The largest changes were reported for symptoms of worry, irritability, fatigue, sleep problems, panic, and feeling worn out. The investigators

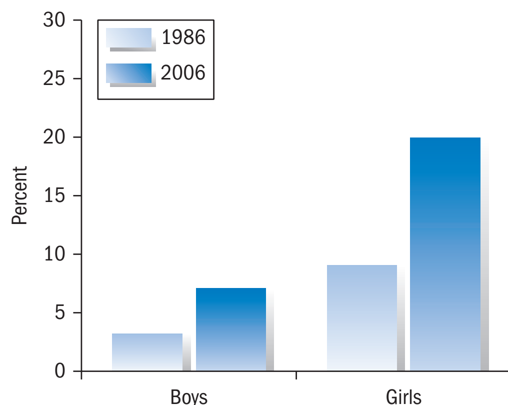


FIGURE 1.3 Percentage of youth reporting frequent feelings of anxiety or depression, 1986 and 2006. *From Collishaw et al., 2010.*

surmised that the 2006 findings were not due to greater willingness of adolescents to report mental health problems nor to increased parental divorce. Further investigation determined that maternal emotional problems had increased during the time span and likely contributed to, but not completely explained, the findings (Schepman et al., 2011).

Overall, research findings are mixed regarding secular trends in young people, with some studies but not all showing increases and some indicating decreases (Collishaw et al., 2004; Costello, Erkanli, & Angold, 2006; Tick, van der Ende, & Verhulst, 2008; Twenge et al., 2010). Moreover, the research results often are complex with regard to types of problems, gender, social class, family, and the like. Continued concern is certainly appropriate, as understanding trends in frequency of problems and what might contribute to change can be valuable in prevention and intervention.

Whether or not problems are increasing, there is little doubt that young people have substantial needs. Yet

their mental health problems too often go unrecognized in schools, primary health facilities, and other settings (Hoagwood, 2005a). In addition, it is estimated that two-thirds to three-quarters of needy youth with diagnosable disorders do not receive adequate treatment (Federal Interagency Forum on Child and Family Statistics, 2011; Merikangas et al., 2011). Mental health services are insufficient, are less available in the most needy communities, and lack effective coordination.

There are several reasons for concern about this situation. Surely, no one wants to see young people suffer the pain or lowered quality of life associated with psychopathology. Moreover, early disturbances can interfere with subsequent developmental processes, leading to an accumulation of problems. Half of all adults with mental illness reported having symptoms by age 14, so that the study of psychopathology of youth has implications across the lifespan (From Discovery to Cure, 2010). Furthermore, mental health problems in young people adversely influence families and the broader society, as reflected in health care expenditures and other indices. Indeed, according to the World Health Organization, many of the disorders that carry the heaviest burden of adult death and disability in the developed areas of the world are related to mental health and are often first observed in youth (Merikangas, Nakamura, & Kessler, 2009).

HOW ARE DEVELOPMENTAL LEVEL AND DISORDER RELATED?

Of concern to professionals and parents alike is whether and how psychological difficulties are related to developmental level. Some relationship does exist between specific problems and the age at which they usually first appear or are identified. Figure 1.4 depicts the age association for several disturbances. The reason for the link is sometimes obvious. Chronological age is correlated with developmental level that, in turn, makes some disorders more likely than others. For instance, developmental speech problems appear when children are first acquiring language skills. But other aspects of onset may be less obvious. Actual onset can occur gradually, with symptoms and social impairment escalating over time. For some disorders, time of onset varies according to gender. Moreover, the time at which a disorder is said to occur may depend on extraneous circumstances. For example, although more severe cases of intellectual disability are identified early in life, most are recognized during the school years when classroom demands call attention to children's abilities to learn.

Taking these distinctions into account, information about developmental level and disorder is helpful in several ways. Knowing the usual age of onset can point to etiology. Very early occurrence suggests genetic and/or prenatal etiology, whereas later onset directs attention to additional developmental influences. Knowing the typical age of onset also serves as a guide to judging the severity or outcome of a disorder: cases that occur especially early are likely to be more severe. For example, typical onset of drug abuse is in adolescence; if it occurs earlier, it is especially associated with severe drug dependency and mental problems later in life (Wills & Dishion, 2004). In addition, parents, teachers, and other adults who are aware of the usual timing of disorder may be more sensitive to the signs of specific problems in youth. In turn, this can lead to preventing the disorder or facilitating early treatment, an outcome thought to aid in reducing the severity or the persistence of disorder and the secondary problems that often are associated with psychological problems (McGorry et al., 2010).

HOW ARE GENDER AND DISORDER RELATED?

For decades, the role of gender in psychopathology in the young was neglected (Crick & Zahn-Waxler, 2003). Several fascinating findings have now emerged. Consistent over the years is the finding of gender differences in the overall rates

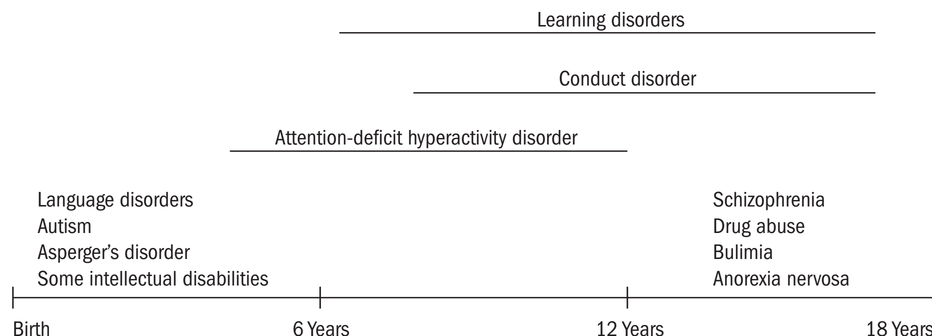


FIGURE 1.4 The age ranges during which some specific disorders typically first occur, are identified, or are most likely to be observed.

TABLE 1.2 Gender Prevalence for Some Disorders of Youth

HIGHER FOR MALES		
Autism spectrum disorder		Attention-deficit hyperactivity disorder
Oppositional disorder		Conduct disorder
Drug abuse		Language disorder
Intellectual disability		Reading disability
HIGHER FOR FEMALES		
Anxieties and fears	Depression	Eating disorder

of many disturbances, with males being more frequently affected than females (Rutter & Sroufe, 2000). Gender differences have been found across time and in many different countries (Seedat et al., 2009). Table 1.2 shows the findings for several specific disorders. But the picture actually is much more complex.

Some gender differences are related to age. Males are particularly vulnerable to neurodevelopmental disorders that occur early in life, whereas females are more vulnerable to emotional problems and eating disorders that more commonly are seen at adolescence (Rutter, Caspi, & Moffitt, 2003). As shown in Figure 1.5, gender differences may exist not only in the rates of disorder but also in developmental change for externalizing problems (aggression, delinquency) and internalizing problems (anxiety, depression, withdrawal, bodily complaints). In addition, problems may be expressed differently according to gender. For example, males tend to display overt physical aggression while females are more likely to exhibit relational aggression by harmful gossip or rumor spreading (Zalecki & Hinshaw, 2004). The severity, causes, and consequences of some disorders may also vary with gender. There is still much to learn about gender differences (e.g., Dekker et al., 2007), and methodological issues must be considered.

Methodological Issues, True Differences

To some extent, reported gender differences may result from methodological practices. In the past, a bias existed for studying males, and an emphasis on one gender over the other can result in mistaken inferences about gender differences. Misleading reports of gender differences also can result from females or males being more willing to report certain problems, for example, girls being more willing to speak of emotional difficulties.

Gender-specific prevalence of disorders also can be an artifact of referral bias when clinical samples are studied. Clinical samples are biased toward boys, partly because help is sought for the disruptive behavior exhibited more often by boys than by girls. Thus, boys with reading problems may be referred over girls with reading problems due

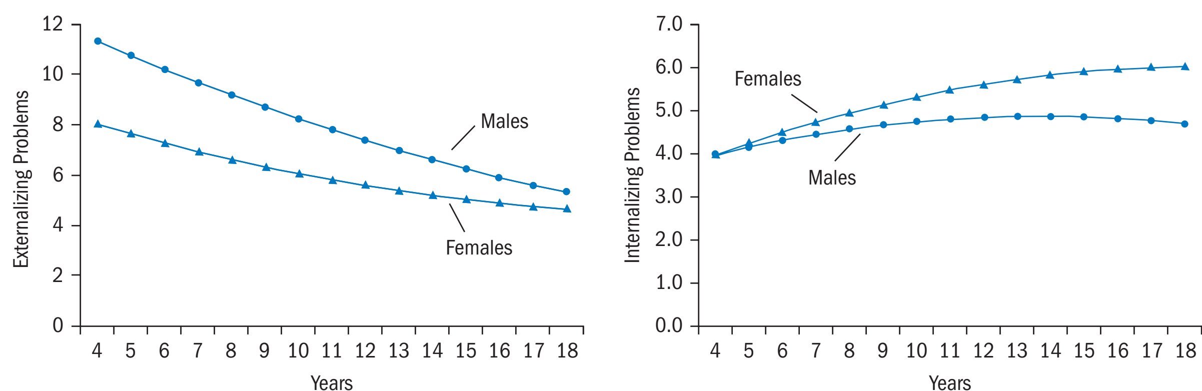


FIGURE 1.5 The presence and developmental change for externalizing and internalizing problems in youth age 4 to 18 years. Externalizing problems drop with age for both genders, while internalizing problems rise for females. *From Bongers, Koot, van der Ende, & Verhulst, 2003.*