The Science and Practice of Abnormal Child Psychology

LEARNING OBJECTIVES

After reading this chapter, you should be able to answer these questions:

• How common are psychological disorders in children and adolescents?
• How can we differentiate normal from abnormal child behavior?
• What is the DSM-5 definition of a mental disorder, and what are its strengths and weaknesses?
• What is the field of developmental psychopathology? How can its principles be used to understand and treat children and adolescents with psychological problems?
• What is the “scientist-practitioner” approach to abnormal child psychology? How can professionals and students integrate science and practice in their work?
• What are some important ethical principles for individuals who work with children and families?

WELCOME TO THE STUDY OF ABNORMAL CHILD PSYCHOLOGY

Childhood is a time of physical maturation, intellectual development, and social-emotional growth. Ideally, children are provided with ample opportunities for play and exploration within the safety and security of a loving family and supportive social network. However, for a significant number of youths, childhood is marked by biological, behavioral, or social-contextual challenges that can adversely affect their development.

The study of child psychopathology is complex and diverse. The sheer number of psychological disorders that can afflict children and adolescents is daunting, to say nothing of the multitude of causal factors and treatments. However, the last 20 years have witnessed a marked increase in the scientific study of abnormal child and adolescent psychology. Theory and empirical research have helped to advance the field, enabling researchers to more fully understand the causes of childhood disorders. Furthermore, clinicians and researchers have worked together to develop new and exciting methods of treatment. Most recently, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has been published, updating the way we define disorders across the life span (American Psychiatric Association, 2013).

There is, perhaps, no more exciting time to be studying abnormal child psychology than now. Students interested in psychological research will discover many areas of child psychopathology that deserve their attention. Each disorder can be explored from multiple perspectives, ranging from its genetic and biological underpinnings to the behavioral and social-cultural
factors that cause and maintain it. At the same time, students interested in helping at-risk youths will discover new developments in the application of psychological research to prevent and treat childhood disorders.

The field of abnormal child psychology is broad and constantly changing. There is much work to be done. Geneticists, neuroscientists, physicians, psychologists, counselors, teachers, parents, and all other individuals who interact with youths can play a role in the prevention and alleviation of childhood disorders and the promotion of children’s mental health. This text is intended to introduce you to this intellectually exciting and personally rewarding discipline. Welcome!

How Common Are Childhood Disorders?

Epidemiologists are scientists who study the prevalence of medical and psychological disorders in the general population (Maughan & Rutter, 2010). Prevalence refers to the percentage of individuals in a given population who have a medical or psychological condition. To estimate prevalence, epidemiologists collect data from thousands of individuals in the population, recording their current physical or psychological health. To estimate the prevalence of psychological disorders among children and adolescents, epidemiologists usually rely on information gathered from parents, other caregivers, or professionals, and (sometimes) children themselves.

Conducting epidemiological research is difficult for several reasons. First, researchers are challenged by the task of collecting data from thousands of people in the population. Many people do not want to participate in lengthy surveys, others do not understand questions asked of them, and still others provide inaccurate information. Second, the information collected depends greatly on who answers the researchers’ questions. For example, parents may be able to comment on children’s disruptive behavior, but they may be less accurate in estimating children’s difficulties with depression or use of alcohol (Loeber, Green, & Lahey, 1990). Third, conducting a large-scale epidemiological survey is costly and time consuming. For these reasons, determining the exact prevalence of childhood disorders has been challenging.

Despite these methodological obstacles, at least seven large epidemiological studies designed to estimate the prevalence of child and adolescent disorders have been conducted in English-speaking countries. Collectively, these studies include data from tens of thousands of youths and their caregivers, using a variety of research strategies. Results indicate that approximately 15% of youths aged 6 to 16 have a diagnosable mental disorder at any given point in time (Breton et al., 1999; British Medical Association, 2006; Costello et al., 1996; Meltzer, Gatward, Goodman, & Ford, 2003; Offord et al., 1987; Shaffer et al., 1996; Simonoff et al., 1997).

A prevalence of 15% indicates that as many as 11,100,000 youths in the United States are experiencing significant psychological distress and impairment (U.S. Census Bureau, 2006). Furthermore, by the time they reach age 16, as many as 30% will have experienced a psychological disorder at some point in their lives (British Medical Association, 2006). The most common category of mental disorders among youths is anxiety disorders (e.g., phobias, fears of separation), followed by Attention-Deficit/Hyperactivity Disorder (ADHD) and conduct problems (e.g., oppositional and aggressive behaviors) (see Table 1.1).

Children's disorders tend to persist over time (Maughan & Rutter, 2010). On average, 40% of children who meet criteria for a psychological disorder tend to also meet criteria for at least one psychological disorder one year later. In some cases, children show homotypic continuity, that is, they show the same problem over time. For example, a child diagnosed with ADHD at age seven will likely have the same disorder at age 8 or 9. However, in most instances, children show heterotypic continuity, that is, their problems change over time into other, related disorders. For example, a child with separation anxiety in early childhood might develop social anxiety in later childhood and depression in adolescence. Their problems might change, but they do not go away.

Psychological disorders have direct, deleterious consequences on the quality of life of children and their families. The direct cost of child and adolescent mental health care in the United States is approximately $12 million annually (Ringel & Sturm, 2001). Youths who experience mental disorders are at risk for lower academic achievement, which can adversely affect their ability to reach their earning potential as adults. Furthermore, the parents of children

<table>
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<tr>
<th>Problem</th>
<th>Prevalence (%)</th>
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<tr>
<td>Any anxiety disorder</td>
<td>6.5</td>
</tr>
<tr>
<td>Attention-Deficit/Hyperactivity Disorder</td>
<td>3.3</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>3.3</td>
</tr>
<tr>
<td>Any depressive disorder</td>
<td>2.1</td>
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<tr>
<td>Any substance use disorder</td>
<td>0.8</td>
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<tr>
<td>Autism Spectrum Disorder</td>
<td>0.3</td>
</tr>
<tr>
<td>Any eating disorder</td>
<td>0.1</td>
</tr>
<tr>
<td>Any bipolar disorder</td>
<td>0.1</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.1</td>
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Source: Based on the Ontario Child Health Study (Offord et al., 1987), the National Institutes of Mental Health Methodology for Epidemiology of Mental Disorders in Children and Adolescents Study (Shaffer et al., 1996), the Great Smoky Mountains Study (Costello et al., 1996), the Virginia Twin Study of Adolescent Behavioral Development (Simonoff et al., 1997), the Quebec Child Mental Health Survey (Breton et al., 1999), the British Child Mental Health Survey (Meltzer et al., 2003), and the British Medical Association Board of Science Survey (British Medical Association, 2006).
and adolescents with mental disorders often show reduced productivity at work because of the demands associated with caring for these youths.

The cost to society of child and adolescent psychological disorders is also enormous. We must not only pay for the direct cost of mental health treatment but also must cover expenses associated with child and adolescent mental illness. These associated costs include incarceration and rehabilitation for youths with conduct problems, drug and alcohol counseling for youths with substance abuse and dependence, and family supervision and reunification services for youths who experience childhood maltreatment. School districts must pay for special educational services for children with cognitive, learning, and behavioral problems that interfere with their ability to benefit from traditional public education. Preventing childhood disorders would spare families considerable suffering and spare society enormous expense. Unfortunately, prevention remains an underutilized approach to dealing with child and adolescent psychopathology in the United States (Tolan & Dodge, 2005).

Although approximately 15% of youths experience full-blown psychological disorders, the percentage of youths who encounter significant mental health problems is even greater (see Table 1.2). To be classified with a mental disorder, youths must show both significant symptoms and marked distress or impairment in day-to-day functioning. However, many youths experience serious problems in their family relationships, educational attainment, and social functioning but fall short of meeting diagnostic criteria for a mental disorder. For example, many children experience considerable feelings of sadness and symptoms of social withdrawal, but they do not meet diagnostic criteria for Major Depressive Disorder. Similarly, many adolescent girls show poor body image and unhealthy eating habits, but they do not qualify for a diagnosis of Anorexia or Bulimia Nervosa. Youths with subthreshold emotional or behavioral problems are clearly not reaching their social and emotional potentials and deserve the attention of parents, teachers, and mental health practitioners. Indeed, as many as 21% of youths in the United States have either a diagnosable mental disorder or a subthreshold behavioral or emotional problem that significantly interferes with their general functioning and quality of life (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). Consequently, approximately one in five youths is in need of psychological treatment or support.

### Sociodemographics and Children’s Mental Health

Mental health problems are not equally distributed across the population (British Medical Association, 2006; Shaffer et al., 1996). First, mental and behavioral disorders are more common among adolescents than among children. Although the prevalence of some disorders, like ADHD, gradually decreases from childhood to adolescence, the prevalence of most disorders, especially substance use problems, depression, and anxiety, increases dramatically during the early teenage years. Although mental health problems can emerge at any age, early adolescence appears to be a time in development that places youths at particular risk.

Second, boys and girls are at different risk for developing psychological disorders across development. Specifically, young boys are more likely than young girls to develop most early childhood disorders, especially developmental disorders (e.g., Autism Spectrum Disorder, Intellectual Disability) and disruptive behavior problems (e.g., ADHD, conduct problems). However, by early adolescence, these differences between genders narrow. By late adolescence, girls show a greater likelihood of emotional disorders, especially depression and anxiety, than do boys.

Third, youths from socially and economically impoverished families and neighborhoods are at increased risk for developing most psychological disorders. Across English-speaking countries, youths from low-income families, single-parent families, parents of low educational attainment, and high-crime neighborhoods show increased prevalence for almost all child and adolescent disorders. In the United States, African American and other ethnic minority children show increased risk for many mental health problems. Researchers are actively searching for the causes of child psychopathology among low-income minority youths, as well as ways to reduce the risks they face.

### The Rise of Pharmacotherapy

One of the greatest changes in the field of abnormal child psychology in the last two decades has been the dramatic increase in the use of medication by children and adolescents. The use of psychotropic medication has increased approximately threefold in the past 15 years (Olsson, Marcus, Weissman, & Jensen, 2002). Recent data indicate that approximately 1 in 10 adolescent boys and 1 in 14

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**Table 1.2** Prevalence of Mental Health Problems Among Youths in the United States

<table>
<thead>
<tr>
<th>Problem</th>
<th>Prevalence (%)</th>
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<tbody>
<tr>
<td>Anxiety problems</td>
<td>13.0</td>
</tr>
<tr>
<td>Disruptive behavior problems</td>
<td>10.3</td>
</tr>
<tr>
<td>Mood problems</td>
<td>6.2</td>
</tr>
<tr>
<td>Substance use problems</td>
<td>2.0</td>
</tr>
<tr>
<td>Any mental health problem</td>
<td>20.9</td>
</tr>
</tbody>
</table>

*Source*: Based on the Methodology for Epidemiology of Mental Disorders in Children and Adolescents (MECA) Study (Shaffer et al., 1996).
adolescent girls who visit a physician are prescribed a **psychotropic medication** (Thomas, Conrad, Casler, & Goodman, 2006). Indeed, psychotropic medication prescriptions for adolescents increased 191% from 1994 to 2001, compared to an increase of only 6% for nonpsychotropic medications (Thomas et al., 2006; see Figure 1.1).

Estimates of the prevalence of psychotropic medication among youths vary (Bonati & Clavenna, 2005; see Table 1.3). Overall, approximately 5.2% of children and adolescents in the United States are taking at least one psychotropic medication. The most frequently prescribed class of medications for youths are psychostimulants, like methylphenidate (i.e., Ritalin), which are often used to treat ADHD. The second most frequently prescribed medications for youths are antidepressants, especially serotonin reuptake inhibitors like paroxetine (i.e., Paxil) and fluoxetine (i.e., Prozac). In most cases, these medications are prescribed by pediatricians and family practice physicians, rather than psychiatrists.

The use of prescription medications is even higher among youths referred for psychiatric treatment. In one epidemiological study of youths referred to mental health professionals in the United States, approximately 29% were prescribed at least one psychotropic medication (Warner, Pottick, & Mukherjee, 2004). Medication was most frequently used to treat children with ADHD, depression, and...
psychotic disorders like Schizophrenia. Youths who show two or more psychiatric disorders are especially likely to be prescribed medication. More than 40% of youths with multiple psychiatric disorders receive medication. Youths receiving inpatient psychiatric treatment are most likely to use prescription medication. Indeed, approximately 70% to 75% of psychiatrically hospitalized youths are prescribed at least one psychotropic medication during the course of their inpatient stay (Dean, McDermott, & Marshall, 2006; Lekhwani, Nair, Nikhinson, & Ambrosini, 2004; Najjar et al., 2004).

Barriers to Children’s Mental Health Services

Some experts have argued that the child mental health system in the United States is in a state of crisis (President’s New Freedom Commission on Mental Health, 2003). Available data indicate that the prevalence of child and adolescent mental health problems has increased over the past two decades. However, families’ access to high-quality mental health services remains grossly inadequate. Only about one third of youths who need mental health services receive treatment (Burns et al., 1995). Families who are able to obtain mental health services often find treatment inadequate or outdated.

Tolan and Dodge (2005) have identified several barriers to children’s access to high-quality, empirically based mental health services. First, financial hardship often interferes with children’s access to comprehensive treatment. In the United States, mental health treatment and medical treatment do not receive equal coverage from insurance companies, despite evidence that mental health problems cost families and society considerable financial expense. Families may find themselves unable to pay for high-quality treatment for their children and adolescents. Families who are uninsured or underinsured face the additional challenge of obtaining treatment from a public social service system that is often overburdened and underfunded.

Second, even if families can pay for high-quality mental health services, they may be unable to find these services. As we will see, evidence-based high-quality mental health treatments are not available in most communities. For example, Multisystemic Therapy (MST) is an empirically supported treatment for older adolescents with serious conduct problems. Many well-designed studies have shown MST to reduce adolescents’ disruptive behavior problems, improve their social and academic functioning, reduce their likelihood of arrest and incarceration, and save money (Henggeler & Lee, 2003). However, few clinicians are trained in providing MST, and MST is available in only a small number of communities. Consequently, many clinicians rely on other, less well-supported interventions.

Third, there are simply not enough experts in child and adolescent mental health to satisfy the need for services. Jenkins (1998) estimated that the current mental health care system is able to address the needs of only about 10% of all youths with psychological problems. Youths who receive treatment are typically those who show the most serious distress or impairment. Youths with less severe problems, such as moderate depression, mild learning problems, or unhealthy eating habits, often remain unrecognized and untreated until their condition worsens. Inadequate mental health services are especially pronounced among poor and ethnic minority youths (Ringel & Sturm, 2001).

Finally, stigma can interfere with children’s access to mental health treatment. Many caregivers are reluctant to refer their children for therapy because of the negative connotations associated with diagnosis and treatment. Approximately 25% of pediatrician visits involve behavioral or emotional problems that could be better addressed by child and adolescent mental health professionals (Horwitz et al., 2002). Stigma associated with the diagnosis and treatment of childhood disorders causes many at-risk youths to be denied treatment.

WHAT IS ABNORMAL CHILD PSYCHOLOGY?

Differentiating Normal and Abnormal Child Behavior

There is no consensus on how to define abnormal behavior in children and adolescents and no agreement on how to best differentiate abnormality from normal functioning. However, mental health practitioners and researchers have proposed several criteria to identify children with behavioral and social-emotional problems.

One approach to defining abnormality is based on statistical deviancy. Using this approach, abnormal behaviors are defined by their relative infrequency in the general population. For example, transient thoughts about death are fairly common among adolescents. However, recurrent thoughts about killing oneself are statistically infrequent and could indicate a mood disturbance, such as depression. Advocates of the statistical infrequency approach might administer a rating scale to clients and identify youths who show symptoms well beyond the range of normality, compared to other children and adolescents of the same age and gender.

The chief limitation of the statistical deviancy approach to defining abnormality is that not all infrequent behaviors are indicative of mental disorders. Imagine a child who is tearful, prefers to stay in her room, does not want to play with friends, and is having problems completing schoolwork. From the statistical deviancy perspective, we might diagnose this girl with depression because she shows mood problems that are rare among children her age. However, if we learn that her grandfather died a few days before her assessment, we would likely interpret her behavior as a normal grief reaction, not as an indicator of Major Depressive Disorder. Although statistical infrequency may be an important
component of a definition of abnormality, it is insufficient. Statistical deviancy does not take into account the context of children’s behavior.

Another approach to defining abnormality is based on disability or degree of impairment. From this perspective, abnormal behavior is defined by thoughts, feelings, or actions that interfere with the individual’s social, academic, or occupational functioning. For example, an adolescent who feels sad because she broke up with her boyfriend would not be diagnosed with depression, as long as she is able to maintain relationships with friends, get along with parents, and perform adequately in school. However, her behavior might be considered abnormal if her functioning deteriorates in any of these areas.

Defining abnormality by level of impairment has a serious drawback: Many people with mental disorders do not show overt impairment in functioning. For example, an adolescent who carefully plans his suicide may show so few overt problems at home or in school that parents and friends are surprised when he attempts self-harm. By most accounts, Eric Harris and Dylan Klebold, the adolescents who killed 12 classmates and a teacher in Columbine High School in April 1999, showed few symptoms of impairment before they committed their heinous crimes (see Image 1.1).

Yet another definition of abnormality might incorporate the individual’s degree of psychological distress. People can show psychological distress through depressed mood, irritability, anxiety, worry, panic, confusion, frustration, anger, or any other feeling of dysphoria. Psychological distress is one of the central features of most anxiety and mood disorders.

One limitation of defining abnormality in terms of psychological distress is that distress is often subjective. Some signs of distress can be observed by others, such as sweaty palms and flushed face. However, distress is usually assessed by asking clients to report their feelings. Subjective assessment of distress in children is problematic for at least two reasons. First, not all children are equally aware of their mood states or able to differentiate among various emotions. For example, some children express dysphoria by crying while others develop physical symptoms, like upset stomach. Furthermore, young children often confuse negative emotions, such as “fear” and “anger.” Second, children’s ratings of distress often cannot be compared against an objective criterion. For example, a child who reports feeling “bad” might be experiencing more distress than another child who reports feeling “terrible.”

A second limitation to defining abnormality based on distress is that many youths with serious behavior problems do not experience negative emotions. For example, adolescents with conduct problems often show no signs of anxiety or depression. They may only express remorse when they are caught and punished. Similarly, younger children with oppositional and defiant behavior toward adults rarely express psychological distress. Instead, their disruptive behavior causes distress to their parents and teachers.

Abnormal behavior might also be defined by actions that violate society’s standards or rules. Put another way, abnormality may be defined in terms of cultural deviancy. For example, Conduct Disorder is characterized by a persistent pattern of behavior that violates the rights of others or the rules of society. Adolescents with Conduct Disorder often have histories of disruptive behavior problems that clearly go against cultural norms and mores: shoplifting, robbery, violence toward others, truancy.

The chief limitation of defining abnormal behavior exclusively by the degree to which it violates social or cultural norms is that these norms can vary considerably from culture to culture. For example, in Western industrialized societies, parents often require young children to sleep in their own beds, usually in separate rooms. Children who refuse to sleep in their own beds may be classified as having a sleep disorder. However, in many non-Western societies, requiring young children to sleep alone is considered cruel and detrimental to their social and emotional development.

Some experts define abnormality in terms of behavioral rigidity. From this perspective, abnormal behavior is characterized by the repeated and inflexible display of certain actions, thoughts, or emotional reactions, especially in response to psychosocial stressors. For example, a child who shows fear at the prospect of separating from his mother may be displaying abnormal behavior if he shows this fear in almost all situations. Under some circumstances, clinginess to parents is adaptive, for example, when the child is in an unfamiliar and potentially dangerous setting, such as a crowded airport. Under other circumstances, separation anxiety is clearly maladaptive, such as when a child is unwilling to leave his parents to attend school. Whereas mental health is characterized by flexibility in responding to changes in situational demands, abnormal behavior may be marked by the persistent use of a limited number of behaviors that are clearly not adaptive in all situations. The chief drawback to defining abnormal behavior in terms of rigidity is that terms like inflexibility and maladaptive are, themselves, vague.

A final way to differentiate abnormality from normal functioning is based on the notion of harmful dysfunction. According to Jerome Wakefield (1992), deviation from normality does not necessarily mean a person has a mental disorder. A disorder exists only when two criteria are met. First, the person must show a dysfunction, that is, a failure in some internal mechanism to perform a function for which it was naturally selected. Second, the dysfunction must cause harm, that is, it must limit or threaten the person in some way. In medicine, heart disease is a disorder because it involves an abnormality in the functioning of the pulmonary system that can greatly interfere with a person’s health.

In the field of psychology, whether a person has a disorder based on the “harmful dysfunction” criterion is somewhat less clear. It depends on both scientific objectivity and social-cultural subjectivity (Wakefield, 1997). In determining whether a youth has a mental disorder, clinicians must be mindful of both the child’s functioning and his or her development and social-cultural context (Image 1.2). Many behaviors
that are objectively dysfunctional may be appropriate or adaptive given the child's context. Consider, Sarah, a girl who lives with her parents on a military base in California. Upon hearing that her mother will soon be deployed to a combat area, she becomes excessively clingy with both parents, has problems eating and sleeping, and refuses to go to school. She may meet diagnostic criteria for Separation Anxiety Disorder, or Major Depressive Disorder. However, her anxiety might be justified given her social context, that is, the imminent deployment of her mother. Wakefield's harmful-dysfunction concept emphasizes that behavior can only be understood in the context of a person's life and surroundings.
The Psychiatric Definition of Abnormality

Most mental health practitioners and researchers use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) to diagnose mental disorders. DSM-5 is published by the American Psychiatric Association and reflects the current psychiatric conceptualization of mental illness. The DSM-5 definition of mental disorder not only reflects Wakefield's notion of harmful dysfunction but also emphasizes the role of impairment and psychological distress in differentiating normal versus abnormal behavior. According to DSM-5,

a mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (American Psychiatric Association, 2013, p. 20)

The DSM-5 conceptualization of a mental disorder is interesting in several respects. First, it adopts a medical model of mental illness in which disorders reside within individuals, rather than between people (Stein, Phillips et al., 2010). Some people have argued that some disorders are relational in nature and can be understood only in an interpersonal context (Heyman et al., 2009). For example, many young children with Oppositional Defiant Disorder argue with their parents, refuse to comply with parental requests, and tantrum when they do not get their way. Interestingly, their defiant behavior is often directed at some adults (e.g., parents) but not others (e.g., teachers). Therefore, the disorder seems to be dependent on the relationship between people and not merely within the child. Relationships may be especially important to mental disorders in children and adolescents, who are typically more dependent on other people for their well-being.

Second, the DSM-5 claims that all mental disorders must have an underlying dysfunction that is typically psychobiological in nature. Indeed, some disorders are associated with specific psychobiological causes. For example, children with ADHD often show underactivity in certain areas of the brain responsible for attention, inhibition, and planning. However, requiring an underlying psychobiological cause is problematic in at least three ways:

1. Researchers have not yet identified specific biological causes for most childhood disorders (Frances, 2009). For example, Autism Spectrum Disorder is a highly heritable condition that leads to serious impairment in social communication and behavior. However, researchers have been unable to identify which genes cause this disorder.

2. When specific abnormalities have been identified in research studies, not all children with the disorder show these abnormalities. For example, some children with Autism Spectrum Disorder show reduced synaptic density and abnormalities in their limbic system; however, these differences in brain structure cannot be used to identify children with the disorder. The brains of most children with autism are not different than the brains of typically developing peers.
3. Even when children show specific biological abnormalities, we usually cannot conclude that these abnormalities cause the disorder. For example, some children with autism show underactivity in a brain region responsible for processing human faces (i.e., the right fusiform gyrus). However, we do not know if underactivity in this brain region causes autism or whether their autistic symptoms lead to deterioration in this brain region. Alternatively, a third variable (e.g., exposure to environmental toxins during pregnancy) may cause abnormalities in both brain and behavior.

Consequently, critics have argued that it may be premature to assume that all disorders have an underlying cause that is both psychological and biological. Some disorders may be caused entirely by psychological problems (First & Wakefield, 2010).

Third, it is worth noting that DSM-5 describes people with mental disorders as “usually” experiencing significant distress or disability (i.e., impairment)—they may not always show both characteristics. Some seriously depressed adolescents experience tremendous emotional pain and frequently think about killing themselves, but they do not show marked impairment in their social or academic functioning. Other youths who show serious conduct problems have been arrested and have dropped out of school, but they report no problems with anxiety, depression, or low self-esteem.

Fourth, mental disorders must be assessed in terms of the individual’s social and cultural background, a point to which we now turn.

Abnormality, Ethnicity, and Culture

According to DSM-5, clinicians must carefully differentiate symptoms of a mental disorder from behaviors and psychological states that are sanctioned in a given culture. Differentiating abnormal symptoms from culturally sanctioned behavior is especially challenging when clinicians are asked to assess youths from other cultures.

Ethnicity and culture can affect the diagnostic process in at least four ways (Alarcon, 2009; Miller & Prosek, 2013):

First, ethnic minority groups living in the United States often have different cultural values that affect their views of children, beliefs about child rearing, and behaviors they consider problematic. For example, white, middle-class parents often place great value on fostering children’s social-emotional development and encouraging child autonomy. These parents often provide high levels of warm and responsive behavior during parent-child interactions. In contrast, many African American parents place relatively greater value on children’s compliance; consequently, they may adopt less permissive and more authoritarian socialization tactics. Clinicians need to be aware of cultural differences in socialization goals and parents’ ideas about appropriate and inappropriate child behavior.

Second, ethnic minorities living in the United States, especially immigrants, encounter psychosocial stressors associated with acculturation. Acculturation stressors can include assimilation into the mainstream culture, separation from extended family and friends, language differences, limited educational and employment opportunities, and prejudice. Many ethnic minorities also face the additional stress of low social and economic status. Many immigrants to the United States, especially those from Latin America, do not share the same legal status as members of the dominant culture. For these reasons, the sheer number of psychosocial stressors encountered by ethnic minority families is greater than those encountered by families who are members of the dominant culture.

Third, language differences can cause problems in the assessment and diagnosis of non-native speakers.

CASE STUDY

CULTURE MATTERS

Julia was a 16-year-old Asian American girl who was referred to our clinic by her oncologist after she was diagnosed with a rare form of cancer. Julia refused to participate in radiation therapy or take medications for her illness. Her physician suspected that Julia was paranoid because she attempted to attack him when he tried to examine her in his office.

With the help of a translator, Julia’s therapist learned that she was a second-generation Hmong immigrant from Southeast Asia who lived with her parents and extended family. Julia and her family had limited contact with individuals outside the Hmong community and refused to participate in Western medicine. Instead, Julia and her parents practiced traditional Eastern folk medicine.

Because Julia’s therapist doubted that folk medicine alone would help her cancer, she suggested that Julia’s community shaman talk with her physician to identify which aspects of medical treatment might be acceptable to Julia and her family. Over time, Julia was able to successfully participate in Western medical treatment by having the shaman attend all of the radiation therapy sessions, bless the medications prescribed by the oncologist, and perform other folk remedies important to Julia and her family.
The assessment and diagnostic process was designed predominantly for English-speaking individuals living in the United States. The words that describe some psychological symptoms are not easily translated into other languages. Furthermore, many symptoms reported by individuals from other cultures do not readily map onto DSM-5 diagnostic criteria. Psychological tests are almost always developed with English-speaking children and adolescents in mind. For example, white children raised in Columbus, Ohio, will likely find the following question on an intelligence test fairly easy: “Who was Christopher Columbus?” However, Cambodian immigrant children who recently moved to the city might find the question extremely challenging. Psychologists must be aware of differences in language and cultural knowledge when interpreting test results.

Fourth, ethnic minorities are often underrepresented in mental health research. Over the past two decades, researchers have made considerable gains in understanding the causes and treatment for a wide range of child and adolescent disorders. However, researchers know relatively little about how differences in children’s ethnicity and cultural backgrounds might place them at greater risk for certain disorders or affect treatment. For example, emerging data suggest that the prevalence of alcohol and drug abuse among adolescents differs, depending on adolescents’ ethnicities. Researchers have only recently begun to create treatment programs designed specifically for minority youths. For example, narrative therapies have been developed to help Spanish-speaking children and adolescents overcome mood and anxiety problems, using culturally relevant storytelling (Costantino, Malgady, & Cardalda, 2005). Youths listen to, write, and sometimes enact stories in which the main characters model adaptive responses to stressful life experiences in a manner that is consistent with social-cultural attitudes and values. Clearly, more research needs to be done to investigate the interplay between psychopathology and culture among ethnic minority youths.

WHAT IS ABNORMAL CHILD PSYCHOLOGY?
Understanding the Development of Psychopathology

Developmental psychopathology is a broad approach to studying normal and abnormal development across the life span. Developmental psychopathologists believe that development is shaped by the complex interaction of biological, psychological, and social-cultural factors over time. An adequate understanding of development, therefore, depends on the appreciation of each of these domains, how they interact, and how they affect the person from infancy through adulthood (Rutter & Sroufe, 2000).

Developmental psychopathologists study human development across several levels of analysis. These levels include the person’s genetics, brain structure and functioning, psychological development (i.e., actions, thoughts, emotions), family interactions and peer relationships, and the broader social-cultural context in which the person lives. Factors on each of these levels can individually affect development. More frequently, however, factors across levels interact over time to shape children’s developmental outcomes (Cicchetti & Toth, 1998).

Probabilistic Epigenesis

Developmental psychopathologists use the term epigenesis to describe the way biological, psychological, and social-cultural factors interact with each other to influence development over time (see Figure 1.2). Development unfolds as genetic and biological factors guide and direct psychological, familial, and social functioning (Gottlieb & Willoughby, 2006).

Consider Nina, a child with Down Syndrome. Nina’s syndrome was caused by a genetic mutation on chromosome 21, probably acquired through an abnormality in her mother’s egg cell. This genetic mutation caused Nina’s brain and central nervous system to develop in an abnormal fashion. Her neurological development, in turn, shaped her psychological functioning during early childhood. Nina’s parents reported delays in her motor development (e.g., sitting up, walking), use of language, and acquisition of daily living skills (e.g., toilet training, dressing). In school, she showed problems in learning to read, write, and count. These psychological characteristics affected the type of care she received from parents and teachers. Nina’s mother was understandably very protective, and her teachers often offered Nina extra attention in school. Nina’s cognitive functioning also affected her relationships with peers. Nina preferred to play with younger children rather than her classmates. By the time Nina reached junior high school, she was well behind her peers academically. However, Nina was able to spend half the school day in a regular sixth-grade classroom, assisted by an aide. She spent the remainder of the day in a special education class. These extra services offered by her school district (a social-cultural factor) enabled Nina to begin a part-time job during high school.

Nina’s story illustrates the unfolding of development over time. Each level of development affects the one beyond it. However, epigenesis is a bidirectional process. Genetic and biological factors certainly affect psychological and social functioning; however, psychological and social factors can also determine the effects of genes and biology on development. Arnold Sameroff (2000) used the term transactional to refer to the way factors across levels affect each other over time.

To understand the transactional nature of development, consider Anthony, another child with Down Syndrome. Anthony’s mother, Anita, was Heartbroken when her obstetrician told her that Anthony had Down Syndrome (Image 1.3). Rather than despair, Anita decided that she was going to...
maximize her son’s cognitive, social, and behavioral potential by giving him the most enriching early environment that she could provide. Anita spent countless hours talking to Anthony, reading books, listening to music, playing games,
and going on outings. Although Anthony acquired language and daily living skills slowly, Anita had high expectations for him. She remained patient and tried to provide structure and help so that Anthony might learn these skills independently. Anita enrolled Anthony in a special needs preschool and was heavily involved throughout his education. Anthony developed fairly good language and daily living skills and was able to graduate with his high school class. Today, Anthony is employed full-time in the mailroom of a large company and lives independently.

Understanding and predicting child development is extremely difficult for two reasons. First, development is influenced by many factors across multiple levels: genes, biology, psychology, family, society. Second, these factors are constantly changing over time, each interacting with the others. Consequently, the unfolding of development is not predetermined by one's genes, biology, or any other factor. Instead, the unfolding of development is probabilistic; a person's developmental outcome can vary depending on the interplay of many biological and environmental factors. Developmental psychopathologists use the term probabilistic epigenesis to refer to the complex transaction of biogenetic, psychological, familial, and social-cultural factors that shape development over time (Cicchetti & Sroufe, 2000; Gottlieb & Willoughby, 2006).

### Developmental Pathways

Developmental psychopathologists often liken child development to a journey along a path. Indeed, they often refer to children as following certain developmental pathways, or trajectories, toward either healthy or unhealthy outcomes (Pickles & Hill, 2006).

As children grow, they face certain developmental tasks or challenges along their paths (see Table 1.4). These tasks depend largely on the age and developmental level of

![Table 1.4 Developmental Tasks in Childhood and Adolescence](image)

(Continued)
PART I  PRINCIPLES OF SCIENCE AND PRACTICE

the child. Erik Erikson (1963) outlined some of the most important social and emotional tasks facing individuals as they progress from infancy through old age. For example, the primary developmental task facing infants is to establish a sense of trust in a loving and responsive caregiver. Infants must expect their caregivers to be sensitive and responsive to their physical, social, and emotional needs and to see themselves as worthy of receiving this care and attention from others. A primary developmental task of adolescence is to establish a sense of identity. Adolescents must develop a coherent sense of self that links childhood experiences with goals for adulthood. Adolescents usually accomplish this task by trying out different social roles and behaviors during the teenage years.

Developmental tasks present forks in life’s path. The child can either successfully master the developmental task or have problems with its successful resolution. Mastery of developmental tasks leads to social, emotional, and behavioral competence, placing children on course for optimal development. For example, infants who establish a sense of basic trust in caregivers may have greater ability to make and keep friends in later childhood (Image 1.4). Unsuccessful resolution of developmental tasks, however, can lead to problems in later development. For example, failure to establish a sense of trust in caregivers during infancy may interfere with children’s abilities to develop close peer relationships later in childhood (Masten et al., 2006).

Progress along developmental pathways, therefore, builds upon itself over time. Early developmental experiences set the groundwork for later developmental experiences. If children show early social, emotional, and behavioral competence, they can use these early skills to master later developmental tasks. However, failure to master early developmental tasks can interfere with the development of later skills and abilities. For example, a preschool child who learns to control his behavior and emotions during play will likely have an easier time making friends when he enters first grade. However, a preschooler who continues to tantrum or act aggressively when he does not get his way may be ostracized by peers in the first-grade classroom.

To understand the hierarchical nature of development, consider another analogy: Development is like a building. Our genetic endowment might form the foundation of the building, providing us with our physical attributes, raw neurobiological potential, and behavioral predispositions. The ground floor might consist of early environmental experiences, such as our prenatal surroundings or the conditions of our birth and delivery. Subsequent floors might consist of postnatal experiences, such as our nutrition and health care, the relationships we develop with our parents, the quality of our education, and the friends we make in school. The integrity of the upper levels of our “building” is partially determined by the strength of the lower levels. For example, problems with the foundation will place additional challenges on the formation of higher levels. However, especially well-developed higher levels can partially compensate for difficulties in the foundation.

The building does not exist in a vacuum, however. The context in which the structure is created is also important. Just as temperature, wind, and rain can affect the construction of a building, so, too, can the child’s social-cultural climate affect his development. Certain social and cultural conditions can promote the child’s psychological integrity: high-quality schools, safe neighborhoods, and communities that protect and value children and families. Other social and cultural factors, such as exposure to poverty and crime, can compromise child development.

Table 1.4  (Continued)

<table>
<thead>
<tr>
<th>Older Adolescents</th>
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<tbody>
<tr>
<td>• Working or preparing for future higher education</td>
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<tr>
<td>• If working, behaving appropriately in the workplace</td>
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<tr>
<td>• If in school, meeting academic standards for courses or degrees</td>
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<td>• Forming and maintaining romantic relationships</td>
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<tr>
<td>• Obeying the laws of society</td>
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<td>• Transitioning from parents, living independently</td>
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Adaptive Versus Maladaptive Behavior

From the perspective of developmental psychopathology, normal and abnormal behavior is determined by the degree to which it promotes children’s competence. Behaviors that allow children to develop social, emotional, and behavioral competence over time and meet the changing demands of the environment are regarded as adaptive. Examples of adaptive behavior include toddlers learning to understand other people’s emotional states, school-age children learning to think before acting, and adolescents using complex moral reasoning to solve interpersonal problems. These behaviors are adaptive because they allow children to understand and interact with their environment in effective and flexible ways (Sroufe, 1997).

Behaviors that interfere with children’s social, emotional, and behavioral competence or do not meet the changing demands of the environment are regarded as maladaptive. Examples of maladaptive behavior include toddlers who do not understand others’ emotional expressions and withdraw from social interactions, school-age children who impulsively hit others when they are angry, and adolescents who fail to show respect to peers. These behaviors are considered maladaptive because they indicate a failure to develop social competencies and they interfere with children’s social-emotional well-being (Sroufe, 1997).

From the perspective of developmental psychopathology, normal behavior is determined by the degree to which the child’s actions are adaptive, given his developmental tasks. Consequently, normality and abnormality are dependent on children’s developmental context. Consider a 2-year-old child who stubbornly refuses to dress in the morning and tantrums when told that he cannot have cookies for breakfast. Although these oppositional behaviors cause parents grief, they are usually not considered abnormal in 2-year-olds. In fact, defiance and stubbornness can reflect toddlers’ developmentally appropriate bids for autonomy. However, the same behaviors shown by a 6-year-old child would likely be considered maladaptive and abnormal. In the context of his age and level of development, these behaviors likely reflect problems balancing needs for autonomy with respect for parental authority (Cicchetti & Aber, 1998).
From the perspective of developmental psychopathology, normal and abnormal behaviors are also determined by the degree to which a behavior is adaptive, given the child's environment. Consequently, normality and abnormality are dependent on children's environmental context. Consider Xavier, a 13-year-old boy who has a history of running away from home, staying out all night, skipping school, and earning low grades. Clearly, Xavier's behavior is problematic. However, if we discover that Xavier is also experiencing physical abuse at home, we might see how his problematic behavior reflects an attempt to cope with this psychosocial stressor. Specifically, Xavier stays out at night and runs away from home to escape physical maltreatment. Furthermore, he likely has difficulty completing assignments and attending school because of his stressful home environment. Although Xavier's behavior deserves the attention of caring professionals, his actions are best understood in terms of the environmental context.

The Importance of Understanding Normal Development

From the perspective of developmental psychopathology, abnormal development reflects a deviation from normality. Therefore, our ability to recognize, understand, and treat childhood disorders depends on our knowledge of normal child development. Consider George, a 14-year-old boy who begins drinking with friends at parties. Approximately once every month for the past 6 months, George has drunk at least five or more alcoholic beverages while partying with friends. He drinks in order to "have fun" and has never gotten into trouble or put himself in dangerous situations while intoxicated. Consider also a 12-year-old girl, Maria, who is dieting to lose weight. Although Maria's weight is average for a girl her age and height, she is very dissatisfied with her body and feels like she needs to lose at least 15 lbs. Whether we regard George and Maria's actions as abnormal depends partially on whether their behaviors are atypical of adolescents their age or inconsistent with the environmental demands they face. Knowledge of normal development can assist us in identifying and treating children's problems.

Developmental psychopathologists also believe that abnormal behavior can shed light on normal child and adolescent development. Youths who clearly show delays in mastering developmental tasks or failures in meeting environmental demands can teach us about how development typically proceeds. For example, children with autism show unusual deficits in perceiving and interpreting other people's social behavior. By studying these deficits, researchers are beginning to understand how the ability to process social information develops in typically developing infants and children.

Focus on Individual Differences

Developmental psychopathologists are very interested in individual differences in child and adolescent development; that is, they want to discover what leads to differences in the way some children develop compared to others. Predicting individual differences in development is extremely difficult because, as we have seen, many factors interact over time to affect children's developmental outcomes. The complex interactions between biogenetic, psychological, familial, and social factors over time produce two phenomena: equifinality and multifinality (Cicchetti, 1990; Sroufe, 1989b).

Equifinality occurs when children with different developmental histories show similar developmental outcomes. For example, imagine that you are a psychologist who conducts psychological evaluations for a juvenile court. As part of your duties, you assess adolescent boys who have been arrested and convicted of illegal activities, such as theft, assault, and drug use, in order to make recommendations to the court regarding probation and treatment. All of the boys that you assess have similar developmental outcomes; that is, they all show conduct problems. However, after interviewing many of the boys, you discover that their developmental histories are quite different. Some boys have long histories of antisocial behavior, beginning in early childhood. Other boys have no histories of conduct problems until their recent arrest. Still other boys' conduct problems are limited to times when they were using drugs and alcohol. Your discovery illustrates the principle of equifinality in child development: There are many different paths to the same developmental outcomes.

The principle of multifinality refers to the tendency of children with similar early experiences to show different social, emotional, and behavioral outcomes. For example, imagine that you are a clinical social worker who evaluates children who have been physically abused. During the course of your career, you have assessed a number of children who have been abused by their caregivers. You notice, however, that some of these children show long-term emotional and behavioral problems while others seem to show few adverse effects. Your observation reflects the principle of multifinality: Children with similar early experiences show different outcomes.

The principle of equifinality makes definitive statements about the causes of psychopathology extremely difficult. Because of equifinality, we usually cannot infer the causes of children's behavioral problems based on their current symptoms. For example, many people incorrectly believe that all adolescents who sexually abuse younger children were, themselves, sexually abused in the past. In actuality, adolescents engage in sexual abuse for many reasons, not only because they were victimized themselves.

The principle of multifinality limits the statements we can make about children's prognosis. For example, many people erroneously believe that if a child has been sexually abused, she is likely to exhibit a host of emotional and behavioral problems later in life, ranging from sexual deviancy and aggression to depression and anxiety. In fact, the developmental outcomes of boys and girls who have been sexually abused vary considerably. Some children show significant maladjustment while others show few long-term...
effects. Their diversity of outcomes illustrates the difficulty in making predictions regarding development.

**Risk and Resilience**

What explains equifinality and multifinality? Why is there such great diversity in children's developmental pathways? The answer is that child development is multiply determined by the complex interplay of genetic, biological, psychological, familial, and social-cultural factors. Some of these factors promote healthy, adaptive development, whereas other factors increase the likelihood that children will follow less-than-optimal, more maladaptive, developmental trajectories.

Developmental psychopathologists use the term risk factors to describe influences on development that interfere with the acquisition of children's competencies or compromise children's ability to adapt to their environments. In contrast, psychologists use the term protective factors to refer to influences on development that buffer the negative effects of risks on children's development and promote adaptive functioning (see Table 1.5). Risk and protective factors occur across levels of functioning: They can be genetic, biological, psychological, familial, or social-cultural (Cicchetti, 2006; Luthar, 2006).

The salience of a risk factor depends on the child's age, gender, level of development, and environmental context. For example, child sexual abuse is a risk factor for later psychosocial problems. However, the effects of sexual abuse depend on the gender of the child and the age at which the abuse occurs. For example, boys often show the greatest adverse effects of sexual victimization when they are abused in early childhood, whereas girls often show the poorest developmental outcomes when abuse occurs during early adolescence (Richters & Cicchetti, 1993).

Similarly, the ability of protective factors to buffer children from the harmful effects of risk depends on context.

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<tr>
<th>Table 1.5 Some Risk and Protective Factors Across Childhood and Adolescence</th>
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(see Image 1.5). For example, many children who experience sexual abuse at the hands of a family member (e.g., stepfather) experience considerable psychological distress and behavioral impairment. However, children who are able to rely on a caring, nonoffending parent are often able to cope with this stressor more effectively than youths without the presence of a supportive parent (Heflin & Deblinger, 2003).

Protective factors are believed to promote resilience in youths at risk for maladaptive development. Resilience refers to the tendency of some children to develop social, emotional, and behavioral competence despite the presence of multiple risk factors. Consider the Case Study (Ramon and Rafael) about two brothers growing up in the same impoverished, high-crime neighborhood.

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**CASE STUDY**

**RAMON AND RAFAEL: DIVERGING DEVELOPMENTAL PATHS**

Ramon, the older brother, begins showing disruptive behavior at a young age. He is disrespectful to his mother, defiant toward his teachers, and disinterested in school. By late elementary school, he has been suspended a number of times for fighting and chronic truancy. In junior high school, Ramon begins associating with peers who introduce him to other antisocial behaviors, such as shoplifting and breaking into cars. By adolescence, Ramon rarely attends school and earns money selling drugs. At 15, Ramon is removed from his mother’s custody because of his antisocial behavior and truancy.

Rafael, the younger brother, also shows early problems with defiance and aggression. However, these problems do not persist beyond the early elementary school years. Although Rafael does not enjoy school, he befriends an art teacher who recognizes his talent for drawing. The teacher offers to tutor him in art and help him show his work. Rafael also takes art classes at a local community center to learn new mediums. Through these classes, he meets other adolescents interested in drawing and painting. Rafael’s grades in high school are generally low; however, he excels in art, music, and draftsmanship. He graduates with his class and studies interior design at community college.

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Image 1.5  Portraits of resilience from both sides of the political spectrum. Barack Obama’s parents separated shortly after his birth in 1961. He was estranged from his father and raised by his mother and grandparents. He became the first African American president of the United States. Condoleezza Rice was born in racially segregated Birmingham, Alabama. In 1963, the Sixteenth Street Baptist Church in her neighborhood was firebombed, killing two girls she knew. She later became provost of Stanford University, national security adviser, and secretary of state.
What accounts for Ramon’s struggles and Rafael’s resilience? Although there is no easy answer, a partial explanation might be the presence of protective factors at just the right time in Rafael’s development. Ramon’s path to antisocial behavior was probably facilitated by antisocial peers who introduced him to criminal activities. In contrast, Rafael’s peer group encouraged prosocial activities and the development of artistic competence. If Rafael’s teacher did not encourage the development of his art talents until later in Rafael’s development, perhaps after he developed friendships with deviant peers, would he have followed the same developmental pathway as Ramon? Although we do not know for sure, we can speculate that these protective factors played an important role in his ability to achieve despite multiple risks (Cicchetti & Toth, 1991; Sroufe & Rutter, 1984).

Most protective factors occur spontaneously: A teacher nurtures a special talent in an at-risk youth, a coach encourages a boy with depression to join a team, or a girl who has been abused is adopted by loving parents. Sometimes, however, protective factors are planned to prevent the emergence of disorders. For example, communities may offer free infant and toddler screenings to identify children with developmental disabilities at an early age. Identification of developmental delays in infancy or toddlerhood can lead to early intensive intervention and better prognosis. Similarly, schools may offer prevention programs for girls who might develop eating disorders. Volunteers might teach girls about healthy eating, risks of dieting, and stress management. Even psychotherapy can be seen as a protective factor. Therapy helps children and adolescents alter developmental trajectories away from maladaptation and toward adaptation (Quinton & Rutter, 1998; Toth & Cicchetti, 1999).

As we have seen, developmental psychopathology is an emerging approach to understanding abnormal child behavior in the context of normal child development, in relation to the environment, and across time. Developmental psychopathology offers a rich and multifaceted perspective on abnormal child psychology across a number of different levels: genetic, biological, psychological, familial, and social-cultural. Throughout this book, the principles of developmental psychopathology will be used to explore the causes and treatment of child and adolescent disorders across these levels and within various developmental contexts.

THE SCIENCE OF ABNORMAL CHILD PSYCHOLOGY

Integrating Science and Practice

The scientist-practitioner approach to abnormal psychology assumes that psychological research and clinical practice are interdependent and equally important facets of psychological training. Psychologists trained in the scientist-practitioner tradition are first and foremost scientists. They are committed to understanding human behavior through careful and systematic empirical investigation. Psychological science is concerned primarily with understanding behavior, with the goal of explaining, predicting, and/or influencing aspects of behavior that are relevant to people’s lives. Psychological scientists, whether they work in research labs or mental health clinics, rely on scientific principles to inform their work, and they try to base their professional activities on knowledge gained through systematic data collection.

Most scientist-practitioners are clinicians who use scientific knowledge to alleviate distress and promote the welfare of their clients. Clinicians are called to apply information gained through research to help children, adults, and families. Furthermore, they may be asked to consult with other professionals, evaluate the effectiveness of social programs, and teach or supervise new generations of mental health experts. These individuals often work in mental health clinics, hospitals, schools, counseling centers, and other places where psychological services are delivered to individuals or groups.

Other scientist-practitioners are primarily engaged in research. Although they may also see clients on a limited basis, these professionals are devoted to understanding the prevalence, causes, and treatment of mental disorders. Researchers might be employed at a college or university, a medical school, a hospital, or an independent research center.

From the scientist-practitioner perspective, both the science and practice of psychology are important to the discipline. Psychological science informs clinical practice by helping psychologists use the most accurate assessment techniques and effective therapeutic methods possible. At the same time, the practice of assessment and therapy guides research by helping scientists focus their efforts on discovering principles and practices that have real-world applications.

The scientist-practitioner approach has its roots in a 1941 report to the American Association for Applied Psychology written by David Shakow (Baker & Benjamin, 2000). In the report, Shakow outlined the importance of research and clinical training in the education and development of clinical psychologists. He argued that psychologists must be able to integrate scientific principles and knowledge with their expertise as clinicians. Shakow recognized that psychologists could not balance their time equally between research and clinical practice; most would consider themselves either chiefly researchers or primarily practitioners. However, he asserted that an appreciation for science and practice was necessary for all psychologists, regardless of their professional role. As Drabick and Goldfried (2000) explain,

The scientist practitioner model sought to encourage the development of practitioners who are both consumers of assessment and treatment research findings and evaluators of their own interventions using empirical methods, as well as researchers who are capable of producing and reporting clinically relevant data to the scientific community. Indeed, graduates would be well-trained clinicians who combined practice with an awareness of scientific research; or, conversely, . . . competent researchers with sensitivity to clinical issues. (p. 330)
Shakow’s report was used by the American Psychological Association (1947) to formulate the first guidelines for the training of clinical psychologists. Today, most university-based clinical training programs identify themselves in the scientist-practitioner tradition.

**Scientifically Informed Practice**

The core tenets of the scientist-practitioner approach are outlined by Richard McFall’s (1991) “Manifesto for a Science of Clinical Psychology.” McFall argued that scientifically based psychology is the only legitimate and acceptable form of understanding and alleviating psychological disorders. Stated another way, psychology is a science that must have its roots in empiricism and objective evaluation. According to McFall, “All forms of legitimate clinical psychology must be grounded in science, … all competent clinical psychologists must be scientists first and foremost, and … all clinicians must ensure that their practice is scientifically valid” (p. 76).

From McFall’s (1991) perspective, the distinction between psychological science and clinical practice is artificial. The only way clinicians can help their clients in a competent and ethical manner is to base their interventions on the research literature and on empirical investigation. Before practicing any form of assessment or treatment, clinicians must ask, “What is the empirical evidence supporting my practice?” Whenever possible, clinicians must rely on assessment strategies and therapy techniques that have empirical support.

Unfortunately, some clinicians do not ground their interventions in the research literature or empirical data (Garb & Boyle, 2004). Instead, they may base their clinical practice on other factors, including theory, clinical experience, and anecdotal information provided by others. Although theories, experience, and anecdotes can be useful when combined with empirical evidence, they are insufficient guides for clinical practice by themselves. Psychological scientists believe that empirical data provide the best evidence either for or against a specific clinical intervention.

Without empirical data, clinicians might intervene in ways that are not effective. Ineffective interventions can harm clients and their families in at least three ways. First, ineffective interventions can cost significant time and money—resources that might be better spent participating in treatment with more empirical support. For example, available treatments for childhood disorders include listening to certain types of music, wearing special glasses, taking large doses of vitamins, avoiding certain textured foods, riding on horseback, swimming with dolphins, re-enacting the birth experience, and a host of other therapies with little systematic support. Although most of these interventions do not cause physical or psychological harm to clients, they can cost significant time, energy, and money. Furthermore, when insurance companies compensate individuals for participating in these therapies, resources available for more evidence-based interventions are diminished.

Second, families who participate in ineffective treatment can lose hope in the therapeutic process and in psychological treatment more generally. For example, many parents of oppositional and defiant children seek help to manage their children’s behavior. Although a number of well-supported interventions exist to treat children’s disruptive behavior, many families are given therapy that lacks empirical support. Consequently, they meet with limited success. As a result, many parents come to believe that psychological interventions will not help their children. Some parents simply give up on treatment.

Third, interventions that lack empirical support can be harmful to clients, families, and society. The history of psychology is marked by examples of clinicians harming individuals and society by practicing without empirical basis. Perhaps nowhere is this more obvious than in the treatment of autism. In the 1960s, Bruno Bettelheim suggested that autism was caused by parents who were cold and rejecting toward their children. Bettelheim’s erroneous theory for the etiology of autism placed unnecessary blame on parents and resulted in a host of interventions that were completely ineffective at alleviating autistic symptoms (Image 1.6).

Later, sociologist Douglas Biklen (1993) recommended that individuals with autism and severe Intellectual Disability might be able to communicate with others if facilitated by a trained therapist. The subsequent practice of “facilitated communication” involved the therapist guiding the client’s hand as the client supposedly typed messages on a keyboard. In one case, a client participating in facilitated communication supposedly reported that he had been abused by his family. As a result, the client was removed from his family’s custody, despite no corroborating evidence of maltreatment. Later, the technique of facilitated communication was discredited by showing that the messages typed by clients actually reflected knowledge and information provided by therapists, not by the individuals with developmental disabilities.

Even more recently, physician Andrew Wakefield and colleagues (1998) incorrectly suggested that the measles-mumps-rubella (MMR) vaccine caused autism in some children susceptible to the disorder. Consequently, many conscientious parents refused to immunize their infants, resulting in an unnecessary and dangerous increase in these childhood illnesses.

Clinicians also harm clients in more subtle ways when they provide information that lacks empirical support. For example, some clinicians erroneously perpetuate the myth that most sexually abused children victimize other children in the future. This incorrect belief can unnecessarily worry parents and stigmatize young victims. Similarly, other clinicians convey the notion that certain childhood disorders, like ADHD, do not exist; rather, problems with hyperactivity and inattention are caused by inadequate parenting. Such unsupported beliefs can cause parents to feel guilty and ineffective and discourage them from seeking effective treatment.

Scientist-practitioners engaged in full-time clinical practice try to approach their professional activities using the
principles of psychological science. From the scientist-practitioner perspective, clinical work is analogous to a research study in which the practitioner’s sample size consists of one individual (i.e., the client). The clinician generates hypotheses about the source of the client’s problem and the best form of treatment, based on data gathered from the client and information presented in the research literature. Then, the clinician administers treatment and evaluates the client’s outcomes using objective criteria. Finally, the clinician modifies her intervention based on information from the client, in order to improve effectiveness.

Clinically Informed Research

Most professionals have focused on the importance of clinicians applying principles of psychological science to their practice. Somewhat less attention has been directed at the importance of researchers conducting studies that are meaningful to therapists. A scientist-practitioner approach to psychopathology implies that psychological research must be relevant to clinical practice.

A number of researchers have recognized the considerable gap between psychological research and clinical practice (Antony, 2005). Unfortunately, many researchers eschew the lack of scientific rigor that characterizes most clinical interventions, while therapists often find psychological research to be inaccessible and detached from their daily practice.

From the scientist-practitioner perspective, researchers can take at least three steps to bridge this gap between research and practice.

First, psychological research must address practical problems that have relevance to clinicians. Although research in basic psychological structure and functioning is extremely important, research that has direct application to clinicians’ day-to-day work is most likely to be used by therapists in the community.

Second, researchers must disseminate their findings in a manner that clinicians can understand and use. As psychology students know, reading an empirical study from a peer-reviewed journal can be challenging. It is extremely tempting to read the article’s abstract, introduction, and discussion and omit the method and results section, in order to avoid the often complex and confusing description of research design and statistics. Furthermore, relatively few research articles are written with clinicians as the primary audience. Often, readers who want to apply findings to their clinical work must determine the implications of research to their practice on their own. Researchers must be more mindful of clinicians when disseminating their research, to maximize the likelihood that clinicians will understand and apply their findings.

Third, the intervention techniques that are developed by researchers must translate to the real world. New therapies are usually evaluated in university clinics and research hospitals, and they are evaluated under ideal circumstances. For
example, when evaluating a new therapy, researchers carefully select clients with only certain disorders, provide therapists with considerable training in delivering the interventions, and monitor clients' participation in treatment and clinicians' adherence to the treatment program. However, when therapies are used outside research settings, they may not be as feasible to administer or as effective at reducing clients' symptoms. For example, behavioral treatments have been shown to reduce children's disruptive behavior problems in carefully controlled research studies. However, when these programs are administered in real-world clinics, as many as 50% of families drop out of treatment before completion.

From the scientist-practitioner perspective, researchers must be mindful of the needs of clinicians when designing, conducting, and reporting their studies. A closer connection is needed between psychological science and clinical practice if applied psychology is to flourish.

Toward Evidence-Based Treatment

In 1993, the American Psychological Association (APA) organized a task force to identify treatments for psychiatric disorders that have demonstrated effectiveness in research studies. The Task Force on Psychological Intervention Guidelines was convened for two reasons. First, members of the task force hoped that if they identified groups of evidence-based treatments, clinicians might have an easier time identifying and using the most efficacious and promising treatments that are available. Second, members of the task force wanted to justify the practice of psychotherapy to insurance companies and show that many forms of psychotherapy are, in fact, supported by empirical data.

The APA task force identified a number of evidence-based psychotherapies for adults. These therapies were divided into three categories. Well-established/efficacious treatments showed support from at least two randomized controlled studies demonstrating the therapy's efficacy over a placebo control group or another existing treatment. Probably efficacious treatments had empirical support for their efficacy but only from one randomized controlled trial or a small number of single-subject studies. A third category of treatments, promising treatments, demonstrated effectiveness in quasi-experimental studies or one single-subject research study and merited further attention.

In 1998, a second task force provided a similar list of evidence-based therapies for child and adolescent disorders (Lonigan, Elbert, & Johnson, 1998). The task force committees identified treatments for ADHD (Pelham, Wheeler, & Chronis, 1998), child and adolescent conduct problems (Brestan & Eyberg, 1998), autism (Rogers, 1998), child and adolescent depression (Kaslow & Thompson, 1998), and child and adolescent anxiety disorders (Ollendick & King, 1998). Treatments for other disorders commonly experienced by youths, such as eating disorders and substance use disorders, were absent from the list because no empirically supported treatments had been identified that met the committee's criteria.

Since the time of the task force's initial identification of evidence-based treatments for child and adolescent disorders, many individuals and professional organizations have suggested modifications to the group's initial criteria for well-established and probably efficacious treatments (Nathan & Gorman, 2002). Many professionals praise the APA's focus on identifying and disseminating evidence-based treatments for specific disorders. Indeed, the focus on evidence-based treatments emphasizes the scientific basis upon which the practice of psychology is founded.

On the other hand, critics have stressed the dangers of overemphasizing the importance of evidence-based treatments in clinical practice (Beutler, Zetzer, & Williams, 1996). Some researchers have challenged the use of randomized, controlled experiments as a means of establishing the efficacy of treatment. These critics argue that randomized, controlled experiments are most sensitive to detecting short-term symptom reduction rather than long-term changes in functioning; consequently, they are more likely to support short-term behavioral interventions rather than long-term therapies. Furthermore, the criteria for well-established treatments favor studies performed in strictly controlled research settings. However, most therapy is practiced under less-than-optimal conditions in community mental health centers. Critics argue that the results of these studies may not generalize to real-world practice (Westen, Novotny, & Thompson-Brenner, 2004).

Students as Emerging Scientists and Practitioners

Psychology students often find themselves providing services to children and adolescents in distress. Students sometimes act as aides for individuals with Intellectual Disability and developmental delays, behavior therapists for youths with autism, tutors for children with learning disabilities, and psychological technicians in residential treatment facilities, juvenile detention centers, and hospitals. Students can also provide paraprofessional services through volunteer experiences. For example, many students mentor at-risk youths, provide in-services to grade school and high school students, monitor telephone crisis hotlines, and help local community mental health centers.

Because students often provide frontline psychological services, they have enormous potential for improving the functioning of children, adolescents, and families. However, students can also contribute to the propagation of inaccurate information and the dissemination of ineffective and unsupported treatments. Although psychology students are not in a position to direct interventions, they can approach treatment from the perspective of psychological science. Specifically, students can ask the following questions:

1. What is the evidence for the intervention or service that I am providing? Is there a theoretical and empirical basis for my work? Are there alternative services that might provide greater benefits to the people I serve?
2. Am I effective? Am I monitoring the effectiveness of the services I provide to determine whether I am helping my clients? Is there any possibility that I might be harming them?

3. Am I providing ethical, time-effective, and cost-effective services? During my work, do I respect the rights and dignity of others, conduct myself in a responsible and professional manner, and represent the field of psychology with integrity? Are my activities being supervised by someone who practices in an ethical and scientifically mindful manner?

As you read this book, consider how you might use the empirical literature to inform your own understanding of child and adolescent disorders. A scientific approach to child psychopathology is not reserved for licensed psychologists or university professors. Instead, all students, parents, teachers, and individuals who work with youths are called upon to use empirical data to help improve the functioning of others.

ETHICS IN WORKING WITH CHILDREN AND FAMILIES

Mental health professionals are placed in positions of authority and trust. Clients usually come to therapists showing emotional distress and impairment. Clients are often vulnerable, and they seek care that is sensitive and responsive to their needs. The provision of competent and ethically mindful services is especially important when clients are juveniles. Parents place their most valuable assets—their children—in the care of therapists, with expectations that clinicians will help their children overcome problems and achieve the highest levels of competence possible.

Ethics refers to the standard of behavior that is determined to be acceptable for a given profession. Ethics should not be confused with a person's morality, that is, his personal beliefs in the rightness or wrongness of a given behavior. Ethical behavior is determined by group consensus; morality is determined by personal determination and belief.

All mental health professionals adhere to a code of ethics that guides their professional practice. Different professional organizations have different ethics codes. These codes include the APA's (2002) Ethical Principles of Psychologists and Code of Conduct, the National Association of School Psychologists’ Professional Conduct Manual and Principles for Professional Ethics, the American Counseling Association’s Code of Ethics, and the American School Counselor Association’s Ethical Standards for School Counselors. Because the APA Ethics Code is the most frequently used system, we will examine it in greater detail.

APA Ethics Code

The primary purpose of the APA Ethics Code is to protect the welfare of individuals with whom psychologists work (e.g., clients, research participants, students). The secondary purpose of the Ethics Code is to educate psychologists, students, and the general public about the ethical practice of psychology. Because the Ethics Code is endorsed by the APA, all APA members and student affiliates are required to be familiar with the code and adhere to its rules. Failure to adhere to the Ethics Code can result in sanctions from the APA, psychology licensing boards, and other professional organizations.

The APA Ethics Code consists of four parts: (a) an Introduction, (b) a Preamble, (c) five General Principles, and (d) specific Ethical Standards. The Introduction and Preamble describe the purpose, organization, and scope of the Ethics Code. The five General Ethical Principles are broad ideals for the professional behavior of psychologists. The General Principles are aspirational in nature; they are not enforceable rules. Instead, the General Principles describe the highest ideals of psychological practice toward which all psychologists should strive (APA, 2010, section 4.02):

A. Beneficence and Nonmaleficence: Psychologists strive to benefit those with whom they work and they take care to do no harm.

B. Fidelity and Responsibility: Psychologists establish relationships of trust, . . . are aware of their professional and scientific responsibilities, . . . uphold professional standards of conduct, clarify their professional roles and obligations, [and] accept appropriate responsibility for their behavior.

C. Integrity: Psychologists seek to promote accuracy, honesty, and truthfulness in science, teaching, and the practice of psychology.

D. Justice: Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology.

E. Respect for People's Rights and Dignity: Psychologists respect the dignity and worth of all people and the rights of individuals to privacy, confidentiality, and self-determination.

The bulk of the ethics code consists of the Ethical Standards: specific rules that guide professional practice. The ethical standards govern all professional activities including assessment, therapy, research, and teaching. Although there are too many Ethical Standards to describe here, we will examine some of the rules that are most relevant to the treatment of children and adolescents.

Competence

The Ethical Standards dictate that psychologists treat, teach, and conduct research only in areas in which they have received appropriate training, supervised experience, or advanced study. Psychologists must be aware of the boundaries of their competence and seek additional training, consultation, or supervision if they want to expand their area of expertise.
Dr. Williams is a clinical psychologist who has 15 years of experience treating adults and couples with psychological problems, especially alcohol abuse. Dr. Williams decides that he wants to expand his practice in order to include adolescents with substance use problems. Should Dr. Williams accept adolescents into his practice?

Because Dr. Williams has not received specialized training or supervision in the treatment of adolescent substance use disorders, it would likely be unethical for him to offer services to adolescents without first receiving additional training. Ideally, Dr. Williams would participate in some additional course work on adolescent substance use disorders and receive supervision from a colleague who has expertise in this area.

Confidentiality

Confidentiality refers to the expectation that information that clients provide during the course of treatment will not be disclosed to others. The expectation of confidentiality serves at least two purposes. First, the expectation of confidentiality increases the likelihood that people in need of mental health services will seek treatment. Second, the expectation of confidentiality allows clients to disclose information more freely and, consequently, it facilitates the therapeutic process.

In most cases, confidentiality is an ethical and legal right of clients. Therapists who violate a client's right to confidentiality may be sanctioned by professional organizations and held legally liable. Most psychologists consider protection of clients' confidentiality to be one of the most important ethical standards.

Although clients have the right to expect confidentiality when discussing information with their therapists, clients should be aware that the information they disclose is not entirely private. There are certain limitations to confidentiality that therapists must make known to clients, preferably during the first therapy session. First, if the client is an imminent danger to self or others, the therapist is required to break confidentiality to protect the welfare of the client or someone he or she threatens. For example, if an adolescent tells his therapist that he plans on killing himself after he leaves the therapy session, the therapist has a duty to warn the adolescent's parents or the police, in order to protect the adolescent from self-harm. The psychologist's duty to protect the health of the adolescent supersedes the adolescent's right to confidentiality.

Second, if the therapist suspects child abuse or neglect, the therapist is usually required to break confidentiality to protect the maltreated child. For example, if during the course of therapy a 12-year-old girl admits to being physically and sexually maltreated by her stepfather, the psychologist would have a duty to inform the girl's mother and the authorities to protect the child from further victimization.

Third, in exceptional circumstances, a judge can issue a court order requiring the therapist to disclose information provided in therapy. For example, a judge might order a psychologist to provide information about an adolescent client who has been arrested for serious criminal activity. Sometimes, information about treatment is necessary for the court proceedings. Court orders to disclose information about treatment are rare; however, psychologists are legally obligated to comply with these orders.

Fourth, therapists can disclose limited information about clients in order to obtain payment for services. For example, therapists often need to provide information about clients to insurance companies. This information typically includes the client's name, demographic information, diagnosis, and a plan for treatment. Usually, insurance companies are the only parties who have access to this information.

Fifth, therapists can disclose limited information about clients to colleagues to obtain consultation or supervision. It is usually acceptable for psychologists to describe clients' problems in general terms in order to gain advice or recommendations from other professionals. However, therapists only provide information to colleagues that is absolutely necessary for them to receive help, and they avoid using names and other identifying information.

In most jurisdictions, the right to confidentiality is held by children's parents, not by children themselves. From a legal standpoint, parents have the right to the information their children or adolescents disclose in therapy.
Of course, the best way to deal with a situation like the one described in the Case Study about Samantha is to prevent it. Therapists usually discuss the limitations of confidentiality with youths and their parents, to clarify under what circumstances information will be shared with parents. Ideally, parents and children reach a confidentiality agreement during the first session. Sometimes, therapists create a written contract to avoid ambiguity and prevent future problems.

Multiple Relationships

Psychologists must avoid multiple relationships. A multiple relationship occurs when a psychologist, who is in a professional role with a client, enters into another relationship with the same individual or a person closely associated with that individual. Multiple relationships can impair psychologists’ objectivity, competence, and the effectiveness of the services that they provide.

A related ethical issue is therapists’ duty to clarify their professional roles. When psychologists provide services to multiple people who have a relationship with one another, they must clarify their relationship with each of these individuals.

Imagine that a mother and her adolescent daughter seek therapy because they frequently argue. At the onset of therapy, the therapist must clarify her relationship with both mother and daughter. One solution is that all parties agree that the clinician will assume the role of primary therapist for the daughter. Although the clinician might occasionally meet with mother and daughter together, the clinician’s primary responsibility might be the interests of the daughter. If the mother seeks help with specific problems (e.g., depression), the clinician might refer her to another therapist. An alternative solution is that all parties agree that the parent-adolescent

**CASE STUDY**

**WHOSE RIGHT TO KNOW?**

Samantha was a 14-year-old girl who was referred to Dr. Graham because of disruptive behavior problems. During the course of therapy, Samantha admitted that she frequently drinks alcohol, uses marijuana, and recently began experimenting with prescription pain medications she obtains from friends. Although Dr. Graham was concerned with Samantha’s substance use, she decided not to disclose the information to Samantha’s parents. Weeks later, Samantha’s father called Dr. Graham and demanded to see her therapy notes regarding Samantha. Samantha’s father suspected that Samantha was using drugs and wanted information from the therapist about his daughter’s substance use.

Dr. Graham needs to balance the father’s legal right to receive information about his daughter’s treatment with Dr. Graham’s ethical obligation to protect Samantha’s confidentiality. The APA Ethics Code states that when a psychologist’s ethical responsibilities conflict with the law, the psychologist should make known her commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner. In this case, Dr. Graham might consult with a colleague to gain another professional’s opinion. Then, she might explain to Samantha’s father that disclosing therapy notes would likely violate Samantha’s trust and destroy the quality of the therapeutic relationship. If Samantha’s father still insists on receiving the information, Dr. Graham might try to reach a compromise between Samantha and her parents. For example, perhaps Samantha could disclose the information to her parents directly, with the therapist facilitating communication between the two parties.

**CASE STUDY**

**A COMPLICATED SITUATION**

Dr. Jacoby is a respected psychologist at a child guidance clinic. Her neighbor, and good friend, asks her to provide therapy for her adolescent daughter, Mariah. Mariah has recently been exhibiting problems with anxiety and depression. Dr. Jacoby agrees to treat Mariah and, consequently, enters into a multiple relationship. Mariah is both Dr. Jacoby’s client and the daughter of Dr. Jacoby’s good friend. During the course of therapy, Mariah tells Dr. Jacoby that she is pregnant and does not want to tell her mother. Dr. Jacoby’s objectivity might be compromised because of her dual relationship. Although the needs of her client should be paramount, she might sacrifice Mariah’s expectation for confidentiality to maintain her friendship with Mariah’s mother.
dyad will be the primary focus of therapy. In this case, the therapist might propose that mother and daughter always meet together for therapy sessions and that the therapist will not meet with either person alone.

Psychologists must carefully identify their relationship with all family members to avoid conflicting roles. When roles are unclear, family members can become estranged from the therapeutic process or feel like their trust has been violated.

**Informed Consent**

Perhaps the best way to avoid ethical problems is to make sure that children and families know what they are agreeing to before they decide to participate in therapy. The APA Ethics Code requires psychologists to obtain informed consent from individuals before assessment, treatment, or research. Informed consent protects people’s right to self-determination. Individuals are entitled to make voluntary and knowledgeable decisions.

Informed consent to therapy includes a number of components. First, individuals are entitled to a description of treatment, its anticipated risks and benefits, and an estimate of its duration and cost. Second, the psychologist must discuss alternative treatments that might be available and review the strengths and weaknesses of the recommended treatment approach. Third, psychologists must remind clients that participation is voluntary and that they are free to refuse treatment or withdraw from therapy at any time. Finally, psychologists should review the limits of confidentiality with their clients.

Children and adolescents, by virtue of their age and legal status as minors, are not capable of providing consent. Consent implies that individuals both understand and freely agree to participate. Young children may not fully appreciate the risks and benefits of participation in treatment. Older children and adolescents may not freely agree to participate because they may be pressured by others (e.g., the psychologist, school personnel) to attend treatment. Instead, consent is obtained from parents or legal guardians. Psychologists are required to obtain the assent of children and adolescents before providing services. To obtain assent, psychologists typically describe the treatment or research using language that youths can understand. They begin only after receiving permission from children and the consent of their parents or caregivers.

**CHAPTER SUMMARY**

- Approximately 15% of children meet diagnostic criteria for a psychological disorder at any given point in time. An additional 5 to 6% of youths show subthreshold symptoms. The most common childhood problems are anxiety disorders, conduct problems, and ADHD.
- The prevalence of childhood disorders depends on age, gender, and social-cultural background. Adolescents, girls, and youths from low-income families are at increased risk for developing problems.
- Although disorders are common, children and families often do not receive appropriate treatment. Barriers to treatment include financial hardship, limited availability of high-quality treatment in most communities, and few professionals trained in evidence-based forms of treatment.
- DSM-5 defines a mental disorder as a behavioral syndrome that exists within the individual, that reflects an underlying psychobiological dysfunction, and that results in clinically significant distress or disability. This definition has been criticized in at least three ways:
  - Some disorders, especially childhood disorders, may be best understood as existing between people (e.g., between parent and child) rather than within an individual.
  - In many instances, people (especially children) with disorders show no biological abnormality that causes their disorder.
  - Socioeconomic background, culture, and ethnicity can greatly influence the way people show psychological symptoms.
- Developmental psychopathology is an interdisciplinary field that seeks to understand childhood disorders from the perspective of normal development. The field assumes that children’s problems are best understood across multiple levels (e.g., genetic, neurobiological, family system, social-cultural) and over time. Risk and protective factors affect children’s ability to perform tasks at each stage of their behavioral, cognitive, and social-emotional development. Success in early developmental tasks can place children on developmental pathways for success in later tasks and greater competence and adaptive functioning.
- The scientist-practitioner approach to abnormal psychology assumes that psychological research and clinical practice are interdependent and equally important. Clinical practice must be informed by theory and empirical data. Research must address the needs of clinicians in the real world. Students can also act as scientist-practitioners by thinking critically about the services they might provide to children and families in the community.
- The American Psychological Association Ethics Code guides the professional practice of psychology. Both professionals and students should adhere to its ethical principles and standards. Standards relevant to the practice of abnormal child psychology include the following:
  - Practicing only within one’s area of competence
  - Protecting the confidentiality of children and families
  - Avoiding multiple relationships and
  - Allowing people to make informed decisions regarding treatment

PART I PRINCIPLES OF SCIENCE AND PRACTICE
KEY TERMS

adaptive 15
behavioral rigidity 7
cultural deviancy 7
developmental pathways 13
developmental psychopathology 11
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition 9
disability or degree of impairment 7
epidemiologists 3
epigenesis 11
equivinality 16
Ethical Standards 23
ethics 23
evidence-based treatments 22
General Ethical Principles 23
harmful dysfunction 7
heterotypic continuity 3
homotypic continuity 3
individual differences 16
limitations to confidentiality 24
maladaptive 15
multifinality 16
prevalence 3
probabilistic 13
protective factors 17
psychological distress 7
psychotropic medication 5
resilience 18
risk factors 17
scientist-practitioner approach 19
statistical deviancy 6

CRITICAL THINKING EXERCISES

1. Some experts believe that the child mental health system is in a state of crisis. Why? What might state governments and/or private social services do to provide high-quality mental health services to children?

2. According to DSM-5, a mental disorder is a pattern of behavior characterized by distress or disability (impairment) that resides within the individual. What might be some limitations to this definition of “mental disorder,” especially when it is applied to children and adolescents?

3. Sigmund Freud wrote about the difficulty of predicting children's development:

   So long as we trace development from its final outcome backwards, the chain of events appears continuous. . . . But if we proceed the reverse way, if we start from the premises and try to follow these up to the final result, . . . we notice at once that there might have been another result and we might have been just as well able to understand and explain the latter. Hence the chain of causation can always be recognized with certainty if we follow the line of analysis backwards, whereas to predict it is impossible. (quoted in Sroufe & Rutter, 1984, p. 17)

   Apply this passage to the concept of “probabilistic epigenesis.”

4. In his "Manifesto for a Science of Clinical Psychology," Richard McFall (1991) argues that the only legitimate form of psychology is scientific psychology. How can psychological research guide the practice of psychotherapy? How can the clinical experiences of therapists inform psychological research? In what ways can students think of themselves as scientists and practitioners?

5. Dr. Maeryn, a child psychologist, promises her adolescent client, “It's important for you to be open and honest in therapy. Everything you say will be kept a secret and never shared with anyone else.” What is problematic about Dr. Maeryn's statement?

EXTEND YOUR LEARNING

Videos, practice tests, flash cards, study guides, and links to online resources for this chapter are available to students online. Teachers also have access to lecture notes, PowerPoint presentations, suggestions for classroom activities, and possible exam questions. Visit: www.sagepub.com/weis2e.