

EVIDENCE-BASED RESEARCH AND PRACTICE

- Chapter 1** The Science and Practice of Abnormal Child Psychology
- Chapter 2** The Causes of Childhood Disorders
- Chapter 3** Research Methods With Children and Families
- Chapter 4** Assessing and Treating Children's Problems

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THE SCIENCE AND PRACTICE OF ABNORMAL CHILD PSYCHOLOGY

LEARNING OBJECTIVES

After reading this chapter, you should be able to do the following:

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| <p>1.1 Critically evaluate the concept of a mental disorder as it applies to children and adolescents.</p> <p>Explain how mental health professionals diagnose youths using DSM-5.</p> | <p>1.3 Describe the characteristics of evidence-based practice and the types of professionals who help children and families in need.</p> <p>Identify and apply four ethical principles that are important when helping children and families.</p> |
| <p>1.2 Describe the prevalence of childhood disorders and how it varies as a function of children's age, gender, socioeconomic status, and ethnicity.</p> | |

There once was a craftsman who used all his skill to create a wonderful new pot. The pot was made of clay, shaped by his weathered hands, and baked into a beautiful form. The man glazed and decorated the pot, using colors and designs that were as unique as they were beautiful. When it was finished, the man carried the pot to a nearby well to fetch some water for his home. To his surprise, he discovered the pot had developed a small crack from the kiln, which caused water to leak from the bottom. At first, the crack was small, but over time it became larger and more noticeable.

One day, the man's friend said, "That pot has a crack. By the time you get home, you've lost half of your water. Why don't you throw it away and get a new one?" The man paused, turned to his friend, and replied, "Yes, it's true that this pot leaks. But each day it waters the flowers on the path from the well to my home." Sure enough, along the path had sprung countless wildflowers of all varieties, while in other areas, the land was barren. In response, the man's friend simply nodded his approval¹ (Image 1.1).

The story of the broken pot illustrates each person's dignity and value. Everyone has unique gifts and talents, although sometimes they are hard to recognize. When studying children with psychological problems, it's easy to focus on limitations and to lose sight of the children themselves. Many of these youths face significant challenges in performing everyday activities like bathing, dressing, or speaking. Other children struggle at school or when



IMAGE 1.1. Sure enough, along the path had sprung countless wildflowers of all varieties, while in other areas, the land was barren.

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interacting with others. Still other youths have difficulty controlling their actions and emotions.

Regardless of their disability, disorder, or diagnosis, these children have intrinsic worth. A challenge facing parents, teachers, and all people who interact with these youths is to not lose sight of the child when we focus on his or her problems. One of my clients, Will, was born with Down syndrome. Although he struggled with reading and math, he taught his classmates to be patient, to act with empathy, and to respect others who are different. Another client, Camden, had attention-deficit/hyperactivity disorder (ADHD). Even with medication and therapy, he had problems staying focused in class; however, he also had an excellent sense of humor and loved to play soccer. Still another client, Chloe, struggled with anxiety and depression, but family therapy helped to improve her relationship with her parents and her connection with others in her community.

¹Adapted from a story by Kevin Kling.

If you're reading this book, it's likely that you enjoy interacting with children and helping others in need. I hope that this book will introduce you to the ways we can use psychological science and evidence-based strategies to help children and families. Students like you often find themselves on the front lines of treatment. Some work in residential treatment facilities with disruptive adolescents. Others serve as behavior therapists for children with developmental disabilities. Still other students volunteer with at-risk youths; they may tutor children with learning delays, serve

as Big Brothers or Big Sisters to disadvantaged children, or facilitate after-school groups for children in high-risk neighborhoods. There is no shortage of people who want to help children in need; the difficulty is finding individuals who are willing to use scientific principles and evidence-based practices to help them. The field desperately needs bright, empathic students who are willing to devote their time and energy to help children using psychological science. I'm so happy that you are willing to take the first step on this rewarding journey.

1.1 IDENTIFYING BEHAVIOR PROBLEMS IN CHILDREN

What Do We Mean by "Abnormal?"

Deviation, Disability, and Distress

There is no consensus on how to define abnormal behavior in children and no agreement on how best to differentiate abnormalities from normal functioning. However, mental health professionals have proposed three broad criteria that help identify psychological problems in youths: deviancy, disability, and distress (Cicchetti, 2016a; Dulcan, 2019).

One approach to defining abnormality is based on *statistical deviation*. 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 rare and could indicate a mood disorder, such as depression. Consequently, psychologists might administer a rating scale to clients and identify youths who show symptoms well beyond the normal range, compared to other children and adolescents of the same age and gender (Achenbach, 2015).

The primary limitation of the statistical deviation 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 deviation perspective, we might diagnose this girl with depression because she shows mood problems that are rare among girls 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 depression. Although statistical infrequency may be an important component of a definition of abnormality, it is insufficient by itself. Statistical deviation does not take into account the context of children's behavior.

A second approach to defining abnormality is based on *disability* or degree of impairment. From this perspective, abnormal behavior is characterized by thoughts, feelings, or actions that interfere with a child's social or academic 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 her parents, and perform adequately in school. On the other hand, her behavior might be considered abnormal if she has difficulty in any of these three areas.

Defining abnormality by level of disability has a serious drawback: Many youths with psychological disorders do not show obvious signs of impairment. For example, 15-year-old Dorothy Dutiel killed herself and a classmate at her high school in Glendale, Arizona. Dorothy obtained a gun from another classmate who did not know that she was depressed and intended harm. After the incident, first responders found a handwritten note in Dorothy's pocket that read, "I would like to clarify that [the student who gave me the gun] and his family are in no way affiliated with my actions. He was under the absolute impression I needed the gun for self-defense. I lied to receive this gun." Dorothy's classmate was unaware that she was depressed because she spent time with friends, continued to do well in school, and did not appear sad. Not all mental health problems are accompanied by overt impairment (Lynch, 2018).

A third approach to defining abnormality includes a child's degree of emotional *distress*. People can show distress through depressed mood, irritability, anxiety, worry, panic, confusion, frustration, anger, or other feelings of dysphoria.

One problem with defining abnormality in terms of distress is that distress is subjective. Although signs of distress can be observed by others (e.g., sweaty palms, flushed face), we usually need to measure distress by asking children how they feel. Some young children are unable to report their feelings. For example, they may complain of physical symptoms like headaches or stomachaches instead of negative emotions. Other children have trouble differentiating their feelings.



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IMAGE 1.2. Not all children with psychological problems experience distress. Sometimes, they cause distress in others, such as their parents.

For example, they might not be able to tell the difference between feeling “angry” and “hurt.” To complicate things further, there is no objective criterion by which we can evaluate the intensity of children’s distress. For example, a child who reports feeling “bad” might be experiencing more distress than another child who reports feeling “terrible.”

A second problem with defining abnormality based on distress is that many youths with serious behavior problems do not experience negative emotions. For example, some adolescents who engage in harmful and destructive behavior show no signs of anxiety or depression. They may only experience sadness or 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 in others, like their parents or teachers (Image 1.2).

A Harmful Dysfunction

Jerome Wakefield (1992, 1997) offers an alternative, influential approach to defining abnormal behavior based on the notion of **harmful dysfunction**. According to this approach, a

behavior is abnormal when two criteria are met. First, the person must show a dysfunction—that is, a failure of some evolutionarily selected internal mechanism to work in the correct manner. Second, the dysfunction must cause harm; it must limit the person’s life activities or threaten their health and well-being in some way (Widiger & Mullins-Sweatt, 2018).

To understand the two criteria, let’s look at an example from the field of medicine. Heart disease is a medical disorder because (1) it involves an abnormality in the functioning of the body’s circulatory system and (2) this underlying dysfunction can cause disability or death. Similarly, Wakefield argues that the harmful dysfunction criteria can be used to identify mental health problems. For example, depression is a disorder because (1) it involves an inability to effectively regulate one’s emotions and (2) this underlying dysfunction can cause impairment, distress, and self-harm (Wakefield, Lorenzo-Luaces, & Lee, 2018).

Review

- Professionals disagree about the best way to define abnormal behavior in children and differentiate it from normal childhood functioning.
- Three features of abnormality include (1) statistical deviation or infrequency, (2) disability or impairment, and (3) distress.
- Jerome Wakefield proposed the harmful dysfunction definition of abnormal behavior. A behavior is abnormal if it reflects an underlying dysfunction in a biological or psychological system and it causes disability or distress.

How Does DSM-5 Define Abnormality?

Definition

In the United States, most mental health professionals use the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* to diagnose mental health problems in children and adults (American Psychiatric Association, 2013). The DSM-5 definition of a **mental disorder** reflects Wakefield’s notion of harmful dysfunction and emphasizes the role of disability and distress in differentiating normal and abnormal behavior:

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)

It is worth noting that DSM-5 describes people with mental disorders as “usually” experiencing significant disability or distress—they may not always show both characteristics. As we have seen, some youths experience tremendous emotional pain, but they do not show marked impairment in their social or academic functioning. Other youths drop out of school, abuse alcohol and other drugs, and/or engage in criminal behavior but do not report anxiety, depression, or low self-esteem. Although most youths with mental health problems experience both distress and impairment, only one feature is required for most DSM-5 diagnoses.

Limitations

DSM-5 is published by the American Psychiatric Association and reflects a medical approach to identifying mental health problems. According to the DSM-5 definition, mental disorders reside within the individual, just like medical illnesses. For example, if someone is diagnosed with smallpox, we know that the illness is caused by a virus that has infected the person’s body. The virus causes symptoms (e.g., fatigue, fever, rash) that lead to severe impairment and an increased risk of death. Similarly, practitioners who adopt the medical model for mental disorders assume that if a child exhibits behavioral, cognitive, or emotional symptoms, these problems are caused by some underlying dysfunction within the child that causes distress or impairment (Stein et al., 2010c).

There are at least three limitations with the DSM-5 medical conceptualization of mental disorders, especially when it is applied to children and adolescents. First, we often do not know the underlying cause for children’s psychological problems. When physicians first described smallpox in the 15th century, they diagnosed the illness based on its symptoms: small blisters (i.e., pox) on the skin. It was not until many years later that researchers discovered that smallpox is caused by a viral infection, not the blisters themselves. Similarly, when a mental health professional diagnoses a child with ADHD, they are describing the child’s symptoms (i.e., hyperactivity and/or inattention), not the underlying cause of the disorder. Although researchers have identified several risk factors for ADHD, a single underlying cause for the disorder remains elusive (Pliszka, 2016).

Second, many childhood disorders are relational in nature—that is, they occur between people rather than within an individual. Consequently, childhood disorders are best understood in an interpersonal context. For example, young children with oppositional and defiant behavior argue with adults, refuse to comply with requests, and throw tantrums 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 the child and specific

people; it does not merely reside within the child. Relationships may be especially important to mental disorders in children and adolescents, who are highly dependent on other people for their well-being (Heyman & Slep, 2020).

Third, children’s behavior can only be understood in terms of their social–cultural surroundings. Behaviors that people would consider “dysfunctional” in one context might be adaptive in a different setting. For example, consider a girl named Nia who lives with her parents on a military base in California. Upon hearing that her mother will soon be deployed to a combat area, Nia becomes excessively clingy with both parents, has problems eating and sleeping, and refuses to go to school. According to the harmful dysfunction criteria, Nia would likely be diagnosed with an anxiety disorder because (1) she has problems regulating her emotions and (2) these problems limit her social and academic functioning. However, her anxiety might be justified given her social context—that is, the imminent deployment of her mother. Behavior is best understood in the context of children’s social–cultural surroundings, never in isolation (Achenbach, 2019).

Review

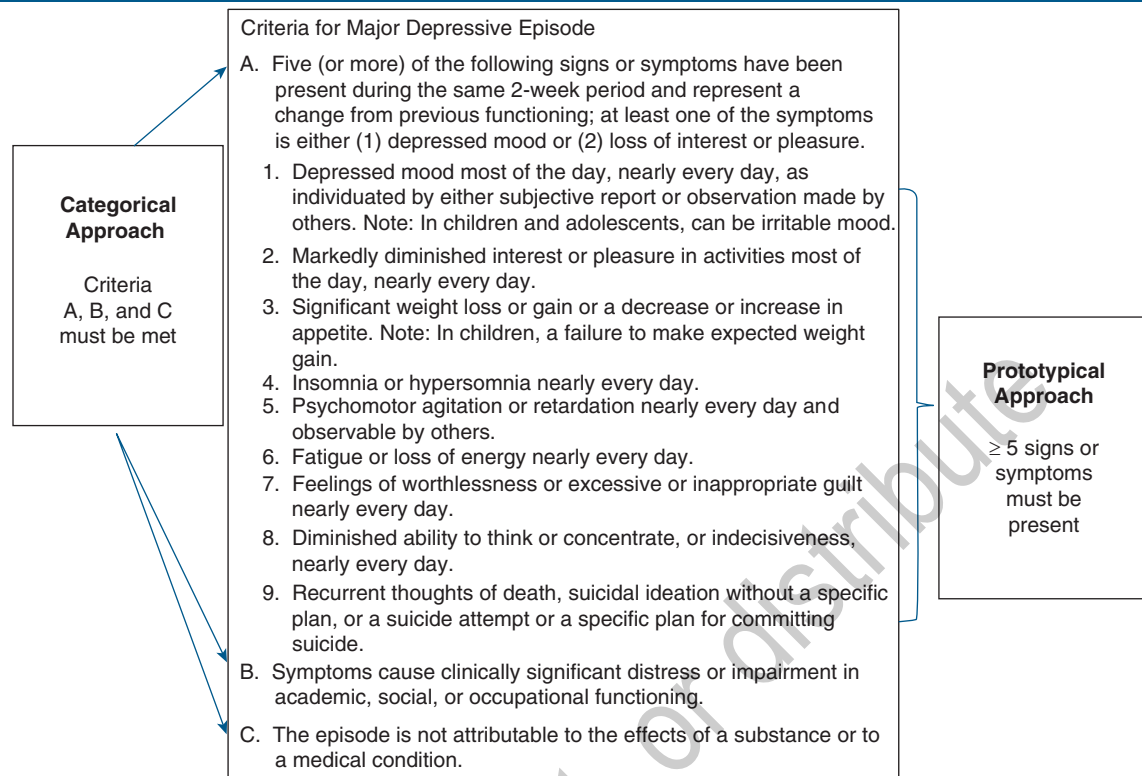
- According to DSM-5, a mental disorder reflects a biological, developmental, or psychological dysfunction that causes disability or distress in the individual. This definition borrows from Wakefield’s notion of a harmful dysfunction.
- DSM-5 adopts a medical approach to mental disorders.
- The medical approach is limited when applied to children and adolescents because (1) we cannot always identify the underlying cause of children’s disorders, (2) many childhood disorders are best understood in an interpersonal context rather than existing only within the child, and (3) children’s behavior is best understood in terms of their social–cultural surroundings.

How Do Psychologists Diagnose Mental Health Problems in Children?

Each DSM-5 disorder is defined by the presence of specific signs and symptoms. A **sign** is an overt feature of a disorder, whereas a **symptom** is a subjective experience associated with a disorder. For example, a sign of depression is weight loss or sluggish movement. In contrast, a symptom of depression is a subjective lack of appetite or energy. To be diagnosed with a given disorder, the individual must have the signs and symptoms described in the manual.

To illustrate the diagnostic approach used in DSM-5, consider the diagnostic criteria for a major depressive episode (Figure 1.1). Depression is characterized by a discrete period of time, lasting at least 2 weeks, in which a child or adolescent experiences a marked disturbance in mood. Children with depression typically experience sad, hopeless, or irritable moods most of the day and no longer engage in activities they previously enjoyed, such as spending time with

FIGURE 1.1 ■ The DSM-5 Diagnostic Approach



Source: Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Copyright 2013). American Psychiatric Association. All Rights Reserved.

family, playing games with friends, or engaging in hobbies and sports. Children with depression can also show a wide range of other cognitive, emotional, and physical problems. This mood disturbance causes distress or leads to problems at school, at home, or with peers (American Psychiatric Association, 2013).

Categorical Classification

DSM-5 uses a hybrid of three different approaches to classification: (1) categorical, (2) prototypical, and (3) dimensional. **Categorical classification** involves dividing mental disorders into mutually exclusive groups, or categories, based on sets of essential criteria. The categorical approach is the oldest approach to classification and is used predominantly in biology and medicine. For example, in the field of biology, an animal is classified as a mammal if it (a) has vertebrae, (b) has hair, and (c) feeds its young with mother's milk. An animal that does not possess these essential features is not a mammal. In the field of medicine, a person is diagnosed with diabetes if she has significant problems regulating her blood glucose. A person without significant blood sugar problems is not diagnosed with diabetes. Similarly, each mental disorder is defined by the presence of essential diagnostic criteria listed in DSM-5. A person without those criteria would not be diagnosed with a given disorder (Widiger & Mullins-Sweatt, 2018).

You can see the categorical approach to classification in the diagnostic criteria for a major depressive episode. The episode has three essential features (labeled A, B, and C). All three are required for a diagnosis of major depression.

Prototypical Classification

Prototypical classification is based on the degree to which the individual's signs and symptoms map onto the ideal picture or prototype of the disorder (Westen, 2012). This approach assumes that individuals with a given disorder may show some variability; not all people with the disorder will manifest it in exactly the same way. For example, if you were asked to generate a mental picture of a bird, you would likely conjure an image of a small, flying animal with a beak that looks like a sparrow or robin. It is much less likely that your initial image of a bird would be something like a penguin or ostrich. A sparrow or robin is closer to the prototype of bird than a penguin or ostrich, although the latter two animals are certainly birds.

Similarly, DSM-5 recognizes that most people with a specific disorder show signs and symptoms similar to the prototype for that disorder; however, DSM-5 also allows for some variability in the way people can manifest these diagnostic features.

You can see elements of the prototypical approach to classification in the DSM-5 criteria for major depression.

Although there are three essential features of the disorder, children can manifest the signs and symptoms of the disorder in nine different ways. Only five of these signs or symptoms are required for the diagnosis. For example, some depressed children experience cognitive difficulties, such as problems concentrating on their schoolwork, beliefs that they are worthless, or recurrent thoughts about death. Other children with depression experience physical problems, such as decreased appetite, insomnia, and fatigue. The prototypical approach allows flexibility in the way children experience each disorder.

Dimensional Classification

Dimensional classification assumes that disorders fall along a continuum of severity ranging from mild to severe. It involves describing the severity of the individual's distress and/or disability on this continuum. One advantage of dimensional classification is that it conveys more information than simple categorical or prototypical classification. For example, rather than merely diagnosing a child with autism, a clinician can describe the child as having mild impairment in social communication but severe behavioral impairment (e.g., repetitive actions and difficulty adjusting to changes in routine). A second advantage of the dimensional approach to classification is that it allows clinicians to monitor changes in children's functioning across time. For example, a child may continue to meet diagnostic criteria for autism after several years of behavior therapy; however, his repetitive behavior might improve from "severe" to "mild."

Previous versions of the DSM were criticized for their exclusive reliance on the categorical and prototypical approaches to classification. Consequently, the developers of DSM-5 attempted to incorporate aspects of dimensional

classification into the newest edition of the manual. Dimensional classification is most easily seen in the DSM-5 Cross-Cutting Symptom Measure, a rating scale that can be used to evaluate the severity of children's signs and symptoms. The rating scale allows dimensional classification on 10 broad domains including physical symptoms and sleep problems, anxiety and depression, anger and irritability, and mania and psychotic symptoms. Children's severity on each domain can be described on a 5-point continuum ranging from "none or not at all" to "severe or nearly every day."

Table 1.1 shows a clinician's ratings of an adolescent using the Cross-Cutting Symptom Measure. These ratings show that the adolescent is experiencing moderate to severe problems with depressed mood and irritability but fewer difficulties with anxiety and worry. The ratings provide additional data, above and beyond the adolescent's diagnosis, and can be used as a baseline from which to assess the youth's progress in treatment.

Some DSM-5 disorders also allow clinicians to provide additional information about their clients using specifiers. A **diagnostic specifier** is a label that describes a relatively homogeneous subgroup of individuals with the same disorder. Usually, specifiers are created based on the person's signs and symptoms. For example, some children with ADHD are primarily hyperactive and impulsive but listen to their parents and teachers, whereas other children with ADHD daydream in class but remain quiet and still. Although all of these children are diagnosed with ADHD, clinicians might assign the specifier "predominantly hyperactive-impulsive presentation" or "predominantly inattentive presentation" to children in the first and second groups, respectively. These specifiers provide a more precise description of children's behavior than the diagnostic label alone.

TABLE 1.1 ■ DSM-5 Cross-Cutting Symptom Measure for Children

During the past TWO (2) WEEKS, how much (or how often) has the child . . .	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day
Mood					
Seemed sad or depressed for several hours?	0	1	2	3	4
Had less fun doing things that he/she used to?	0	1	2	3	4
Seemed more irritated or easily annoyed than usual?	0	1	2	3	4
Anxiety					
Said he/she felt nervous, anxious, or scared?	0	1	2	3	4
Has not been able to stop worrying?	0	1	2	3	4

Review

- DSM-5 uses a categorical approach to classification because it requires children to meet specific criteria to be diagnosed with a disorder. Youths who do not meet all criteria are not diagnosed with the disorder.
- DSM-5 also uses a prototypical approach to classification for many disorders. Children can show a subset of possible signs and symptoms that reflect a typical child with the disorder.
- DSM-5 uses a dimensional approach to classification for several disorders. Clinicians can indicate the severity of children's disability or distress on a continuum ranging from mild to severe.

What Are the Advantages and Disadvantages of Diagnosing Children?

Possible Benefits

Diagnosis has a number of benefits. Perhaps the most obvious benefit to diagnostic classification is *parsimony*. Imagine that you are a psychologist who has just assessed a 3-year-old child with suspected developmental delays. You discover that the child shows severe and pervasive problems with social communication and repetitive behavior. Instead of describing each of these symptoms, you can simply use the appropriate diagnostic label: autism spectrum disorder.

A second advantage to diagnosis is that it can aid in *professional communication*. Another mental health professional who sees your diagnosis knows that your client exhibits the signs and symptoms of autism described in DSM-5. The second professional does not need to conduct her own assessment of the child to arrive at an independent diagnosis to know something about the child's functioning.

A third advantage is that a diagnosis can aid in *prediction*. If you know that your client has autism, you can use the existing research literature to determine the child's prognosis or likely outcome. For example, most children with autism show chronic impairment in social and communicative functioning; however, prognosis is best among children with higher cognitive abilities and better developed language skills. The research literature also indicates that children who participate in treatment before age 4 often have the best developmental outcomes. You might share this information with the child's parents so they can make more informed decisions regarding the child's education and treatment (Pijl, Buitelaar, de Korte, Rommelse, & Oosterling, 2019).

A fourth and closely related benefit of diagnostic classification is that it can help *to plan treatment*. If you know that your client has autism, you can also use the existing research literature to plan an intervention. For example, a number of studies have indicated that early, intensive behavioral interventions can be effective in improving the social and communication skills of young children with autism. Other forms of

treatment, such as art and music therapy, have far less empirical support (Volkmar, Reichow, Westphal, & Mandell, 2015).

Fifth, diagnostic classification can help individuals *obtain social or educational services*. For example, the Individuals With Disabilities Education Improvement Act of 2004 (IDEIA) is a federal law that entitles children with autism to special education because of their developmental disability. Special education might involve enrollment in a special needs preschool, early intensive behavioral training paid by the school district, provision of a classroom aide or tutor, academic accommodations, occupational skills training, and other services.

Sixth, diagnostic classification can be *helpful to caregivers*. Although no parent is happy when his or her child is diagnosed, many parents feel relieved when their child's disorder is finally identified. After hearing that her 3-year-old child had autism, one parent said, "Well, I finally know what's wrong. I always suspected it and now I know. I suppose we can finally move forward." Diagnostic labels can also facilitate communication between caregivers of children with similar disorders in order to share information and gain social support.

Finally, diagnostic classification can *facilitate scientific discovery*. Researchers who conduct studies on the causes and treatment of autism can compare the results of their investigations with the findings of others. Indeed, many studies are conducted by teams of researchers across multiple locations. As long as researchers use the same diagnostic criteria and procedures to classify children, results can be combined to generate a more thorough understanding of the disorder.

Potential Drawbacks

The DSM-5 classification system also has some inherent disadvantages and risks (Hyman, 2011; Rutter, 2011). One drawback of the DSM-5 approach is that it often gains parsimony at the expense of detailed information. Although a diagnostic label can convey considerable information to others, it cannot possibly provide the same amount of information as a thorough description of the individual. As we have seen, children assigned the same diagnosis can display different patterns of behavior and levels of impairment. We must not overlook the unique strengths and weaknesses of each child.

A second criticism of the DSM-5 diagnostic system is that it does not adequately reflect the individual's environmental context. Mental health professionals seek to understand children's problems in the context of their developmental level and surroundings. Many problematic behaviors exhibited by children and adolescents can be seen as attempts to adapt to stressful environments at specific points in time. For example, some physically abused children attempt to cope with their maltreatment by becoming defensive and mistrusting others. Although these coping strategies can psychologically protect them when they were experiencing abuse, they may interfere with the development of interpersonal relationships later in life (Cicchetti & Doyle, 2016).

A third drawback of the DSM-5 lies in its focus on individuals. DSM-5 conceptualizes psychopathology as something

that exists within the person. However, childhood disorders are often relational in nature. For example, youths with oppositional defiant disorder show patterns of noncompliant and defiant behavior toward others, especially adults in positions of authority. Considerable research indicates that the quality of parent–child interactions plays an important role in the development of oppositional defiant disorder. Furthermore, treatment for this disorder relies heavily on parental involvement. However, in the DSM-5 system, oppositional defiant disorder is diagnosed in the child. The DSM-5 approach to diagnosis can overlook the role caregivers, other family members, and peers play in the development and maintenance of children’s problems.

A fourth limitation of the DSM-5 system is that distinctions between normality and abnormality are sometimes arbitrary. In the categorical approach used by DSM-5, individuals either have a disorder or they do not. For example, to be diagnosed with ADHD, a child needs to show at least six symptoms of inattention or hyperactivity–impulsivity. If the child displays only five of the required six symptoms, he would not qualify for the ADHD diagnosis. Although this lack of diagnosis might seem like a good thing, it could mean that he does not receive the treatment or support services that he needs.

A final criticism of the DSM-5 is that sometimes boundaries between diagnostic categories are unclear. Categorical classification systems, like DSM-5, work best when all members of a diagnostic group are homogeneous, when there are clear boundaries between two different diagnoses, and when diagnostic categories are mutually exclusive. Unfortunately, these conditions are not always met. When two disorders include the same signs or symptoms, children can be diagnosed with both disorders, causing an artificial co-occurrence of the two conditions. For example, bipolar disorder is a serious emotional disorder seen in approximately 1% to 2% of youth. Some studies indicate that as many as 80% of youths with bipolar disorder also meet diagnostic criteria for ADHD. In most cases, children with bipolar disorder clearly show symptoms of ADHD, even when they are not having mood problems. In some instances, however, the high co-occurrence of bipolar disorder and ADHD is caused by the same signs and symptoms included in the diagnostic criteria for both disorders: an increase in activity, short attention span, distractibility, talkativeness, and impulsive behavior. Some children with bipolar disorder may be incorrectly diagnosed with ADHD also because of this overlap in signs and symptoms (Youngstrom, Arnold, & Frazier, 2010).

Research Domain Criteria

The National Institute of Mental Health (NIMH) is attempting to move beyond the current DSM-5 system of classifying mental disorders based on descriptions of signs and symptoms (Insel & Lieberman, 2013). NIMH has launched the **Research Domain Criteria (RDoC) initiative** to identify the genetic and biological causes of each disorder. The RDoC are based on

the assumption that mental disorders are “biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior” (Insel & Lieberman, 2013). The goal of this initiative is to use genetic and biomedical research to identify the underlying causes of these disorders in order to provide more effective treatments. Specifically, research targets several levels of analysis: genes, molecules, cells, neural circuits, physiology, and behavior.

Critics of DSM-5 argue that instead of being a “bible” of mental disorders, it functions more like a dictionary—providing mere definitions in terms of observable signs and self-reported symptoms. Instead, advocates of the RDoC initiative argue that a new system is needed that addresses the underlying genetic and neurological causes for each disorder (Reed, Robles, & Dominguez-Martinez, 2018).

The DSM-5 and RDoC initiative reflect different approaches to conceptualizing mental disorders (Lilienfeld & Treadway, 2016). Time will tell if classification based on underlying genetic risk and neural circuitry increases diagnostic validity and leads to more effective treatment than one based on description. In the meantime, psychologists should not forget the rich information that is gained from approaching childhood disorders from both biological and psychosocial perspectives in the context of youths’ development and surroundings. Recent advances in mental health research indicate that psychological, familial, and sociocultural influences are at least as important in explaining the cause and maintenance of childhood disorders as the genetic and biological factors emphasized by these other diagnostic systems (Cicchetti, 2016a, 2016b). Furthermore, most evidence-based treatments for these disorders operate at these “higher” levels by improving the psychological, familial, and sociocultural functioning of children and families (Christophersen & Vanscoyoc, 2013). We must not neglect these psychosocial interventions for helping at-risk youths while simultaneously looking to the future.

Review

- A DSM-5 diagnosis is parsimonious, it allows professionals to communicate clearly with each other, and it can be helpful in predicting outcomes and planning treatment. A diagnosis can also help children gain access to educational or psychological services, help caregivers understand their child’s behavior, and facilitate research.
- A DSM-5 diagnosis may not provide a detailed description of the child’s strengths and functioning, may not reflect the child’s developmental or environmental context, and may focus too much on the child rather than on important people in his or her life.
- Whereas a DSM-5 diagnosis is based largely on the signs and symptoms of each disorder, the proposed RDoC initiative classifies children based on underlying biological causes.

How Do Social–Cultural Factors Affect Our Understanding of Mental Health?

Culture, Race, and Ethnicity

As we have seen, children’s mental health problems must be understood in the context of their family’s cultural background and experiences. **Culture** refers to the values, knowledge, and practices that people derive from their membership in social groups. It reflects their history, developmental experiences, and current social contexts that shape their perspective. Aspects of one’s culture include their geographic origin, migration status, language, religion, disability status, sexual orientation, and identity. Culture is highly influenced by people’s social network—that is, their family, friends, and members of their community (Comas-Diaz & Brown, 2018).

Race is a culturally constructed category that can be used to divide people into groups based on superficial physical traits. Although race has no agreed-upon biological definition, race is used by the US Census Bureau for demographic purposes and racial identification can influence people’s values, beliefs, and actions. In the United States, race categories include White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. People can also identify as multiracial (English et al., 2020).

Ethnicity is a culturally constructed identity that is used to define groups of people and communities. A child’s ethnicity

can be rooted in a common history, geographic location, language, religion, or shared experience that distinguishes one group from others. For example, an adolescent might identify as Latino because he was born in Latin America. He might be White, Black, indigenous American, Mestizo, or multiracial. Another adolescent might identify as Hispanic because she speaks Spanish. She might have been born in Barcelona, Buenos Aires, or Baltimore. A third adolescent might identify as a Honduran American immigrant. Although he was born in Latin America and speaks Spanish, his experiences immigrating to the United States with his family are most important to his identity and worldview (Comas-Diaz & Brown, 2018).

Mental health professionals must carefully differentiate symptoms of a mental disorder from behaviors and psychological states that are sanctioned in a given society or culture. For example, a 3-year-old named Joseph insists on sleeping with his parents at night. Although Joseph’s refusal to go to bed by himself may indicate a sleep disorder, it might also reflect his family’s social–cultural beliefs and values. For example, in many non-Western societies, requiring young children to sleep alone is considered cruel and detrimental to their social and emotional development. If Joseph’s sleeping is culturally appropriate, it does not concern his parents, and it does not limit his family’s activities, it would not be classified as a mental health problem (Mindell, Sadeh, Kwon, & Goh, 2013).

Differentiating abnormal symptoms from culturally sanctioned behavior is especially challenging when clinicians are

CASE STUDY

THE IMPORTANCE OF CULTURE, RACE, AND ETHNICITY

Between Two Worlds

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 to take medication for her illness. Her physician suspected that Julia was paranoid because she flew into a rage when he tried to examine her in his office.

Julia reluctantly agreed to meet with a therapist in our clinic who was aware of Julia’s social–cultural background. Julia was the American-born daughter of Hmong immigrants from Laos in Southeast Asia. Julia’s parents sought asylum in the United States because of the Laotian civil war and genocide of the Hmong people. Julia’s parents did not speak English and had limited contact with individuals outside the Hmong community. Julia attended a public high school and had good English language skills but was mistrustful of American culture and Western medicine.

Julia admitted that she was scared about her cancer diagnosis and wanted to receive treatment. However, she also wanted to respect her parents and to honor her family’s traditional values and way of life. Her therapist suggested that a



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Hmong faith healer 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 community elders attend all of the radiation therapy sessions, purify the medications prescribed by the oncologist, and perform other remedies important to Julia and her family.

asked to assess youths from other cultures (Causadias, Vitriol, & Atkin, 2019). Consider Julia, an Asian American adolescent from a diverse background.

Children's culture, race, and ethnicity can affect the diagnostic process in at least four ways. First, members of 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, non-Latino White parents often place great value on fostering children's social-emotional development and encouraging child autonomy. These parents often provide 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 have high expectations for their children and adopt less permissive parenting strategies. Clinicians need to be aware of cultural differences in socialization goals and parents' ideas about appropriate and inappropriate child behavior (Comas-Diaz & Brown, 2018).

Second, recent immigrants living in the United States often 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. Some immigrants do not share the same legal status as members of the dominant culture. For these reasons, the sheer number of psychosocial stressors encountered by these families is greater than those encountered by families who are members of the dominant culture (Vu, Castro, Cheah, & Yu, 2019).

Third, language and cultural differences can cause problems in the assessment and diagnosis of minority youths. The assessment and diagnostic process was designed predominantly for English-speaking individuals living in the United States and other Western societies. 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, children raised in Columbus, Ohio, will likely find the following question on an intelligence test fairly easy: "Who was Christopher Columbus?" However, 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 (Benisz, Dumont, & Kaufman, 2018).

Fourth, ethnic minorities are often underrepresented in mental health research. Over the past 2 decades, researchers have made considerable gains in understanding the causes of 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. Furthermore, researchers have only recently begun to create treatment programs designed specifically for ethnic

minority youths. For example, special therapies have been developed to help Latino children cope with traumatic events using culturally relevant support. Youths meet in groups to learn mindfulness techniques and other coping strategies that are consistent with their social-cultural attitudes and values. Clearly, more research needs to be done to investigate the interplay between psychopathology and culture (Hoskins, Duncan, Moskowitz, & Ordóñez, 2018).

Review

- Children's development and functioning must be understood in light of their culture, race, ethnicity, and identities.
- Mental health professionals should be especially sensitive to (1) the way social and cultural factors affect families' expectations for their children and ideas about child-rearing, (2) families' immigration history and degree of acculturation, (3) the way language can influence how families describe their children's behavior, and (4) the degree to which ethnic minority families are underrepresented in mental health research.

1.2 THE PREVALENCE OF CHILDHOOD DISORDERS

How Common Are Mental Disorders in Children?

Prevalence and Incidence

Researchers conduct epidemiological studies to estimate the prevalence of psychological disorders in the general population. **Prevalence** refers to the percentage of individuals in a given population who have a medical or psychological condition. To estimate the prevalence of psychological disorders among children and adolescents, epidemiologists gather information from parents, teachers, and mental health professionals. Sometimes, epidemiologists also collect data from children and adolescents themselves, especially when questions deal with behaviors, thoughts, or feelings that might be hidden from parents (e.g., alcohol and other drug use, suicidal ideation). Epidemiologists can use this information to determine *point prevalence*, the percentage of youths with a disorder at a given point in time, and *lifetime prevalence*, the percentage of youths with a disorder at any point in their lifetime.

Sometimes, epidemiologists want to determine the likelihood that a child will develop a disorder in a given period of time. **Incidence** refers to the percentage of new cases of a disorder in a discrete period of time—usually 1 year. Because incidence only refers to new cases of a disorder, it is typically a much smaller number than prevalence. For example, the lifetime prevalence of autism spectrum disorder is approximately 1.8%; that is, roughly 1.8% of youths in the United States have been diagnosed with autism. However, the incidence of autism

is approximately 0.3%; that is, in any given year, approximately 0.3% of children will be diagnosed with autism for the first time (Centers for Disease Control and Prevention, 2020c).

Determining the prevalence of children's mental health problems is challenging for several reasons. First, there is no single agency that tracks the prevalence of mental disorders in children and adolescents. Instead, prevalence must be estimated using data from many individual studies conducted by different research teams (Costello & Angold, 2016).

Second, epidemiological studies use different methods to collect data, yielding slightly different results. For example, the National Health Interview Survey (NHIS) estimates the prevalence of childhood disorders by interviewing 12,000 parents each year. In contrast, the National Youth Risk Behavior Survey estimates behavior and substance use problems in adolescents by administering questionnaires to 16,000 high school students annually. These different research methods (e.g., interviewing parents vs. administering questionnaires to teens) can yield different findings. For example, parents are very good at reporting the severity of children's disruptive behavior but are less accurate in estimating children's difficulties with depression or use of alcohol. In contrast, adolescents may be more accurate reporters of their own mood and substance use, but they may underestimate the severity of their behavior problems (Kamphaus, Reynolds, & Dever, 2014; Stiffler & Dever, 2015).

Third, it is difficult to gather high-quality data. Many people do not want to participate in lengthy surveys, others do not understand the questions asked of them, and still others provide inaccurate information. Conducting large-scale interviews or surveys is also costly and time-consuming.

Despite these methodological obstacles, researchers have conducted several large epidemiological studies designed to estimate the prevalence of childhood disorders. Collectively, these studies include data from tens of thousands of children and their caregivers, using a variety of research strategies. Altogether, these data suggest that 13% to 15% of youths experience a psychological disorder in any given year. Slightly more than 20% of youths experience a disorder at some point before adulthood (Perou et al., 2016).

Recent data indicate that the overall prevalence of children's mental health problems is on the rise. For example, in the past decade, there has been a 24% increase in the number of children receiving mental health or substance abuse treatment in the United States. The number of youths prescribed medication to treat psychological disorders has also increased approximately 28% during that same time (Visser, Danielson, & Bitsko, 2014). Finally, the rate of hospital admissions for children with psychological disorders, such as depression, has increased 80% in the past 20 years (Pfundtner, Wier, & Stocks, 2013).

Table 1.2 shows the prevalence of specific mental disorders among children and adolescents in the United States. As you might suspect, ADHD is the most common condition. Almost 9% of youths are diagnosed with this disorder at some point before adulthood. Anxiety disorders, such as separation anxiety disorder or social phobia, are also relatively common.

TABLE 1.2 ■ Prevalence of Mental Disorders in Children and Adolescents

Diagnosis	Past 12 Months	Lifetime
Any disorder	13.1%	20.1%
ADHD	8.1%	8.9%
Anxiety disorders	4.0%	4.7%
Depression	3.0%	3.9%
Conduct problems	2.1%	3.9%
Autism spectrum disorder	0.3%	1.8%
Eating disorders	0.2%	0.7%
Bipolar spectrum disorders	0.2%	0.3%
Tics/Tourette disorder	0.2%	0.3%
Schizophrenia	<0.1%	0.1%

Note: This table shows the median percentage of youths with each disorder from the following datasets (for 2013–2020): Centers for Disease Control and Prevention, National Comorbidity Survey Replication–Adolescent Supplement, National Health Interview Survey, National Health and Nutrition Examination Survey, National Survey of Children's Health, National Survey on Drug Use and Health, and the National Youth Risk Behavior Survey.

Certain conditions, such as autism, are more common than previously thought. Approximately 1 in 59 children will develop this serious condition (Centers for Disease Control and Prevention, 2020c). Other problems such as eating disorders and schizophrenia are relatively rare in children.

Comorbidity and Costs

Children's disorders tend to occur together. **Comorbidity** refers to the presentation of two or more disorders in the same person at the same time. On average, approximately 40% of children and adolescents with one mental disorder have at least one other condition (Merikangas & He, 2014). Certain disorders show high comorbidity in children and adolescents. For example, 75% of youths with depression also experience an anxiety disorder that interferes with their daily functioning (Cummings, Caporino, & Kendall, 2014). Approximately 50% of young children with ADHD also exhibit conduct problems, such as oppositional and defiant behavior toward parents or other adults (Pliszka, 2015). For many mental health problems, comorbidity is the rule rather than the exception in children.

Psychological disorders negatively affect the lives of children and families. The total cost of child and adolescent mental health care in the United States is approximately \$247 billion annually (Centers for Disease Control and Prevention, 2016b). Children with mental health problems need evidence-based interventions, such as counseling and/or medication, to help them manage their symptoms and improve their functioning. Children's mental health problems can also compromise their caregivers' well-being, leading to reduced

productivity at work and increased tension at home. The cost to communities is also enormous. Societal costs include rehabilitation for youths with conduct problems, drug and alcohol counseling for youths with substance use disorders, and family supervision and reunification services for youths who experience maltreatment. School districts must pay for special education services for children with cognitive, learning, and behavior problems that interfere with their ability to benefit from regular education. Preventing childhood disorders would spare families suffering and save communities money. Unfortunately, prevention remains an underutilized approach to dealing with child and adolescent psychopathology in the United States (Forbes, Rapee, & Krueger, 2020).

Review

- Prevalence refers to the percentage of children in a given population with a disorder. Incidence refers to the percentage of new cases of a disorder in a discrete period of time.
- Between 13% and 15% of youths experience a psychological disorder each year; 20% of youths experience a disorder before reaching adulthood. The most common disorders in children are ADHD and anxiety disorders.
- Approximately 40% of youths with one disorder have another (comorbid) disorder.

What Factors Influence the Prevalence of Childhood Disorders?

Age

The prevalence of mental disorders varies with age. On average, adolescents are more likely than younger children to

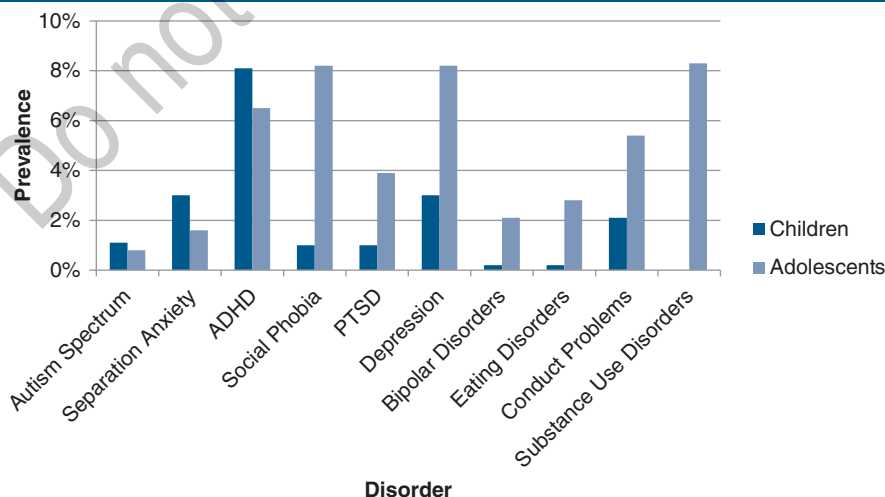
experience mental health problems. The best data that we have regarding the prevalence of mental health problems in adolescents comes from the results of the National Comorbidity Survey Replication–Adolescent Supplement (Kessler et al., 2012a). The researchers who conducted this study interviewed a nationally representative sample of more than 10,000 adolescents ages 13 to 17. They also administered rating scales to parents to gather additional data on adolescents' functioning. Results showed that 23.4% of adolescents reported a mental health problem in the past month and 40.3% reported a mental health problem in the previous year. Although most of the problems experienced by adolescents were mild to moderate in severity, the overall prevalence of problems was much higher than in previous studies involving younger children (Kessler et al., 2012b).

The National Comorbidity Survey study also allows us to compare the prevalence of specific disorders across childhood and adolescence (Figure 1.2). Certain disorders are more common among younger children: autism, separation anxiety, and ADHD. However, the prevalence of most disorders increases with age. For example, adolescents are much more likely to experience problems with social phobia, depression, bipolar disorders, and eating disorders than prepubescent children. Problems with alcohol and other drug use also typically emerge in adolescence and are relatively rare among prepubescent children (Merikangas & He, 2014).

Gender

The prevalence of psychological disorders also varies across gender. In early childhood, many disorders are more typically seen in boys. For example, boys are 4 times more likely than girls to be diagnosed with autism spectrum disorder and 3 times more likely than girls to be diagnosed with ADHD. Boys are also more likely than girls to show disruptive behavior problems, such as oppositional defiant disorder. The prevalence of other

FIGURE 1.2 ■ The Prevalence of Childhood Disorders Varies by Age



Note: In general, adolescents are more likely to experience disorders than younger children. However, some disorders, like autism and separation anxiety disorder, are more common among younger children (Kessler et al., 2012a; Perou et al., 2016).

disorders is approximately equal in young boys and girls (Perou et al., 2016).

By adolescence, however, girls are more likely than boys to experience mental health problems (Kessler et al., 2012a). Adolescent boys continue to be at greater risk than adolescent girls for conduct problems and physical aggression. Similarly, adolescent boys are slightly more likely than adolescent girls to develop problems with alcohol and other drugs. However, adolescent girls are 2 to 3 times more likely than adolescent boys to experience problems with depression or anxiety. Furthermore, adolescent girls are 5 to 10 times more likely than adolescent boys to be diagnosed with an eating disorder.

Psychologists have struggled to explain why girls show a dramatic increase in mental health problems during adolescence. Researchers have suggested many causes ranging from biological changes during puberty to unreasonable social-cultural expectations placed on females throughout the lifespan. Recently, however, researchers have identified two particularly important factors: stressful life events and the way girls think about those events.

In one study, researchers followed a large sample of adolescents from late childhood through middle adolescence (J. L. Hamilton, Stange, Abramson, & Alloy, 2015). Most youths reported increased stress during this time period; however, girls were particularly sensitive to interpersonal stressors—that is, stressful events that involved important people or relationships in their lives. For example, girls were especially likely to report difficulties with parents, peers, or romantic partners during their tween and teen years.

Perhaps more importantly, the way girls thought about these interpersonal stressors influenced their mood. For example, adolescents who believed they were responsible for these interpersonal problems (e.g., “It’s my fault my mom is angry with me”) were more likely to experience depression than adolescents who did not blame themselves (e.g., “My mom is just grouchy after working all day”). Similarly, adolescents who tended to overthink these events (e.g., “I wonder why my friends are mad at me? Was it something I said?”) were also more likely to experience problems with depression than girls who did not dwell on these events. These findings suggest that girls’ thoughts about interpersonal problems can greatly determine their well-being (From Science to Practice).

Socioeconomic Status

Socioeconomic status (SES) is a variable that reflects three aspects of a child’s environment: (1) parents’ levels of education, (2) parents’ employment, and (3) family income. As you might expect, these three variables are correlated; parents with greater educational attainment tend to work more complex, higher-paying jobs. Overall, children from lower-SES families are at greater risk for developing mental disorders than children from middle- or high-SES families (Kessler et al., 2012a).

There are at least two explanations for the association between SES and risk for psychological disorders. First, higher-SES parents may be less likely to experience psychological problems themselves. They pass on genes conducive

FROM SCIENCE TO PRACTICE

INTERPERSONAL STRESS AND GENDER



Imagine that you are a middle school student. Some classmates are talking in the hallway. When you say “hi,” they ignore you. Why? Did you do something wrong? Did you say something stupid? Did you wear the wrong clothes to school that day?

Note: Based on J. L. Hamilton and colleagues (2015).

Researchers found that adolescent girls are especially sensitive to interpersonal situations like these—much more than adolescent boys. When girls interpret these situations negatively (e.g., “They’re mad at me”), blame themselves (e.g., “I must have said something wrong”), and ruminate or think about the situation over and over, they can become depressed. In fact, adolescent girls are twice as likely as boys to develop depression.

Cognitive therapy is based on the premise that if adolescents can change the way they think about situations like these, they will feel better. A cognitive therapist would likely ask her client to look for alternative explanations for her classmates’ behavior. Is it possible that your classmates didn’t hear you say “hi” or they were busy doing something else? Generating alternative explanations for events like these can improve adolescents’ mood.

to better mental health to their children. Second, higher-SES parents may be better able to provide environments for their children that protect them from psychological problems. For example, parents with higher incomes may be better able to afford higher-quality health care, nutrition, or schooling for their children. These early experiences, in turn, can protect their children from the emergence of mental health problems.

Of course, genetic and environmental factors often interact to place children at risk for disorders. For example, in one large study, researchers examined the prevalence of ADHD in children from low- and high-income families (Rowland et al., 2019). Children from low-income families were 6 times more likely than children from high-income families to have ADHD if neither parent had the disorder. However, if a parent also had ADHD, low-income children were 10 times more likely than high-income children to have the disorder. These findings suggest that both genetic risk and environmental quality affect prevalence.

A related predictor of children's mental health is family composition. Recent research indicates that youths living with only one biological parent are twice as likely to develop an anxiety or mood disorder as youths living with both biological parents. Furthermore, adolescents living in single-parent homes may be 6 times more likely to develop a behavior or substance use disorder as youths living in a two-parent household (Kessler et al., 2012a). The association between single-parent families and increased mental health problems is partially explained by SES; single parents often earn lower family incomes than two-parent families. However, single parents also report greater stress and may have more difficulty monitoring their children's behavior than two-parent families. These factors, in turn, can contribute to their children's behavior problems (Frick, 2013).

Race and Ethnicity

The relationship between ethnicity and childhood disorders is complex. Certain disorders are more commonly diagnosed in non-Latino White families. For example, the prevalence of autism spectrum disorder is approximately twice as high among young non-Latino White children (1.1%) compared to Latino (0.5%) or African American (0.4%) youths. Similarly, ADHD is more frequently diagnosed in non-Latino White youths (9.1%) than in African American (8.0%) or Latino (4.1%) children. Anxiety disorders are also slightly more common among White youths compared to their non-White peers (Perou et al., 2016).

On the other hand, African American youths are more likely to develop conduct problems than White youths. Specifically, approximately 8.1% of African American youths will develop oppositional defiant behavior or conduct disorder at some point in childhood, compared to 4.2% of White and 3.9% of Latino youths (Perou et al., 2016).

What explains these differences? One possibility is that differences in SES partially explain these differences in mental

disorders across ethnicities. Sadly, members of many minority groups in the United States disproportionately come from lower-SES families (Taylor & Wang, 2013). Consequently, minority families often face many of the same risks confronted by low-SES families: reduced access to high-quality health care and nutrition, less optimal child care, impoverished educational experiences, and higher family stress. Immigrant families also face special risks, such as stress associated with language differences and acculturation (Coll & Magnuson, 2014). These risk factors might explain the higher prevalence of conduct problems among some minority youths. Indeed, when researchers control for SES, there are fewer differences in the percentage of children diagnosed with mental disorders across ethnic groups (Hayden & Mash, 2014).

Another possibility is that children's racial or ethnic background might partially determine the likelihood that their disorders are identified and treated. For example, African American and Latino children tend to be diagnosed with autism much later than non-Latino White children (Ratto, Reznick, & Turner-Brown, 2015). Research indicates that minority parents are often less able to recognize the early signs of autism; consequently, their children's disorder may remain undiagnosed and untreated (Magaña, Lopez, Aguinaga, & Morton, 2013). Similarly, recent research has found that many Latino parents regard the hyperactive-impulsive symptoms of ADHD to be developmentally normative. Consequently, they may be less likely to view their children's symptoms as problematic and less likely to seek treatment (Gerdes, Lawton, Haack, & Hurtado, 2014).

A third possibility is that these differences in prevalence reflect cultural values across racial and ethnic groups. For example, African American adolescents are much less likely to develop alcohol and other drug use problems than non-Latino White adolescents (Kessler et al., 2012a). Some experts have argued that African American culture, which tends to discourage heavy alcohol use, protects many of these youths from substance use problems (Zapolski, Pedersen, McCarthy, & Smith, 2014). Furthermore, the more African American adolescents endorsed these cultural beliefs, the more likely they were to avoid alcohol and other drugs (Stock et al., 2013).

Review

- The prevalence of mental health problems is higher among adolescents than among prepubescent children.
- In childhood, boys are more likely to experience a mental health problem than girls. In adolescence, girls are more likely to experience a mental health problem than boys.
- SES reflects parents' education, employment status, and income. Children from low-SES families are at increased risk for mental health problems.
- Certain disorders, like ADHD and anxiety disorders, are most often diagnosed in non-Latino White children. Other disorders, like conduct problems, are most

often diagnosed in children from other racial or ethnic backgrounds. These differences might reflect family SES, cultural factors that affect help-seeking, and/or actual differences in prevalence as a function of race and ethnicity.

Do Most Children With Mental Health Problems Receive Treatment?

Access to Treatment

Although 20% of children and adolescents will develop a mental health problem at some point prior to adulthood, only about one-half of these youths receive treatment. Recent epidemiological studies indicate that only 51% of children and 45% of adolescents with mental disorders receive therapy or medication (Centers for Disease Control and Prevention, 2016b; Costello, He, Sampson, Kessler, & Merikangas, 2014). The likelihood that a youth will receive treatment depends on his or her disorder. For example, youths with ADHD are most likely to receive treatment, usually in the form of stimulant medication (e.g., Adderall, Ritalin). In contrast, youths with anxiety disorders are least likely to receive treatment, despite the fact that anxiety disorders are among the most treatable of all childhood mental health problems (Weisz et al., 2017).

Children and adolescents with mental health problems are most likely to receive treatment at a school (24%), specialized mental health clinic (23%), or medical facility (10%). Some children receive services through other social agencies (8%), clinics that offer complementary or alternative medicine (5%), or the juvenile justice system (5%). As we might expect, youths with ADHD and learning disabilities are most likely to receive treatment at school, whereas youths with certain high-risk conditions such as eating disorders and substance use problems are more likely to visit specialized mental health clinics or hospitals. Children and adolescents with anxiety and mood disorders are most likely to be treated by their pediatricians.

Not all children have equal access to high-quality mental health care. High-SES families are most likely to obtain mental health services for their children usually from psychologists and physicians. In contrast, youths from lower-SES backgrounds disproportionately receive treatment through public schools, human-service agencies, and the juvenile justice system. Furthermore, African American youths are less likely than non-Latino White youths to receive treatment (Costello et al., 2014).

Altogether, these data indicate that only about one-half of youths with mental health problems receive the treatment they need. When children are able to access treatment, it is often not delivered by mental health specialists. Instead, many youths receive care from school personnel, juvenile justice officers, nurses, and pediatricians. We desperately need students to devote their careers to providing specialized mental health services to children and adolescents, either by delivering

evidence-based treatment themselves or by removing socio-cultural barriers to families' access to high-quality care.

The Use of Medication

One of the greatest changes in the field of abnormal child psychology in the past 2 decades has been the increased use of **psychotropic medication**—that is, prescription medication used to treat behavioral, cognitive, or emotional problems. Approximately 7.5% of all school-age children and adolescents are taking at least one psychotropic medication at any point in time (Howie, Pastor, & Lukacs, 2014; Jonas, Gu, & Albertorio-Diaz, 2013).

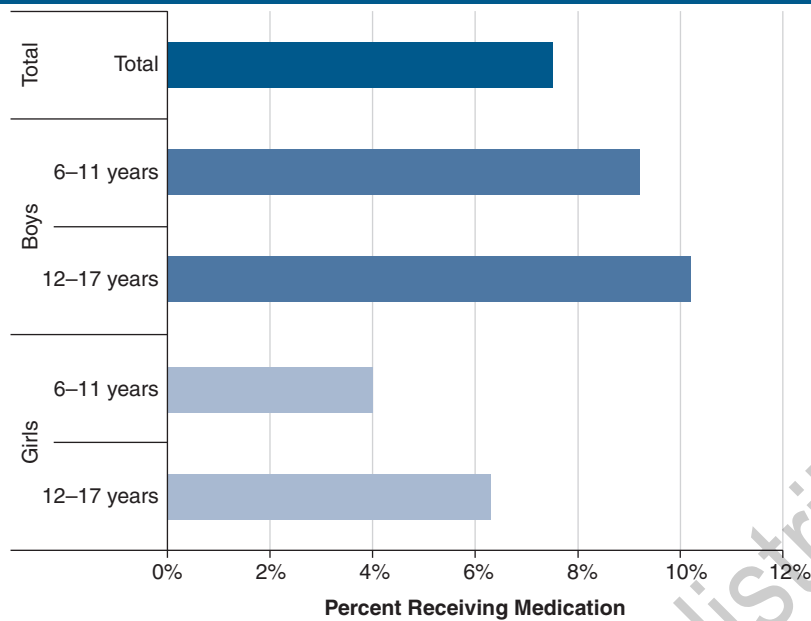
The use of psychotropic medication varies as a function of children's age (Figure 1.3). Medication is more frequently prescribed to adolescents than to prepubescent children. The greater use of psychotropic medication among adolescents likely reflects the greater overall prevalence of mental health problems in adolescents compared to younger children. Furthermore, adolescents' mental health problems tend to be more severe and, consequently, may be more likely to require medication. Although young children are less likely to be prescribed medication than older children and adolescents, approximately 2% of preschoolers are taking at least one medication to manage a mental health problem (Chirdkiatgumchai et al., 2013; Fontanella, Hiance, Phillips, Bridge, & Campo, 2014).

Medication use also varies by gender. Regardless of age, boys are more likely to receive medication for psychological problems than girls. This gender difference in medication use reflects the fact that boys are approximately 3 times more likely than girls to be diagnosed with ADHD and to receive medication for that condition.

The percentage of youths receiving medication to treat psychological problems has more than doubled over the past 20 years. Interestingly, the percentage of children participating in psychotherapy, a nonmedicinal treatment, has remained relatively stable during this same time period (Olfson, Blanco, Wang, Laje, & Correll, 2014; Olfson, He, & Merikangas, 2013).

Two factors seem to be driving the overall rise in the use of psychotropic medication among children and adolescents. First, clinicians are getting better at recognizing mental disorders in youths. Second, physicians have more medication options for children now than 2 decades ago (Bowers, Weston, Mast, Nelson, & Jackson, 2020).

Interestingly, not all types of psychotropic medications have shown the same increase in popularity. Medications used to treat ADHD, such as Ritalin and Adderall, showed a dramatic increase in the past 2 decades. In contrast, medications used to treat anxiety disorders (i.e., anxiolytics) and thought disorders like schizophrenia (i.e., antipsychotics) have increased at a slower pace. Only one class of medication for children and adolescents has declined in popularity: antidepressants. In the 1990s, physicians began prescribing antidepressant medications, like Prozac, to youths with depressive

FIGURE 1.3 ■ Medication Use by Children and Adolescents

Note: Approximately 7.5% of youths use psychotropic medications at any point in time. Boys are more likely to use medication than girls and adolescents are more likely to use medication than prepubescent children (Howie et al., 2014).

symptoms. In 2004, however, the US Food and Drug Administration (FDA) issued a warning to physicians that youths prescribed antidepressants were significantly more likely to experience suicidal thoughts (4%) than youths with depression who took placebo (2%). Because of this warning, antidepressant prescriptions declined. Today, antidepressants are usually reserved for youths who show more serious depressive symptoms and who are not showing adequate improvement in psychotherapy (Friedman, 2014).

Is medication overprescribed? To answer this question, researchers examined psychological problems and medication use in a large, nationally representative sample of adolescents (Merikangas & He, 2014). In the previous year, approximately 40% of adolescents experienced a mental health problem. However, only 14.2% of adolescents with mental health problems were prescribed medication. These findings challenge the widespread belief that psychotropic medication is overprescribed to youths. On the contrary, many children and adolescents who might benefit from medication never receive it.

Barriers to Treatment

Researchers and policy experts have identified several barriers to families' access to high-quality mental health treatment (Garland et al., 2013; Santiago, Kaltman, & Miranda, 2013). First, economic barriers can limit children's access to treatment. Psychotherapy, medication, and other forms of treatment can be expensive. Even families with private health insurance may be limited in the duration or type of treatment they can receive. Low-income families may face the additional challenge

of obtaining treatment from a public social service system that is often overburdened and underfunded. Low-income parents also face practical barriers to treatment, such as finding time off work, transportation to and from sessions, and childcare for their other children.

Second, social-cultural factors might decrease a family's willingness to participate in therapy. For example, some ethnic minority families may perceive psychological treatment to be ineffective or irrelevant to their immediate concerns. Instead of seeking psychotherapy or counseling, these families might consult with physicians, clergy, or elders in their community for treatment, advice, or support. Other parents from culturally diverse backgrounds might view therapies developed primarily for White, middle-class families as inapplicable to them. For example, some parents might disagree with therapists' recommendation to avoid spanking children when they misbehave. Still other parents may be unable to find therapists who can communicate in their language (American Psychological Association, 2017b).

Even if families are able and willing to participate in treatment, they may be unable to find high-quality mental health services. As we will see, evidence-based mental health treatments are not available in many communities. For example, multisystemic therapy is an effective treatment for older adolescents with serious conduct problems. Many well-designed studies have shown multisystemic therapy to reduce adolescents' disruptive behavior problems, improve their social and academic functioning, reduce their likelihood of arrest and incarceration, and save the community money (Dopp, Borduin, Wagner, & Sawyer, 2014; van der Stouwe, Asscher,

Stams, Deković, & van der Laan, 2014). However, few clinicians are trained in providing multisystemic therapy, and it is available in only a small number of communities.

Third, there are simply not enough experts in child and adolescent mental health to satisfy the need for services. Our current mental health system is able to address the needs of only about 10% of all youths with psychological problems. Furthermore, only 63% of counties in the United States have a mental health clinic that provides treatment for children and adolescents (Cummings, Wen, & Druss, 2013). 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 disabilities, or unhealthy eating habits, often remain unrecognized and untreated until their condition worsens. Inadequate mental health services are especially pronounced in disadvantaged communities.

Finally, stigma can interfere with children's access to mental health treatment (O'Driscoll, Heary, Hennessy, & McKeague, 2012). **Stigma** refers to negative beliefs about individuals with mental disorders that can lead to fear, avoidance, and discrimination by others or shame and low self-worth in oneself (Corrigan, Bink, Schmidt, Jones, & Rüschi, 2016). Stigmatization of mental illness comes in many forms. During casual conversation, people use terms like *crazy*, *wacked*, *nuts*, and *psycho* without giving much thought to the implications these words have for people with mental health problems. Children may use the derogatory term *retard* to tease their classmates. Parents of children with psychological disorders often report discrimination from school and medical personnel because of their child's illness. Some insurance companies discriminate against individuals with mental disorders by not providing equal coverage for mental and physical illnesses. Movies and television shows unfairly depict people with mental health problems as violent, unpredictable, deranged, or devious. Even children with mental disorders are portrayed in a negative light (Martinez & Hinshaw, 2016).

Some parents are reluctant to refer their children for therapy because of the negative connotations associated with diagnosis and treatment. In fact, roughly 25% of all pediatrician visits involve behavioral or emotional problems that could be better addressed by mental health professionals (Horwitz et al., 2002). Parents often seek help from pediatricians and family physicians to avoid the stigma of mental health treatment. Stigma associated with the diagnosis and treatment of childhood disorders causes many at-risk youths to receive less-than-optimal care (Bowers, Manion, Papadopoulou, & Gauvreau, 2013).

Stigma can also negatively affect youths and their families in several ways. First, it can cause a sense of shame or degradation that decreases self-esteem and lowers self-worth. The negative self-image generated by the social judgments of others, in turn, can exacerbate symptoms or hinder progress in therapy. Second, stigma can lead to self-fulfilling prophecies.

Youths may view themselves negatively because of their diagnostic label. In some cases, children may alter their behavior to fit the diagnostic label or use the diagnosis to excuse their behavior problems. Third, stigmatization can decrease the likelihood that families will seek psychological services. Many youths who show significant behavioral, emotional, and learning problems do not receive treatment because parents do not want them to receive a diagnosis (Martinez & Hinshaw, 2016).

Review

- Only one-half of children with mental health problems receive treatment. Non-Latino White children and youths from high-SES families are most likely to receive care.
- Roughly 7.5% of school-age children are taking at least one psychotropic medication at any point in time. Medication is more often used by adolescents (rather than children) and boys (rather than girls).
- Barriers to treatment include financial problems, a lack of high-quality treatment in the community, a shortage of well-trained clinicians, and stigma.

1.3 INTEGRATING SCIENCE AND PRACTICE

What Is Evidence-Based Practice?

The Importance of Science

Imagine that you experience unusual pain in your stomach that does not go away with the help of over-the-counter medicine. You schedule an appointment with your physician in the hope that she might be able to identify the cause of your ailment and prescribe an effective treatment. You would hope that your physician's assessment, diagnostic, and treatment strategies are evidence based—that is, that they reflect the scientific research and best available practice (Rousseau & Gunia, 2016).

Psychologists and other mental health professionals who work with children and families also strive for evidence-based practice. According to the American Psychological Association (APA), **evidence-based practice** is “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force, 2006, p. 273). The purpose of evidence-based practice is to deliver the highest-quality mental health services to children, adolescents, and families and to promote mental health in the community (J. Hamilton, Daleiden, & Youngstrom, 2015).

Clinicians who adopt an evidence-based approach to their practice consider the following three factors when helping children and families in need:

Scientific research: According to the research literature, what methods of assessment and forms of treatment work best for children with this particular problem?

Clinical expertise: According to my own professional experience and judgment, what is the best way for me to assess and treat this child?

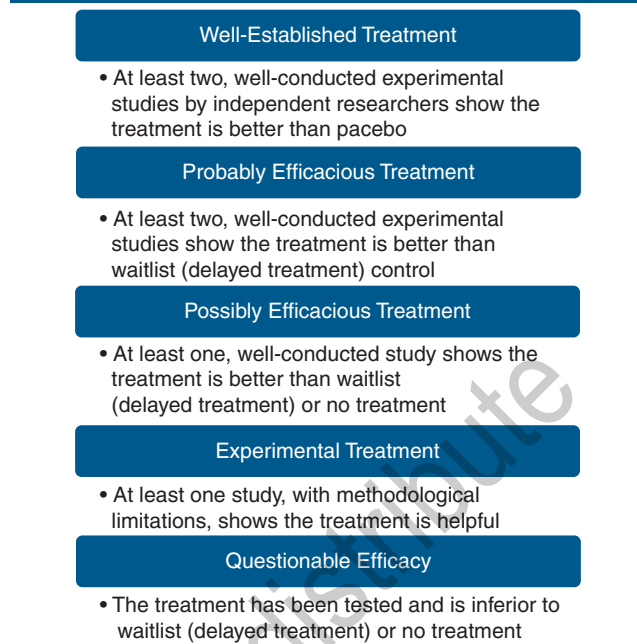
Patient characteristics: How might the child's age, gender, and social-cultural background, or the family's expectations and preferences for treatment, affect the way I help them?

Evidence-based practice, therefore, begins with consideration of the scientific research literature. If parents request treatment for their son with ADHD, which form of treatment is most likely to be helpful? Fortunately, professional organizations have identified **evidence-based treatments**—that is, psychotherapies and medications that have been shown in research studies to reduce children's symptoms and improve their functioning. For example, the Society of Clinical Child and Adolescent Psychology (2020) maintains an excellent website, effectivechildtherapy.org, that describes the most empirically supported psychosocial treatments for childhood disorders. Similarly, the American Academy of Child and Adolescent Psychiatry (2020) issues guidelines to help physicians identify medications and psychosocial treatments that are effective for childhood disorders.

Evidence-based treatments are typically categorized into one of five levels, depending on how well they are supported by research (Figure 1.4). For example, a type of behavior therapy called “parent training” is considered a well-established treatment for children with ADHD because several high-quality experimental studies, conducted by independent teams of researchers, have shown that it reduces children's ADHD symptoms. Consequently, behavior parent training, in which parents learn to monitor their children's behavior and reinforce appropriate actions, is considered a first-line psychosocial treatment. Neurofeedback training, on the other hand, is considered possibly efficacious because it has less empirical support. Although one well-designed study suggests that this treatment can help children regulate brain activity and behavior, the study needs to be replicated before it can be considered a first-line treatment. In contrast, social skills training has questionable efficacy for treating ADHD. Most children with ADHD already have adequate social skills and know how to behave in social situations; their main problem is inhibiting their behavior long enough to implement this knowledge (Evans, Owens, & Bunford, 2014).

Evidence-based practice does not simply mean using evidence-based treatments. Clinicians must also apply their knowledge and experience to tailor interventions to meet the social-emotional needs of children and families. Imagine that a mother brings her son with ADHD to their first therapy session. The therapist might initially decide to use behavior parent training. However, the therapist soon senses that the

FIGURE 1.4 ■ Levels of Evidence-Based Treatments



Note: Treatments can be organized hierarchically based on their level of empirical support. Well-established treatments are supported by multiple, well-conducted experiments showing that the treatment is more effective than placebo (Southam-Gerow & Prinstein, 2014).

mother needs time in the initial session to describe her own frustration with her son's behavior and her ex-husband's lack of interest in sharing caregiving responsibilities. The skillful therapist knows that evidence-based treatments must be modified to meet the immediate needs of families. Consequently, the therapist might see her initial goal as providing empathy and building an alliance with a mother who feels powerless or isolated as a caregiver (Rajwan, Chacko, Wymbs, & Wymbs, 2014).

Finally, evidence-based practice requires clinicians to consider the characteristics and sociodemographic backgrounds of the children and families they serve (Gonzales, Lau, Murray, Pina, & Barrera, 2016). For example, therapists sometimes have difficulty engaging fathers in parent training. Consequently, researchers have modified traditional parent training to better address the interests of fathers. A treatment called COACHES (Coaching Our Acting-Out Children: Heightening Essential Skills) allows fathers to practice parent management techniques as they play soccer with their children (Image 1.3). Several studies show that the COACHES program not only engages fathers who might otherwise avoid therapy but also improves children's behavior on the playing field and at home (Isaacs, Webb, Jerome, & Fabiano, 2015).

Review

- Evidence-based practice refers to the integration of high-quality research and clinical expertise to promote the welfare of children and families. It considers the child and family's strengths and challenges, their cultural



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IMAGE 1.3. COACHES is an evidence-based therapy designed specifically for fathers. The best evidence-based treatments are tailored to meet the needs of children and families.

identities and backgrounds, and their preferences for treatment.

- Evidence-based treatments have been shown to reduce children's behavior problems and/or improve their functioning in high-quality, research studies.
- Evidence-based practice is important because it increases the likelihood that clinicians will help their clients and reduces the risk of harm.

What Professionals Help Children and Families?

The Helping Professions

Children's mental health problems are complex. As a result, their treatment often requires coordinated care from professionals with different educational backgrounds and training (Image 1.4). In this section, we will learn about the different types of professionals who provide these services. There are so many helping professions relevant to children and families, we cannot review all of them here. However, we'll examine some of the major fields of study with the hope that it might motivate you to learn more about these fields on your own (Landrum & Davis, 2014; Metz, 2016; Norcross & Sayette, 2016).

Psychologists assess, diagnose, and treat individuals with mental disorders. They hold a doctoral degree (PhD or PsyD) in clinical or counseling psychology. Psychologists are not physicians; consequently, most do not prescribe medication but instead rely on psychotherapy and other nonmedicinal interventions. Child psychologists complete a 4- or 5-year graduate program and a 1-year internship accredited by the APA. Many also receive postdoctoral specialization in assessment, therapy, or neuropsychology. They work in hospitals, clinics, residential treatment facilities, private practice, and colleges/universities.

School psychologists assess, diagnose, and treat children with behavioral, cognitive, and social-emotional problems that interfere with their functioning at school. Most specialize in



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IMAGE 1.4. Treatment for children with mental health problems often requires coordinated care from professionals with diverse educational backgrounds.

the identification and treatment of developmental and learning disabilities, deliver school-based mental health services, and act as liaisons between children's families and the school. Most have a specialist degree in education (EdS) or a doctoral degree in education or psychology (EdD or PhD) and are accredited by the National Association of School Psychologists or the APA.

Psychiatrists are physicians (MD or DO) who specialize in the assessment, diagnosis, and treatment of mental disorders. They complete medical school and a 4-year residency in psychiatry and are certified by the American Board of Psychiatry and Neurology. Child psychiatrists specialize in mental disorders in children and adolescents. Most of their work involves prescribing psychotropic medications and monitoring children's response to treatment.

Pediatricians are physicians (MD or DO) who treat children and adolescents with medical illnesses. They may also prescribe psychotropic medications to children with disorders such as ADHD, anxiety, and depression. They complete medical school and a 3-year pediatric residency and are certified by the American Board of Pediatrics. Developmental-behavioral pediatricians have specialization in evaluating and treating children with developmental disorders and behavior problems. They work in hospitals and clinics.

Psychiatric-mental health nurses are nurses who specialize in the treatment of individuals with mental disorders. Psychiatric-mental health nurse practitioners earn either a master's or doctoral degree and, in many states, can practice independently. They tend to work in hospitals, clinics, and residential treatment facilities.

Licensed professional counselors (LPCs) are professionals who treat mental health problems in children, adolescents, adults, and families. Most LPCs have a master's degree and have completed postgraduate supervised clinical work before practicing independently. LPCs often adopt a treatment approach that focuses on clients' strengths and goals, rather than disorders and limitations. LPCs work in community mental health centers and private practice.

Marriage and family therapists are mental health professionals trained in couples and family systems therapy. They are licensed to diagnose and treat mental and emotional disorders within the context of a couple or family. Most have a master's degree and work in outpatient clinics and private practice.

Social workers are professionals who provide counseling and support to individuals and families experiencing psychosocial stress. Most licensed social workers (LSWs) have a bachelor's or master's degree and provide case management services to children and families. Licensed clinical social workers (LCSWs) typically have a master's degree and can also provide therapy. They work in hospitals, clinics, residential treatment facilities, social service agencies, and schools.

Speech–language pathologists assess, diagnose, and treat communication disorders in children, such as language delays, articulation problems, and stuttering. They may also help children who have language problems because of an injury, developmental disability, or autism. Most have a master's degree and work in schools, clinics, and hospitals.

Occupational therapists treat sick, injured, or disabled children through the therapeutic use of everyday activities and exercises. They help children develop, recover, and improve the skills needed for play, education, and daily living. They typically have a master's degree and work in schools, clinics, and hospitals.

Special education teachers help students with cognitive, emotional, and physical disabilities. They adapt lessons to meet the needs of these students. Some also teach basic communication and daily living skills to students with severe disabilities. They typically have a bachelor's or master's degree in education with a teaching license and work in schools.

School counselors help students develop academic and social skills to succeed in school. Career counselors also assist youths with the process of making career decisions by helping them develop skills or choose a career or educational program. Most have a master's degree in school counseling and work in schools.

Child life experts are professionals who help children and families cope with psychosocial stressors through activities and play. They may help children separated from their families because of trauma or children hospitalized because of illness or injury. Most have a bachelor's degree with a background in child development and family systems. They work in clinics, residential treatment facilities, and hospitals.

Students as Evidence-Based Helpers

College students often find themselves providing services to children and families in need. Students work as aides for people with developmental disabilities; behavior therapists for youths with autism; tutors for children with learning disabilities; or psychological technicians in residential treatment facilities, juvenile detention centers, and hospitals. Students 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.

Do you provide frontline services like these? If so, you can greatly help children, adolescents, and families in need. Although you may not be in a position to direct interventions, you can approach treatment from the perspective of psychological science. Here are three groups of questions to ask yourself as you help others:

What is the evidence for the intervention or service that I am providing? Is there a scientific basis for my work? Are there alternative services that might provide greater benefits to the people I serve?

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?

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 ethically and scientifically mindful manner?

As you read this book, consider how you might use scientific principles to inform your understanding of child and adolescent disorders. A scientific approach to helping is not reserved for mental health professionals. All people who work with youths are called upon to use scientific evidence to help improve the functioning of others.

Review

- Treatment often involves coordinated services from psychologists, physicians, teachers, and other professionals.
- Students can also use the principles of evidence-based practice when they volunteer to help children and families in need.

Why Is Ethical Treatment Important?

The APA Ethics Code

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, her personal beliefs in the rightness or wrongness of a given behavior. Ethical behavior is determined by group consensus; morality is determined by one's personal convictions (Knapp, Gottlieb, & Handelsman, 2015). 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 (2017a) Ethical Principles of Psychologists and Code of Conduct, the National Association of School Psychologists (2010) Principles for Professional Ethics,

the American Counseling Association (2014) Code of Ethics, and the American School Counselor Association (2010) Ethical Standards for School Counselors. Because the APA Ethics Code is the most frequently used system, we will examine it in greater detail.

The **APA Ethics Code** provides a common set of principles and standards upon which psychologists build their professional and scientific work (APA, 2017a). 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). 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 (Koocher & Campbell, 2018).

The first part of the Ethics Code describes five general **ethical principles**: 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 ideal standards of psychological practice toward which all psychologists should strive:

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

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.

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

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

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 second part of the Ethics Code consists of the **ethical standards**: specific rules that guide professional practice and research. The ethical standards govern all major 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. These rules fall into four categories (Koocher, 2008), sometimes called the Four Cs of ethics: (1) competence, (2) consent, (3) confidentiality, and (4) conflicts of interest.

Competence

According to the APA Ethics Code (2017a), “psychologists provide services, teach, and conduct research with populations and in areas only within their boundaries of competence.”

Competence refers to the use of education, training, and professional experience to deliver evidence-based services to individuals and the community. In general, psychologists achieve and maintain competence in three ways. First, psychologists have the educational background necessary to assess, diagnose, and treat the children, families, and groups with whom they work. Second, psychologists seek additional training and supervised experiences to maintain their awareness of evidence-based practice and, perhaps, expand their clinical work to new populations. Third, psychologists monitor their own mental and physical health and sociocultural awareness to make sure that these factors do not limit their ability to deliver effective care (Nagy, 2011).

Practicing within the boundaries of competence is important because it protects the welfare of clients. Psychologists who practice outside their areas of training will likely be less effective than therapists who are more knowledgeable and skillful. Therapists who practice outside the boundaries of their competence also risk harming their clients.

Competence is especially relevant to the assessment and treatment of children and adolescents. There is a shortage of clinicians who have received formal education and training in diagnosing and treating childhood disorders. Many clinicians, whose educational and clinical experiences largely focused on adults, may be tempted to provide care outside their boundaries of competence. Consider the case of Dr. Williams, a psychologist struggling with an ethical issue related to competence.

Dr. Williams is an expert in treating substance use disorders in adults. However, she lacks specialized training and supervision in the treatment of adolescent substance use disorders. It would likely be unethical for her to offer services to adolescents without first receiving additional training. Ideally, Dr. Williams would participate in some additional coursework on adolescent substance use disorders and receive supervision from a colleague who has expertise in this area.

Competence is also relevant to psychology students. Students often serve on the front lines of mental health treatment for children. For example, some students deliver behavioral interventions to children with autism, others help administer summer treatment programs for youths with ADHD, and still others work in group homes or residential treatment facilities. Because of their status as students, they must receive supervision from psychologists or other licensed mental health professionals who accept responsibility for their work. Students should always feel comfortable with their level of supervision and never feel pressured to accept more responsibility than they have received training to provide. Equally as important, students should never feel embarrassed to ask for help from their supervisor.

CASE STUDY

ETHICS WITH CHILDREN: COMPETENCE

Well-Intentioned Dr. Williams

Dr. Williams is a clinical psychologist who has 15 years of experience treating adults and couples with psychological problems, especially alcohol abuse. In fact, Dr. Williams has gained recognition in her community for her expertise in helping adults with chronic alcohol use problems. One day, she receives a telephone call from a mother who requested an appointment for her 15-year-old son. The son was recently suspended for bringing alcohol to a school athletic event and has been arrested for underage alcohol possession. Should Dr. Williams accept this client?



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CASE STUDY

ETHICS WITH CHILDREN: CONSENT

Resentful Rachel

Rachel was an 11-year-old girl referred to our clinic by her guidance counselor for disruptive behavior at school. Rachel had been increasingly moody and recently initiated two loud arguments with teachers. Her parents admitted that Rachel showed similar outbursts at home and has alienated herself from many of her former friends at school and in the neighborhood.

During the first session, Rachel sat quietly between her parents with her arms crossed in a defensive manner. Rachel's mother reported, "Rachel has been really touchy. She flies off the handle so easily, snaps at us, and then hides in her room for the rest of the evening." Her father added, "We're hoping you might be able to talk with her and identify the problem." At that point, Rachel uncrossed her arms, stood up, pointed at her parents, and yelled, "I'll tell you what the problem is! Him and her!" She exited the room, slamming the door behind her.



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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 Ethics Code requires psychologists to obtain **consent** from individuals before assessment, treatment, or research. The person must have the ability to understand the facts and consequences of participating in treatment. The person also must voluntarily agree to participate. Consent protects people's right to self-determination (Nagy, 2011).

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 (APA, 2017a).

Informed consent is especially important when treating children and adolescents. Children, unlike adults, rarely refer themselves to therapy. Instead, children and adolescents are usually referred to therapy by parents, teachers, other school personnel, pediatricians, or (sometimes) the juvenile court. Although these adults may want the child to participate in treatment, the child's motivation might be low. Consider Rachel, a girl who refuses to participate in therapy.

Children and adolescents, by virtue of their age and legal status as minors, are usually 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, like Rachel, may not freely agree to participate because they may feel pressured by others. Instead, proxy consent is obtained from parents or legal guardians. Then, psychologists obtain the **assent** of children and adolescents before providing services. To obtain assent, psychologists typically describe treatment using language that youths can understand, discuss goals for therapy that might be acceptable to the child or adolescent, and ask the youth for tentative permission to initiate treatment (Shumaker & Medoff, 2013). Although Rachel's parents provide consent for therapy, a skillful therapist knows that obtaining Rachel's assent is essential. Assent gives Rachel a voice in the initial stages of therapy and allows her to set goals (and parameters) for therapy that are important to her, not only to her parents and teachers (Knapp et al., 2015).

In rare cases, children can receive treatment without parental consent (Hecker & Sori, 2010). For example, clinicians can provide therapy to children who are in a state of crisis (e.g., thinking about killing themselves). Similarly, clinicians can delay obtaining parental consent if youths seek treatment because of suspected abuse, neglect, or endangerment. Psychologists who work in clinics and schools may also provide short-term mental health services to youths who are pregnant or experience sexual health concerns (Jacob & Kleinheksel, 2012). Parental consent is delayed in these special cases to provide immediate care to children in need or to allow youths to access services they might avoid if parental consent was required (Gustafson & McNamara, 2010).

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, it increases the likelihood that people in need of mental health services will seek treatment. Second, it allows clients to disclose information more freely and facilitates the therapeutic process (Koocher & Campbell, 2018).

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. Many psychologists consider protecting clients' confidentiality the most important ethical standard (Sikorski & Kuo, 2015).

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 *limits of confidentiality* that therapists must make known to clients, preferably during the first therapy session (DeMers & Siegel, 2018).

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 guardians 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 required to break confidentiality to protect the child. For example, if during the course of therapy a 12-year-old girl admits to being 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.

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.

Therapists also have a duty to protect children and adolescents from harm when they know youths are engaging in potentially dangerous behaviors. Frequently, ethical dilemmas arise when the therapist's duty to protect children comes into conflict with the therapist's responsibility to protect confidentiality. Consider Renae, a girl who is testing the limits of confidentiality.

When therapists face decisions about confidentiality, they must weigh two factors: (1) the frequency, intensity, and duration of the potentially harmful or maladaptive behavior and (2) the importance of maintaining the therapeutic process (Sullivan, Ramirez, Rae, Razo, & George, 2010). In general, therapists are more likely to break confidentiality as the risk of harm increases. For example, if Renae's decision to have sex was made freely and if she was at low risk for pregnancy

CASE STUDY

ETHICS WITH CHILDREN: CONFIDENTIALITY

Risqué Renae

Renae is a 16-year-old high school sophomore who was participating in therapy for long-standing problems with depression. During one session, Renae tells her therapist that her parents are leaving for an overnight trip that weekend and she intends to have sex with her boyfriend while they are gone. She explains that this decision is “huge” because she has never had sex with anyone before.

Renae’s therapist asks questions about Renae’s sexual health and access to birth control. She also wants to know if Renae is experiencing any pressure to initiate a sexual relationship. Should Renae’s decision to have sex remain confidential, between Renae and her therapist, or do her parents have a right to know her plans?



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CASE STUDY

ETHICS WITH CHILDREN: CONFLICTS OF INTEREST

Margaret’s Mournful Mother

Margaret was a 12-year-old girl who was referred to our clinic for oppositional and defiant behavior. Although Margaret was largely compliant at school, she would frequently disrespect her mother and throw tantrums to avoid responsibilities at home.

The therapist met with Margaret’s mother to gain additional information. During the course of the conversation, it became clear that Margaret’s mother was very depressed and was experiencing considerable marital problems with Margaret’s father. She said she was having a hard time caring for Margaret and performing her other responsibilities at home and work. She also admitted to thoughts of suicide.

The therapist believed that Margaret’s disruptive behavior was connected to her mother’s depressed mood. She offered to counsel Margaret’s mother individually, in addition to providing therapy for Margaret’s disruptive behavior. Was this a good decision?



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or illness, most therapists would respect her confidentiality. However, if we learned that Renae’s “boyfriend” was a 25-year-old man that she met online, we would need to take steps to protect her from harm. In any case, therapists place considerable importance on maintaining the therapeutic relationship. Would Renae ever trust her therapist (or any other therapist) if the therapist disclosed this information to Renae’s parents? What might the implications of disclosure be on Renae’s long-term mental health?

According to the Health Insurance Portability and Accountability Act (HIPAA), the right to confidentiality is

held by children’s parents, not by children themselves. Consequently, parents have the right to the information their children disclose in therapy (Sikorski & Kuo, 2015). Therapists must balance parents’ rights with adolescents’ expectations for confidentiality. On one hand, parents have the right to know about the medical and psychological treatment for their children; on the other hand, adolescents are unlikely to fully participate in therapy if their thoughts and feelings are shared with parents without their permission.

Most psychologists raise the issue of confidentiality with parents and teens early in treatment. Here is one strategy:

Psychotherapy works best when adolescents have confidence in the privacy of their conversations. At the same time, parents want to feel confident about their adolescent's well-being and safety. Since you (parents) were once teenagers, you certainly know that an adolescent may want to use therapy to talk about sex, alcohol, or other activities. Let's discuss about how we can assure your child's confidentiality so she can talk openly about what's on her mind, and at the same time assure you (parents) about your adolescent's safety. (Koocher & Daniel, 2012)

Conflicts of Interest

Usually, when parents seek treatment for their children, they have their children's best interests at heart. Occasionally, however, ethical issues arise when it is unclear whether psychologists are providing services to children or to their parents. The Ethics Code indicates that psychologists must avoid such conflicts of interest—that is, instances in which the psychologist engages in relationships that impair her objectivity, competence, or effectiveness with her client.

Conflicts of interest can arise in child and adolescent therapy in several ways. One conflict occurs when a therapist is in a professional role with the child and then (inadvertently) enters into another role with the child's parent. Consider the case of Margaret, a girl who presents a dilemma to her therapist related to a potential conflict of interest.

Although well intentioned, the therapist entered into a multiple relationship with Margaret and her mother. 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 are problematic when they impair the objectivity of services that psychologists provide (Campbell, Vasquez, Behnke, & Kinscherff, 2010). Would the therapist be able to effectively treat Margaret while also simultaneously providing services to her mother? Might it be better for the therapist to refer Margaret's mother to another provider?

Conflicts of interest can also occur in situations of separation and divorce (Shumaker & Medoff, 2013). Imagine that Margaret's family situation goes from bad to worse. Margaret's father decides to divorce Margaret's mother and seek custody of Margaret. Her father requests Margaret's psychological records, which include information about her mother's depressed mood and difficulty caring for Margaret. He intends on using this information to gain custody of his daughter.

The therapist now finds herself serving as a therapist for Margaret, a therapist for her mother, and a potential witness for her father. Clearly, the therapist's objectivity is threatened! At this point, the therapist must make this conflict known to both adults and explain the importance of limiting access to Margaret's records.

Therapists can avoid conflicts of interests by asking this question: Who is my client? In most instances, therapists identify the child or the entire family as their client. In these instances, the therapist does not provide services to other members of the family independently. If parents present goals in therapy that are separate from those of their child or the family, the therapist will acknowledge those goals but refer the parent to another provider to avoid a multiple relationship (Koocher & Campbell, 2018).

Review

- Ethical practice increases the likelihood that a clinician will help her client (i.e., beneficence) and avoid harm (i.e., nonmaleficence).
- The APA Ethics Code consists of broad ethical principles (i.e., aspirational goals) that guide psychologists' professional activities and specific standards (i.e., rules) they must follow when conducting research, helping clients, or interacting with the public.
- Four ethical standards are especially important when working with children and families: (1) competence, (2) consent, (3) confidentiality, and (4) conflicts of interest. They are sometimes called the Four Cs of professional ethics.

Key Terms

APA Ethics Code: A common set of principles and standards upon which psychologists build their professional and scientific work; other professions (e.g., school psychologists, social workers) have similar ethics codes

Assent: Agreement to participate in treatment or research provided by a person who is unable to give consent because of his or her age or cognitive ability

Categorical classification: Diagnostic approach in which disorders are divided into mutually exclusive groups based on sets of essential criteria

Comorbidity: The presentation of two or more disorders in the same person at the same time

Competence: The education, training, and professional experience mental health professionals use to deliver evidence-based services; professionals must practice within its boundaries

Confidentiality: The expectation that information that children and families provide during the course of treatment will not be disclosed to others without their consent

Consent: A person's informed and free decision to participate in treatment

Culture: Values, knowledge, and practices that people derive from membership in social groups

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5): A compendium of mental disorders and diagnostic criteria adopted by the American Psychiatric Association and used by most mental health professionals in the United States

Diagnostic specifier: A label that describes a relatively homogeneous subgroup of individuals with a given disorder

Dimensional classification: Diagnostic approach in which the severity of the individual's distress and/or impairment is described on a continuum

Ethical principles: Broad ideals or aspirational goals for the professional practice of psychology

Ethical standards: Specific rules that guide professional practice in psychology

Ethics: Principles and standards of a profession that ensure high-quality care and protect the rights and dignity of others

Ethnicity: A culturally constructed identity that is used to define groups of people and communities; it can be rooted in a common history, geographic location, language, religion, or shared experience that distinguishes that person or group from others

Evidence-based practice: The integration of empirical research with clinical expertise to help children and families in the context of their characteristics, culture, and preferences

Evidence-based treatments: Psychotherapies and medications that have been shown in well-designed research studies to reduce children's symptoms and improve their functioning

Harmful dysfunction: A definition of abnormal behavior characterized by (1) a failure of some internal mechanism to perform a function for which it was naturally selected and (2) the failure causes harm

Incidence: The percentage of new cases of a disorder in a discrete period of time, usually 1 year

Mental disorder: "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" (DSM-5)

Multiple relationship: Occurs when a therapist, 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; it can impair the objectivity and quality of care

Prevalence: The percentage of individuals in a given population who have a medical or psychological condition

Prototypical classification: Diagnostic approach that is based on the degree to which the individual's signs and symptoms map onto the ideal picture of the disorder

Psychotropic medications: Prescription drugs used to treat psychological disorders, such as anxiety, depression, and schizophrenia

Race: A culturally constructed category that can be used to divide people into groups based on superficial physical traits

Research Domain Criteria (RDoC) initiative: A program supported by NIMH to create a new system of classifying mental disorders based on underlying genetic and biological causes

Sign: An observable feature of a disorder (e.g., hyperactivity, sluggish movement)

Socioeconomic status (SES): A composite variable that reflects three aspects of a child's environment: (1) parents' levels of education, (2) parents' employment, and (3) family income

Stigma: Negative beliefs that can lead to fear, avoidance, and discrimination by others or shame and low self-worth in oneself

Symptom: A subjective experience associated with a disorder (e.g., anxiety, depressed mood)

Critical Thinking Exercises

1. According to DSM-5, a mental disorder is a pattern of behavior characterized by distress or disability that resides within the individual. What might be some limitations to this definition, especially when it is applied to children and adolescents?
2. Approximately 40% of youths in the general population who have a mental disorder have at least one other comorbid condition. However, the prevalence of comorbidity among children referred to

mental health clinics is much higher—between 70% and 80%. What might explain this difference?

3. Abdi is a 14-year-old boy who was sent to the emergency department of a hospital following a suicide attempt. Abdi, a recent Somali immigrant, does not speak English. After Abdi was medically stable, the psychologist at the hospital interviewed him through a translator, in order to determine whether he met diagnostic criteria for depression or another mental disorder. If you were the psychologist, what considerations might you keep in mind while interviewing Abdi?
4. Allison is a psychology major who is interested in working with children and families after graduation. Allison does not want to earn a doctoral or medical degree. What are some other career options for her? How might she find more information about those careers?
5. Taylor is a student intern at a community mental health center. During her internship, she suspects that one of her clients, a 9-year-old-boy, may be physically abused by his parents. The boy's parents engage in "rough discipline" such as hard spanking. The boy has never complained and there have never been any marks on his body. What should Taylor do?

Test Yourself and Extend Your Learning

Videos, flashcards, and links to online resources for this chapter are available to students. Teachers also have access to PowerPoint slides to guide lectures, a case

study book (with answers) to prompt classroom discussions, and exam questions. Visit abnormalchildpsychology.org.

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