CHAPTER SUMMARY

Abnormal functioning can occur at any time in life. Some patterns of abnormality, however, are more likely to emerge during particular periods—during childhood, for example. As the problems and, at times, mistreatment of young people receive greater attention, the special needs of these individuals are becoming more visible. In this chapter you will read about disorders that have their onset during childhood or early adolescence, the study of which are likely to continue at a rapid pace.

TOPIC OVERVIEW

Childhood and Adolescence

Childhood Anxiety Disorders
Separation Anxiety Disorder
Treatment for Childhood Anxiety Disorders

Depressive and Bipolar Disorders
Major Depressive Disorder
Bipolar Disorder and Disruptive Mood Dysregulation Disorder

Oppositional Defiant Disorder and Conduct Disorder
What Are the Causes of Conduct Disorder?
How Do Clinicians Treat Conduct Disorder?

Elimination Disorders
Enuresis
Encopresis
Neurodevelopmental Disorders
Attention-Deficit/Hyperactivity Disorder
Autism Spectrum Disorder
Intellectual Disability

Putting It Together: Clinicians Discover Childhood and Adolescence

LECTURE OUTLINE

I. DISORDERS OF CHILDHOOD AND ADOLESCENCE
   A. Abnormal functioning can occur at any time in life
   B. Some patterns of abnormality, however, are more likely to emerge during particular periods

II. CHILDHOOD AND ADOLESCENCE
   [Video: Parental Death and Young Children: The Psychological Impact; Harlow’s Studies on Dependency in Monkeys; Theory of Mind: Taking the Perspective of Others]
   A. People often think of childhood as a carefree and happy time—yet it also can be frightening and upsetting
      1. Children of all cultures typically experience at least some emotional and behavioral problems as they encounter new people and situations
      2. Surveys indicate that worry is a common experience:
         a. Bedwetting, nightmares, temper tantrums, and restlessness are other problems experienced by many children
   B. Adolescence also can be a difficult period
      1. Physical and sexual changes, social and academic pressures, personal doubts, and temptation cause many teenagers to feel nervous, confused, and depressed
      2. A particular concern among children and adolescents is that of being bullied
         a. More than one-quarter of students report being bullied frequently, and more than 70 percent report having been a victim at least once
   C. Beyond these common concerns and psychological difficulties, at least one-fifth of all children and adolescents in North America also experience a diagnosable psychological disorder
      a. Boys with disorders outnumber girls, even though most of the adult psychological disorders are more common in women
   D. Some disorders of children—childhood anxiety disorders and childhood depression—have adult counterparts
      1. Other childhood disorders—elimination disorders, for example—usually disappear or radically change form by adulthood
      2. There also are disorders that begin in birth or childhood and persist in stable forms into adult life
         a. These include autism spectrum disorder and intellectual disability (previously called mental retardation)

III. CHILDHOOD ANXIETY DISORDERS
   [Video: Selective Mutism]
   A. Anxiety is, to a degree, a normal and common part of childhood
      1. Because children have had fewer experiences than adults, their world is often new and scary
      2. Children also may be affected greatly by parental problems or inadequacies
3. Beyond such environmental problems, there also is genetic evidence that some children are prone to an anxious temperament

B. Childhood anxiety disorders
1. For some children, such anxieties become long-lasting and debilitating, interfering with their daily lives and their ability to function appropriately; they may be suffering from an anxiety disorder
2. Surveys indicate that between 8 and 29 percent of all children and adolescents display an anxiety disorder
3. Some of these disorders are similar to their adult counterparts, but more often they take on a somewhat different character due to cognitive and other limitations
   a. Typically, anxiety disorders of young children are dominated by behavioral and somatic symptoms
   b. They tend to center on specific, sometimes imaginary, objects and events
   c. They are more often than not triggered by current events and situations
4. Separation anxiety disorder, one of the most common childhood anxiety disorders, follows this profile and is displayed by 4 to 10 percent of all children (See Table 17-1 on text p. 568.)
   a. Sufferers feel extreme anxiety, often panic, whenever they are separated from home or a parent
   b. A separation anxiety disorder may further take the form of a school phobia or school refusal—a common problem in which children fear going to school and often stay home for a long period

C. Treatments for childhood anxiety disorders
1. Despite the high prevalence of these disorders, approximately two-thirds of anxious children go untreated
2. Among the children who do receive treatment, psychodynamic, behavioral, cognitive, cognitive-behavioral, family, and group therapies, separately or in combination, have been applied most often—each with some degree of success
3. Clinicians have also used drug therapy in some cases, often in combination with psychotherapy, but it has begun only recently to receive much research attention
4. Because children typically have difficulty recognizing and understanding their feelings and motives, many therapists, particularly psychodynamic therapists, use play therapy as part of treatment

IV. CHILDHOOD MOOD PROBLEMS
[Video: Disruptive Mood Dysregulation Disorder (Child Bipolar Disorder)]
A. Approximately 2 percent of children and 8 percent of adolescents currently experience major depressive disorder; as many as 20 percent of adolescents experience at least one depressive episode

B. Major depressive disorder
1. As with anxiety disorders, very young children lack some of the cognitive skills that help produce clinical depression, thus accounting for the low rate of depression among the very young
2. Depression in the young may be triggered by negative life events (particularly losses), major changes, rejection, or ongoing abuse
3. Childhood depression is commonly characterized by such symptoms as headaches, stomach pain, irritability, and a disinterest in toys and games
4. Clinical depression is much more common among teenagers than among young children
   a. Suicidal thoughts and attempts are particularly common
5. While there is no difference between rates of depression in boys and girls before the age of 13, girls are twice as likely as boys to be depressed by the age of 16
a. Several factors have been suggested, including hormonal changes, increased stressors, and increased emotional investment in social and intimate relationships.
b. Another factor that has received attention is teenage girls’ growing dissatisfaction with their bodies.

6. For years, it was generally believed that childhood and teenage depression would respond well to the same treatments that have been of help to depressed adults—cognitive-behavioral therapy, interpersonal approaches, and antidepressant drugs—and many studies indicated the effectiveness of such approaches.

a. However, some recent studies and events have raised questions about these approaches and findings, especially in relation to the use of antidepressant drugs, highlighting again the importance of research, particularly in the treatment realm.

C. Bipolar disorder and disruptive mood dysregulation disorder

1. For decades, conventional clinical wisdom held that bipolar disorder is exclusively an adult mood disorder, where the earliest age of onset is the late teens.
2. However, since the mid-1990s, clinical theorists have begun to believe that many children display bipolar disorder.
3. Most theorists believe that the growing numbers of children diagnosed with this disorder reflect not an increase in prevalence but a new diagnostic trend.
4. Other theorists believe the diagnosis is currently being overapplied to children and adolescents.

a. They suggest the label has become a clinical “catchall” that is being applied to almost every explosive, aggressive child.
5. The DSM-5 task force concluded that the childhood bipolar label has been overapplied and, to rectify the situation, DSM-5 included a new category: disruptive mood dysregulation disorder, which is targeted for children with severe patterns of rage (See Table 17-2 on text p. 573.)

a. This issue is particularly important because the current shift in diagnoses has been accompanied by an increase in the number of children who receive adult medications.
b. Few of these drugs have been tested on and approved specifically for use in children.

V. OPPOSITIONAL DEFIANT DISORDER AND CONDUCT DISORDER

[Video: Observational Learning of Aggression: Bandura’s Bobo Doll Study Animation; Girls Bullying Girls]

A. Children consistently displaying extreme hostility and defiance may qualify for a diagnosis of oppositional defiant disorder or conduct disorder (See Table 17-3 on text p. 575.)

1. Those with oppositional defiant disorder are argumentative and defiant, angry and irritable, and, in some cases, vindictive.
2. As many as 10 percent of children qualify for this diagnosis.
3. The disorder is more common in boys than girls before puberty but equal in both sexes after puberty.

B. Children with conduct disorder, a more severe problem, repeatedly violate the basic rights of others.

1. They often are aggressive and may be physically cruel to people and animals.
2. Many steal from, threaten, or harm their victims, committing such crimes as shoplifting, forgery, mugging, and armed robbery.
3. Conduct disorder usually begins between 7 and 15 years of age.
4. As many as 10 percent of children, three-quarters of them boys, qualify for this diagnosis.
5. Children with a mild conduct disorder may improve over time, but severe cases frequently continue into adulthood and develop into antisocial personality disorder or other psychological problems

C. Many clinical theorists believe that there are actually several kinds of conduct disorder
   1. One team distinguishes four patterns:
      a. Overt-destructive
      b. Overt-nondestructive
      c. Covert-destructive
      d. Covert-nondestructive
   2. It may be that the different patterns have different causes

D. Other researchers distinguish yet another pattern of aggression found in certain cases of conduct disorder—relational aggression—in which individuals are socially isolated and primarily display social misdeeds
   1. Relational aggression is more common among girls than boys

E. Many children with conduct disorder are suspended from school, placed in foster homes, or incarcerated
   1. When children between the ages of 8 and 18 break the law, the legal system often labels them juvenile delinquents
   2. More than half of the juveniles who are arrested each year are recidivists, meaning they have records of previous arrests
      a. Boys are much more involved in juvenile crime than are girls, although rates for girls are on the increase

F. What are the causes of conduct disorder?
   1. Many cases of conduct disorder have been linked to genetic and biological factors, drug abuse, poverty, traumatic events, and exposure to violent peers or community violence
   2. They have most often been tied to troubled parent-child relationships, inadequate parenting, family conflict, marital conflict, and family hostility

G. How do clinicians treat conduct disorder?
   1. Because aggressive behaviors become more locked in with age, treatments for conduct disorder are generally most effective with children younger than 13
   2. A number of interventions have been developed, but none of them alone is the answer for this difficult problem
      a. Today’s clinicians are increasingly combining several approaches into a wide-ranging treatment program
   3. Given the importance of family factors in conduct disorder, therapists often use family interventions
      a. One such approach is called parent-child interaction therapy
      b. A related family intervention is video modeling
      c. When children reach school age, therapists often use a family intervention called parent management training
      d. These treatments often have achieved a measure of success
   4. Other sociocultural approaches, such as community residential treatment programs and programs at school, have also helped some children improve
      a. One such approach is treatment foster care
   5. In contrast to these other approaches, institutionalization in juvenile training centers has not met with much success and may, in fact, strengthen delinquent behavior
   6. Treatments that focus primarily on the child with conduct disorder, particularly cognitive-behavioral interventions, have achieved some success in recent years
      a. In problem-solving skills training, therapists combine modeling, practice, role-playing, and systematic rewards
b. Another child-focused approach, The Anger Coping and Coping Power Program, has children participate in group sessions that teach them to manage anger more effectively.
c. Studies indicate that these approaches do reduce aggressive behaviors and prevent substance use in adolescence.

7. Recently, drug therapy also has been used.

8. It may be that the greatest hope for reducing the problem of conduct disorder lies in prevention programs that begin in early childhood.
a. These programs try to change unfavorable social conditions before a conduct disorder develops.
b. All such approaches work best when they educate and involve the family.

VI. ELIMINATION DISORDERS

A. Children with elimination disorders repeatedly urinate or pass feces in their clothes, in bed, or on the floor.
1. They already have reached an age at which they are expected to control these bodily functions.
2. These symptoms are not caused by physical illness.

B. Enuresis
1. Enuresis is repeated involuntary (or in some cases intentional) bedwetting or wetting of one’s clothes.
   a. It typically occurs at night during sleep but may also occur during the day.
2. Children must be at least 5 years of age to receive this diagnosis.
3. The problem may be triggered by a stressful event.
4. The prevalence of the disorder decreases with age.
5. Those with enuresis typically have a close relative who has had or will have the same disorder.
6. Research has not favored one explanation for the disorder over others.
   a. Psychodynamic theorists explain it as a symptom of broader anxiety and underlying conflicts.
   b. Family theorists point to disturbed family interactions.
   c. Behaviorists often view it as the result of improper, unrealistic, or coercive toilet training.
   d. Biological theorists suspect a small bladder capacity or weak bladder muscles.
7. Most cases of enuresis correct themselves without treatment.
   a. Therapy, particularly behavior therapy, can speed up the process.

C. Encopresis
1. Encopresis, repeatedly defecating in one’s clothing, is less common than enuresis and less well researched.
2. The problem:
   a. Is usually involuntary.
   b. Seldom occurs during sleep.
   c. Starts after the age of 4.
   d. Is more common in boys than girls.
3. Encopresis causes intense social problems, shame, and embarrassment.
4. Cases may stem from stress, constipation, improper toilet training, or a combination.
5. The most common treatments are behavioral and medical approaches, or combinations of the two.
   a. Family therapy also has been helpful.
VII. LONG-TERM DISORDERS THAT BEGIN IN CHILDHOOD

[Video: ADHD: The Case of Liam; Medicating ADHD: Liam 5 Years Later; Down Syndrome, Intimacy, and Marriage; Apps for Autism: The Use of iPads; Autism Spectrum Disorder: A Different Pattern; Autistic Prodigy; Current Research into Autism Spectrum Disorder; Does the MMR Vaccine Cause Autism Spectrum Disorder?; Dr. Ivar Lovaas Treats a Young Autistic Child with Behavioral Intervention; Reading and Reading Disorders: Specific Learning Disorders; Two Faces of Autism Spectrum Disorder]

A. The neurodevelopmental disorders often have a significant impact throughout the person’s life:
   1. Attention-deficit/hyperactivity disorder (ADHD)
   2. Autism spectrum disorder
   3. Intellectual disability

B. Clinicians have developed a range of treatment approaches that can make a major difference in the lives of people with these problems

C. Attention-Deficit/Hyperactivity Disorder
   1. Children who display attention-deficit/hyperactivity disorder (ADHD) have great difficulty attending to tasks or behave overactively and impulsively, or both (See Table 17-5 on text p. 583.)
      a. The primary symptoms of ADHD may feed into one another, but in many cases one of the symptoms stands out more than the other
   2. About half the children with ADHD also have:
      a. Learning or communication problems
      b. Poor school performance
      c. Difficulty interacting with other children
      d. Misbehavior, often serious
      e. Mood or anxiety problems
   3. Approximately 4 to 9 percent of schoolchildren display ADHD, as many as 70 percent of them are boys
      a. Those whose parents have had ADHD are more likely than others to develop it
      b. This disorder usually persists through childhood, but many children show a lessening of symptoms as they move into mid-adolescence
      c. Between 35 and 60 percent continue to have ADHD as adults
   4. How do clinicians assess ADHD?
      a. ADHD is a difficult disorder to assess
         (a) Ideally, the child’s behavior should be observed in several environmental settings because symptoms must be present across multiple settings for a diagnosis
         (b) It also is important to obtain reports of the child’s symptoms from their parents and teachers
         (c) Clinicians also commonly employ diagnostic interviews, rating scales, and psychological tests
   5. What are the causes of ADHD?
      a. Clinicians generally consider ADHD to have several interacting causes, including:
         (a) Biological causes, particularly abnormal dopamine activity and abnormalities in the frontal-striatal regions of the brain
         (b) High levels of stress
         (c) Family dysfunction
         b. Sociocultural theorists also point out that ADHD symptoms and a diagnosis of ADHD may actually create interpersonal problems and produce additional symptoms in the child
   6. How is ADHD treated?
      a. About 80 percent of all children and adolescents with ADHD receive treatment
b. There is, however, disagreement about the most effective treatment for the disorder

c. The most commonly applied approaches are drug therapy, behavioral therapy, or a combination

d. Millions of children and adults with ADHD are currently treated with methylphenidate (Ritalin), a stimulant drug that has been available for decades, or with certain other stimulants
   (a) It is estimated that 2.2 million children in the United States, 3 percent of all schoolchildren, take Ritalin or other stimulant drugs for ADHD
   (b) However, many clinicians worry about the possible long-term effects of the drugs and others question the applicability of study findings to minority children
   (c) Extensive investigations indicate that ADHD is overdiagnosed in the United States, so many children who are receiving stimulants may, in fact, have been inaccurately diagnosed
   (d) On the positive side, stimulant drugs are apparently very helpful for those who do have the disorder, and most studies indicate that they are safe

e. Behavioral therapy has been applied in many cases of ADHD
   (a) Parents and teachers learn how to apply operant conditioning techniques to change behavior
   (b) These treatments often have been helpful, especially when combined with stimulant drug therapy

7. Multicultural factors and ADHD
   a. Race seems to come into play with regard to ADHD
      (a) A number of studies indicate that African American and Hispanic American children with significant attention and activity problems are less likely than white American children to be assessed for ADHD, receive an ADHD diagnosis, or undergo treatment for the disorder
      (b) Children from racial minorities who do receive a diagnosis are less likely than white children to be treated with interventions that seem to be the most helpful, including the promising (but more expensive) long-acting stimulant drugs
   b. In part, racial differences in diagnosis and treatment are tied to economic factors
   c. Some clinical theorists further believe that social bias and stereotyping may contribute to the racial differences seen in the diagnosis and treatment of ADHD
   d. While many of today’s clinical theorists correctly alert us that ADHD may be generally overdiagnosed and overtreated, it is important that they also recognize that children from certain segments of society may actually be underdiagnosed and undertreated

D. Autism spectrum disorder
1. Symptoms appear early in life, before age 3
2. Just a decade ago, autism spectrum disorder seemed to affect approximately 1 out of every 2000 children; it now appears that at least 1 in 600 and perhaps as many as 1 in 150 children display the disorder
3. Approximately 80 percent of all cases appear in boys
4. As many as 90 percent of children with the disorder remain severely disabled into adulthood and are unable to lead independent lives
   a. Even the highest-functioning adults with autism spectrum disorder typically have problems in social interactions and communication and have restricted interests and activities
5. What are the features of autism spectrum disorder?
a. Autism spectrum disorder is marked by extreme unresponsiveness to other people, severe communication deficits, and highly rigid and repetitive behaviors, interests, and activities (See Table 17-6 on text p. 587.)
b. The individual’s lack of responsiveness and social reciprocity—extreme aloofness and lack of interest in people—has long been considered a central feature of the disorder
c. Communication problems take various forms
   (a) One common speech peculiarity is echolalia, the exact phrasing spoken by others
   (b) Another is pronominal reversal, or confusion of pronouns
d. Autism spectrum disorder also is marked by limited imaginative play and very repetitive and rigid behavior
   (a) This has been termed a “perseveration of sameness”
   (b) Many sufferers become strongly attached to particular objects—plastic lids, rubber bands, buttons, water—and may collect, carry, or play with them constantly
e. The motor movements of people with this disorder may be unusual
   (a) Often called “self-stimulatory” behaviors, some children jump, flap their arms, and make faces
   (b) Some individuals with autism spectrum disorder also may engage in self-injurious behaviors
   (c) Children may at times seem overstimulated and/or understimulated by their environments
6. What are the causes of autism spectrum disorder?
   a. A variety of explanations for autism spectrum disorder have been offered
      (a) Sociocultural explanations are now seen as having been overemphasized
      (b) More recent work in the psychological and biological spheres has persuaded clinical theorists that cognitive limitations and brain abnormalities are the primary causes of the disorder
   b. Sociocultural causes
      (a) Theorists initially thought that family dysfunction and social stress were the primary causes of autism
         (i) Kanner argued that particular personality characteristics of parents created an unfavorable climate for development—“Refrigerator parents”
            (ii) These claims had enormous influence on the public and the self-image of parents, but research totally failed to support this model
      (b) Some clinicians proposed a high degree of social and environmental stress, a theory also unsupported by research
   c. Psychological causes
      (a) According to certain theorists, people with autism spectrum disorder have a central perceptual or cognitive disturbance
         (i) One theory holds that individuals fail to develop a theory of mind—an awareness that other people base their behaviors on their own beliefs, intentions, and other mental states, not on information they have no way of knowing
            (ii) Repeated studies have shown that people with autism have this kind of “mindblindness”
      (b) It has been theorized that early biological problems prevented proper cognitive development
   d. Cognitive-biological causes
      (a) While a detailed biological explanation for autism spectrum disorder has not yet been developed, promising leads have been uncovered
Examinations of relatives keeps suggesting a genetic factor in the disorder.
1. Prevalence rates are higher among siblings and highest among identical twins.

Some studies have linked the disorder to prenatal difficulties or birth complications.

Researchers also have identified specific biological abnormalities that may contribute to the disorder, particularly in the cerebellum.

Many researchers believe that autism spectrum disorder may have multiple biological causes.

Perhaps all relevant biological factors lead to a common problem in the brain—a “final common pathway”—that produces the features of the disorder.

Finally, because it has received so much attention over the past 15 years, it is worth examining a biological explanation that has NOT been borne out.

In 1998, some investigators proposed that a postnatal event—the MMR vaccine—might produce autism in some children, thus alarming many parents.

Virtually all research conducted since then has argued against this theory and, in fact, the original study was found to be flawed and was retracted.

7. How do clinicians and educators treat autism spectrum disorder?
   a. Treatment can help people with autism spectrum disorder adapt better to their environments, although no treatment yet known totally reverses the autistic pattern.
   b. Treatments of particular help are cognitive-behavioral therapy, communication training, parent training, and community integration.
   c. In addition, psychotropic drugs and certain vitamins have sometimes helped when combined with other approaches.

   a. Cognitive-behavioral therapy
      i. Behavioral approaches have been used in cases of autism to teach new, appropriate behaviors, including speech, social skills, classroom skills, and self-help skills, while reducing negative ones.
      1. Most often, therapists use modeling and operant conditioning.
      ii. Therapies ideally are applied when they are started early in the children’s lives.
      iii. Given the recent increases in the prevalence of autism spectrum disorder, many school districts are now trying to provide education and training for children in special classes; most school districts, however, remain ill equipped to meet the profound needs of these students.

   b. Communication training
      i. Even when given intensive behavioral treatment, half of the people with autism spectrum disorder remain speechless.
      ii. They are often taught other forms of communication, including sign language and simultaneous communication—a method of combining sign language and speech.
      iii. They also may use augmentative communication systems, such as “communication boards” or computers that use pictures, symbols, or written words to represent objects or needs.
      iv. Such programs also now use child-initiated interactions to help improve communication skills.

   c. Parent training
Today’s treatment programs involve parents in a variety of ways:

1. For example, behavioral programs train parents so they can apply behavioral techniques at home.

2. In addition, individual therapy and support groups are becoming more available to help parents deal with their own emotions and needs.

(d) Community integration

(i) Many of today’s school-based and home-based programs for autism teach self-help; self-management; and living, social, and work skills.

(ii) In addition, greater numbers of group homes and sheltered workshops are available for teens and young adults with this disorder.

1. These programs help individuals become a part of their community and also reduce the concerns of aging parents.

E. Intellectual disability

1. In DSM-5, the term “mental retardation” has been replaced by “intellectual disability”:

   a. This term is applied to a varied population.

   b. As many as 3 of every 100 persons meets the criteria for this diagnosis:

      (a) Approximately three-fifths of them are male, and the vast majority display a mild level of the disorder.

2. People receive a diagnosis of intellectual disability (ID) when they display general intellectual functioning that is well below average, in combination with poor adaptive behavior (See Table 17-7 on text p. 595.):

   a. IQ must be 70 or below.

   b. The person must have difficulty in such areas as communication, home living, self-direction, work, or safety.

   c. Symptoms must appear before age 18.

3. Assessing intelligence:

   a. Educators and clinicians administer intelligence tests to measure intellectual functioning.

   b. These tests consist of a variety of questions and tasks that rely on different aspects of intelligence:

      (a) Having difficulty in one or two of these subtests or areas of functioning does not necessarily reflect low intelligence.

      (b) An individual’s overall test score, or intelligence quotient (IQ), is thought to indicate general intellectual ability.

   c. Many theorists have questioned whether IQ tests are indeed valid:

      (a) Intelligence tests also appear to be socioculturally biased.

   d. If IQ tests do not always measure intelligence accurately and objectively, then the diagnosis of intellectual developmental disorder also may be biased:

      (a) That is, some people may receive the diagnosis partly because of test inadequacies, cultural difference, discomfort with the testing situation, or the bias of a tester.

4. Assessing adaptive functioning:

   a. Diagnosticians cannot rely solely on a cutoff IQ score of 70 to determine whether a person suffers from intellectual developmental disorder:

      (a) For proper diagnosis, clinicians should observe the functioning of each individual in his or her everyday environment, taking both the person’s background and the community standards into account.

5. What are the features of intellectual developmental disorder?

   a. The most consistent feature of ID is that the person learns very slowly:

      (a) Other areas of difficulty are attention, short-term memory, planning, and language.
(b) Those who are institutionalized are particularly likely to have these limitations

b. Traditionally, four levels of intellectual developmental disorder have been distinguished:
   (a) Mild (IQ 50–70)
   (b) Moderate (IQ 35–49)
   (c) Severe (IQ 20–34)
   (d) Profound (IQ below 20)

6. Mild ID
   a. Some 80–85 percent of all people with intellectual developmental disorder fall into the category of mild ID (IQ 50–70)
   b. They sometimes are called the “educable” level because they can benefit from schooling
   c. Their jobs tend to be unskilled or semiskilled
   d. Intellectual performance seems to improve with age
   e. Research has linked mild ID mainly to sociocultural and psychological causes, particularly:
      (a) Poor and unstimulating environments
      (b) Inadequate parent-child interactions
      (c) Insufficient early learning experiences
   f. Although these factors seem to be the leading causes of mild ID, at least some biological factors also may be operating
      (a) Studies have implicated mother’s moderate drinking, drug use, or malnutrition during pregnancy in cases of mild ID

7. Moderate, severe, and profound ID
   a. Approximately 10 percent of persons with intellectual developmental disorder function at a level of moderate ID (IQ 35–49)
      (a) They can care for themselves, benefit from vocational training, and can work in unskilled or semiskilled jobs
   b. Approximately 3 to 4 percent of persons with intellectual developmental disorder function at a level of severe ID (IQ 20–34)
      (a) They usually require careful supervision and can perform only basic work tasks
      (b) They are rarely able to live independently
   c. About 1 percent of persons with intellectual developmental disorder function at a level of profound ID (IQ below 20)
      (a) With training, they may learn or improve basic skills but require a very structured environment
   d. Severe and profound levels of intellectual developmental disorder often appear as part of larger syndromes that include severe physical handicaps

8. What are the causes of intellectual developmental disorder?
   a. The primary causes of mild ID are environmental, although biological factors may be operating in some cases
   b. The primary causes of moderate, severe, and profound ID are biological, although people who function at these levels are also greatly affected by their family and social environment
   c. Chromosomal causes
      (a) The most common chromosomal disorder leading to ID is Down syndrome
      (b) Fewer than one of every 1,000 live births result in Down syndrome, but this rate increases greatly when the mother is older than 35
      (c) Several types of chromosomal abnormalities may cause Down syndrome, but the most common is trisomy 21
(d) Fragile X syndrome is the second most common chromosomal cause of ID

d. Metabolic causes
(a) In metabolic disorders, the body’s breakdown or production of chemicals is disturbed
(b) The metabolic disorders that affect intelligence and development typically are caused by the pairing of two defective recessive genes, one from each parent
   (i) Examples include:
      1. Phenylketonuria (PKU)
      2. Tay-Sachs disease

e. Prenatal and birth-related causes
(a) As a fetus develops, major physical problems in the pregnant mother can threaten the child’s healthy development
   (i) Low iodine 5 cretinism
   (ii) Alcohol use 5 fetal alcohol syndrome (FAS)
   (iii) Certain maternal infections during pregnancy (e.g., rubella, syphilis)
(b) Birth complications also can lead to ID, particularly a prolonged period without oxygen (anoxia)

f. Childhood problems
(a) After birth, particularly up to age 6, certain injuries and accidents can affect intellectual functioning
   (i) Examples include poisoning, serious head injury, excessive exposure to X rays, and excessive use of certain chemicals, minerals, and/or drugs (e.g., lead paint)
   (ii) In addition, certain infections, such as meningitis and encephalitis, can lead to ID if they are not diagnosed and treated in time

9. Interventions for people with intellectual developmental disorder
a. The quality of life attained by people with intellectual developmental disorder depends largely on sociocultural factors
   (a) Thus, intervention programs try to provide comfortable and stimulating residences, social and economic opportunities, and a proper education

b. What is the proper residence?
   (a) Until recently, parents of children with intellectual developmental disorder sent them to live in public institutions—state schools—as early as possible
      (i) These overcrowded institutions provided basic care, but residents were neglected, often abused, and isolated from society
      (ii) During the 1960s and 1970s, the public became more aware of these sorry conditions, and, as part of the broader deinstitutionalization movement, demanded that many people be released from these schools
   (b) People with ID faced similar challenges by deinstitutionalization as people with schizophrenia
   (c) Since deinstitutionalization, reforms have led to the creation of small institutions and other community residences (group homes, halfway houses, local branches of larger institutions, and independent residences) that teach self-sufficiency, devote more time to patient care, and offer education and medical services
      (i) These programs follow the principle of normalization—they try to provide living conditions similar to those enjoyed by the rest of society
   (d) Today, the vast majority of children with intellectual developmental disorder live at home rather than in an institution
(i) Most people with ID, including almost all with mild intellectual developmental disorder, now spend their adult lives either in the family home or in a community residence.

c. Which educational programs work best?
   (a) Because early intervention seems to offer such great promise, educational programs for individuals with intellectual developmental disorder may begin during the earliest years.
   (b) At issue are special education versus mainstream classrooms.
      (i) In special education, children with ID are grouped together in a separate, specially designed educational program.
      (ii) Mainstreaming places them in regular classes with students from the general school population.
      (iii) Neither approach seems consistently superior.
      (iv) Teacher preparedness is a factor that plays into decisions about mainstreaming.
   (c) Many teachers use operant conditioning principles to improve the self-help, communication, social, and academic skills of individuals with ID.
      (i) Many schools also employ token economy programs.

d. When is therapy needed?
   (a) People with intellectual developmental disorder sometimes experience emotional and behavioral problems.
   (b) Approximately 30 percent or more have a diagnosable psychological disorder other than ID.
   (c) Furthermore, some suffer from low self-esteem, interpersonal problems, and adjustment difficulties.
   (d) These problems are helped to some degree with individual or group therapy, and psychotropic medication sometimes is prescribed.

e. How can opportunities for personal, social, and occupational growth be increased?
   (a) People need to feel effective and competent to move forward in life.
      (i) Those with intellectual developmental disorder are most likely to achieve these feelings if their communities allow them to grow and make many of their own choices.
   (b) Socializing, sex, and marriage are difficult issues for people with ID and their families.
      (i) With proper training and practice, the individuals can learn to use contraceptives and carry out responsible family planning.
      (ii) National advocacy organizations and a number of clinicians offer guidance in these matters.
      (iii) Some have developed dating skills programs.
   (c) Some states restrict marriage for people with ID.
      (i) These laws rarely are enforced.
   (d) Finally, adults with ID need the financial security and personal satisfaction that come from holding a job.
      (i) Many can work in sheltered workshops but there are too few training programs available.
      (ii) Additional programs are needed so that more people with ID may achieve their full potential, as workers and as human beings.
LEARNING OBJECTIVES

17.2. Describe the childhood mood problems of major depressive disorder and bipolar disorder.
17.3. Describe the prevalence, symptoms, causes, and treatments of oppositional defiant disorder and conduct disorder.
17.4. Name and describe the elimination disorders. Discuss possible causes and treatments.
17.5. Describe the prevalence, symptoms, causes, and treatments of attention-deficit/hyperactivity disorder (ADHD).
17.6. Describe the symptoms of autism spectrum disorder. Discuss the various etiologies and treatments that have been proposed.
17.7. Describe the prevalence of the various types of intellectual disability, and discuss the environmental, genetic, and biological factors that contribute to intellectual disability. Describe and evaluate treatments and therapies for individuals with intellectual disability, including normalization programs and behavioral techniques.

KEY TERMS

attention-deficit/hyperactivity disorder (ADHD)
augmentative communication system
autism spectrum disorder
cerebellum
conduct disorder
disruptive mood dysregulation disorder
Down syndrome
encopresis
enuresis
fetal alcohol syndrome
intellectual disability (ID)
intelligence quotient (IQ)
mainstreaming
methylphenidate (Ritalin)
mild ID
moderate ID
neurodevelopmental disorders
normalization
oppositional defiant disorder
play therapy
profound ID
separation anxiety disorder
severe ID
sheltered workshop
MEDIARRESOURCES

Internet Sites

Please see Appendix A for full and comprehensive references. Sites relevant to Chapter 17 material are:

http://www.thearc.org
This site includes information on the Arc, an organization of and for people with intellectual and developmental disabilities, chapter locations, and links to additional resources.

http://www.conductdisorders.com/
This site is maintained by a “group of parents raising challenging children.”

http://www.nimh.nih.gov/health/publications
This website, provided by the National Institute of Mental Health, supplies downloadable links to PDF files and booklets on a variety of mental health topics, including ADHD and conduct disorders.

http://www.chadd.org
Run by children and adults with ADHD, this site offers support for individuals, parents, teachers, professionals, and others.

Mainstream Films

Films relevant to Chapter 17 material are listed and summarized below.

Key to Film Listings:
P = psychopathology focus
T = treatment focus
E = ethical issues raised

Please note that some of the films suggested may have graphic sexual or violent content due to the nature of certain subject matters.

The Breakfast Club
From 1985, this John Hughes classic follows five high school students from different social groups spending a Saturday together in detention. P, comedy/serious film

Charly
From the award-winning book Flowers for Algernon, this 1968 film portrays Charly, an adult suffering from intellectual disability. The film details Charly’s experiences with doctors attempting to “cure” him, leading up to his participation in an experimental treatment that raises his IQ to genius levels but not his emotional maturity. Issues of informed consent and the responsibilities that accompany science are handled well. P, T, E, serious film
Crazy/Beautiful
This 2001 film stars Kirsten Dunst as a troubled, rebellious rich girl who abuses drugs and alcohol and is medicated for depression. Her romance with a boy from the wrong side of the tracks helps her put her life back together. **P, serious film**

Dead Poet’s Society
This 1989 film stars Robin Williams as an unconventional teacher in a strict prep school. The suicide of one of his students is explored. **P, E, serious film**

Dominick and Eugene
From 1988, this touching film follows fraternal twins—one (Ray Liotta) is an ambitious medical student, the other (Tom Hulce) is a “slow” trash collector. **P, serious film**

Equus
In this 1977 film, psychiatrist Richard Burton treats a young boy (Peter Firth) who has blinded horses, seemingly for no reason. **P, T, E serious film**

I Am Sam
From 2001, this Sean Penn film follows Sam Dawson, a father with the mental capacity of a 7-year-old. **P, E, serious/commercial film**

Mad Love
This 1995 stars Chris O’Donnell as a teen “saving” Drew Barrymore after her family puts her in a psychiatric hospital. **P, serious film**

The Other Sister
From 1999, this film stars Juliette Lewis as a young woman with intellectual disability striving for independence from her (overly) protective mother (Diane Keaton). **P, commercial/serious film**

Rain Man
This 1988 film stars Dustin Hoffman as a man with autism and savant syndrome who is forced to travel cross-country with his self-centered, greedy younger brother (Tom Cruise). **P, T, serious film**

Thirteen
This disturbing film from 2003 follows two girls on the edge of adolescence and identity development. **P, serious film**

What’s Eating Gilbert Grape
This 1994 film stars Johnny Depp as Gilbert, the eldest brother in a family with a very large mother (Darlene Cates) who hasn’t left the house since her husband committed suicide years before. Leonardo DiCaprio plays Arnie, Gilbert’s teenage brother who suffers from intellectual disability and needs constant supervision. **P, serious film**

Other Films:
Igby Goes Down (2002), problems of childhood and adolescence. **P, serious film**
Silent Fall (1994), autism. **P, commercial/serious film**
Spellbound (1945), problems of childhood and adolescence. **P, T, E, commercial thriller/romance**

Recommendations for Purchase or Rental
Films on Demand is a Web-based digital delivery service that has impressive psychology holdings. The catalog can be accessed at http://ffh.films.com/digitallanding.aspx. In addition, the following videos and other media are available for purchase or rental and appropriate for use in class or for assignment outside of class.

Behavioral Treatment of Autistic Children
Focus International
1160 E. Jericho Turnpike
CLASS DEMONSTRATIONS AND ACTIVITIES

Case Study
Present a case study to the class.

Panel Discussion
Have students volunteer to discuss their own experiences with childhood disorders. (NOTE: A brief reminder about sensitivity and professionalism is worthwhile here.)

“It’s Debatable: Ritalin: Straightjacket or Miracle Drug?” (See the Preface of this Instructor’s Resource Manual for conducting this activity.)
Using the text as a platform, have students volunteer (or assign them) in teams to opposite sides of the debate topic. Have students present their cases in class following standard debate guidelines.

“It’s Debatable: Targeted for Bullying” (See the Preface of this Instructor’s Resource Manual for conducting this activity.)
Have students volunteer (or assign them) in teams to opposite sides of the debate topic. Use MediaSpeak on text p. 576 of the text as a starting point. Have students present their cases in class following standard debate guidelines.
Ritalin
The use of stimulant medications such as Ritalin has led to one of the more effective treatments for attention-deficit/hyperactivity disorder. The drugs reduce the activity-level problems, thereby making the child more manageable at home and in the classroom. Ask your students to put themselves in the roles of parents, teachers, and children and to discuss the implications, both pro and con, of using stimulant medications to control children’s behavior.

SUGGESTED TOPICS FOR DISCUSSION

Bullying
Using MediaSpeak on text p. 576 in the text as a platform, lead a discussion on bullying in schools. Do students think it is a serious problem? What are their suggestions for reducing it?

Children’s Problems
Lead a discussion about ways to help children deal with such family adjustments as divorce, financial changes, and death. Ask for student input into the types of problems these children can be expected to encounter.

Learning Disabilities
Using PsychWatch on p. 597 of the text, lead a discussion on how students feel about labeling learning disabilities (LDs) as mental illness. Students with learning disabilities show few, if any, signs of emotional disturbance, and some authorities question classifying learning disabilities as psychological disorders. Inform the class that several students in your class will fit into this classification. Use an overhead projector to list the advantages and disadvantages of calling LDs mental illness.

Presume You Are a Teacher . . .
Johnny is 7 years old and in the first grade. He has trouble sitting still, often loses things, is very loud, and acts very impulsively. He is disruptive to your classroom. You are fairly certain he has ADHD. You are meeting with his parents tomorrow night during Parent-Teacher Night. As typically happens at these events, you and the child’s parents will have 10 minutes together. You want to convince them to seek an evaluation. What do you say? Do you recommend a formal evaluation by a mental health professional? Why or why not?

Presume You Are a Mental Health Professional . . .
Johnny is 7 years old and in the first grade. He has trouble sitting still, often loses things, is very loud, and acts very impulsively. Your evaluation has determined that he meets criteria for ADHD. His parents are coming to your office tomorrow to discuss the results. How do you tell them? What if they feel that they’ve done something wrong? Do you recommend psychotherapy? Do you recommend medication?

Presume You Are a Therapist . . .
Lead a discussion on the ethical issues of counseling with children and adolescents. As minors, their parents have a legal right to information about their treatment. How would students—acting as therapist—deal with confidentiality issues? What do they think a parent should have the right to know? How would they explain the various aspects of confidentiality to an elementary school child? To an adolescent?
Mainstreaming
Lead a discussion on the topic of mainstreaming students with intellectual developmental disorder (ID). What are the pros and cons of this issue? Does mainstreaming risk setting up the child with ID for social rejection? Many students will have been exposed to this practice in the K–12 schooling.

ASSIGNMENTS/EXTRA CREDIT SUGGESTIONS

Write a Pamphlet
Using a software program like Microsoft Publisher or simply paper and markers, students can create a pamphlet on one or all of the disorders of childhood and adolescence. Students should be encouraged to be as accurate and up-to-date as possible and also to present all sides of the disorder (e.g., alternate treatment approaches or theories).

Keep a Journal
In addition to helping students synthesize material, this activity is helpful in developing writing skills. Have students keep a journal of their thoughts on course material through the semester. This can be done in the first or last five minutes of class or as an out-of-class assignment. Have students submit their journals for review on an ongoing basis, because they can have the tendency to delay writing until the end of the semester. Some suggestions for journal topics include reactions to the case examples; strengths and weaknesses of prevailing theoretical explanations; hypothetical conversations with sufferers of specific disorders, and so on.

Presume You Are an Expert . . .
Tell the students that you received a phone call from your senator last night at home. He or she recognized that you are doing a fine job instructing students on the issue of childhood abuse. Your senator wants you and several students to come to Washington, D.C., to testify before a Senate subcommittee on a new law intended to prevent the abuse of children. Ask students to prepare a five-minute presentation outlining a recommendation for a law that might reduce child abuse. Remind them that their testimony will influence law. Also remind them that their testimony is “expert” and that they may be challenged about the validity of what they are saying.

Essay Topics
For homework or extra credit, have students write an essay addressing one (or more) of the following topics:

(1) Discuss the issue of bullying (see MediaSpeak, text p. 576). From your experience, is bullying really problematic? What interventions do you think should be researched and implemented to stem this (growing) problem?

(2) Discuss the use of stimulant drugs as treatment for ADHD.

Research Topics
For homework or extra credit, have students write a research report addressing one (or more) of the following topics:

(1) Conduct a “Psych Info” search and write an annotated bibliography on Ritalin as a treatment for ADHD. What types of symptoms are best treated by this medication? What studies are examining the risks? Have validity studies been conducted to examine the criteria used for diagnosis?
(2) Research and review the literature on child abuse (see *PsychWatch* on text p. 581). What are the predictors of child abuse? What are the long-term problems victims have? What treatments are successful for abusers? For victims?

(3) Research and review the literature on ADHD and race. What conclusions are being drawn?

(4) Research and review the literature on learning, communication, and/or developmental coordination disorders (see *PsychWatch*, text p. 597). What are the symptoms, treatments, and prognoses for these disorders? What interventions are being investigated?

**Film Review**

To earn extra credit, have students watch one (or more) of the mainstream films listed in this chapter and write a brief report (3 to 5 pages). Students should summarize the plot of the film in sufficient detail to demonstrate familiarity, but should focus their papers on the depiction of psychological abnormality. What errors or liberties did the filmmaker take? What is the message (implicit or explicit) concerning people with mental illness?