Chapter 14
Abnormal Behavior in Childhood and Adolescence
Sheila K. Grant, Ph.D.
Professor

Cultural Beliefs About What Is Normal and Abnormal

Cultural beliefs help determine whether people view behavior as normal or abnormal.

Because children rarely label their own behavior as abnormal, definitions of normality depend largely on how a child’s behavior is filtered through the family’s cultural lenses.

Cultures vary with respect to the types of behaviors they classify as unacceptable as well as the threshold for labeling child behaviors as deviant.

Prevalence of Mental Health Problems in Children and Adolescents

According to a report from the U.S. Surgeon General, 1 in 10 children suffers from a mental disorder severe enough to impair development (“A Children’s Mental Illness ‘Crisis,’” 2001).

The most commonly diagnosed psychological disorders in children age 6 to 17 are learning disabilities (11.5%) and attention-deficit hyperactivity disorder (8.8%).

A telephone survey based on a national probability sample of American youth ages 12 to 17 found that 7% of the boys and 14% of the girls had suffered from major depression in the 6-month period preceding the survey (Kilpatrick et al., 2003).

Risk Factors for Childhood Disorders

Many factors contribute to increased risk of developmental disorders, including genetic susceptibility, environmental stressors (such as living in decaying neighborhoods), and family factors (such as inconsistent or harsh discipline, neglect, or physical or sexual abuse).

Children with parents who suffer from depression also stand a higher risk of developing psychological disorders, perhaps because it leads to greater family stress.

Gender is yet another discriminating factor.

Risk Factors for Childhood Disorders

Many factors contribute to increased risk of developmental disorders, including genetic susceptibility, environmental stressors (such as living in decaying neighborhoods), and family factors (such as inconsistent or harsh discipline, neglect, or physical or sexual abuse).

Children with parents who suffer from depression also stand a higher risk of developing psychological disorders, perhaps because it leads to greater family stress.

Gender is yet another discriminating factor.

Play therapy.
Pervasive Developmental Disorders

Pervasive developmental disorders (PDDs) - A class of developmental disorders characterized by significantly impaired behavior or functioning in multiple areas of development.

Autism - A pervasive developmental disorder characterized by failure to relate to others, lack of speech, disturbed motor behaviors, intellectual impairment, and demands for sameness in the environment.

Asperger's disorder - A pervasive developmental disorder characterized by social deficits and stereotyped behavior but without the significant language or cognitive delays associated with autism.

Rett's disorder - A pervasive developmental disorder characterized by a range of physical, behavioral, motor, and cognitive abnormalities that begin after a few months of apparently normal development.

Childhood disintegrative disorder - A pervasive developmental disorder involving loss of previously acquired skills and abnormal functioning following a period of apparently normal development during the first 2 years of life.

Autism

The word autism derives from the Greek *autos*, meaning "self."

The term was first used in 1906 by the Swiss psychiatrist Eugen Bleuler to refer to a peculiar style of thinking among people with schizophrenia.

Autistic thinking is the tendency to view oneself as the center of the universe, to believe that external events somehow refer to oneself.

In 1943, another psychiatrist, Leo Kanner, applied the diagnosis "early infantile autism" to a group of disturbed children who seemed unable to relate to others, as if they lived in their own private worlds.

Delays in diagnosis can be detrimental, because the earlier children with autism are diagnosed and treated, the better they generally.

Autism is more common in boys than in girls, about four times as.

The disorder generally becomes evident in toddlers between 18 and 30 months of age, but the average child is not diagnosed until about age 6.
**Autism**

Perhaps the most poignant feature of autism is the child’s utter aloneness.

Other features include language and communication problems and ritualistic or stereotyped behavior.

The child may also be mute, or if some language skills are present, they may be characterized by peculiar usage, as in *echolalia* (parroting back what the child has heard in a high-pitched monotone); pronoun reversals (using “you” or “he” instead of “I”); use of words that have meaning only to those who have intimate knowledge of the child; and tendencies to raise the voice at the end of sentences, as if asking a question.

**Theoretical Perspectives**

An early and now discredited belief held that the autistic child’s aloofness was a reaction to parents who were cold and detached—“emotional refrigerators” who lacked the ability to establish warm relationships with their children.

Psychologist O. Ivar Lovaas and his colleagues (1979) suggest that children with autism have perceptual deficits that limit them to processing only one stimulus at a time.

As a result, they are slow to learn by means of classical conditioning (association of stimuli).

**Treatment**

Using operant conditioning methods, therapists and parents engage in the painstaking work, systematically using rewards and mild punishments to increase the child’s ability to attend to others, to play with other children, to develop academic skills, and to eliminate self-mutilative behavior.

The most widely used behavioral treatment programs are highly intensive and structured, offering a great deal of individual, one-to-one instruction.

In a classic study, psychologist O. Ivar Lovaas of UCLA demonstrated impressive gains in autistic children who received more than 40 hours of one-to-one behavior modification each week for at least 2 years (Lovaas, 1987).

**Mental Retardation**

*Mental retardation*—A generalized delay or impairment in the development of intellectual and adaptive abilities.

The course of mental retardation is variable.

Many children with mental retardation improve over time, especially if they receive support, guidance, and enriched educational opportunities.

Those who are reared in impoverished environments may fail to improve or may deteriorate further.

**Causes of Mental Retardation**

The causes of mental retardation include biological factors, psychosocial factors, or a combination of these factors (APA, 2000).

Biological causes include chromosomal and genetic disorders, infectious diseases, and maternal alcohol use during pregnancy.

Psychosocial causes include exposure to an impoverished home environment marked by the lack of intellectually stimulating activities during childhood.
**Down Syndrome and Other Chromosomal Abnormalities**

**Down syndrome** - A condition caused by the presence of an extra chromosome on the 21st pair and characterized by mental retardation and various physical anomalies.

Down syndrome occurs in about 1 in 800 births.

It usually occurs when the 21st pair of chromosomes in either the egg or the sperm fails to divide normally, resulting in an extra chromosome.

---

**Fragile X Syndrome and Other Genetic Abnormalities**

**Fragile X syndrome** - An inherited form of mental retardation caused by a mutated gene on the X chromosome.

The syndrome is the second most common form of retardation overall, after Down syndrome.

The disorder is caused by a defective gene in an area of the X sex chromosome that appears fragile, hence the name.

---

**Phenylketonuria (PKU)** - A genetic disorder that prevents the metabolism of phenylpyruvic acid, leading to mental retardation unless the diet is strictly controlled.

It is caused by a recessive gene that prevents the child from metabolizing the amino acid phenylalanine, which is found in many foods.

Phenylketonuria (PKU) is a genetic disorder that occurs in 1 in 10,000 births.
### Prenatal Factors

Some cases of mental retardation are caused by maternal infections or substance abuse during pregnancy.

Rubella (German measles) in the mother, for example, can be passed along to the unborn child, causing brain damage resulting in retardation.

It may also play a role in autism. Although the mother may experience mild symptoms or none at all, the effects on the fetus can be tragic.

Other maternal infections that may cause retardation in the child include syphilis, cytomegalovirus, and genital herpes.

### Cultural-Familial Causes

Most cases of mental retardation fall in the mild range of severity and have no apparent biological cause or distinguishing physical feature.

**Cultural–familial retardation** - A mild form of mental retardation that is influenced by impoverishment of the home environment.

Children in impoverished families may lack toys, books, or opportunities to interact with adults in intellectually stimulating ways.

### Intervention

The services that children with mental retardation need depend on the level of severity and type of retardation.

With appropriate training, children with mild retardation may approach a sixth-grade level of competence.

They can acquire vocational skills and support themselves minimally through meaningful work.

### Types of Learning Disorders

**Dyslexia** - A learning disorder characterized by impaired reading ability.

**Learning disorder** - A deficiency in a specific learning ability in the context of normal intelligence and exposure to learning opportunities.

Learning disorders are typically chronic disorders that affect development well into adulthood.

Children with learning disorders tend to perform poorly in school.

**Mathematics Disorder** - Mathematics disorder describes children with deficiencies in arithmetic skills. They may have problems understanding basic mathematical terms or operations, such as addition or subtraction; decoding mathematical symbols (+, –, etc.); or learning multiplication tables. The problem may become apparent as early as the first grade (age 6) but is not generally recognized until about the second or third grade.

**Disorder of Written Expression** - Disorder of written expression refers to children with grossly deficient writing skills. The deficiency may be characterized by errors in spelling, grammar, or punctuation, or by difficulty in composing sentences and paragraphs. Severe writing difficulties generally become apparent by age 7 (second grade), although milder cases may not be recognized until the age of 10 (fifth grade) or later.
Types of Learning Disorders

**Reading Disorder** - Reading disorder—dyslexia—characterizes children who have poorly developed skills in recognizing words and comprehending written text.

Dyslexia is estimated to affect about 4% of school-age children (APA, 2000) and is much more common in boys than in girls. Boys with dyslexia are also more likely than girls to show disruptive behavior in class and so are more likely to be referred for evaluation.

Understanding and Treating Learning Disorders

Much of the research on learning disorders focuses on dyslexia, with mounting evidence pointing to underlying abnormalities in the ways the brain of a dyslexic child processes visual and auditory information.

People with dyslexia have difficulty processing the sounds corresponding to particular letters (e.g., seeing an f or a ph or a gh and saying or hearing in our minds an f sound).

Recently, scientists speculated that dyslexia may take two general forms, one more genetically influenced and the other more environmentally influenced.

Communication Disorders

**Communication disorders** are persistent difficulties in understanding or using language.

The categories of communication disorders include expressive language disorder, mixed receptive/expressive language disorder, phonological disorder, and stuttering.

Each of these disorders interferes with academic or occupational functioning or ability to communicate socially.

Communication Disorders

**Expressive language disorder** is a persistent impairment in the use of spoken language, such as slow vocabulary development, errors in tense, difficulties recalling words, and problems producing sentences of appropriate length and complexity for the individual's age.

**Mixed receptive/expressive language disorder** refers to difficulties both understanding and producing speech.

**Phonological disorder** is a persistent difficulty articulating the sounds of speech in the absence of defects in the oral speech mechanism or neurological impairment.

Attention-Deficit and Disruptive Behavior Disorders

Attention-deficit and disruptive behavior disorders are a diverse range of problem behaviors, including **attention-deficit hyperactivity disorder** (ADHD), **conduct disorder** (CD), and **oppositional defiant disorder** (ODD).

These disorders are socially disruptive and usually more upsetting to other people than to the children who are diagnosed with these problems.

The rate of comorbidity (co-occurrence) among these disorders is very high.
Attention-Deficit Hyperactivity Disorder

**Attention-deficit hyperactivity disorder (ADHD)** - A behavior disorder characterized by excessive motor activity and inability to focus one's attention.

**Hyperactivity** - An abnormal behavior pattern characterized by difficulty in maintaining attention and extreme restlessness.

ADHD is divided into three subtypes:

(a) predominantly inattentive type

(b) predominantly hyperactive or impulsive type

(c) combination type characterized by high levels of both inattention and hyperactivity-impulsivity (APA, 2000).

The disorder is usually first diagnosed during elementary school, when problems with attention or hyperactivity-impulsivity make it difficult for the child to adjust to school.

### Theoretical Perspectives

We know that ADHD tends to run in families, which is suggestive of a genetic contribution.

But more direct evidence comes from findings of a higher concordance rate for the disorder among monozygotic (MZ) twins than among DZ (dizygotic) twins.

Rapidly accumulating evidence from brain-imaging studies of children with ADHD shows dysfunctions in parts of the brain, especially the prefrontal cortex, that regulate attention and impulsive behavior.

### Treatment

It may seem odd that many of the drugs used to help ADHD children calm down and attend better in school are actually stimulants, such as the widely used drug Ritalin and longer-acting stimulants, including Concerta, a one-dose-a-day drug.

Concerta quickly became the most commonly prescribed drug for treating ADHD (Bauchner, 2003).

Perhaps it’s not so odd that these drugs are effective, especially when you consider that stimulant drugs activate the prefrontal cortex, the part of the brain that regulates attentional processes and control over impulsive, acting-out behavior.
**Conduct Disorder**

Conduct disorder - A psychological disorder in childhood and adolescence characterized by disruptive, antisocial behavior.

Whereas children with ADHD seem literally incapable of controlling their behavior, children with conduct disorder purposefully engage in patterns of antisocial behavior that violate social norms and the rights of others.

Whereas children with ADHD throw temper tantrums, children diagnosed as conduct disordered are intentionally aggressive and cruel.

**Oppositional Defiant Disorder**

Oppositional defiant disorder (ODD) - A psychological disorder in childhood and adolescence characterized by excessive oppositionality or tendencies to refuse requests from parents and others.

Children with ODD tend to be negativistic or oppositional.

They defy authority by arguing with parents and teachers and refusing to follow requests or directives.

**Theoretical Perspectives on ODD and CD**

Some theorists believe that oppositionality is an expression of an underlying temperament described as the “difficult-child” type (Rey, 1993).

Others believe that unresolved parent–child conflicts or overly strict parental control lie at the root of the disorder.

Psychodynamic theorists look at ODD as a sign of fixation at the anal stage of psychosexual development, when conflicts between the parent and child emerge over toilet training.

**Childhood Anxiety and Depression**

Anxiety is abnormal, however, when it is excessive and interferes with normal academic or social functioning or becomes troubling or persistent.

Children, like adults, may suffer from different types of diagnosable anxiety disorders, including specific phobias, social phobias, generalized anxiety disorder (GAD), obsessive–compulsive disorder (OCD), and posttraumatic stress disorder (PTSD).

Although these disorders may develop at any age, we consider further a type of disorder that typically develops during early childhood: separation anxiety disorder.

**Separation Anxiety Disorder**

Famed attachment researcher Mary Ainsworth (1989) chronicled the development of attachment behaviors and found that separation anxiety normally begins during the first year.

The sense of security normally provided by bonds of attachment apparently encourages children to explore their environments and become progressively independent of their caregivers.

Separation anxiety disorder - A childhood disorder characterized by extreme fear of separation from parents or other caretakers.

**Understanding and Treating Childhood Anxiety Disorders**


Psychoanalytic theorists argue that childhood anxieties and fears, like their adult counterparts, symbolize unconscious conflicts.

Cognitive theorists focus on the role of cognitive biases. Anxious children tend to show the types of cognitive distortions found in adults with anxiety disorders, including interpreting ambiguous situations as threatening and expecting bad things to happen.
Childhood Depression

Depressed children and adolescents typically have feelings of hopelessness; distorted thinking patterns and tendencies to blame themselves for negative events; and lower self-esteem, self-confidence, and perceptions of competence.

They report episodes of sadness and crying, feelings of apathy, as well as insomnia, fatigue, and poor appetite.

They may also experience suicidal thoughts or even attempt suicide.

Understanding and Treating Childhood Depression

All in all, the distorted cognitions of depressed children include the following:

1. Expecting the worst (pessimism)
2. Catastrophizing the consequences of negative events
3. Assuming personal responsibility for negative outcomes, even when this is unwarranted
4. Minimizing accomplishments and focusing only on negative aspects of events

Suicide in Children and Adolescents

In addition to increasing age, other factors associated with heightened risk of suicide in children and adolescents include the following:

- Gender.
- Geography.
- Ethnicity.
- Depression and hopelessness.
- Previous suicidal behavior
- Prior sexual abuse.
- Family problems.
- Stressful life events.
- Social contagion.

Elimination Disorders

Fetuses and newborn children eliminate waste products reflexively. As children develop and undergo toilet training, they develop the ability to inhibit the natural reflexes that govern urination and bowel movements.

For some children, however, problems with control persist in the form of enuresis and encopresis, disorders of elimination that are not due to organic causes.

Enuresis

The term enuresis derives from the Greek roots en-, meaning "in," and οὐρον, meaning "urine."

Enuresis - Failure to control urination after one has reached the expectable age for attaining such control.

Enuresis, like so many other developmental disorders, is more common among boys.

Enuresis is estimated to affect 7% of boys and 3% of girls by age 5.

Encopresis

Encopresis - Lack of control over bowel movements that is not caused by an organic problem in a child who is at least 4 years old.

Like enuresis, this condition is most common among boys.

Soiling may be voluntary or involuntary and is not caused by an organic problem, except in cases in which constipation is involved.

Among the possible predisposing factors are inconsistent or incomplete toilet training and psychosocial stressors, such as the birth of a sibling or beginning school.
QUESTIONS?