Third Edition

Disorders of Childhood

DEVELOPMENT AND PSYCHOPATHOLOGY

Robin Hornik Parritz ▪ Michael F. Troy

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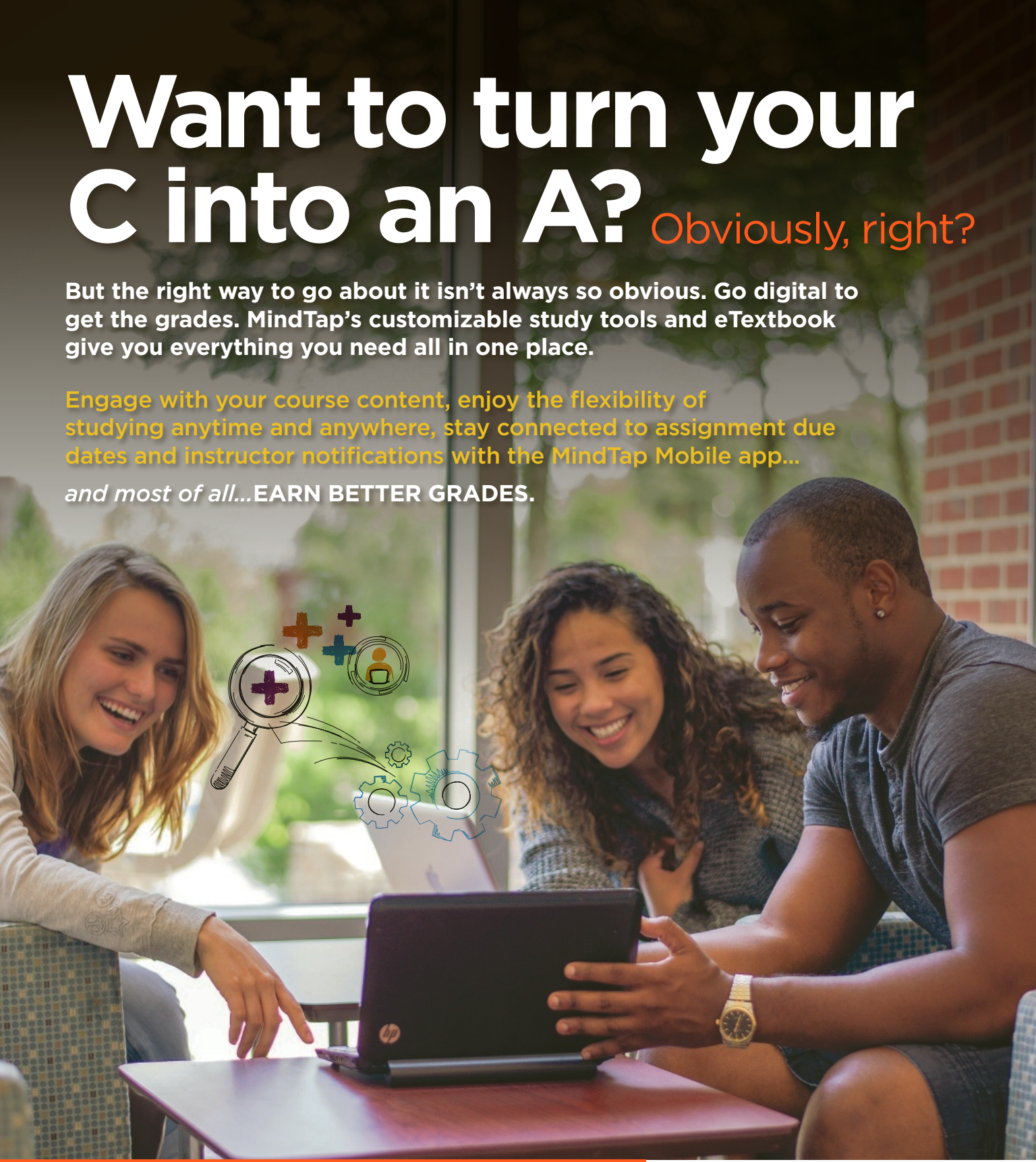

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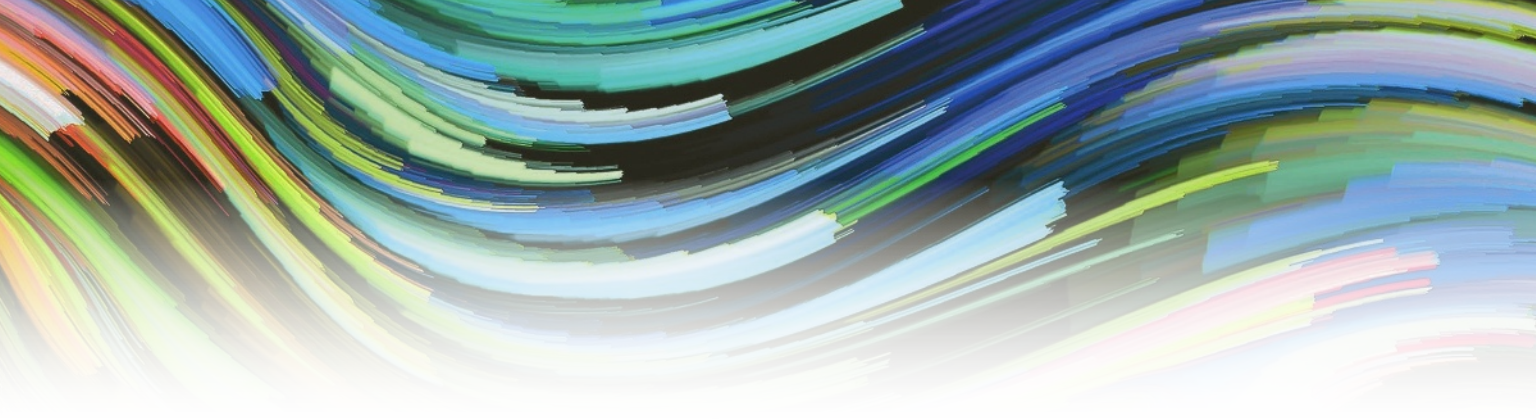

THIRD EDITION

DISORDERS OF CHILDHOOD

Development and Psychopathology

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Dedication

Robin dedicates this book to Ari, Adam, and Jesse, with love and gratitude for these sweet babies, exuberant children, and remarkable men.

Mike dedicates this book to Kevin and Brendan, whose lives are his treasured memories, and Mimi, who brings new blessings.

Brief Contents

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About the Authors

Robin Hornik Parritz, Ph.D., is a Professor of Psychology and Chair of the Department of Psychology at Hamline University in St. Paul, Minnesota. Robin received her undergraduate degree in psychology from Brandeis University in 1983, and her Ph.D. in Clinical Psychology from the University of Minnesota in 1989. Her research and clinical areas of interest include emotions and emotional development, developmental psychopathology, and programs designed to increase knowledge and decrease stigma related to mental illness. Robin teaches courses in Disorders of Childhood, Abnormal Psychology, Theories of Psychotherapy, Psychology of Emotion, and Clinical Psychology.

Michael Troy, Ph.D., is a clinical psychologist, Medical Director of Behavioral Health Services, and Associate Medical Director of the Neuroscience Institute at Children's Hospitals and Clinics of Minnesota. Michael received his undergraduate degree from Lawrence University in 1980 and his Ph.D. in Clinical Psychology from the University of Minnesota in 1988. He completed his internship and fellowship at Hennepin County Medical Center before joining the staff of Children's Hospital of Minnesota. His clinical and academic interests include developmental psychopathology, developmental neuroscience, therapeutic assessment, and teaching child clinical psychology as part of medical and community education programs.

Preface

Writing a textbook on the psychological disorders of infants, children, and adolescents involves multiple decisions about content, emphasis, and organization. These decisions reinforce and extend the knowledge base of the field and determine what is distinctive about the authors' approach. The decisions we made while writing this book were influenced by our academic and clinical experiences involving both typical and atypical development. When we made the decision to write this book, we were particularly interested in providing a text that was both relevant and compelling. Our hope was to provide students with the type of meaningful framework and conceptual integration that has come to characterize our field. We also wanted to offer teachers a more practical and more true-to-life approach to organizing their courses.

In this third edition, we reorganized several chapters to better reflect how disorders, combinations of disorders, and challenging diagnostic issues present in real-world clinical settings. For example, we moved the chapter on maltreatment and trauma- and stressor-related disorders to the set of chapters focused on early childhood. We also included new content on the transition to psychosis and personality disorders in a reorganized chapter on substance-related disorders and transition to adult disorders, in order to emphasize that the developmental psychopathology perspective does not end with adolescence, but rather continues to inform our understanding of individuals and disorders across the lifespan.

Multiple themes recur throughout the text; together, they distinguish our clinical and teaching emphases. Each of these themes is informed by the principles and practices of *developmental psychopathology*, an interdisciplinary approach that asserts that maladaptive patterns of emotion, cognition, and behavior occur in the context of typical development. The first theme emphasizes multifactor explanations. *Multifactor explanations* of disorders encompass biological, psychological, and sociocultural factors. These factors are examined in detailed analyses of etiologies, assessments, diagnoses, developmental pathways, and interventions. Especially distinctive is the way that we make sure to discuss the multiple ways that factors at every level of analysis need to be explored for both typically and atypically developing children. In this third edition, for example, we expanded the coverage of neuroscience research, including brain development and function (e.g., patterns of connectivity) and behavior genetics and epigenetics (e.g., gene-by-environment processes and interactions, differential sensitivity). We also expanded our emphasis on understanding the multiple environments in which children develop (e.g., relationships, families, peer groups, cultures).

The second theme focuses on *developmental frameworks* and *developmental pathways*, and this perspective is reflected in the sequencing of chapters, unique sections that open each chapter and summarize key developmental tasks and challenges, and our descriptions of disorders over time. Disorders that emerge or are diagnosed early in development are presented first, followed by disorders that emerge or are diagnosed in the elementary-school years, followed by those that emerge or are diagnosed in adolescence. This sequencing serves several purposes. First, it allows students to consider specific disorders and sets of disorders that occur in a particular developmental period in proximity and relation to one another. Second, this sequencing allows for an ongoing focus on the constructs of risk and resilience and provides a basis for coherent discussions of early-occurring disorders as risk factors for later-occurring disorders. For example, the chapter on disorders of early childhood focuses first on understanding the nature and course of these disorders in and of themselves; it also previews the multiple connections that will be made in subsequent chapters between temperament and attachment difficulties and later forms of psychopathology. Third, this sequencing emphasizes a more complex understanding of disorders: For example, we think differently about depression that is identified early and on its own than we do about depression that follows and may be related to an anxiety disorder or attention deficit/hyperactivity disorder.

The sections at the beginning of chapters that summarize the developmental tasks and challenges experienced by typically developing children are especially relevant, given the disorders discussed in the chapter. For instance, a detailed summary of the development of

self-regulation, effortful control, and executive function is presented before a clinical presentation of attention deficit/hyperactivity disorder. An overview of prosocial behavior is presented at the beginning of the chapter on oppositional defiant disorder and conduct disorder, and a review of stress and coping is provided in the chapter on maltreatment and trauma- and stressor-related disorders. These introductory sections help students appreciate the developmental contexts of disorders and their core symptoms; to make distinctions among the everyday issues that most children experience, more difficult types of problems, and clinically meaningful psychopathology; and to make comparisons between the factors that influence the multiple pathways of typical development and the multiple pathways of psychopathology.

Discussions of developmental pathways, or descriptions of disorders over time, accurately reflect how each child's psychopathology unfolds over time in real life. This pathway model also emphasizes opportunities for growth and change. For example, we describe age-related experiences, such as the transition to middle school, that are associated with some struggling children getting back on track and certain well-functioning children experiencing distress. In this third edition, we continue to provide up-to-date coverage of models describing developmental cascades, the accumulating consequences of multiple transactions across domains, levels, and systems. These new constructs emphasize the integrative and dynamic nature of development and psychopathology.

The third theme takes into account the *child in context* and calls attention to the multiple settings in which the child is embedded. Discussions throughout the text are intended to highlight the many ways in which children and their disorders are understood in larger social contexts (e.g., families, schools and communities, cultures, and historical eras). In the third edition, new summaries provide information on children's mental health in global context, as well as additional research findings comparing children's adjustment and maladjustment from diverse cultural backgrounds and in various countries.

The fourth theme involves a *broad focus on the whole child,* rather than a narrow focus on disorder, developmental delay, or impairment. This holistic appreciation of the child emphasizes patterns of interests, abilities, and strengths. We make sure that our case studies include this kind of information to remind students as often as possible that the diagnosis of a particular disorder does not provide all the important information about a child. We need to appreciate the everyday joys and special accomplishments that are part of all children's lives. In addition, we believe that this holistic focus provides a number of opportunities to talk about the stigma associated with mental illness and to encourage awareness, tolerance, respect, and compassion for children and adolescents who struggle with disorders.

Our hope is that this book will enable students to think about disorders in the same way that caring adults think about disorders they encounter every day—in terms of an individual child who is coping with distress and dysfunction: a boy or girl of a certain age, with a specific temperament, characteristic strengths, and personal history and a family and a network of friends embedded in a community and culture. We believe that we have written a textbook that places the child at the center of comprehensive and meaningful information, reflecting the most up-to-date understandings of child and adolescent psychopathology, in a format designed to support learning and understanding.

Key Features

In addition to the previously discussed case studies woven throughout, our textbook offers a variety of feature boxes that highlight important topics of interest for students. The themes covered in these boxes are (1) The Child in Context, (2) Clinical Perspectives, (3) Risk and Resilience, and (4) Emerging Science. For study and review, each chapter includes a chapter summary and list of key terms that appear in boldface in the text.

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- **Online Instructor's Manual.** This supplement, prepared by Rebecca Fraser-Thill, contains valuable resources for preparing for class, including chapter outlines, lecture topics, YouTube video suggestions, and class activities.
- **Online Microsoft PowerPoint Lecture Outlines.** Prepared by Rebecca Fraser-Thill, these handy and accessible lecture outlines are a great starting point for helping instructors prepare for class.

Acknowledgments

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1 Introduction

CHAPTER OUTLINE

WHEN WE THINK ABOUT childhood and growing up, images of wonder, energy, excitement, and joy are common. Babies sharing first smiles and taking first steps; kindergarteners singing loud songs and looking forward to family vacations; children reading books, riding bikes, and sleeping over with friends; teens studying for exams, learning to drive, and falling in love. In the midst of all this growth and change, however, we notice children who are almost always sad, worried, afraid, or angry. We meet children who believe that they are bad, that they have no control over their lives, that the world is an awful place. There are children who lash out at others, and some who withdraw from relationships. Some of these children exhibit patterns of feelings, thoughts, and behaviors that are best understood as psychological disorders.

The goal of this textbook is to provide a basic understanding of these children and their disorders, and of the theories, methodologies, and findings of developmental psychopathology. We need to understand so that we may meaningfully describe the psychological disorders of infancy, childhood, and adolescence. We need to understand so that we can identify the numerous factors that increase vulnerability to psychopathology. We need to understand so that we can design appropriate interventions for struggling children. We need to understand so that we can increase awareness and empathy for children who deserve to be treated with dignity and respect. And we need

to understand so that we can provide the necessary support and resources to families, schools, and communities.

Our approach in writing and organizing this textbook is based on the central premise of **developmental psychopathology**, which suggests that we gain a better understanding of children's disorders when we think about those disorders *within the context of typical development*. We believe that infant, child, and adolescent psychopathology can be understood only by placing descriptions of disorders against the background of usual emotional, cognitive, and behavioral development. We also believe that it is necessary to acknowledge the everyday problems and difficult phases that characterize typical child development, and to make clear both the connections and the distinctions between adaptation and maladaptation. We present discussions of children's disorders in a sequence that follows the child's own growth from birth through early adulthood and emphasizes that both children and their disorders develop and change over time.

Defining Disorders of Infancy, Childhood, and Adolescence

Emma is a five-and-a-half-year-old girl whose parents are becoming increasingly concerned about her. She has always been somewhat quiet and reserved, taking her time to check out unknown situations and new children, but usually warming up to join activities and play time. As kindergarten approaches, Emma is exhibiting more anxiety around others, preferring to stay home, close by her mother. She is displaying new fears about the dark, about strangers, and about getting lost in the new school building. Emma is also crying more frequently and seems almost constantly on edge.

Should Emma's parents call the pediatrician? The kindergarten teacher? A child psychologist? Should they wait a few months to see if Emma grows out of this phase and hope that waiting doesn't make things worse?

Understanding psychopathology is complicated. Parents, teachers, and children themselves are often confused about whether a particular pattern of feelings, thoughts, and behaviors reflects an actual disorder, and if so, whether that disorder involves minor, moderate, or major maladjustment. One of the first steps leading to accurate and useful conceptualizations of psychopathology is to recognize the many connections between typical and atypical development. In Emma's case, it is important to consider other children's experiences of wariness and fear, differences among children's temperaments, and how much her distress interferes with daily life.

To provide some context for decision making about Emma, it may be helpful to review some of the many approaches to the field of child development itself. Models of childhood and child development have been influenced by historical notions of children as miniature adults, blank slates, savages, and innocent beings, as well as more recent images of "children" as innately and surprisingly competent individuals (Hwang, Lamb, & Sigel, 1996; Mintz, 2006). Depending on the model, our understanding of childhood may lead us to expect that almost all typically developing children will engage in idyllic play, or skill learning, or avoidance of danger. However, we need to think realistically about whether most children amuse themselves for hours on end, or practice the piano or take swimming lessons without complaint, or never run into the street without looking for cars.

Most contemporary theorists, researchers, and clinicians emphasize that a useful model of typical development requires a dynamic appreciation of children's strengths and weaknesses as they experience salient, age-related challenges (see Table 1:1). A model like this takes into account the complexities of individual, familial, ethnic, cultural, and societal beliefs about desirable and undesirable outcomes for children and adolescents. Against this multilayered background of typical child development, we are then able to identify children whose distress and dysfunction are exceptional.

TABLE 1:1 Salient, Age-Related Issues of Development

Infancy
Major issue: Formation of an effective attachment
Additional issues:
- Basic state and arousal regulation
- Development of reciprocity
- Dyadic regulation of emotion

Toddler Period
Major issue: Guided self-regulation
Additional issues:
- Increased autonomy
- Increased awareness of self and others
- Awareness of standards for behavior
- Self-conscious emotions

Preschool Period
Major issue: Self-regulation
Additional issues:
- Self-reliance with support (agency)
- Self-management
- Expanding social world
- Internalization of rules and values

School Years
Major issue: Competence
Additional issues:
- Personal efficacy
- Self-integration
- Competence with peers
- Competence in school

Adolescence
Major issue: Individuation
Additional issues:
- Autonomy with connectedness
- Identity
- Peer network competence
- Coordinating school, work, and social life

Transition to Adulthood
Major issue: Emancipation
Additional issues:
- Launching a life course
- Financial responsibility
- Adult social competence
- Coordinating work, training, career, and life

From: Sroufe (2013). The promise of developmental psychopathology: Past and present. *Development and Psychopathology,* 25, 1222.

What Is Normal?

Note that we primarily use the terms typical *and* atypical *when referring to development and patterns of adaptation and maladaptation. Sometimes, however, we use the terms* normal *and* abnormal. *Although we understand that there may be some negative connotations to these terms, our intent is to use them as objectively as possible and to make connections with long-standing and current descriptions of abnormal psychology.*

Common descriptions of normality and psychopathology often focus on (1) **statistical deviance**, the infrequency of certain emotions, cognitions, and/or behaviors; (2) **sociocultural norms**, the beliefs and expectations of certain groups about what kinds of emotions, cognitions, and/or behaviors are undesirable or unacceptable; and (3) mental health perspectives, theoretical or clinically based notions of distress and dysfunction.

Statistical Deviance

From a statistical deviance perspective, a child who displays too much or too little of any age-expected behavior (such as dependency or assertiveness) might have a disorder. Children of a certain age above the "high number" cutoff, or below the "low number" cutoff, would meet the criterion for disorder (see Fig. 1:1). Thinking again about Emma, we would be more concerned about a possible disorder if she is much more anxious and fearful than her peers, and less concerned if many of her peers are also experiencing these difficulties.

Sociocultural Norms

From a sociocultural norm perspective, children who fail to conform to age-related, gender-specific, or culture-relevant expectations might be viewed as challenging, struggling, or disordered. Keep in mind, however, that there is significant potential for

FIGURE 1:1 Statistical deviance model of disorder.

disparity among various sociocultural groups and norms. For instance, pressure in a particular neighborhood or peer group to prove oneself with belligerent or aggressive behavior may contribute to the diagnosis of psychopathology by others outside that neighborhood or peer group. When we consider Emma's fears and anxieties this time, we would be focused on specific social and cultural expectations for a young girl's independence. Do her feelings and behaviors fall within a generally acceptable range? Depending on the particular social and cultural settings, norms will vary, but there will always be certain patterns of emotion, cognition, and behavior that are considered evidence of psychopathology.

Mental Health Perspectives

From a mental health perspective, a child's psychological well-being is the key consideration. The landmark report of the U.S. Surgeon General (U.S. Department of Health and Human Services, 2000, p. 123) states that "mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology." Using this criterion, children who have a negative quality of life, who function poorly, or who exhibit certain kinds of symptoms might have a disorder. Again, we think of Emma. From this perspective, what matters most is how Emma's fears and anxieties make the transition to kindergarten distressing, and whether she is able to participate comfortably in various academic and social tasks.

The Role of Values

Closer examination of these definitions reveals that each one raises questions about the role of values in conceptualizations of mental health and psychopathology (Sonuga-Barke, 1998; Wakefield, 2002). Box 1:1 provides an example of a value-informed set of children's needs for psychological well-being. A key value judgment involves distinctions between adaptation and maladaptation and personal or group standards of *adequate or average* adaptation, or *optimal* adaptation (Offer, 1999). *Adequate adaptation* has to do with what is considered okay, acceptable, or good enough. *Optimal adaptation* has to do with what is excellent, superior, or "the best of what is possible." The following cases illustrate poor adaptation, adequate adaptation, and optimal adaptation.

BOX 1:1

The Child in Context

The Irreducible Needs of Children

Our understanding of children's psychological disorders is informed continuously by our understanding of children's usual development. When we think about what happens in children's lives, we need to remember not only the range and variety of hoped-for outcomes, but also the basic, bottom-line components of "what every child must have to grow, learn, and flourish." Two prominent children's advocates, T. Berry Brazelton and Stanley Greenspan, have described these essential needs (Brazelton & Greenspan, 2000). They include

- The need for ongoing nurturing relationships
- The need for physical protection, safety, and regulation
- The need for experiences tailored to individual differences
- The need for developmentally appropriate experiences
- The need for limit setting, structure, and expectations
- The need for stable, supportive communities and cultural continuity

In our descriptions and discussions of children's disorders, we will refer repeatedly to prevention and intervention strategies that are based on these needs. Satisfaction of these needs—from birth through adulthood—is an index of our concern, compassion, and commitment to children's well-being.

Poor Adaptation

The Case of Dylan

Dylan is an eight-year-old boy who lives with his mother and two older siblings in an affluent suburb. He is currently struggling in a variety of ways and in multiple contexts. He is having trouble with the increasingly demanding academics in his private school and is usually ignored by his classmates. At home, Dylan is angry and withdrawn.

Dylan's mother had a history of depression before having children. After years of healthy functioning, she became depressed following Dylan's birth, a problem that she has struggled with throughout his early childhood. Dylan was described as a "difficult" baby, who cried frequently and slept poorly. As a toddler, he had

frequent temper tantrums that often involved biting and scratching. In fact, Dylan's parents were asked to withdraw him from his preschool because of his poor emotional and behavioral regulation. When these issues with Dylan escalated, so did his mother's depression, as well as conflict between his parents, who disagreed on what should be done to manage Dylan's behavior.

Dylan's father died just before the start of kindergarten. Following the unexpected loss, Dylan's anxiety, always present but overshadowed by his behavior problems, became increasingly evident. Over the next two years, both his first- and second-grade teachers provided Dylan with extra support and encouragement, but with little positive effect. At the beginning of third grade, the school counselor suggested to Dylan's mother that they see a child psychologist. Although Dylan's mother wanted to comply with the referral, she felt overwhelmed by the challenges of single parenting and her depression and never arranged for Dylan to see a therapist. As his classmates became more focused on developing friendships and enjoying academic experiences, Dylan felt increasingly isolated, lonely, and unhappy. ■

Adequate Adaptation

The Case of Antoine

Antoine is a six-year-old boy who is currently in his third foster home. Antoine was severely neglected early in his life and was removed from his biological mother's home when he was nine months old by the county's child protection services. After two brief foster placements, Antoine has been in a stable and nurturing foster home for two years.

Although his teachers have no concerns about his basic academic skills, they note that Antoine does have difficulty paying attention and that he is frequently impulsive. Antoine has several friends that he likes to play with, but he is seldom sought out as a playmate by other children. His feelings are hurt easily, and he sometimes misinterprets the intentions of others, feeling that they are out to get him. Consequently, he is quicker than other children to resort to name-calling or shoving when he is upset.

Antoine is more comfortable and relaxed at home with his foster parents, but he asks often if he will have to move away from them. While being as reassuring as possible, his foster parents have acknowledged that they do not know how long Antoine will be with them. He clearly worries about leaving his current home, and although his psychotherapist attempts to provide support for his concerns, Antoine is adamant that he does not want to talk about any possible relocation. ■

Optimal Adaptation

The Case of Jenna

Jenna is a six-year-old girl who, like Dylan and Antoine, suffered an early loss. Jenna's mother was a single parent who died in an automobile accident when Jenna was two. Following her mother's death, Jenna went to live with her maternal grandparents. Although distraught at the loss of their daughter, they dedicated themselves to caring for Jenna to the best of their ability.

In addition to her grandparents, Jenna is involved with and supported by her many relatives who live nearby and include her in their lives. Jenna's teachers describe her as bright and enthusiastic in the classroom. She is excited about learning to read and seems to have a special aptitude for math. Jenna is well liked by both the girls and the boys in her class, and she is often invited to play dates and birthday parties.

At home, Jenna enjoys hearing stories about her mother and thinking of how loving and proud her mother would be. There are times, of course, when Jenna and her grandparents cry together about Jenna's mother. And as Jenna gets older, she may become more aware of her absent biological father and seek to learn more about him. But Jenna and her grandparents are able to take comfort in each other and in the warm and secure home that they have created together. ■

Even with the traumatic beginnings of their childhoods, both Antoine and Jenna are moving in a positive developmental direction, in contrast with Dylan. Still, Antoine's adequate adaptation is different from Jenna's optimal adaptation in the degree to which each successfully manages past traumas and current challenges, the quality of caregiving and friendship, and the potential for growth in coming years. Neither adequate nor optimal adaptation guarantees smooth sailing throughout development. Challenges are inevitable, and struggles themselves are not evidence of disorder. Indeed, challenges and struggles are viewed by most developmental psychologists as forces of growth. Sameroff (1993, p. 3), in fact, suggests that "all life is characterized by disturbance that is overcome, and that only through disturbance can we advance and grow. . . . In this view, it is the overcoming of challenge that furnishes the social,

emotional, and intellectual skills that produce all forms of growth, both healthy and unhealthy."

The Impact of Values on Definitions of Disorder

Other important judgments involving values are tied to specific definitions of disorder. With statistical deviance definitions, it sometimes makes sense to examine *both* extremes of the continuum (e.g., too much intense emotion as well as too little) because we have made a judgment that there is a desirable middle course related to the characteristic in question (again, see Fig. 1:1). At other times, it makes sense to focus only on the "bad" end of the continuum and ignore the "good" end (e.g., too little empathy, but not too much empathy; too little intelligence, but not too much intelligence). In these specific cases, judgments are made that some types of extreme characteristics are to be accepted or even prized.

With sociocultural definitions, value judgments are the very basis of definitions of disorder. Whether casual use of mind-altering substances is tolerated or condemned by a particular sociocultural group influences conceptualizations of pathological addiction. Whether independence or connectedness is more valued influences conceptualizations of pathological dependency.

With mental health definitions, the values of psychologists, psychiatrists, and clinical social workers are embedded in both scientific and lay community decision making. Returning to the Surgeon General's description of psychological well-being, clinicians must evaluate whether a young person's life is characterized by a positive quality, adequate functioning, and few symptoms. Whether these particular benchmarks represent the least we can do for children and adolescents, or the best we can hope for, is yet another value judgment. Indeed, recent discussions of models of mental health have emphasized the difference between the absence of mental illness and the presence of flourishing. For example, to enhance individuals' opportunities for flourishing, Keyes (2007) argues for increased resources for programs that focus on the promotion of mental health across the lifespan, as well as for programs that focus on the prevention and treatment of mental illness.

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Cultural norms influence developmental expectations.

Definitions of Psychopathology and Developmental Psychopathology

In this textbook, we will work within the framework provided by the following definitions of disorder. The term ***psychopathology*** *refers to intense, frequent, and/or persistent maladaptive patterns of emotion, cognition, and behavior.* ***Developmental psychopathology*** *extends this description to emphasize that these maladaptive patterns occur in the context of typical development and result in the current and potential impairment of infants, children, and adolescents.*

Rates of Disorders in Infancy, Childhood, and Adolescence

If definitions of disorder are problematic, estimates of rates of disorder are even more so. The multipart task of estimating rates of disorder includes (1) identifying children with clinically significant distress and dysfunction, whether or not they are in treatment (and most of them are not); (2) calculating levels of general (e.g., anxiety disorders) and specific (e.g., generalized anxiety, separation anxiety disorder, phobia) psychopathologies and the impairments associated with various disorders; and (3) tracking changing trends in the identification and diagnosis of specific categories of disorder, such as autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), and depression (Costello, Erkanli, & Angold, 2006; Maughan, Iervolino, & Collishaw, 2005). Personal, clinical, and public policy implications must be considered when collecting these data. For instance, specific diagnoses may or may not qualify for insurance coverage; or increases or decreases in the diagnosis of certain disorders may have an impact on the staffing of special education programs in schools.

Frequencies and patterns of distributions of disorders in infants, children, and adolescents can be estimated with varied methodologies and within varied groups. These frequencies and patterns are the focus of the field of **developmental epidemiology** (McLaughlin, 2014). Prevalence and incidence rates are both measures of the frequency of psychopathology. **Prevalence** refers to the proportion of a population with a disorder (i.e., all current cases of the disorder); **incidence** refers to the rate at which new cases arise (i.e., all new cases in a given time period). Random sampling of a general population is one option for estimating prevalence (e.g., using surveys, phone questionnaires, and/or detailed psychopathology screening instruments). For example, the investigators in the Great Smoky Mountains Study interviewed over 1,400 participants up to nine times between 9 and 21 years of age (Copeland, Shanahan, Costello, & Angold, 2011). Sampling in schools, using teachers' assessments, is another option. Alternatively, samples can focus on disorders that are seen in children's primary care and mental health clinics.

Whatever method is selected, there can be no doubt that many children struggle with clinically significant disorders. Recent data from the National Health and Nutrition Examination Study, sponsored by the Centers for Disease Control and Prevention (CDC), estimate that 13% of children between 8 and 15 years of age in the United States met the criteria for any disorder (Merikangas et al., 2009). These rates are comparable to those reported in a large-scale, meta-analytic review of the prevalence of disorders in children and adolescents from 27 countries and every world region (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015; see Fig. 1:2).

Allocation of Resources, Availability, and Accessibility of Care

Although it is always the case that children's psychopathology deserves our attention, our compassion, and our best clinical responses, a number of critical issues demand renewed and innovative efforts. Even with research-based knowledge about ways to promote children's physical and mental well-being that has been available for years (e.g., Weisz, Sandler, Durlak, & Anton, 2005), parents, schools, communities, and policy makers have struggled to allocate often-scarce emotional, social, and financial resources. One continuing difficulty involves access to care. Recent investigations suggest that fewer than half of children and adolescents who need mental health interventions receive them (Costello, He, Sampson, Kessler, & Merikangas, 2014; Merikangas et al., 2011; also see Fig. 1:3). Indeed, "the current state of affairs not only fails to take responsibility for the health and welfare of children, it also fails to recognize the costs and waste in economic and human potential" (Tolan & Dodge, 2005, p. 602).

Barriers to care are widespread and have been extensively summarized (Owens et al., 2002; Stiffman et al., 2010). Structural barriers include limited policy perspectives, disjointed systems, lack of provider availability, long waiting lists, inconveniently located services, transportation difficulties, and inability to pay

Outcome	N studies	Sample size
Any anxiety disorder	41	63130
Any depressive disorder	23	59492
MDD	22	68382
ADHD	33	77297
Any disruptive behavior disorder	19	38324
ODD	28	69799
CD	28	73679
Any mental disorder	41	87742

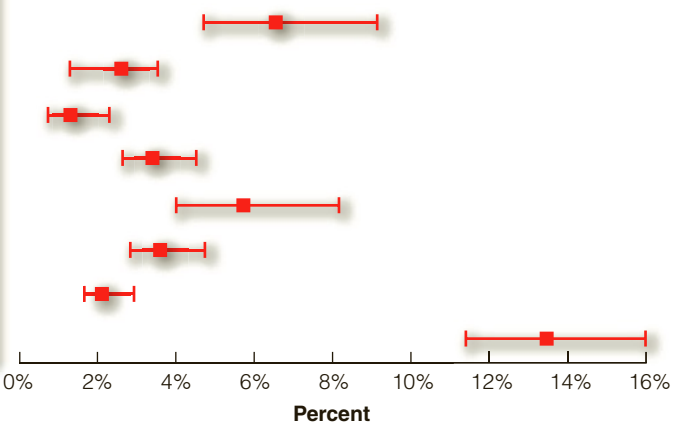
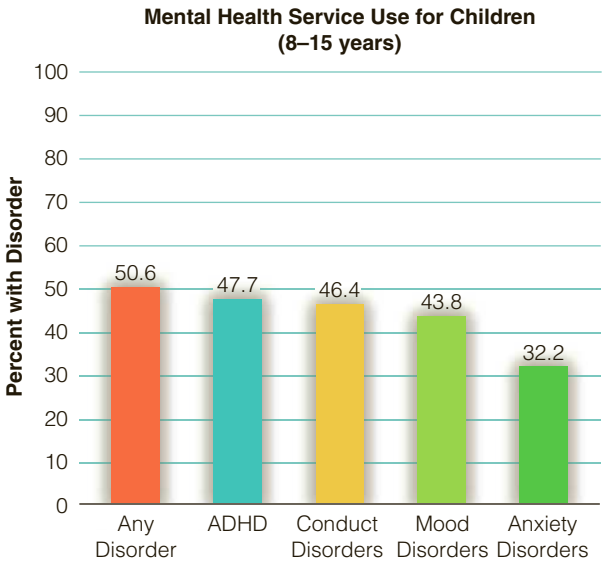


FIGURE 1:2 Worldwide prevalence estimates of specific disorders in children and adolescents.

Source: From Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015, p. 356 , http://web.a.ebscohost.com/ehost/detail/imageQuickView?sid=1cbf8d11-c8fd-4251-812b-d4c8ce4be24a@sessionmgr4005&vid=0&ui=30637764&id=101158041&code=101158041&parentui=101158041&db=iqv&tag=AN



Demographics Associated with Mental Health (MH) Service Use:

- Females are 50% less likely than males to use MH services.
- 12–15-year-olds are 90% more likely than 8–11-year-olds to use MH services.
- No differences were found between races for mood, anxiety, or conduct disorders. Mexican Americans and other Hispanic youth had significantly lower 12-month rates of ADHD compared to non-Hispanic white youth.

Data courtesy of CDC

FIGURE 1:3 Percentage of children and adolescents with various disorders who receive mental health services.

and/or inadequate insurance coverage. Barriers related to perceptions about mental health difficulties include the inability to acknowledge a disorder, denial of problem severity, and beliefs that difficulties will resolve over time or will improve without formal treatment. Barriers related to perceptions about mental health services involve a lack of trust in the system, previous negative experiences, and the stigma related to seeking help.

When children do receive psychological care, the cost of appropriate intervention, whether oriented to the individual, the family, or the school, is often prohibitive, and insurance coverage varies widely. Until recently, most health insurance policies placed restrictive limits on reimbursement of mental health coverage. State and federal legislation to eliminate these kinds of restrictions has made progress of late, but many families still face such coverage limits. The availability of effective therapies and treatments for a variety of psychological disorders is significant only if infants, children, and adolescents are able to take advantage of them.

Inadequate money for prevention efforts is also a public policy dilemma, especially given recent estimates that the economic burden of treatment of child and adolescent mental illness surpasses $10 billion (Hsia & Belfer, 2008; National Institute of Mental Health, 2004). There is abundant research, for example, documenting the positive psychosocial impact of early educational programs, but full funding and increased access remain difficult. And for children from minority and disadvantaged backgrounds, access to treatment and prevention programs is even more problematic

(Bringewatt & Gershoff, 2010; Murry, Heflinger, Suiter, & Brody, 2011).

Tolan and Dodge (2005, pp. 607–608) propose a four-part model for a comprehensive system that "simultaneously promotes mental health within normal developmental settings, provides aid for emerging mental health issues for children, targets high-risk youth with prevention, and provides effective treatment for disorders: (1) Children and their families should be able to access appropriate and effective mental health services directly; (2) Child mental health should be a major component of healthy development promotion and attention in primary care settings such as schools, pediatric care, community programs, and other systems central to child development; (3) Efforts should emphasize preventive care for high-risk children and families; (4) More attention must be paid to cultural context and cultural competence." These kinds of proposals lay the groundwork for resource allocation and policy implementation that will have long-standing consequences for the well-being of countless children.

The Globalization of Children's Mental Health

Discussions of mental health and mental illness involving resource allocation and public policy increasingly emphasize global perspectives that require careful thinking about Western models of development, disorder and intervention, as well as the vastly different experiences of children who live in resource-rich versus resource-poor countries. Patel, Flisher, Nikapota, and Malhotra (2007) and Omigbodun (2008) identify rapid social change, urbanization and urban poverty, and inadequate health and educational services as key factors that increase children's vulnerability to psychopathology in resource-poor countries in Eastern and Central Europe, Africa, Asia, Latin America, and the Pacific region. In these countries, awareness of mental illness issues and promotion of mental health are limited by allocation of scarce resources to urgent medical needs, a lack of formal mental health policies and programs, and too few mental health professionals. The costs of impairment and lost potential are enormous (Belfer, 2008).

We must also emphasize that, across the globe, millions of children are struggling in the face of unimaginable trauma, including exposure to disease and death, armed conflict, abandonment and homelessness, and dislocation (Omigbodun, 2008; Vostanis, 2012). These terrible situations require increased awareness, advocacy, and a responsibility to provide interventions to ensure children's safety and well-being. Interventions include both prevention efforts and treatment for those with various disorders. To facilitate the success of interventions, mental health professionals must consider how to implement treatments in countries where the health and welfare systems work differently (or are nonexistent), as well as how to provide treatment to children who are difficult to reach (Atilola, 2015; Patel, 2012). Treatments must take into account local and culture-based approaches and community caretaking and service models (Atilola, 2015). Holistic approaches with achievable goals, embedded in health, social, and educational networks, have been proposed. These multicomponent treatments focus on children and adolescents, on families, and on communities and systems (Patel, 2012; Wuermli, Tubbs, Petersen, & Aber, 2015). Finally, the development and implementation of globally useful interventions require recognition of the current disconnect between where research takes place and where the need is greatest, as well as a commitment to do better on behalf of the world's children (Atilola, 2015; Patel, 2012; Wuermli et al., 2015).

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Far too many children experience displacement, hardship and loss; the negative impact on physical and psychological well-being is enormous.

The Stigma of Mental Illness

A final issue concerns the continued and painfully unnecessary **stigmatization** of individuals with psychopathology (Corrigan, 2005; Hinshaw, 2005; Pescosolido, 2007). For parents concerned about their children's distress or dysfunction, there is almost always shame, fear, and/or blame (dos Reis, Barksdale, Sherman, Maloney, & Charach, 2010; Heflinger, Wallston, Mukolo, & Brannan, 2014). For children,