CHAPTER 15: Disorders of Childhood and Adolescence
(Neurodevelopmental Disorders)

Chapter Overview/Summary

Children used to be viewed as “miniature adults.” It was not until the second half of the twentieth century that a diagnostic classification system focused solely on the special problems of children. In this chapter, the DSM-5 classification system is followed in order to provide clinical descriptions of a wide range of childhood behavior problems.

Attention-deficit/hyperactivity disorder is one of the more frequent behavior problems of childhood. In this disorder, the child shows impulsive, overactive behavior that interferes with his or her ability to accomplish tasks. The major approaches to treating hyperactive children have been medication and behavior therapy. Using medications such as amphetamines with children is somewhat controversial. Behavior therapy, particularly cognitive-behavioral methods, has been shown to be effective in modifying the behavior of hyperactive children.

In oppositional defiant disorder, children repeatedly engage in negativistic, defiant, disobedient, and hostile behavior toward authority figures. Many children will progress to conduct disorder. In conduct disorder, a child engages in persistent aggressive or antisocial acts. A number of potential causes of conduct disorder or delinquent behavior have been determined, ranging from biological factors to personal pathology to social conditions.

Children who suffer from anxiety disorders typically do not cause difficulty for others through their conduct. Rather, they are fearful, shy, withdrawn, insecure, and have difficulty adapting to outside demands. The anxiety disorders may be characterized by extreme anxiety, withdrawal, or avoidance behavior. A likely cause for these disorders is early family relationships that generate anxiety and prevent the child from developing more adaptive coping skills.

Childhood depression shares many of the same characteristics as adult depression although children may exhibit more irritability. Multiple factors may cause depression in children and adolescents. Treatment may include antidepressants or cognitive-behavioral therapy. Antidepressant use with children and adolescents remains controversial due to the reported side effects, only moderate efficacy, and the potential for increasing suicide.

Several other disorders of childhood involve behavior problems centering on a single outstanding symptom rather than pervasive maladaptive patterns. The symptoms may involve enuresis, encopresis, sleepwalking, or tics.

In autistic children, extreme maladaptive behavior occurs during the early years and prevents affected children from developing psychologically. Treatment with medications has not been able to normalize the behavior of autistic children. Newer instructional and behavior-modification techniques such as those documented by Lovaas have been found helpful in autism.

Intellectual disability (formerly referred to as mental retardation) is diagnosed when significant subaverage cognitive functioning is accompanied by deficits in adaptive functioning before the age of 18. Relatively common forms of such intellectual disability, which in these cases is normally at least moderate in severity, include Down syndrome, phenylketonuria (PKU), and certain cranial anomalies. This organic type of mental deficit accounts for only some 25% of all cases of intellectual disability. Specific learning disabilities are those in which failure of mastery is limited to circumscribed areas, chiefly involving academic skills such as reading; general cognitive ability may be normal or superior. Affected children are commonly described as learning disabled (LD). Some localized defect in brain development is often considered the primary cause of the disorder. Learning disorders create great turmoil and frustration in victims, their families, schools, and professional helpers.

A number of potential causal factors were considered for the disorders of childhood and adolescence. Although genetic predisposition appears to be important in several disorders, parental psychopathology, family disruption, and stressful circumstances, such as parental death or desertion and child abuse, can have an important causal influence. Recent research has underscored the importance of multiple risk factors in the development of psychopathology.

There are special problems, and special opportunities, involved in treating childhood disorders. The need for preventive and treatment programs for children is always growing, and in recent years, the concept of child advocacy has become a reality in some states. Unfortunately, the financing and resources necessary for such services are not always readily available, and the future of programs for improving psychological environments for children
remains uncertain. **Juvenile delinquency** is a growing problem that impacts millions of children and their families each year.

**Detailed Outline**

I. **Maladaptive Behavior in Different Life Periods**
   A. **Varying Clinical Pictures**
      1. Childhood disorders differ from those in other life periods.
      2. Some emotional disturbances in childhood are short-lived.
      3. Results of one study found that those children who had been psychiatrically hospitalized (between ages 5–17) showed twice the mortality due to unnatural causes (suicide common) at follow-up 4–15 years later.
      4. **Developmental psychopathology.**
   B. **Special Psychological Vulnerabilities of Younger Children**
      1. Children have a limited capacity to understand problems.
      2. More difficulty coping as cannot put problems into perspective of a past and future.
      3. Use unrealistic concepts to explain things.
      4. Children have a limited perspective.
      5. Children are dependent on others for help.
      6. Lack of experience may make problems seem unmanageable.
   C. **The Classification of Childhood and Adolescent Disorders**
      1. No formal classification system for children until the 1950s.
         a. Childhood schizophrenia.
         b. Adjustment reaction of childhood.
         c. Kraepelin’s 1883 classic textbook.
      2. DSM-II (1968) added additional disorders but problems remained.
         a. Inadequacies stemmed from using adult models of pathology.
         b. Developmental level of a child was ignored.
         c. Environmental influences were not discussed.

II. **Common Disorders of Childhood**
   A. **Attention-Deficit/Hyperactivity Disorder (ADHD)**
      1. Clinical picture in attention-deficit hyperactivity disorder
         a. Difficulties that interfere with effective task-oriented behavior—impulsivity, excessive or exaggerated motor activity, sustaining attention.
         b. Talk incessantly, socially intrusive, and immature.
         c. Usually 7–15 points lower in IQ.
         d. Social problems.
         e. Prevalence is thought to be 3%–7% of school-aged children in the U.S. and 8% in the U.K.
         f. 6–9 times more prevalent among preadolescent boys than girls.
         g. Comorbid with oppositional defiant disorder (ODD).
      2. Causal factors in attention-deficit/hyperactivity disorder
         a. Considered to have multiple biological and psychological causes.
         b. General agreement that there are processes operating in the brain that disinhibit the child’s behavior.
         c. Environmental factors.
         d. Family pathology.
         e. Parental personality.
      3. Treatments and outcomes
         a. Cerebral stimulants are widely used in treatment; **Ritalin** quite common, effective in the short term.
         b. Newer medications such as **Pemoline** (enhances cognitive processing) and **Strattera** (atomoxetine), a non-stimulant medication, have been introduced.
         c. Long-term effects of these drugs are less well known; some concern has been raised about the development of psychotic symptoms and abuse potential.
         d. **Adderall**—reduces symptoms of impulsivity and hyperactivity.
Behavior techniques using selective reinforcement, family therapy, positive reinforcement, and structuring of learning materials have been successful.

4. ADHD beyond adolescence
   a. In DSM-5 some adjustments made to the age level of the appearance of symptoms to allow diagnosis in adult years.
   b. Development of aggressive behavior and substance abuse in some cases.
   c. 34.6% of cocaine abusers met criteria for ADHD.
   d. 4.4% of adults have ADHD.
   e. Boys at risk for adult criminality.
   f. Girls at risk for antisocial, addictive, mood, anxiety, and eating disorders.
   g. Need for more longitudinal research.

B. Disruptive, Impulse-control, and Conduct Disorder
1. Clinical picture of oppositional defiant disorder:
   a. Precursor of antisocial behavior.
   b. Juvenile delinquency.
   c. DSM-5 subtypes: angry/irritable mood, argumentative/defiant behavior and vindictiveness.
   d. Severity rating added.
   e. Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures.
   f. Usually begins by age 8 for ODD, and age 9 for conduct disorder.
   g. Developmental sequence from oppositional to conduct.
   h. Risk factors of family discord, socioeconomic disadvantage, and antisocial behavior in the parents.
   i. 11.2% for boys and 9.2% for girls.
2. Clinical picture in conduct disorder
   a. Persistent repetitive violation of rules and a disregard for the rights of others; also show a deficit in social behavior.
   b. Frequently comorbid for substance abuse.
3. Causal factors in oppositional disorder and conduct disorder
   a. A self-perpetuating cycle
      (1) Genetic predisposition leading to low verbal intelligence, mild neuropsychological problems, and difficult temperament set the stage.
      (2) Difficult temperament leads to poor attachment; cognitive problems lead to school failure and social rejection.
      (3) Because placed with other delinquent children, childhood typically adopts additional delinquent behaviors in order to be accepted by peers.
   b. Age of onset and links to antisocial personality disorder
      (1) Early onset associated with later psychopathy (25%–40%).
      (2) Link between conduct disorder and antisocial personality is stronger among lower socioeconomic class children.
      (3) More than 80% of boys with early onset conduct disorder continue to have multiple problems of social dysfunction.
      (4) Adolescent—onset cases do not share same risk factors or same long-term consequences.
   c. Psychosocial factors
      (1) Family and social context factors.
      (2) Socially rejected children.
      (3) Reaction to the child with strong negative affect.
      (4) Family setting characterized by ineffective parenting, rejection, harsh and inconsistent discipline, parental neglect.
      (5) Low SES, poor neighborhoods, parental stress, and depression all increase risk.
4. Treatments and outcomes
   a. Society tends to take a punitive, “teach a child a lesson,” rather than a treatment-based, approach.
b. Focus of treatment is on dysfunctional family patterns, altering child’s aggressive or maladaptive behaviors.

c. Cohesive family model
   (1) Family-group approach.
   (2) Parent-child interactions are examined.
   (3) Obtaining treatment cooperation from parents is difficult.
   (4) If child is removed from home this is frequently interpreted as further rejection.

d. Behavioral and biologically based treatments
   (1) Antidepressant medication and cognitive-behavior therapy.
   (2) Teaching control techniques to parents.
   (3) Parents may have difficulty carrying out treatment program.

III. Anxiety and Depression in Children and Adolescents
A. Anxiety Disorders of Childhood and Adolescence
   1. Separation anxiety disorder
      a. Classified under Anxiety Disorders in DSM-5.
      b. Most common of the childhood anxiety disorders.
      c. Characterized by excessive fears; excessive anxiety about separation from major attachment figures.
      d. More common in girls.
      e. Clear psychological stressors are usually identified.
   2. Causal factors in anxiety disorders
      a. Unusual constitutional sensitivity may be present.
      b. Feelings of inadequacy may be due to trauma or illness.
      c. Modeling of anxious parents and an overprotective parent.
      d. An indifferent or detached parent may instill insecurity.
      e. Social-environmental factors:
         (1) Cultures that favor inhibition, compliance, and obedience increase the levels of fear reported.
         (2) In United States, white children are more likely to report with school refusal and African American children more likely to report with post-traumatic stress disorder (PTSD) symptoms.
         (3) Strong association between exposure to violence and a reduced sense of security and psychological well-being.
      f. Feelings of control over reinforcing events.
   3. Treatments and outcomes
      a. Success experiences alleviate anxiety.
      b. Biologically based treatment
         (1) Medication usage is becoming more common.
         (2) Fluoxetine is useful.
      c. Psychological treatment
         (1) Behavior therapy focused on assertiveness training and desensitization has proven effective.
         (2) Cognitive-behavioral therapy is also effective.

B. Childhood Depression and Bipolar Disorder
1. Clinical picture in childhood depression:
   a. Depressive symptoms include: withdrawal, crying, avoidance of eye contact, physical complaints, poor appetite, suicide, and perhaps aggressive behavior.
   b. Prevalence rates: under age 13—2.8%, 13 to 18—5.6% (girls 5.9%, boys 4.6%).
   c. Adolescents aged 14 to 18—1.7% have made a suicide attempt.
   d. Increase in bipolar diagnoses in children and adolescents in the United States.
   e. Rates are equal for boys and girls prior to adolescence; twice as common in girls during adolescence.
   f. Adult criteria for depression are used in diagnosis (though irritability allowed for children).
2. Causal factors in childhood depression:
a. Biological factors:
   (1) Genetic component assumed based on parental depression.
   (2) Biological changes in neonate as a result of maternal alcohol consumption.

b. Learning factors:
   (1) Maladaptive learning from negative parental behavior.
   (2) Exposure to early traumatic events.
   (3) Parent-child interaction in transmission of depressed affect.
   (4) Depressive symptoms are positively correlated with the tendency to attribute positive events to external, specific, and unstable causes and negative events to internal, global, and stable causes; with fatalistic thinking; and with feelings of helplessness.
   (5) 15.1 Developments In Research: Bipolar Disorder in Children and Adolescents: Is There an Epidemic?

3. Treatments and outcomes
   a. Effectiveness of antidepressants may, at best, be moderate, with the potential for many undesirable side effects.
   b. Suicide appraisal important; 7%–10% of adolescents report at least one suicide attempt; SSRIs increases suicide potential.
   c. Providing supportive environment important.
   d. Cognitive-behavioral treatments proven effective.

C. Developments in Research: Bipolar Disorder in Children and Adolescents: Is There an Epidemic?
   a. In the late 1990s many psychologists began diagnosing and treating bipolar disorder in children and adolescents.
   b. DSM-5 modified diagnosis of childhood depression to prevent overdiagnosis of bipolar disorder.
   c. New diagnosis of disruptive mood regulation disorder has been included in DSM-5 for children aged 18 or under.
   d. Increased use of diagnosis of bipolar disorder for children raises the question of overdiagnosis, especially in light of increased use of antidepressant prescriptions for children and adolescents.
   e. On the other hand, are younger people acquiring the disorder more commonly?

IV. Elimination Disorders (Enuresis, Encopresis), Sleepwalking, and Tics
A. Elimination Disorders (Enuresis, Encopresis), Sleepwalking, and Tics
1. Enuresis
   a. Defined as the habitual involuntary discharge of urine after the expected age of continence, age 5. In DSM-5, functional enuresis described as bed-wetting that is not organically caused.
   b. 5%–10% of 5-year-olds, 3%–5% of 10-year-olds, and 1.1% of children aged 15 or older.
   c. More common in boys.
   d. May result from variety of organic conditions, disturbed cerebral control of bladder, medication side effects, small functional bladder capacity, weak urethral sphincter.
   e. Primary versus secondary functional enuresis.
   f. Causes can include faulty learning, immaturity, disturbed family relationships, or stressful events.
   g. Conditioning procedures have been found to be the most effective form of treatment:
      (1) Mowrer & Mowrer (1938)—bell and pad.
      (2) Biobehavioral approach: using bell and pad along with desmopression is very effective.
   h. Medication has been found useful for short periods:
      (1) Imipramine may decrease the deepest stages of sleep.
Intranasal desmopression (DDAVP) reduces the need to urinate by concentrating urine.

2. **Encopresis**
   a. Children who have not learned appropriate toileting for bowel movements after age 4.
   b. Less common than enuresis; about 1% of 5-year-olds.
   c. Six times more common in males, average age of 7 with a range of 4–13.
   d. Constipation common, requiring medical evaluation.
   e. Conditioning procedures have reported success.

3. **Sleepwalking disorder**
   a. Onset usually between ages 6–12.
   b. Incidence for one episode is 10%–30%; incidence for repeated episodes is low—from 1%–5%, girls more likely.
   c. Children do not recall the sleepwalking episodes.
   d. Causes not understood; sleepwalking appears related to anxiety.
   e. Little information on treatment although behavioral therapy has proven effective.

4. **Tic disorders**
   a. Tic—persistent, intermittent muscle twitch or spasm, usually limited to a localized muscle group.
   b. Classified under motor disorders in DSM-5.
   c. Occur most frequently between the ages of 2–14; average age of onset is 7–8.
   d. More common among males.
   e. Lifetime prevalence of 2.6% for transient tic disorder, 3.7% for chronic tic disorder, and 0.6 for Tourette’s disorder.
   f. **Tourette’s disorder** is an extreme tic disorder.
      (1) Involves multiple motor and vocal patterns.
      (2) Some tics preceded by an urge or sensation that is relieved by the tic—compulsive quality.
      (3) Prevalence about .56%.
      (4) 1/3 manifest coprolalia—uttering of obscenities.
      (5) Evidence suggests organic basis.
      (6) Family and behavioral intervention strategies are critical.
   g. Tics are associated with other psychological disorders, especially obsessive-compulsive disorder.
   h. Most tics do not have an organic basis but are due to self-consciousness or tension in social situations and are associated with severe behavioral problems.
   i. Behavioral interventions and cognitive restructuring (perfectionist expectations about self-image) used successfully for treatment.
   j. Neuroleptics are tic-suppressing drugs.

V. **Neurodevelopmental Disorders**
   A. **Neurodevelopmental Disorders**
      1. Group of severely disabling conditions.
      2. Account for about 3.2% of clinic cases.
      3. Considered to be the results of some structural differences in brain.
      4. Examples of these disorders include Asperger’s and autism.
   B. **Autism Spectrum Disorder**
         a. First described by Kanner in 1943.
         b. Autistic behavior such as lack of empathy, inattention to others, and inability to imitate is shown as early as 20 months of life.
         c. A social deficit:
            (1) Do not show affection.
            (2) Do not want physical contact.
            (3) Sigman argues that autistic children lack social understanding.
            (4) Lack of social interaction and spontaneous play.
(5) Encopresis common.

d. An absence of speech:
   (1) Imitative defect.
   (2) Speech is either absent or is rudimentary (says “yes” or engages in echolalia).

(e) Self-stimulation:
   (1) Usually takes the form of repetitive movements such as head banging, spinning, and rocking.
   (2) Bizarre repetitive behaviors are typical.
   (3) Will actively arrange environment to exclude or limit variety.
   (4) Active aversion to auditory stimuli (not consistent).

(f) Intellectual ability:
   (1) Demonstrate marked impairment.
   (2) Deficits in social reasoning but can manipulate objects.

(g) Maintaining sameness:
   (1) Many become preoccupied by, or form attachments to, unusual objects (rocks, light switches, film negatives, keys).
   (2) Violent temper tantrums result when object or environment is altered even slightly.

2. Causal factors in autism:
   a. Precise cause is unknown.
   b. Inborn defect that impairs perceptual-cognitive-functioning.
   c. Defective genes from radiation or other conditions during prenatal development.
   d. Based on twin studies, 80%–90% of variance in risk for autism is based on genetic factors.
   e. If a child has autism there is 3%–5% risk for the sibling to also have autism.
   f. Occurs in 30–60 people per 10,000.
   g. Identified before the child is 30 months, but can show signs by 20 months.
   h. Fragile X syndrome occurs in about 8% of autistic males.

3. Treatments and outcomes of Autism
   a. Medical treatment: has not proven effective.
      (1) Haloperidol—evidence does not support use.
      (2) Clonidine—may reduce severity of symptoms.
      (3) Antidepressants—21.7% effective.
      (4) Antipsychotics—16.8% effective.
      (5) Stimulants—13.9% effective.
   b. Behavioral treatment: has been used successfully.
      (1) Institutional settings:
          (a) Elimination of self-injurious behavior.
          (b) Mastery of the fundamentals of social behavior.
          (c) Development of language skills.
      (2) Lovaas:
          (a) Behavioral treatment approach.
          (b) Highly positive results from a long-term experimental program.
          (c) Intensive and conducted in homes with aid of parents.
          (d) 47% achieved normal intellectual functioning (compared to 2% of untreated controls); 40% mildly retarded range (compared to 45% of untreated controls).
   c. Effectiveness of treatment:
      (1) Long-term effectiveness has been poor.
      (2) Study of high-functioning autistic children.
      (3) Poor transfer of learning outside of institution.
      (4) Developments in Practice: Can Virtual Reality Video Games Improve Treatment of Children with Neurodevelopmental Disorders?
VI. Specific Learning Disorders
A. Specific Learning Disorders
1. Problems may be manifested in language, speech, mathematical, or motor skills.
2. Dyslexia—manifested as problems in word recognition and reading comprehension; often markedly deficient in spelling.
3. Diagnosis is restricted to when there is a clear impairment in school performance or daily living activities.
4. Learning disorders—refers to delayed development.
5. More common in boys.
6. Learning disability initially identified based on a disparity between expected and actual academic performance.
7. Despite 40 years of diagnosis and research, many in school settings still:
   a. Blame the victim.
   b. See the children as troublesome.
8. Low self-esteem may remain even after secondary schooling is finished.

B. Causal Factors in Learning Disorder
1. A subtle central nervous system immaturity, defect, or dysfunction is probably present.
2. Language-related LDs may be due to a defect in the brain’s normal laterality; “minimal brain dysfunction” was a popular term a few years back.
3. Psychosocial-based hypotheses have limited empirical support.
4. What strategies do good learners use? (Worden’s approach)
   a. Memory strategies.
   b. Monitoring their performances.
   c. Metastrategy information.
5. Motivational factors.

C. Treatments and Outcomes
1. Ellis—integrative strategy instruction.
   a. Teacher-directed instructional strategies are directed at orienting, framing, applying, and extending.
   b. Has not been rigorously tested for efficacy.
2. Long-term follow-up suggests that problems continue into college.

D. Thinking Critically about DSM-5: Changes to the Diagnostic System are Nominal for Some Disorders
1. The term “mental retardation” has come to be unacceptable
2. “Intellectual disability” is the new term to replace it
3. Definition requires:
   a. Significantly subaverage general intellectual functioning.
   b. Significant limitations in adaptive functioning.
   c. Problems must have begun before the age of 18.

VII. Intellectual Disability
A. Levels of Intellectual Disability (see Table 15.1 for the ranges of disability severity).
   a. Mild intellectual disability:
      (1) Largest number of intellectually disabled are in this level.
      (2) Considered educable.
      (3) Social adjustment is similar to adolescence.
   b. Moderate intellectual disability:
      (1) Considered trainable.
      (2) Most in this group can achieve partial independent living.
   c. Severe intellectual disability:
      (1) Institutionalization is usually required.
   d. Profound intellectual disability:
      (1) Physical deformities are common.
      (2) Can usually be diagnosed in infancy.

B. Causal Factors in Intellectual Disability
1. Genetic-chromosomal factors:
a. Typically moderate to severe intellectual disability.
b. Down syndrome and Fragile X show the clear role of genetics.
c. Chromosomal defects may influence metabolism, which affects the brain.

2. Infections and toxic agents:
a. A number of infections, such as syphilis, HIV-1, German measles, genital herpes, and viral encephalitis can cause brain damage.
b. Carbon monoxide, lead, alcohol, and incompatibility in blood types are toxic agents that cause brain damage.

3. Trauma (physical injury):
a. Difficulties in labor due to malposition of the fetus or other complications.
b. Hypoxia can result from a number of factors.

4. Ionizing radiation:
a. X-rays.
b. Nuclear power leakages.

5. Malnutrition and other biological factors:
a. Malnutrition affects mental development indirectly by altering a child’s responsiveness, curiosity, and motivation to learn.
b. Some cases of severe and profound retardation are clearly associated with brain pathology but specific cause is unknown.

C. Organic Retardation Syndromes (see Table 15.2 for a list of genetic disorders associated with intellectual disability)

1. Down syndrome
a. Most common: mild and moderate conditions; 5.9 per 10,000 births.
b. Amniocentesis has reduced the incidence.
c. Physical features usually are present.
d. Life expectancy for Down children has risen dramatically; however, they experience accelerated aging process.
e. Most learn self-help skills and acceptable social behaviors; skills decrease after age 40.
f. Greatest intellectual deficits are found in verbal and language skills.
g. A trisomy of chromosome 21 is present in 94% of Down syndrome cases.
h. Age of parent at conception is critical: for a mother in her 20s, risk is 1 in 2000; by age 40, risk is 1 in 50; age of father also important.

2. Phenylketonuria (PKU)
a. A rare metabolic disorder where a missing liver enzyme prevents phenylalanine from being broken down; found in 1 of 12,000 births.
b. Becomes apparent at the age of 6 to 12 months.
c. To inherit PKU, both parents must carry the recessive gene.
d. Severe to profound retardation is seen in untreated patients.
e. Early detection can be achieved through urinalysis.
f. Restriction of diet can prevent mental retardation; some children become intellectually disabled in spite of treatment.

3. Cranial anomalies.
a. Macrocephaly (large-headedness):
(1) Increased size and weight of brain and skull.
(2) Visual impairments and convulsions also present.
b. Microcephaly (small-headedness):
(1) Circumference of head rarely exceeds 17 inches (normal is 22 inches).
(2) Short stature, tendency for skull to be cone-shaped, with a receding chin and forehead.
(3) Moderate, severe, and profound mental retardation.
(4) Majority show little language development.
(5) Condition may be caused by intrauterine infection, pelvic irradiation, and possible genetic factors.
c. **Hydrocephaly:**
   (1) Relatively rare condition in which there is an accumulation of cerebrospinal fluid causing brain damage and enlargement of the skull.
   (2) Clinical picture depends upon the extent of neural damage.
   (3) Can be present at birth or begin after birth following the development of a brain tumor, subdural hematoma, meningitis, etc.
   (4) Surgery is used in treatment; shunting devices inserted to drain cerebrospinal fluid.

D. **Treatment, Outcomes, and Prevention**
1. Treatment facilities and methods.
   a. Institutionalization should be seen as a last resort because it erodes self-care skills; institutionalized children fall into two groups:
      (1) Enter at an early age due to severe mental retardation and accompanying physical impairment.
      (2) Enter during adolescence with mild mental retardation, no physical impairments but difficulty adjusting, leading to delinquency or other behavioral problems.
   b. Community-oriented residential care has positives for adolescents.
   c. Many state institutions are overcrowded and have limited education programs.
   d. It is questionable whether the intellectually disabled at any level receive adequate services.
   e. Public Law 94-142 requires education in the “least restrictive” environment.
   f. Group homes or halfway houses began to appear in the 1970s.
2. Education and inclusion programming.
   a. Typically involves mapping out target areas of improvement (personal grooming, social behavior, basic academic skills, simple occupational skills).
   b. Specific skills are divided into simple components that can be learned and reinforced.
   c. Children fare best when they attend regular classes for much of the day.
   d. **Mainstreaming**—inclusion programming.

VIII. **Planning Better Programs to Help Children and Adolescents**
A. **Special Factors Associated with Treatment of Children and Adolescents**
1. Child’s inability to seek assistance.
   a. Child dependent on others to recognize problem and to take them for help.
   b. Law identifies four areas in which treatment without parental consent is permitted:
      (1) Mature minors.
      (2) Emancipated minors.
      (3) Emergency situations.
      (4) Court ordered treatment.
2. Vulnerabilities that place children at risk for developing emotional problems:
   a. Experience or are exposed to violence.
   b. Undesirable home environment including inadequate housing.
   c. Disruptive childhood experiences (deaths).
   d. Parental substance abuse.
   e. High risk behaviors such as engaging in sexual acts, delinquency, using alcohol or drugs.
   f. Abuse, parental divorce, family turbulence, homelessness.
3. Need for treating parents as well as children.
   a. Treatment program may focus on parent behaviors.
   b. Fathers are particularly difficult to engage in therapy.
   c. May be difficult to arrange with working parents.
   d. Poorer families lack money and transportation.
4. Possibility of using parents as change agents.
   a. Encouraging results have been obtained.
b. Barriers to parental involvement: coming from a disadvantaged background, parents who were antisocial, parents under great stress.

c. See 15.3 The World Around Us: The Impact of Child Abuse on Psychological Adjustment.

5. Problem of placing a child outside the family.
   a. Four types of facilities are commonly used:
      (1) Foster homes.
      (2) Private institutions such as group homes.
      (3) County or state institutions.
      (4) Homes of relatives.
   b. Quality of new home critical for child’s adjustment.
   c. Removing child from home results in child feeling rejected by parents, unwanted by new caretakers, rootless, constantly insecure, lonely, and bitter.
   d. Trend today is toward permanent planning.

6. Value of intervening before problems become acute:
   a. Identify and provide help to those at special risk.
   b. Double goal of reducing stressors in child’s life and strengthening the child’s coping mechanisms.

B. Family Therapy as a Means of Helping Children
   1. Used to improve disruptive family relationships and promote a more positive atmosphere for children.

C. Child Advocacy Programs
   2. 74 million people under age of 18.
   3. Advocacy attempts to secure services for children in need.
   4. Confusion, inconsistency, and uncertainty continue to hamper various advocacy groups.
   5. Federal and state funding has been repeatedly cut.

IX. Unresolved Issues: Can Society Deal with Delinquent Behavior?
A. Juvenile delinquency is a legal term and refers to illegal acts committed by individuals between the ages of 8–18 (depending on state law).

B. Incidence difficult to determine.
   1. More than 2 million go through juvenile court each year.
   2. In 2008, 2.1 million juveniles were involved in 16% of crimes, 1,740 were murders.
   3. Most juvenile crime committed by males; female rates are rising.
   4. Both incidence and severity are higher for lower-class adolescents.

C. Causal Factors in Delinquency
   1. Personal pathology:
      a. Genetic determinants: possible hereditary contributions in hyperactivity, impulsivity, and physiological reactivity.
      b. Brain damage and learning disability—probably less than 1%.
      c. Psychological disorders: hyperactivity, pervasive developmental disorders; 14% of cases have documented some type of psychological disorder.
      d. Antisocial traits.
      e. Drug abuse.
   2. Pathogenic family patterns:
      a. Parental absence or family conflict.
      b. Parental rejection and faulty discipline.

D. Undesirable Peer Relationships
   1. Haney & Gold (1973)—2/3 of delinquent acts were committed in association with one or two other people; most of the remainder involved three or four others.
   2. Estimate there are 23,388 youth gangs in the United States.
   3. 32% of homeless youth join gangs.

E. Dealing with Delinquency
   1. Institutions and training schools; “boot camps.”
   2. Harsh, punitive programs often fail because they do not reinforce alternative behaviors.
   3. Behavior techniques have shown promise.
4. Counseling parents and related environmental changes are a vital concern.
5. Probation can be very effective.
6. Recidivism:
   a. Overall rates for those sent to training schools are high.
   b. Depends on the type of offender and the facility or procedures used.
   c. Factors predicting recidivism include: type of offense, family problems, having delinquent peers, ineffective use of leisure time, conduct problems.
   d. Must provide a more positive peer culture.

**Key Terms**

Adderall  
attention-deficit/hyperactivity disorder (ADHD)  
autism spectrum disorder  
conduct disorder  
developmental psychopathology  
Down syndrome  
dyslexia  
echolalia  
encopresis  
enuresis  
hydrocephaly  
intellectual disability  
juvenile delinquency  
learning disorders  
macrocephaly  
mainstreaming  
microcephaly  
neurodevelopmental disorders  
oppositional defiant disorder (ODD)  
Pemoline  
phenylketonuria (PKU)  
Ritalin  
separation anxiety disorder  
sleepwalking disorder  
Strattera  
tic  
Tourette’s syndrome