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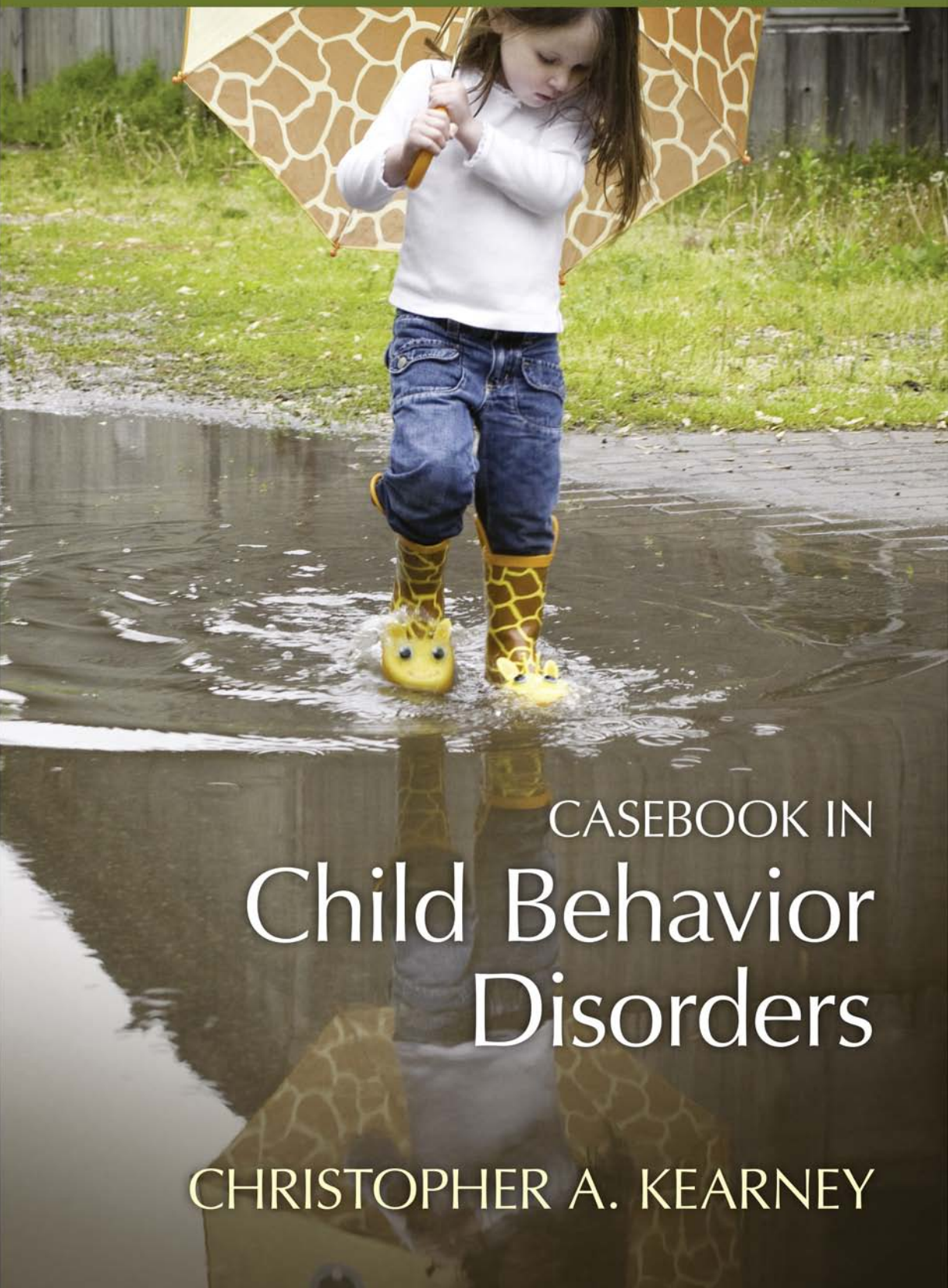

CASEBOOK IN Child Behavior Disorders

CHRISTOPHER A. KEARNEY

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SIXTH EDITION

CHRISTOPHER A. KEARNEY
University of Nevada, Las Vegas

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***Casebook in Child Behavior Disorders*, Sixth Edition**
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To my clients and students

Contents

Preface

With the explosion of knowledge about childhood behavior disorders comes a heightened sense of responsibility to appreciate the problems these disorders create for children, their parents, and others who address these children. One goal of this casebook is to synthesize current thinking about childhood behavior disorders with the cases of specific children and their significant others, whether at home, school, or in other settings. My purpose is to show how the lives of the children and their families are both painful and disrupted on a daily basis.

Representing the Breadth of Children's Psychopathology

I present a wide variety of cases to illustrate the continuum of psychopathology in youth. The cases represent internalizing and externalizing disorders and mixed symptomatology (diagnoses?). Cases in Chapters 1, 14, and 15 purposely omit diagnoses, so instructors can discuss possibilities. Instructors can access case solutions in a special supplement. A student can derive a clinical picture for each case by reading about symptoms, major assessment methods, risk factors and maintaining variables, developmental aspects, and treatment strategies. These sections represent types of information professionals find most important when addressing a particular case. Each case concludes with questions to stimulate student review or group discussion. The breadth of these cases is reflected as well by the fact that children's presenting symptoms often differ from DSM-5 criteria and by substantial differences in treatment outcome.

Real Cases Can Be Used in Different Settings, in Different Ways

This casebook was primarily designed for undergraduate and beginning graduate students in psychology, but the text is written so people of other disciplines and interests may find the material useful and appealing. The cases are based on actual case histories or composites of cases seen by different mental health professionals. The names and some of the details of the cases were changed to protect the confidentiality of the people involved. Resemblances to actual people are coincidental because details were altered.

An Empirical Approach

This casebook generally reflects an empirical approach derived from a cognitive-behavioral-family systems orientation. This does not imply, however, that other forms of treatment are invalid for a certain population. An intricate combination of biological and other interventions is often needed to successfully resolve a particular case of child-based psychopathology.

About the Author

Christopher A. Kearney is distinguished professor of psychology at the University of Nevada, Las Vegas. He is also the director of the UNLV Child School Refusal and Anxiety Disorders Clinic in Las Vegas. Dr. Kearney received his B.A. from the State University of New York at Binghamton and his M.A. and Ph.D. from the State University of New York at Albany. He completed his internship at the University of Mississippi Medical Center. Dr. Kearney's research focuses primarily on the classification, assessment, and treatment of school refusal behavior and internalizing disorders in children and adolescents. He has also worked with adults with severe developmental disorders. Dr. Kearney has authored several books on anxiety disorders and school refusal behavior in youth; in addition, he has written numerous journal articles and book chapters. Dr. Kearney is a fellow of the American Psychological Association and the recipient of the Harry Reid Silver State Research Award and Distinguished Teaching Award from the University of Nevada, Las Vegas.

Chapter 1

Mixed Case One

Symptoms

Michael Rappoport was a 9-year-old European American male referred by his parents to an outpatient mental health clinic. Michael was in fourth grade at the time of his initial assessment. His parents, Mr. and Mrs. Rappoport, referred Michael for what they described as "difficult" and "unruly" behavior. During the telephone screening interview, Mrs. Rappoport said Michael was not listening to her or to his teacher, was failing subjects at school, and was occasionally aggressive toward his 5-year-old sister. She hinted that the family was experiencing conflict and financial problems since Mr. Rappoport lost his job several weeks before. The Rappoports were scheduled for an intake assessment session that week but the family either postponed or failed to show for their appointment three times before attending.

A clinical psychologist who specialized in childhood behavior disorders interviewed Michael and his parents separately. The psychologist interviewed Michael first and found him to be polite, social, and responsive to most questions. Michael went into detail about his pets, soccer team, and neighborhood friends. When asked why he thought he was at the clinic, however, Michael shrugged and said his parents did not like him very much. He said his parents often yelled at him and that his father "hits me when I'm bad." The psychologist asked Michael how his father hit him and how often this occurred, but Michael again shrugged and did not answer.

The psychologist then asked Michael about behaviors his parents considered bad. Michael said he would often run and hide in his room when his parents fought, which was often, and that his mother did not like running in the house. He was usually in trouble for failing to do his homework and for getting poor grades in school. Michael struggled with most of his subjects. He also said he and his little sister "didn't get along."

Michael complained his teachers "yell at me for everything." His teacher often reprimanded Michael for not staying in his seat, paying attention, or completing homework assignments. Michael said the work was too difficult for him,

especially reading assignments, and that he could not concentrate on them. He usually had to sit close to his teacher during the day because of these problems and often missed recess to complete past work.

The psychologist noticed, as the conversation turned to misbehavior, that Michael's mood became more downcast and his interaction with her more withdrawn. Michael cried at one point and said he often felt "lonely and sad." He felt deprived of time with friends at school and was embarrassed to bring his friends to his house to play. He was sad that his parents often fought and worried about what would happen in the future. Michael denied thoughts about harming himself but did muse about what his parents would think if he were dead.

The psychologist concluded her initial interview with Michael by asking him what he would like to see different in his life. Michael said he wished his father were out of the house because of the constant fighting there. Michael said he wished he did better in school and could avoid trouble. The psychologist asked Michael if he wanted to feel differently as well but Michael simply shrugged.

The psychologist then interviewed Mr. and Mrs. Rappoport. The two were clearly irritated with one another. Mrs. Rappoport apologized for the earlier scheduling postponements and indirectly blamed her husband. Mr. Rappoport rolled his eyes in response and said, "Let's get on with this." The psychologist asked both parents what brought them to the clinic. Mr. Rappoport shrugged but Mrs. Rappoport quickly listed a series of problems regarding Michael.

Mrs. Rappoport said Michael was "impossible to control." He was argumentative, boisterous, and noncompliant. Mrs. Rappoport complained that Michael would not listen to instructions and would often yell obscenities at her when she asked him to do something. Michael would also run around the house during a tantrum, which occurred almost every day. His tantrums—which included yelling, crying, and punching something—often occurred after parental commands or when Mr. and Mrs. Rappoport were "discussing something." Michael would often end up in his room or be spanked by his father after these tantrums. This did little to control his behavior, however. In addition, Michael was becoming aggressive with his 5-year-old sister—he was caught slapping the child on several occasions. Michael could no longer spend time alone with her.

Mrs. Rappoport said Michael was doing poorly at school. He was failing almost all subjects and had problems with reading and spelling. This was somewhat surprising because Michael was a good student up to the middle of third grade (last year). Michael was difficult to control in the classroom, often throwing tantrums and complaining the work was too difficult. He often refused to do his homework and had to sit near his teacher so she could better monitor his behavior. Michael's academic problems and misbehavior grew so bad that his teacher, Mrs. Greco, suggested a referral to special education. Mr. and Mrs. Rappoport strongly resisted this suggestion, however.

Mrs. Rappoport finished her comments about Michael by saying he was often sullen and sometimes "quirky" in his behavior. Michael would often cry when upset and withdraw to his room. He was also concerned about contracting AIDS (acquired immune deficiency syndrome). One of Michael's classmates returned to class following a bout with hepatitis and this triggered a fear of

AIDS and other diseases in Michael. He thus washed his hands about 10 times a day to prevent possible contagion.

The psychologist then asked Michael's parents about other family matters. Mrs. Rappoport again did most of the talking and said her husband recently lost his job and that the family had financial problems. She admitted that she and her husband fought "sometimes" but did not feel this led to Michael's misbehavior. She insisted that the focus of the interview and later therapy be on Michael, who was displaying the most problematic behavior. Despite several gently prodding questions, she and her husband did not provide more detail regarding their marriage or disciplinary style.

The psychologist spoke with Michael's teacher, Mrs. Greco, with parental permission. She said Michael was a relatively good student during the first month of the year but that his grades and behavior worsened since then. Mrs. Greco said Michael was struggling with many of his assignments even though he was intelligent and could easily do the work if motivated. This seemed particularly true for assignments involving extensive reading and writing. Mrs. Greco said she never recommended Michael for special education, as claimed by Mr. and Mrs. Rappoport, but did feel that Michael's parents needed to take a more active role to address their son's academic problems. She also speculated that Michael's parents, who were difficult to address in their own right, were a primary cause of many of Michael's problems.

Mrs. Greco said Michael's misbehavior was becoming intolerable as well. She complained her student was often noncompliant, inattentive, and disruptive. She described how Michael refused to do assigned work by throwing papers, crying, and stomping his feet around the room. She thus sent him to the principal's office about once a week. Michael was overactive and needed reminders to sit in his seat. He demanded a substantial amount of attention from Mrs. Greco, who said her ability to attend to the rest of her class was suffering.

The psychologist felt Michael and his family had several problems that needed treatment. Michael had a combination of internalizing, externalizing, and academic problems. His family was marked by substantial conflict and intense life stressors. Potential maltreatment from corporal punishment was also an issue the psychologist believed she would have to explore further.

Assessment

The general purpose of assessment, or collection of information on children and their families in a clinical setting, is to answer three basic questions:

1. What is the behavior problem?
2. Why is the problem continuing to occur?
3. What is the best treatment for the problem?

These questions may seem straightforward but are sometimes difficult to answer. This is especially so in a complicated case like the Rappoports'.

The first question—"What is the behavior problem?"—might raise several additional questions. Is there an actual behavior problem that needs to be addressed? Was Michael referred for treatment because his behavior was truly abnormal or because he upset his parents and teacher? Some of his behaviors might be developmentally appropriate for a 9-year-old. What if a child's behavior problem understandably results from family variables such as conflict, disarray, maltreatment, or negative parent attitudes? What if the "behavior problem" lies more with the family than with the child? Michael's sadness may have been due to his parents' fighting. A psychologist does not automatically assume a child is the one who needs the bulk of attention during treatment.

Deciding upon the behavior problem can also be difficult if one person such as a child says no problem exists and other people such as parents disagree. A therapist should look for behaviors that clearly interfere with a child's daily functioning. Several of Michael's behaviors did so and therefore needed to be addressed. If a child does have behavior problems, then a decision must be made as to which behaviors are most severe and should be addressed first. Different symptoms from different disorders overlap in many youths referred for treatment. Michael certainly had several overt symptoms but his acting-out behaviors might have been linked to more serious internalizing problems such as anxiety or depression.

The second question to be answered from an assessment—"Why is the problem continuing to occur?"—is fraught with difficulty as well. A therapist must determine what *maintains* each behavior problem in a child. These maintaining variables, as mentioned throughout this casebook, include sensory reinforcement, attention, escape from aversive situations, and tangible rewards such as money. Different variables maintain different behaviors, as may have been true for Michael. His tantrums and aggression toward his sister could be a way to get attention; his handwashing could be a way to escape or reduce worry about contamination; his noncompliance could be a way to solicit bribes from his parents.

These questions—"What is the behavior problem?" and "Why is the problem continuing to occur?"—refer to form and function of behavior. Knowing the form *and* function of a child's behavior makes answering the last major question easier; that is, "What is the best treatment for the problem?" Suppose Michael's most severe behavior problem was his tantrums at home and school (form). Eliminating this behavior problem might help reduce other behavior problems such as general noncompliance. Suppose also that Michael's tantrums were motivated by attention from parents at home but escape from work at school (function). Michael's parents might wish to ignore his tantrums at home but Michael's teacher might wish to work through his tantrums at school and not allow him to leave class.

Mental health professionals use various assessment methods to answer these questions; these methods are described in this casebook. Common methods include interviews, self-report and cognitive measures, self-monitoring, physiological and medical procedures, role-play, parent or family and teacher measures, sociometric ratings, direct observation, and intelligence, achievement, and personality tests. A multidimensional approach to assessment is often necessary to evaluate different areas of functioning (e.g., social, academic, intellectual, emotional) that may be problematic.

Michael and his parents were administered versions of the Anxiety Disorders Interview Schedule—a semistructured interview that covers various internalizing and externalizing disorders (Silverman & Albano, 1996; Silverman, Saavedra, & Pina, 2001). The psychologist diagnosed Michael with three disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). One disorder involved an internalizing problem, the second involved an externalizing problem, and the third involved an academic problem. The psychologist rated each disorder as moderate to severe. Michael also endorsed fears of medically related stimuli (e.g., sickness, germs, hospitals, injections), social and evaluative situations (e.g., large crowds, being criticized), and parental arguing.

Michael completed self-report measures such as the Multidimensional Anxiety Scale for Children 2 (MASC 2) and Revised Child Anxiety and Depression Scales (Chorpita, Moffitt, & Gray, 2005; March, 2013). Michael indicated he was often tearful, indecisive, shy, and unhappy in school. He worried about schoolwork, evaluations from others, the future, what his parents would say to him, and bad things happening to him. He had nightmares, trouble concentrating, and various somatic complaints such as feeling sick to his stomach. Michael believed terrible things would happen to him, that he was alone, and that he could never be as good as other kids. Michael seemed anxious and depressed about different areas of his life. Areas of most concern included his current family situation, medical status, social evaluations, and future events.

Michael's parents completed the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001), Family Environment Scale (FES, 4th ed.; Moos & Moos, 2009), Parental Expectancies Scale (PES; Eisen, Spasaro, Brien, Kearney, & Albano, 2004), and Revised Dyadic Adjustment Scale (RDAS; Ward, Lundberg, Zabriskie, & Berrett, 2009), which is a measure of general marital satisfaction. Mr. and Mrs. Rappoport endorsed high levels of attention problems and aggressive behaviors on the CBCL. They emphasized their son's impulsivity, nervousness, poor school performance, arguing, meanness, disobedience, screaming, temper tantrums, and demands for attention. They endorsed few internalizing symptoms. Mr. and Mrs. Rappoport rated their family as conflictive and detached on the FES and confirmed their high expectations that Michael should take much responsibility at home on the PES.

Mr. and Mrs. Rappoport indicated on the RDAS that they frequently disagreed with one another in several areas, especially finances. They rarely had positive conversations with one another or showed affection. These responses contrasted somewhat with their verbal reports during their interview. The Rappoport family was clearly in distress but Mr. and Mrs. Rappoport continued to see Michael's externalizing behaviors as the main problem. They referred especially to his noncompliance and disruptive behavior.

Other assessment instruments in this case included the Teacher's Report Form (TRF; Achenbach & Rescorla, 2001), a continuous performance test, and the Wechsler Intelligence Scale for Children (5th ed.; Wechsler, 2015). Michael's teacher, Mrs. Greco, completed the TRF and emphasized Michael's social and attention problems, especially his regressive behavior, crying, lack of concentration, impulsivity, disorganization, and underachievement. A continuous performance test, which

measures impulsivity, indicated that Michael's speed of response resembled that of children with attention-deficit/hyperactivity disorder (ADHD). Michael's intelligence test score was in the high average range, suggesting that his academic problems were not because of intellectual deficit. Michael was instead performing far below his ability.

The psychologist believed Michael had various behavior problems that were not well defined. Different functions maintained many of these problems as well. On top of all these, Michael's family situation involved marital tension, conflict, financial stress, and possible maltreatment. Any treatment program would thus likely have to involve the entire family and a complex strategy.

Risk Factors and Maintaining Variables

Several models have been proposed to explain causes of childhood behavior disorders. Psychodynamicists emphasize inborn sexual drives and intrapsychic personality conflicts as precursors to later psychopathology. Attachment theorists speculate that a caregiver's failure to provide for an infant's needs could lead to future psychopathology in that child. These models may have some relevance for youth but the validity of both remains an open question.

A more widely held etiological model, and one mentioned throughout this casebook, is a behavioral one. Behaviorists claim children learn or receive reinforcement for abnormal behaviors. Examples include parents who inadvertently reward noncompliance, family members who provide sympathy for depressive behaviors, and peers who reward delinquent behaviors. Social learning theorists propose that children imitate or model inappropriate behavior of others. Examples include increased child aggression following parental spanking and excessive substance use after watching others drink alcohol or use illegal drugs.

Learning models did seem to apply to Michael's behaviors. Parental attention reinforced his aggression. Social learning triggered Michael's medical anxieties, fear of AIDS, and handwashing. Several of Michael's classmates discussed the student who had hepatitis—describing his hospital stay, isolation from others, injections, and constant need for cleanliness. Like many 9-year-olds, they exaggerated the stories. Michael took them seriously, however, and thus became fearful and compulsive in his handwashing.

Cognitivists believe child psychopathology relates to distorted thought processes that trigger or maintain behavior problems. Examples include anxiety and depression from irrational thoughts of negative evaluations from others and eating disorders maintained by irrational beliefs about beauty and weight loss. Affective theorists claim that some people have difficulty regulating their emotions and subsequently have trouble with motivation, behavior organization, or communication with others. Someone who was maltreated may experience ongoing anxiety or arousal from cues that remind him or her of the maltreatment and this may lead to posttraumatic stress disorder.

Distorted thought processes were not clearly an issue for Michael but he did worry about present and future events. His emotional state was excitable and Michael therefore had problems regulating his behavior. Because of his

excitability and impulsivity, he had difficulty concentrating on his schoolwork, organizing materials, maintaining conversations with others, and controlling temper tantrums. These problems subsequently led to poor grades, feelings of isolation, and punishment for disruptive classroom behavior.

Child psychopathology clearly relates as well to biological factors. Biological risk factors include genetic predispositions, chromosomal aberrations, central nervous system changes, neurochemical imbalances, and stress and temperament. Evidence supports a genetic predisposition for several disorders such as depression. Chromosomal aberrations such as Down syndrome often lead to moderate intellectual disability. Central nervous system changes can lead to specific developmental problems such as learning disorder or to pervasive disabilities such as autism. Neurochemical imbalances, stress, and difficult temperament influence problems as diverse as social anxiety and ADHD. A medical examination revealed no outstanding problems for Michael. Less obvious problems such as subtle brain changes or ongoing stress, however, might partly explain his misbehaviors.

Family systems models may help explain childhood disorders that result from inconsistent parenting or family dysfunction. The Rappoports' ongoing conflict might have sparked Michael's behavior in several ways. The stress of the conflict could have triggered his sullenness, withdrawal, and isolation. His parents' verbal threats to one another regarding harm or divorce might have fueled Michael's worries about the future. Such depression and worry could then lead to difficulties in concentration, lack of motivation, and poor schoolwork. Mr. and Mrs. Rappoport's fighting also took time away from disciplining Michael for his behavior. Michael's tantrums and other disruptive behaviors were often ignored until they became severe.

Each of these models—psychodynamic, attachment, behavioral, social learning, cognitive, affective, biological, and family systems—holds that specific causal pathways lead to childhood behavior disorders. No one model successfully explains all aspects of a childhood disorder, however. The complexity of childhood disorders instead demands an integrative approach. Combinations of variables from these different perspectives, or multiple causal pathways, are needed to explain fully the etiology of a disorder. Different child, parent, peer, and teacher factors influenced Michael's behavior. The presence of multiple causal pathways suggests as well that successful treatment for children with behavior problems must involve many targets.

Developmental Aspects

Developmental psychopathology refers to study of antecedents and consequences of childhood behavior disorders and how the disorders compare to normal behavior development (Lewis & Rudolph, 2014). An important task of developmental psychopathologists is to identify pathways that lead to normal development, mental disorder, or some fluctuation of the two in children. A developmental psychopathologist may wish to discover what child and family factors lead to depression. He or she might also want to know what factors prevent the development of

depression, what factors help a person with depression return to mental health, and what factors maintain depression over time.

An important task in developmental psychopathology involves discovering whether childhood behavior problems are stable over time and whether they lead to problems in adulthood. Some childhood behavior problems are *very* stable over time. Consequently, they usually interfere with functioning in adulthood. Examples include autism, profound intellectual disability, and aggressive forms of schizophrenia. Severe forms of late adolescent problems, such as conduct disorder or excessive substance use, may carry into adulthood and create ongoing difficulties.

Other childhood behavior problems remain *fairly* stable over time. They may or may not lead to problems in adulthood depending on severity of the disorder and whether early intervention occurs. Examples include ADHD, learning disorders, aggression, school refusal behavior, eating disorders, pediatric conditions, and effects from maltreatment.

Other childhood behavior problems tend to be *less* stable over time. These problems may dissipate but could still cause problems over time if aggravated by negative environmental events. Examples include fear, anxiety, depression, and elimination disorder.

Childhood behavior disorders may be stable over time but symptoms of the disorders may not remain the same. Children with ADHD tend to become less overactive as they mature, but ongoing restlessness and difficulty concentrating as well as lagging social development create other problems in adolescence. Similarly, a child who wants to coerce items from family members may do so using noncompliance in childhood but aggression in adolescence. A child behaviorally inhibited as a preschooler may avoid new social situations in childhood and become depressed in adolescence.

Symptom change was evident for Michael. His problem behaviors at age 9 differed somewhat from his preschool days but some of his general behavior *patterns* remained the same. His parents described Michael as an "ornery" child who was fussy and who complained about what he had to eat. Mrs. Rappoport also said Michael was a "very sensitive child" who overreacted to criticism and inadvertent contact from others. These general characteristics were somewhat imbedded in Michael's current behavior problems. His temper tantrums were a regressive way of coping with stress and his sudden fear of disease was an overreaction to his classmates' stories. Michael's behaviors were different over time but his behavior patterns were somewhat stable.

Variables that help determine the stability of a childhood behavior problem involve proximal and distal factors (Hayden & Mash, 2014). Proximal factors are those close to a child that have more direct impact on his behavior, such as

1. development of a disorder early in life, especially one that affects language;
2. major changes in a child's brain or other physical status;
3. early and ingrained learning patterns;
4. strong biological predispositions triggered by early environmental events;

5. ongoing experiences that threaten a child's self-esteem and social and academic competence;
6. obstacles that lead a child to pursue more maladaptive behavior patterns.

Regarding the latter, obstacles such as family conflict or sexual maltreatment could initiate an adolescent's noncompliance or increased alcohol use.

Michael did not have major stressors or biological problems early in life. He did learn that one of the best ways to get parental attention, however, was to act inappropriately. Michael effectively trained his parents over time to give him attention when he was noncompliant, aggressive toward his sister, or problematic in school. In addition, Michael experienced several obstacles when he tried to build long-term friendships, such as loss of recess at school and discomfort bringing potential friends to his house. Lack of friendships then led to maladaptive behaviors such as social withdrawal and depressed mood.

Other factors that affect the stability of childhood behavior problems are distal ones, or those that indirectly affect a child. Distal factors include

1. poverty and/or homelessness;
2. marital conflict and/or inconsistent or neglectful parenting;
3. loss of a parent early in life;
4. severe family dysfunction;
5. general community disorganization.

Marital conflict was most pertinent to Michael. Some of Michael's tantrums were triggered by his parents' fighting or were done deliberately to get his parents to stop fighting.

Treatment

Treatment for the Rappoport family got off to a rough start. Mr. Rappoport became progressively more withdrawn and, after 3 weeks, stopped attending therapy. He did agree, however, to speak with the psychologist by telephone and to help his wife with therapy procedures. Mrs. Rappoport remained adamant about maintaining the focus of treatment on her son. The psychologist, in response, spent the first four sessions describing the family mechanisms behind many of Michael's behaviors and the necessity of including Mrs. Rappoport and Michael's teacher in therapy. Mrs. Rappoport reluctantly but eventually agreed to participate in the therapy. She also agreed to consider the psychologist's recommendation that she and her husband pursue marital therapy.

During this 4-week period when Mrs. Rappoport considered her role in the therapy, the psychologist worked with Michael to address his fear of disease and excessive handwashing. Michael was fully educated about the transmission of disease in general and of AIDS in particular. The psychologist focused on external causes and internal effects of illness much to Michael's fascination. His self-reported anxiety

regarding illness and general medical procedures declined somewhat during this time.

The psychologist then focused on Michael's handwashing that occurred when sitting next to someone who "looked sick." The psychologist first had Michael sit next to different people in the clinic's waiting area. He could wash his hands only if someone next to him sneezed. Otherwise, he entered the psychologist's office and did not wash for at least an hour. Michael saw that his anxiety declined without handwashing during this time. Michael was required to wait even longer before washing in subsequent sessions. He practiced waiting before handwashing in real-life settings as well. His response to this approach was immediate and positive. By the end of the 4-week period, he was washing his hands for a normal amount of time each day.

Mrs. Rappoport agreed to play a more active role in treatment but insisted that the first area of focus be on Michael's noncompliance, tantrums, and aggression. The psychologist explained that Michael often reacted to his parents' fighting by acting out, so Mrs. Rappoport and her husband agreed to hold their "discussions" in private as much as possible. Both parents were shown they waited too long to respond to Michael's misbehaviors. Instead, one parent or the other was to place Michael in time-out immediately for 10 minutes if he was noncompliant to a direction. The psychologist felt time-out was a good alternative punishment to spanking as well. Further assessment yielded no evidence of maltreatment but everyone agreed spanking was not a preferred option. Three weeks of therapy thus focused on using time-outs following noncompliance. Michael did heed his parents more, though he may have been compliant simply because of the extra attention he received.

Michael's tantrums also decreased during this period, suggesting again that reduced parental fighting and increased attention influenced his behavior. His aggression toward his sister worsened in this initial stage of therapy, however. The psychologist therefore recommended that Mr. and Mrs. Rappoport increase their supervision of Michael and his sister when they were together. Much of his aggression could thus be prevented. The psychologist did not recommend spanking for aggression because children often model this aggressive behavior. The psychologist instead advised Mr. and Mrs. Rappoport to ignore Michael after he hit his sister and give their daughter much sympathy and extra attention. This combination worked moderately well during the next 3 weeks.

At this time in therapy, Michael's parents separated and Mr. Rappoport left the house. Mrs. Rappoport continued to participate in Michael's treatment despite her depressed mood. The psychologist decided to provide support to Mrs. Rappoport and fine-tune therapy recommendations from previous sessions. Mrs. Rappoport would thus not be overwhelmed with new treatment responsibilities but would still be able to control Michael's behavior. Fortunately, Michael's response to his father's absence was not too negative because the two spent time together on the weekends. Michael also promised to help his mother with household chores because his father was no longer there to assist.

Given Mrs. Rappoport's emotional state, the psychologist focused more on Michael's school-related problems. This shift of focus let the psychologist spend

about half the therapy time with Mrs. Greco, Michael's teacher, who graciously offered to attend. Mrs. Rappoport did not wish Michael medicated for his behavior, so the psychologist established a token economy based on a card system. Michael received a warning for acting-out behavior; if he did not stop, he would have to change his card from green to yellow. If he continued to act out, he would receive another warning and then a red card. A red card meant Michael would have to spend the rest of the day doing his schoolwork in the principal's office. A green card for the entire day meant Michael could receive different prizes or classroom privileges.

Michael's acting-out behaviors did not change over a 5-week period. In addition, Mrs. Greco said the token economy was difficult for her to maintain consistently. Part of the problem was defining exactly what acting-out behaviors should be considered. The psychologist thus changed the focus of the token economy to Michael's academic behaviors. Michael was required to stay in the classroom regardless of his behavior; instead, Mrs. Greco rewarded or disciplined Michael primarily for amount of work completed. Unfortunately, Michael's homework performance or grades still did not change.

This lack of change may have been partly due to Michael's family situation, which worsened. Mr. and Mrs. Rappoport decided to divorce and Mr. Rappoport suddenly moved to a job in another state. Within 3 weeks, he was gone and had no face-to-face contact with Michael or other family members for some time. Michael went through a month-long period of sadness and lack of motivation regarding school, friends, and sports. He eventually rebounded to some extent when his father resumed direct contact with him but he remained uninterested in therapy.

Mrs. Rappoport and Michael attended therapy intermittently during the next 6 weeks. Eventually, despite urgings from the psychologist, Michael and his mother no longer visited the clinic. Mrs. Rappoport consulted with the psychologist occasionally by telephone over the next year and said the family situation and Michael's home behavior had stabilized. Michael's academic problems and school-related misbehaviors continued to some extent, however.

DISCUSSION QUESTIONS

1. Which of Michael's behaviors do you think were more "disturbed" and which do you think were more "disturbing" to his parents and teacher? Which of Michael's behavior "problems" might seem normal for a 9-year-old?
2. What were Michael's primary behavior problems? Identify five you consider most important and explain your reasoning. Three DSM-5 diagnoses were assigned to Michael. Which ones do you think were most pertinent? Defend your answer.
3. In a case like Michael's, the family may be as problematic as the child. How would you explain to parents and others that their behavior must change if a

child's behavior is to change? How would you convince a family to stay in treatment if you believed they could greatly benefit from doing so? Should you do so if family members say they are no longer interested in therapy? Why or why not?

4. A key goal for developmental psychopathologists is to identify pathways that lead to, and away from, mental disorder. Choose a childhood disorder or behavior problem and develop a causal model for it. Form a theory about why some children develop that particular problem and others do not. Discuss "protective" factors that help children avoid such misbehaviors. Outline factors that might move a child away from maladaptive behavior or improve his or her prognosis for the future.
5. Outside of Rappoport family members and Michael's teacher, which people might be important for addressing Michael's behavior problems? What would you want to ask or say to these people? Why?

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Chapter 2

Social Anxiety and Withdrawal

Symptoms

Bradley Mavin was a 12-year-old European American male referred to a specialized clinic for youths with social anxiety and withdrawal. Bradley was in seventh grade at the time of his initial assessment. His stepfather and mother, Mr. and Mrs. Nelson, referred Bradley to the clinic after reading a newspaper advertisement calling for participants in a group therapy project. The project involved testing an assessment and treatment protocol for youths with social problems. During the telephone screening interview, Mrs. Nelson said Bradley was having trouble adjusting to his new middle school and seemed depressed and withdrawn. He also seemed upset about her recent divorce and remarriage. Bradley was thus missing more school than usual and his grades were suffering.

An advanced doctoral student in clinical child psychology interviewed Bradley during the intake session. Bradley was initially cautious and unsure of himself, avoiding eye contact and speaking softly. The doctoral student, who had experience with shy and socially anxious children, first talked to Bradley about various topics he seemed to enjoy. These topics included his pets, school projects, and sisters. Bradley seemed more relaxed following this development of rapport. The student then questioned Bradley about his recent social problems.

Bradley said his new middle school was quite different from the elementary school he was in since kindergarten. He said many of his friends from elementary school now went to a different middle school and so he did not know many people at his current location. He wanted to transfer to the other middle school to be with his old friends. Bradley claimed that few of his new classmates spoke to him or invited him for lunch or other activities. The interviewer discovered, however, that Bradley rarely initiated contact with others in school. Bradley said he "hated" physical education class where everyone "made fun of him" for his size; he was slightly smaller than his peers. He generally felt lonely, sad, and "left out."

Bradley also complained about oral presentations in his English class—an assignment he never had before. He said his first oral presentation went badly. He was supposed to give a presentation on the history of automobiles but

became anxious when asked to stand before his classmates. Bradley said he trembled and had trouble breathing, which made his hands and voice shake noticeably. He saw some of his classmates snicker and decided then not to give another presentation. Unfortunately, he was required to give three other presentations; not doing so would result in a failing grade.

Bradley started refusing school because of these experiences. He began by occasionally skipping his physical education class but in the past month missed 1–2 full days of school per week. Bradley would stay home, do homework, and watch television when skipping school. He already asked his parents to transfer him to a new middle school or place him in home schooling.

The interview then focused on other areas of Bradley's social life. Bradley said he was active with neighborhood friends but avoided anyone new. He had a good relationship as well with his mother and two sisters. His relationship with his stepfather was strained, however. Bradley said his stepfather was strict and was not afraid to spank him for various offenses. His stepfather was livid about his refusal to go to school and his parents often fought about this issue. They immediately called the number in the newspaper when they saw it was for children with social problems.

Mr. and Mrs. Nelson largely confirmed Bradley's report during their interview. Mrs. Nelson said Bradley was a well-behaved son until about 2 years ago when she and her first husband separated (Bradley's biological father was currently out of state and had no contact with the family). Bradley then became withdrawn and unwilling to play with other children in his neighborhood. Contrary to Bradley's report, he still avoided many of his old neighborhood friends and spent much of his free time doing homework or playing video games. He did participate in family dinners and outings but generally preferred to stay close to his mother and sisters.

Mrs. Nelson said Bradley's situation worsened during the past 3 months. She confirmed Bradley's fears about his physical education class and oral presentations and agreed that he made few, if any, new friends. She also confirmed that Bradley wanted to be placed in home schooling and she was about to do so when she saw the clinic's advertisement. Mrs. Nelson then decided Bradley might benefit more from therapy than home schooling and she wanted the advice of clinic staff members on this matter.

Mrs. Nelson said Bradley was an excellent student who was generally shy. He enjoyed working on his school projects as much as other kids enjoyed playing baseball. He was a "loner" who rarely interacted with other children his age and who preferred to play with his two younger sisters. Otherwise, he was a normal child who was compliant, polite, and dutiful regarding his household responsibilities.

Mr. Nelson added that his relationship with Bradley was difficult and that the two "just didn't seem to connect." Mr. Nelson was adamant about Bradley's return to school but deferred to his wife when she recommended therapy. He said he wanted to help Bradley with his problems but was not sure he could. Mr. Nelson hoped therapy would help Bradley become more self-confident and improve their relationship.

The therapist secured Mr. and Mrs. Nelson's permission to interview Bradley's teachers at school. All said Bradley was a fine student with excellent potential but was shy and withdrawn. Bradley's English teacher, Mrs. Arnot, said her student did well on all assignments up to the oral reports. His first oral report had not gone badly but Bradley clearly had physical symptoms of anxiety. She said she had a strict class rule that students could not make jokes or laugh when anyone gave an oral report, and no one did during Bradley's report. Bradley approached her after class and cried profusely, however, asking to be relieved of his remaining oral presentations.

Bradley's physical education teacher echoed this report but said Bradley was teased to some extent. The teacher said Bradley needed to "grow up," interact more with other kids, and become more assertive. Conversations with Bradley's other teachers and guidance counselor confirmed that Bradley avoided many social situations, especially those that required meeting new people, working cooperatively with others, and performing before an audience. The therapist preliminarily concluded that Bradley was moderately socially withdrawn and met criteria for social phobia/social anxiety disorder.

Assessment

The essential feature of social phobia or social anxiety disorder is a "marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others" (American Psychiatric Association, 2013, p. 203). Social functioning with people known to the person such as family members is good but social fear occurs when a person interacts with unknown others or during situations where the person might feel negatively evaluated, humiliated, or embarrassed. The person usually has a panic attack or panic symptoms when exposed to social situations. Children may display "crying, tantrums, freezing, clinging, or failing to speak in social situations" (p. 202). Those with social phobia, though not necessarily children, recognize their fear as unreasonable and endure social situations with great distress if they cannot avoid them. The disorder must significantly interfere with daily functioning, last at least 6 months, and not be due to a medical condition or substance. Social phobia can be restricted to fear of speaking or performing in public.

Bradley appeared to meet these criteria. He was fearful and anxious when meeting new people and was reportedly "nervous and sick" in large social situations. Bradley was uncomfortable in situations involving close evaluation from others such as physical education class and oral presentations. Bradley reported nausea and trembling during these situations and was convinced that others could see him become upset. His level of social anxiety and withdrawal thus interfered with his academic functioning. Bradley's social interactions with his family and relatives were appropriate, however.

The assessment of youths with social anxiety typically includes interviews, self-report measures, self-monitoring, parent and teacher measures, and perhaps physiological evaluation. Therapists often use several measures because results

from them do not always highly correlate. A child may report no cognitive symptoms of anxiety in stressful situations but still have substantial physiological arousal.

Semistructured interviews for children with anxiety disorders include the Anxiety Disorders Interview Schedule (Chapter 1). Clinicians often use this interview in research settings to identify anxiety symptoms and other pertinent problems in children and adolescents. Bradley's therapist worked in a specialized research clinic and used this interview.

The interview has questions regarding concerns about evaluations of others and feelings of embarrassment or shame in social situations. Therapists ask a child about level of fear in social situations such as answering a question in class, taking a test, eating before others, and dating. Fear of these situations is rated on a 0–8 scale where 8 represents greatest amount of fear. In addition, questions are raised about whether a child's social fear declines when certain (e.g., younger) people are present and how much social anxiety interferes with daily functioning.

Bradley said he was afraid he would do something stupid or clumsy in different social situations, especially when meeting new people or performing before others. He was concerned as well about snickering from others and feeling embarrassed at these times. Bradley identified social situations that made him feel most nervous: oral reports, physical education class, eating in the cafeteria, starting or maintaining conversations, and answering questions in class.

The assessment of youths with social anxiety can include self-report measures such as the Social Anxiety Scale for Children-Revised (La Greca, 1998; Sanna et al., 2009) and Social Phobia and Anxiety Inventory for Children* (Beidel, Turner, & Morris, 2000; Scaini, Battaglia, Beidel, & Ogliari, 2012). Sample items from the latter include

1. I feel scared when I have to join in a social situation with a large group of boys and girls.
2. I feel scared when I meet new kids.
3. I am too scared to ask questions in class.
4. I leave social situations (parties, school, playing with others) where there are boys or girls my age that I don't know.
5. When I am someplace (a party, school, soccer game, or anyplace where I will be with others), my heart beats fast.

Bradley's self-rated symptoms included worry when doing something before others, worry about being teased, worry about what others thought of him, nervousness when talking to others not well known to him, feelings of shyness, feelings others were making fun of him, and difficulty asking others to play.

Bradley's therapist asked him to self-monitor several behaviors. Bradley was asked to write down social situations during the day that caused him to feel

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nervous or sick. He rated, on a 0–10 scale, how nervous and sad he felt during these situations. The therapist further described various thoughts Bradley might have during these situations and asked him to record these as well. Bradley also noted other concerns he had during the day.

Over a 2-week period, Bradley's self-monitoring revealed two main findings:

1. His social anxiety was highest when he entered school, went from class to class, and ate lunch in the cafeteria. He did not rate his physical education and English classes as highly anxious *unless* he had to perform individually before others.
2. Bradley's thoughts during unpleasant social situations were somewhat distorted. He believed others often watched him closely and evaluated him negatively. More darkly, Bradley thought others plotted to "gang up on him" and steal his books and other materials.

Therapists commonly use parent and teacher measures to evaluate children with social anxiety, most notably the Child Behavior Checklist and Teacher's Report Form (Achenbach & Rescorla, 2001). Mr. and Mrs. Nelson noted their son's clinging, clumsiness, preference for younger playmates, and teasing by others. Bradley's English teacher, Mrs. Arnot, recorded Bradley's crying and hurt feelings during evaluative situations. Physiological assessments such as heart rate and sweat indices are sometimes used to assess youths with social anxiety but not in Bradley's case.

The assessment of children who are socially withdrawn can include sociometric measurement and direct observation. Sociometric measurement involves soliciting peer ratings of a child suspected of being rejected or neglected (Poulin & Dishion, 2008). Sociometrics may include nominations, as when children simply list names of classmates they would most or least like to work and play with. In addition, teachers or children can give general rankings of each child in a classroom. This is done to identify one particular child's level of popularity and social interaction. Paired rankings, where each child is directly compared to every other child, may also be examined. Sociometric measures are done carefully, though, so children are not singled out for further rejection. Sociometric measures were not solicited in Bradley's case, however.

Bradley's therapist instead conducted a direct observation of her client during selected times at school. Bradley knew the therapist would come to school to observe him but did not know when. The therapist observed Bradley during lunchtime and outside during his physical education class. The therapist noticed that Bradley generally stood alone, rebuffed interactions from others, and seemed emotionally depressed. The therapist confirmed that Bradley was anxious in these situations and lacked some basic social interaction skills.

Risk Factors and Maintaining Variables

Many factors likely lead to anxiety and withdrawal in youth, perhaps involving a combination of biological vulnerability, family factors, stressful life events, and

child characteristics (Ollendick & Benoit, 2011). Studies indicate a genetic contribution to social anxiety in twins and the risk for social phobia is greater for relatives of someone with the disorder than the general population (Stein & Stein, 2008). Genetic data may partly reflect an environmental factor, however: how anxious parents raise anxious children.

Family factors do seem to have a strong influence on the development of social anxiety and withdrawal in children. Anxious children tend to model perceptions of environmental threat from their parents (Muris & Field, 2010). They watch the carefulness, caution, and avoidance shown by their parents and imitate the behavior in their social situations. This seemed true for Bradley. His mother was a shy and reserved woman who reportedly enjoyed the traditional role of wife and mother. Much of her social life involved her husband and children and she infrequently associated with others. She appeared anxious when meeting new clinic staff members. Bradley may have adopted many of his mother's withdrawn, anxiety-based social interaction behaviors.

Other family variables related to social anxiety in children include overprotection, lack of parental warmth, and disrupted attachment (Essex, Klein, Slattery, Goldsmith, & Kalin, 2010; Knappe et al., 2009). Bradley's mother was clearly overprotective, often demanding to know where her son was at different times of the day and even picking out his clothes in the morning. She kept him physically close to her when shopping or working outside. Bradley's relationship with his mother was affectionate, however, and his early attachment with her was secure. He had more difficulty getting along with his stepfather, as was the case with his biological father, but this did not seem too relevant to his current social anxiety or withdrawal.

Children with anxiety disorders may have parents with anxiety disorders, depression, or excessive substance use. Bradley's biological father had alcoholism and possible depression. Bradley's mother said she felt depressed and would retire to her room when "down in the dumps." Bradley perhaps modeled this behavior in addition to others noted earlier.

Various stressful life events, especially those related to social trauma, can influence the development of anxiety and withdrawal. Bradley experienced recent trouble during his oral reports and physical education class. Discussions with Bradley and his mother revealed, however, that Bradley's friendships generally declined in number since fourth grade. Events at that time disrupted Bradley's friendships. Many of his early school-age friends moved out of town when its main industry relocated. In addition, others teased Bradley in first and second grades for occasional wetting.

Precursors to child social anxiety and withdrawal include child characteristics such as social apprehension, feelings of uncontrollability, and behavioral inhibition (Kearney, 2005). Many children such as Bradley expect the worst possible outcome in social situations. When faced with social or evaluative situations, Bradley complained that others were out to harm him or did not like him. He was convinced that peers would ridicule his oral presentation even though no evidence supported this belief. Bradley said he did not ask others to play or work with him because they would "probably push me or steal my stuff."

Children with social anxiety often report feelings of uncontrollability as well. This refers to a general sense of learned helplessness whereby children feel their actions will have little impact on their environment. This may help explain why many children with anxiety have symptoms of depression. Bradley displayed uncontrollability when he said it was pointless to start conversations with others or relax when speaking in class. In addition, the therapist saw that Bradley often stayed by himself and walked with his head down. This behavior suggested that Bradley did not think he could make a positive change in his social situations.

Child social anxiety and withdrawal closely relates as well to behavioral inhibition, which is a type of temperament marked by high arousal and withdrawal from new situations, including social ones. Behavioral inhibition affects about 10–20% of children and may relate to various childhood anxiety disorders (Clauss & Blackford, 2012; Hirshfeld-Becker et al., 2008). This is so because the temperament is associated with escape, avoidant, dependent, and passive behaviors. Bradley clearly showed these behaviors. He was timid and shy in situations involving people outside his family and withdrew quickly from unfamiliar situations. He seemed dependent on his mother for emotional support and was relatively unassertive.

Various factors thus conspire to cause social anxiety and withdrawal in children. The problem may begin with an irritable, withdrawn temperament and a moderate biological vulnerability to high arousal. As the child grows, negative social events may predispose him or her to develop a sense of learned helplessness or uncontrollability about the surrounding environment. These events may trigger high biological arousal. The person may then become socially apprehensive as he or she scans his or her environment for potential threats. The person then avoids more and more social situations (Kearney, 2005).

Several factors can maintain social anxiety or withdrawal. A child may complain to his or her parents about social mistreatment at school and receive positive attention. Such attention may be in the form of sympathy, verbal praise, or physical affection. Conversely, a child may wish to escape different situations that involve added work or stress, such as helping a parent at a party. Claims of social anxiety and negative physical symptoms such as a stomachache might help get a child out of certain responsibilities (Kearney & Drake, 2002). Attention-seeking and escape-motivated behaviors were evident in Bradley's case.

Developmental Aspects

One of the core aspects of social anxiety and withdrawal—behavioral inhibition—has a moderately stable course (Hirshfeld-Becker et al., 2008). Inhibited or temperamentally difficult infants often show irregular eating and sleeping patterns, withdrawal from novel situations, poor adaptability, irritable mood, and intense reactions to aversive stimuli such as loud noises. Conversely, less inhibited or temperamentally "easy" infants have more positive mood and good adaptability.

These characteristics—inhibition and adaptability—remain core aspects of an individual's personality with age. Inhibited children tend to become shier, fearful

of others, cautious, and introverted during preschool years. They can become quieter and cling to adults more over time. This is especially so when new social situations arise. Inhibited children may show more adverse physiological arousal and emotional reactivity in these situations than adaptable children (McDermott et al., 2009).

One developmental model of social withdrawal indicates that these early inhibitions make some school-age children more hesitant to explore new social situations outside the home (Rubin, Coplan, & Bowker, 2009). This reluctance negatively affects normal play and prevents a child from acquiring social and cognitive skills necessary for advanced social relationships. A child thus becomes more anxious during social interactions, avoids them, and feels isolated. Recognizing this social failure, a child may develop a sense of insecurity and poor self-esteem. He or she may be predisposed to develop conditions such as separation or social anxiety disorder.

Mrs. Nelson said Bradley was a somewhat "fussy" baby but not one who was overly difficult to care for. She said Bradley played appropriately with others during preschool and was never aggressive. She did recall that Bradley's preschool teachers said he was shy, however, and waited for others to approach him before he would interact. Exceptions included adults, whom Bradley liked more than peers. This was demonstrated by his excessive politeness, compliance, and sensitivity to adult feedback. Mrs. Nelson admitted that her marital problems sometimes led her to be overprotective and emotionally dependent on her son. She often kept him physically close to her.

Mrs. Nelson reported some separation anxiety on Bradley's part during elementary school but this faded over time. Of greater concern were her marital problems that worsened and caused great disruption in the family. These problems intensified after the arrival of Bradley's two younger sisters. Mrs. Nelson admitted that her husband's failure to help her with the children caused her to rely more on Bradley, who became responsible for some of the feeding, laundry, and housecleaning chores. Time that might have been spent developing friendships was instead put toward fulfilling family responsibilities. These stressful family events reinforced the emotional bond and dependence between Bradley and his mother.

These patterns deepened during Bradley's later elementary school years. Mrs. Nelson divorced her husband and shifted even more household responsibilities onto Bradley. Bradley then relied more on his schoolwork as a source of self-esteem, which took time away from church group activities, participation in sports, and other social events. The therapist thought Bradley lost some opportunities to build better social skills during this time and had trouble understanding how to approach others or how to maintain conversations.

The developmental aspects of specific play behaviors may have important ramifications for treating socially anxious and withdrawn children. Very young children are highly egocentric, adult focused, and rule oriented. Cooperation, sharing, and appreciation of others become more evident during the later preschool period, however. A child playing a game learns to wait for another child to take his or her turn before proceeding. These behaviors are often the

foundation of later social skills development, so treatment for socially withdrawn children may be crucial at this time.

The successful development of these early play behaviors may link to later social behaviors such as delaying immediate gratification, listening to others, appreciating the viewpoint of others, understanding the concept of friendship, solving problems without aggression, communicating effectively, and being assertive. Children who lack these skills are likely to become deficient in social relationships and perhaps require treatment. Bradley's self-discipline and conversational skills with adults were well developed but his understanding of peer relationships was not. He was not very knowledgeable about how many friends most people had or even how friendships developed in the first place. He did not link the development of friendships to better quality of life. Bradley's communication skills with peers, especially his articulation, needed improvement as well.

Gender differences appear for play and social behaviors as well. Preschool boys are more likely to play with transportation toys but girls prefer dolls. Girls are more likely to play with toys traditionally thought of as masculine or feminine but boys prefer primarily masculine toys. Boys tend to be more physically active and spend more time outdoors than girls, which leads to competitive but more frequent and durable social contacts (Leaper, 2015). Bradley often stayed indoors or close to home during his preschool and elementary school years. This may have prevented some peer social contacts. Bradley's social profile was more traditionally feminine as well. He was meeker, more adult oriented, and more attracted to solitary activities than most boys. The therapist thought these characteristics contributed to Bradley's rejection by male peers.

What about the long-term development of a child with social anxiety or withdrawal? Social isolation and poor social skills development relate to various problems in adolescence such as depression, negative self-esteem, and loneliness (Rubin et al., 2009). Other possible consequences include excessive substance use, ongoing academic and occupational difficulties, and increasingly poor interpersonal relationships. A warm family environment, academic competence, and perceptions that one is sufficiently involved in social activities can mediate these long-term effects, however. Bradley showed some of these mediators, which could blunt some ill effects of his early social withdrawal. His academic prowess and family support may allow him to become a late bloomer and develop lasting friendships in high school and college.

Treatment

Therapists, who treat a socially anxious or withdrawn child, often note whether the problem is due to (1) lack of social skills or (2) social anxiety that blocks the display of already developed social skills. Bradley originally attended group therapy for his social skills. His immediate problem was social phobia and school refusal behavior, however, so Bradley first began individual therapy to address his anxiety in specific situations.

Therapy for youths with social anxiety often involves exposure to anxiety-provoking social situations and building skills to cope with or reduce anxiety. Clinicians may also use cognitive therapy to help youths think more realistically in social situations. A common strategy is to build a "social hierarchy" or list of specific interactive situations a person avoids. These situations are arranged in order from least to most anxiety provoking (Hofmann & DiBartolo, 2014). Bradley listed four situations: entering the cafeteria to buy and eat lunch, participating in physical education class, meeting new people, and giving an oral presentation (the last being the most aversive).

A child then addresses each item on the social hierarchy in the therapeutic setting, beginning with the lowest anxiety-provoking item. Bradley's first item involved his cafeteria behaviors. Bradley discussed his fears about this setting, including dropping food, going too slowly in line, not having enough money to pay the cashier, and being stared at while eating. The therapist first helped Bradley identify thoughts that had no basis. The therapist asked Bradley if any of the "in-line" behaviors he mentioned happened before. They had not. The therapist thus demonstrated that Bradley did not have enough evidence for his thought and should develop a more realistic one. Bradley then said he might drop some food or fail to have enough money but agreed this was unlikely. The therapist pointed out that Bradley rarely looked at anyone while eating and therefore should not expect others to look at him. To confirm this, the therapist took Bradley to a local cafeteria to show him that no one else watched him eat.

The therapist then addressed more difficult items on Bradley's hierarchy. Bradley discussed his fears of physical education class and oral reports, which were remarkably similar: he believed others unfairly dismissed him or made rude comments about his performance. Regarding physical education class, Bradley complained about not being picked for a team even though he was good athletically. Regarding English class, he complained his classmates ignored him or belittled his oral report. The therapist pointed out Bradley's tendency to overestimate others' harsh evaluations and criticism, as he did in the cafeteria setting. She pointed out as well that Bradley's self-imposed withdrawal perhaps made other children wary or avoidant of him.

The therapist asked Bradley to approach more classmates in his physical education class and ask to be picked for a team before class. The therapist helped Bradley practice different lines of conversation to introduce himself and tell people of his skill in a particular area such as basketball. With Bradley's permission, the therapist contacted the physical education teacher to ask whether Bradley could make team selections more often and assume a leadership role when possible. Bradley adapted well to this new situation and his anxiety during physical education class diminished sharply.

A greater concern was Bradley's refusal to do another oral report. The therapist instructed Bradley to give a series of oral reports to her in the office. This first consisted of reading newspaper and magazine articles. The therapist later assigned brief reports on a topic Bradley had to research. The therapist gave Bradley extensive feedback on his presentation skills during these reports, especially his voice projection, eye contact with the audience, enunciation of

syllables, and control of physical anxiety symptoms. Bradley learned to tense and release different muscle groups that were most problematic during his talks. These included tense facial and jaw muscles as well as trembling legs.

Bradley's oral presentation skills in the office were good after frequent therapy sessions in a 1-month period. His therapist then subjected Bradley to a greater audience of unknown people, some of whom were told beforehand to engage in distractions such as sighing, not paying attention, and snickering. Bradley found these distractions upsetting at first but subsequently worked through them and gave his reports without much trouble. The therapist used cognitive techniques so Bradley would not "catastrophize" the situation. After watching his classmates, Bradley eventually acknowledged that not all of them laughed during the oral presentations. He also saw, with the therapist and teacher's help, that when people did laugh the consequences were not dreadful. Bradley then gave his oral reports in class (the teacher had graciously delayed his remaining reports until last). Bradley gave three reports in a 3-day period and, though his performance was just fair, his anxiety did decline with each presentation. Bradley was able to resume full-time school attendance.

Bradley later participated in group therapy with other children with social skill deficits and social withdrawal. The main purpose was to build Bradley's skills for meeting new people. Group therapy members learned to approach someone and introduce themselves. Group members turned to the one on their left, looked that person in the eye, said hello and their name, and offered a handshake. Many group members found this anxiety-provoking but all did at least a fair job. They developed other skills over time such as the ability to maintain a conversation, compliment others, exit a social situation with grace, and control physical anxiety symptoms. The group also engaged in social outings to practice their skills in real-life settings. Each group member was further assigned the task of joining two social activities in their church, school, or neighborhood.

Group therapy for people with social anxiety and withdrawal has two primary advantages: (1) discovering others have a similar problem and (2) social support. Both advantages were comforting to Bradley, and two members of his group became his good friends. Following a 6-month therapy program, Bradley improved substantially in specific areas of concern such as speaking before others and maintaining a conversation. He remained somewhat shy overall and still avoided some social situations when anxious. He thus attended several booster sessions over the next 2 years. Bradley's overall social functioning was determined to be fair to good by the end of this time.

DISCUSSION QUESTIONS

1. What differentiates children who are (a) naturally shy, (b) socially anxious, (c) socially withdrawn, (d) neglected, or (e) rejected? Explore family and peer factors as well as child characteristics.

2. What characteristics make one child more "popular" than others?
3. Was Bradley's social anxiety and withdrawal primarily due to personal or family factors? How could a parent encourage more appropriate social behaviors in a child? What activities would be most effective to help a child develop positive social skills? What social skills are most important for a child to have?
4. What gender expectations do we generally have regarding child social behavior? Explore activities often considered "off limits" for boys and girls. How might this harm the development of social skills?
5. What aspects of your own social behavior do you wish you could improve? What might be the best way to do so? How would you enlist the help of others? How might you help someone who is shy but wants to be more socially active?
6. How might you respond to a child who has no friends but says he or she does not care?
7. How might you address a child who decided to join a gang or hang out with the "wrong crowd"? What are advantages and disadvantages of this social behavior?
8. What might you have added to Bradley's treatment program? How might you have included his family members in treatment? How might you improve Bradley's social relationship with his stepfather?
9. What could be done in schools to help children with social anxiety or withdrawal?

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Chapter 3

Depression

Symptoms

Anna Thompson was a 16-year-old African American female referred to the adolescent unit of an inpatient psychiatric hospital. Her mother, Mrs. Thompson, referred Anna after discovering her daughter bleeding from her wrists in her bedroom. The amount of blood was not substantial but Mrs. Thompson brought Anna to a hospital emergency room for treatment. The attending physician said Anna was not seriously injured but recommended commitment to an inpatient psychiatric hospital for evaluation. Mrs. Thompson consented to a short-term commitment of her daughter given Anna's recent depressive behaviors. A psychiatrist who specialized in adolescent behavior disorders interviewed Anna the next day.

Anna was initially hesitant about talking and angry with her mother for committing her. She was more forthcoming after some initial discussion, however. Anna said she recently moved to a new school following her mother's divorce and that no one seemed to like her. She was upset about being in the racial minority and having few friends. When asked if a specific recent event upset her, Anna said she felt other teenagers made derogatory remarks about her weight as she ate alone during lunch (Anna was quite overweight). Anna could not be more specific, however, so whether remarks were actually made about her was unclear.

Anna said the past 13 months were difficult. Her parents separated and eventually divorced following some marital conflict. For reasons Anna did not completely understand, her mother moved out of state with Anna and separated her from her father and 13-year-old brother. This was traumatic for Anna because she was close to her father and brother but could no longer contact them. Anna enrolled in her new school in August and began attending in September. She missed about one-third of school days in the first 2 months, however, and had not attended in the past 2 weeks. Anna said she was lonely because her mother often worked and she had no new friendships.

Anna's mood worsened over the past 2 weeks. She greatly missed her entire family and complained she could not spend Thanksgiving with her father and

brother (her mother already said this was impossible). She thus became less active, lying around the house, watching television, and chatting online. She left the house only twice in the past week and was overeating and oversleeping. Her mother worked a lot and did not talk to Anna much in the past 2 weeks. When they did converse, she tried to persuade Anna to go back to school.

The psychiatrist then raised the topic of Anna's injuries from the day before. Anna said she was feeling bad and wondered what it would be like if she committed suicide. She wondered how her family would feel and who would come to her funeral. She said she was not optimistic about the future and that suicide sometimes seemed preferable to living. Anna insisted, however, that her behavior was not an actual suicide attempt. She claimed she made a few scrapes with a butter knife to see what would happen. She did get herself to bleed but did not feel her injuries were serious (the medical report confirmed Anna's statements). Anna said her mother came into her room, saw blood, and "freaked out." Anna's mother told her to get into the car and enter the emergency room. The attending physician asked about her injuries and Anna told him truthfully what happened. She was then transferred to her current unit with a person sitting outside her room to watch her.

The psychiatrist asked Anna if she had current thoughts about harming herself, and Anna said no. She said again she did not want to kill herself the day before and that she now wanted to leave the unit. She also asked to see her mother and was told she would see her that evening. Anna promised the psychiatrist not to harm herself and to speak with him immediately if she had suicidal thoughts or impulses. The psychiatrist gave Anna a mild sedative and she slept for the remaining afternoon.

The psychiatrist later interviewed Anna's mother, Mrs. Thompson, who provided more information about the family situation. Mrs. Thompson said she and her husband had many past arguments about several issues, most notably his alcohol use and the family's financial status. The last straw came, however, when Mrs. Thompson caught her husband leaning over Anna as she slept. Mrs. Thompson suspected Anna's father of sexual misconduct though this was unproven. Anna denied this in conversations with her mother but Mrs. Thompson felt she and Anna should leave the state. Mrs. Thompson said she parted company with her son as well because he was unruly and because they had a poor relationship.

Mrs. Thompson confirmed some of Anna's reports with respect to recent events. She confirmed she was busy at work and unable to devote the kind of attention to Anna that her daughter was used to. The two did share time together on the weekends, however, though not in the past 3 weeks, and had good rapport. Mrs. Thompson confirmed that she and Anna had little contact with Anna's father and brother. This would include, she said, the upcoming holiday season.

Mrs. Thompson verified that Anna missed a lot of school in the past 2 months and did not make new friends. Both were concerned about Anna's weight and Mrs. Thompson knew this was a major source of embarrassment and frustration for her daughter. Despite these situations, Mrs. Thompson said

she was shocked to find Anna bleeding in her bedroom. Mrs. Thompson never considered the possibility of suicide but the apparent seriousness of the situation led her to agree to the inpatient commitment.

The psychiatrist spoke with Anna's guidance counselor at school with Mrs. Thompson's permission. The counselor, Mrs. Deetz, was upset about Anna's condition and said Anna commented about suicide 1 month earlier. Anna came to Mrs. Deetz's office and complained that students in her physical education class ridiculed her weight. Anna cried, complained she could not make friends, and said, "I wish I was dead." Mrs. Deetz then changed Anna's schedule so she would not have to attend that particular physical education class. She also made several recommendations regarding extracurricular activities but Anna dismissed them because she would be in the racial minority. Mrs. Deetz insisted, however, that Anna's concerns about social rejection were unfounded. She remained concerned about Anna and offered to assist the psychiatrist in any way possible.

The psychiatrist reinterviewed Anna the next day to confirm she had no current suicidal thoughts or impulses. He placed her on a low dose of antidepressant medication and asked her to attend group therapy sessions that morning and evening. Anna agreed and the psychiatrist noted that her mood improved somewhat from the day before. Given information received so far, however, the psychiatrist suspected Anna just experienced a major depressive episode and should remain on suicide watch.

Assessment

The essential feature of a major depressive episode is "a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities" (American Psychiatric Association, 2013, p. 163). The mood in children and adolescents may be irritable rather than sad. A person must experience five of the following symptoms during a 2-week period to qualify for the disorder: constant depressed mood, lack of interest in previously enjoyable activities, significant weight loss or gain, difficulty sleeping or oversleeping each day, restlessness or feeling slowed down, daily fatigue, feelings of inappropriate guilt or worthlessness, difficulty concentrating or making decisions, and suicidal thoughts or attempts. The symptoms must cause significant interference in daily functioning and must not be due to substance use, a medical condition, or an understandable reaction to life events such as death of a family member.

Many of these symptoms applied to Anna. Her mood over the past month was depressed and she rarely initiated activities for fun. She did not show appreciable weight gain but was overeating and oversleeping. This latter activity—hypersomnia—is common in people with depression who want to escape aversive life events. Early-morning awakenings are also common in this population but Anna did not report these. Anna said she felt "very slowed down" and often tired. She felt guilty about her parents' breakup even though this was unwarranted. Anna had no trouble concentrating but this may be because she did not regularly

attend school. Each of these depressive symptoms, in combination with Anna's suicidal thoughts and gesture, led the psychiatrist to his initial diagnosis.

The assessment of depression in adolescents can take many forms such as laboratory testing, interviews, self-report measures, and direct observation. Anna underwent various medical tests in the inpatient hospital to identify different conditions that might explain her depression. Several neurological and medical conditions can produce symptoms of depression, including brain and hormonal changes, cardiovascular problems, and severe illnesses, among others (Boldrini & Mann, 2015). Various substances can also produce symptoms of depression. Medical conditions and substances did not apply to Anna, however.

A laboratory test for depression is the dexamethasone suppression test (DST). A person is evaluated for his or her ability to suppress cortisol secretion. People with depression tend to have high levels of cortisol—a stress-induced hormone. DSTs generally do not completely differentiate youths with and without depression (Lopez-Duran, Kovacs, & George, 2009). A positive DST finding does not necessarily mean a person has depression, only that one marker is present. A negative DST result was found for Anna.

An interview is particularly important for assessing people with possible depression. Clinicians use interviews to obtain information and develop rapport with someone initially unwilling to share personal issues. Structured interviews for this population include the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (Kaufman et al., 1997) and Children's Interview for Psychiatric Syndromes (Weller, Weller, Fristad, Rooney, & Schecter, 2000). Most mental health professionals, including the psychiatrist in this case, rely on an unstructured interview to explore characteristics unique to a certain case.

Several topics should be explored when interviewing someone with possible depression. These topics include symptom description, history of symptoms, family history, and associated problems such as anxiety, substance use, and acting-out behaviors. A youth's perception of his or her symptoms, family situation, and other issues can be discussed as well. An interviewer should assess whether someone has thoughts about harming himself or herself. Many people who attempt suicide are willing to communicate their intent beforehand and accurately convey their plan for doing so. The more detailed a suicide plan, the more a person may be at risk for harm. Other important signs should be examined as well, including sudden changes in behavior and recent environmental stressors such as loss of a relationship.

Anna's symptom history was described earlier. Her perceptions of her situation and significant others in her life were discussed during inpatient group therapy sessions. Anna was confused by recent life events, especially her mother's quick departure from Anna's father and brother. She said she missed the rest of her family and former friends. She admitted feeling scared and upset on the psychiatric unit but acknowledged she had more social contact now than in the past 6 weeks.

Self-report measures are commonly used to assess depression in many inpatient and outpatient settings. Primary examples include the Reynolds Adolescent Depression Scale-2 (Reynolds, 2004) and Children's Depression Inventory

2 (CDI 2*; Kovacs, 2010). Anna completed the CDI during her inpatient stay and during later outpatient counseling. The CDI is a 27-item measure of recent depressive symptoms such as feeling sad, crying, self-blame, indecisiveness, fatigue, eating and sleeping problems, and loneliness. Sample subitems from the CDI include:

1. I am sad all the time.
2. I want to kill myself.
3. I feel like crying every day.
4. I feel alone all the time.
5. Nobody really loves me.

Anna's CDI score was in the clinical range following admission to the hospital. She endorsed several items, particularly those related to feeling sad, tired, lonely, and unmotivated. Her score diminished to the normal range by the end of her 3-week stay, however. The psychiatrist also assessed Anna for hopelessness—a construct often associated with depression in general and suicide in particular. The Hopelessness Scale for Children is a 17-item true-false instrument that emphasizes feelings about the future (Thurber, Hollingsworth, & Miller, 1996). Anna did not complete this scale but her answers to the psychiatrist's questions indicated a moderate to high level of hopelessness.

Direct observation of behavior can be helpful for assessing depression. Assessors should look for:

1. sad facial expressions;
2. decreased social and motor activity such as less talking, game playing, or interactions with others;
3. excessive solitary behavior such as reading or watching television;
4. slow speech;
5. decreased eye contact;
6. arguing;
7. poor affect in the form of frowning, complaining, or lack of smiling.

Hospital staff members initially noted some of these characteristics in Anna. They saw that Anna kept to herself unless someone encouraged her to attend group activities. Anna also looked sad and talked softly to others.

Other forms of assessment for this population include peer and adult ratings (Steiger, Allemand, Robins, & Fend, 2014). Peer ratings were not obtained for Anna because her classmates did not know her very well. Mrs. Thompson's ratings on the Child Behavior Checklist (Achenbach & Rescorla, 2001) were

obtained, however, during later outpatient treatment. These ratings indicated a moderate to high degree of loneliness, sadness, crying, and guilt on Anna's part.

Risk Factors and Maintaining Variables

Many cases of depression result from a mixture of biological and psychological factors. People with depression may have neuroendocrine changes such as abnormal cortisol regulation or reduced growth hormone secretion. Changes in the neurotransmitters—norepinephrine and serotonin—influence depression as well. Low levels of each occur in this population and drugs that increase levels of these neurotransmitters are good antidepressants (Zhou et al., 2015). No major physical abnormalities were present in Anna but an undetected physiological factor may have caused some of her depressive symptoms. Anna did not respond much to antidepressant medication either, suggesting that her depression was more environmentally based, or exogenous, than biologically based, or endogenous.

Genetic factors can predispose adolescents to depression. Identical twins are about twice more likely to share depressive symptoms than fraternal twins. Youths whose natural parents had depression are more likely to show depression themselves, even when raised by adoptive, nondepressed parents. Immediate family members of depressed adolescents are more likely to be depressed than the general population (Thapar, Collishaw, Pine, & Thapar, 2012). Genetic factors do not explain all variables associated with adolescent depression, however. Environmental factors often trigger biological predispositions to depression.

Anna's family history regarding depression was spotty. Mrs. Thompson had some depressive symptoms but whether these were simply normal reactions to recent life events was unclear. Anna's father was thought to have a history of depression and alcoholism but Anna's mother did not know whether he experienced a major depressive episode. Anna herself had never experienced major depression either. Her current state may have been more environmentally based. Anna and her mother, however, knew few additional family members, so a more detailed family history of depression was unavailable.

Psychological theories of depression may have been more pertinent to Anna. Psychodynamic theory holds that depression results from overdependence on others. When an overdependent person loses someone close, either through perceived loss, death, abandonment, or separation, that person engages in introjection. Introjection is a process whereby a person internalizes feelings of anger and hatred toward the lost one. Feelings of self-blame and worthlessness thus occur and depression begins.

A more widely accepted psychological model of mood disorder is a behavioral one. This model holds that depression generally results from decreased reinforcement for active, prosocial behavior and increased reinforcement for depressed behavior. An adolescent may do all the things expected of her, such as going to school, finishing chores, completing homework, and working at a part-time job. If others take these behaviors for granted, however, the youth

receives little positive attention. Conversely, if the youth becomes depressed and his or her performance in these activities slips, then others may notice, provide sympathy and support, and inadvertently reward depressive symptoms. Suicidal gestures such as the one displayed by Anna may also be done for attention.

Anna was not depressed solely for attention but did relish the social contact her situation brought. She said her mother was more interested in her life now than before her inpatient stay. She enjoyed talking to the other adolescents and staff members on her inpatient ward. Some of the nurses grumbled that Anna was a general nuisance as her discharge approached; she constantly asked them personal questions and wondered aloud if she could maintain contact with them. Mrs. Thompson and the psychiatrist noted this as well and agreed that Anna's mother should encourage and reward her daughter's future social behavior with peers.

A related behavioral theory of depression holds that social incompetence or social skills deficits are central to the disorder (Nilsen, Karevold, Roysamb, Gustavson, & Mathiesen, 2013). Anna was capable of talking and making friends when motivated to do so, however, as she was on the inpatient ward. A self-control model stipulates that people with depression selectively attend to negative life events, overpunish and underreward themselves, and focus on unrealistic goals and short-term outcomes (Auerbach & Ho, 2012; Spence & Reinecke, 2004). This model did apply somewhat to Anna who focused almost exclusively on negative aspects of her family and her social life. When Anna did focus on the future, she did so in the form of "pie-in-the-sky" expectations. Anna thought she and her mother would eventually reconcile with her father and that she could meet her high school obligations after entering college.

A popular psychological model of depression is Beck's cognitive theory, which emphasizes dysfunctional ways of viewing oneself, the world, and the future (Beck & Haigh, 2014). Some youths with depression have cognitive distortions about surrounding events and believe things are worse than they actually are. An adolescent may believe everyone will laugh at him or her during an oral presentation despite clear evidence to the contrary—this is catastrophization. Anna displayed personalization, or attributing external events to oneself without cause. She thought classmates whispering in hallways were necessarily talking about her and making rude remarks. No evidence existed to support this thought, however.

A related cognitive theory of depression is learned helplessness, which links sadness to inaccurate attributions about different life events (Stange, Alloy, Flynn, & Abramson, 2013). People with depression may attribute causes of negative events to internal, global, and stable factors. Failure on a test might result in negative self-statements regarding the situation's internality (e.g., "It was my fault"), globality ("I am a failure at everything"), and stability ("I will always fail these tests"). Such thinking is often the result of experiences in which a person felt or had little control over environmental events. Anna often blamed negative, uncontrollable life events such as her parents' divorce on herself. She was pessimistic about her future social life. Thoughts like these also occur in nondepressed adolescents, however, so assessing cognitive symptoms of depression in adolescents is sometimes difficult.

Other factors relate to onset and maintenance of depression such as unassertiveness, impulsivity, anxiety, low peer attachment, poor social support, unpopularity, problem-solving deficits, ineffective coping styles, poor school performance, detached parents, disorganized or hostile families, negative reactions to life stressors, and economic disadvantage (Hammen, Rudolph, & Abaied, 2014). Several of these applied to Anna, especially her troublesome family situation, impulsivity, lack of friendships, and a belief that she had little support from others.

Some theorists combine many risk factors into an integrative model of depression (Gotlib & Hammen, 2014). Some people are likely to have a genetic predisposition to depression as well as troublesome family experiences, poor interpersonal skills and coping styles, and feelings of inadequacy. Later stressful life events may trigger these biological and psychological predispositions to produce depression. Stress hormones, attributions, social contacts and support, and degree of hopelessness among other variables can mediate severity of depression, however. Anna's general predisposition to depression may have developed from negative family interactions. A stressful move to a new school, lack of social support, and cognitive distortions may then have conspired to help produce her major depressive episode.

Developmental Aspects

The developmental course of depression is a controversial topic. Some claim only adolescents and adults can experience "true" cognitively based clinical depression. Researchers have looked at symptoms of depression in preschoolers and young children as well, however. The prevalence and symptomatology of depression across different age groups are not dramatically different but some important distinctions such as cognitive factors exist.

Depression in preschoolers can involve sadness, irritability, withdrawal, slow movement, crying, and somatic complaints such as stomachaches (Luby, Gaffrey, Tillman, April, & Belden, 2014). These symptoms could be due to other disorders, however, and symptoms of depression are sometimes manifested by oppositional behavior at this age. A diagnosis of depression is thus often difficult to make in preschoolers.

Children during the school-age period become more able and willing to express themselves when emotionally distraught. Depressive symptoms in 6- to 12-year-olds may include somatic complaints such as headaches and stomachaches, sadness, poor school performance and concentration, crying, irritability, fatigue, insomnia, increased or decreased motor activity, worry, and low self-esteem. Suicidal thoughts and attempts also become more prevalent as children age (Steele & Doey, 2007). These symptoms sometimes indicate other disorders, however. In addition, some children with depression show no overt symptoms. Mrs. Thompson said Anna never had obvious behavior problems.

Depression in adolescence and adulthood is closer to the "classic" depression represented by DSM criteria. Adolescents and adults tend to show more depressed mood, psychomotor slowness, and sleep problems than preschoolers or

school-age children. Other symptoms common to adolescents with depression were evident in Anna. She was socially withdrawn, especially after her move. Those with depression sometimes shy away from new stimuli or lack energy to cope with new interpersonal situations. Anna enjoyed social contact but was inhibited by fears of rejection and humiliation. Symptoms of worry and anxiety are common to adolescents with depression. Anna constantly worried about her life situation, in particular family finances, her social status, and her mother's general welfare. Anna technically met diagnostic criteria for generalized anxiety disorder, which involves pervasive worrying. Anna's cognitive distortions exacerbated these anxiety symptoms as well.

Other symptoms particularly common to adolescents with depression include disruptive behaviors, somatic complaints, low self-esteem regarding body image, and suicidal ideation (Hammen et al., 2014). Anna did not have acting-out behavior problems but did have somatic complaints such as headaches and stomachaches. She was also highly concerned and depressed about her weight. Anna gained a substantial amount of weight in the past few months and felt socially rejected as a result. Her continued overeating and lack of participation in group activities were not helping matters, however. Weight management thus became an important part of her outpatient treatment plan. Anna was obviously having thoughts of suicide and her suicidal gesture indicated that she was at greater risk than the general population for harming herself. The psychiatrist believed Anna's gesture was largely the result of a desire for attention and related to Anna's sometimes impulsive behavior.

Many people experience their first major depressive episode in adolescence and the mean duration of an episode is 12 weeks (Eaton et al., 2008). Extended depression may relate to severity of life events, degree of suicidal ideation and impairment, and comorbid disorders such as anxiety or substance abuse. Anna did have substantial anxiety. Risk for depression increases with the presence of family dysfunction, as was the case for Anna. A high level of expressed emotion, or open hostility among family members, aggravates depression in youth. Low self-esteem predicts depression as well (Steiger et al., 2014).

About 50% of those who experience one major depressive episode will eventually experience a second episode within one year (Eaton et al., 2008). A large percentage of those with a depressive episode will continue to display dysthymia, or ongoing depressed mood without major interference in daily functioning (Thapar et al., 2012). Anna continued to experience occasional depressed mood and social withdrawal even after outpatient therapy.

Adolescents can show persistent depressive symptoms over time. People with persistent depression often have other mental disorders, more severe symptoms, negative cognitions and rumination, inhibition, history of maltreatment, and family history of mood disorders (Klein & Allmann, 2014). Ongoing access to treatment and family and social support are also key predictors of whether an adolescent will remain depressed. Anna's referral to outpatient therapy and development of peer support were critical aspects of her recovery. Peer support was especially pertinent because Mrs. Thompson continued to deny Anna contact with her father or brother.

Treatment

Treatment for adolescents with depression can occur in inpatient and outpatient settings, as was the case for Anna. Inpatient therapy aims to reduce severe depressive symptoms, suicidal ideation, and imminent harm. Treatments to accomplish these, in addition to individual and family therapy, include antidepressant medication, group therapy, and milieu therapy. Milieu therapy involves establishing an environment that encourages a client to take responsibility for her recovery and participate actively in treatment activities. The psychiatrist, nurses, and other staff members encouraged Anna to attend group therapy sessions and maintain good personal hygiene.

Group therapy typically focuses on resolving interpersonal problems, building social support, and developing social, conversational, and problem-solving skills (Straub et al., 2014). Short-term group therapy is the norm in an inpatient setting such as Anna's. Anna's stay on the unit was 3 weeks, as was the case for many adolescents there, so group therapists emphasized discussion and support. Anna spoke about her recent problems and fears and discovered that her concerns often overlapped with those of other group members. None of Anna's primary problems were completely solved but her mood generally improved during her hospital stay.

Antidepressant medications for adolescents include tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), and monoamine oxidase (MAO) inhibitors. Several tricyclic antidepressants are available, including imipramine, amitriptyline, nortriptyline, and desipramine. Their effectiveness for depressed adolescents is not strong, however. The SSRI studied most in adolescents with depression is fluoxetine (Prozac) and this drug is effective especially in combination with cognitive behavioral procedures (March et al., 2007). Psychiatrists may use MAO inhibitors if tricyclic and SSRI antidepressants do not work but these drugs have potentially dangerous side effects.

Anna received a low dose of fluoxetine while in the hospital. She told the psychiatrist her mood improved during her 3-week stay, but whether this was due to the drug or Anna's increased social contact was unclear. Anna did report, however, a substantial decrease in anxiety, which may have been the result of the fluoxetine.

A clinical psychologist later saw Anna for outpatient therapy. Outpatient therapy for adolescent depression often involves a behavioral approach supplemented by medication. Anna continued to take fluoxetine for 6 months, after which the drug was discontinued. Behavior therapy for clients with depression often includes scheduling additional activities, increasing positive reinforcement from others, building social and problem-solving skills, and practicing social skills in different settings (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011).

The psychologist, Anna, and Mrs. Thompson discussed several treatment goals, including resumption of school attendance, improved mood and socialization, and weight loss. The psychologist made a verbal contract with Anna regarding suicide. Anna agreed to contact her mother or the therapist when she had thoughts of suicide or was tempted to hurt herself.

The psychologist helped Anna develop ways to increase her self-esteem and socialization. Using a problem-solving approach, the two decided Anna

could join a local weight-loss clinic, resume school attendance part-time, and participate in at least one peer activity. Anna adopted these solutions and within 2 months had lost some weight, received partial academic credit through an after-school program, and started singing in the school choir. The therapist worked with Mrs. Thompson to increase her time with Anna on the weekends and participate in at least one activity with her daughter outside the home. Mrs. Thompson encouraged Anna to ask others to visit the house for dinner.

The therapist then focused on Anna's social skills, which were good but needed "fine-tuning." Anna had difficulty approaching people she did not know well, especially boys. The therapist worked with Anna to help her start and maintain conversations, integrate verbal and nonverbal behaviors, and apply these skills to those she met at school. Anna had little difficulty talking to people once she knew them and was eventually able to connect with members of her choir and after-school class. Anna avoided these situations at times to spend time with her mother but the therapist and Mrs. Thompson continued to encourage Anna to maintain social contacts with her peers.

Anna's psychologist recognized that some deeper problems needed to be addressed as well during therapy. Anna continued to put herself down, complain about her family situation, and suspect others of wrongdoing. The psychologist thought Anna was intelligent and capable of absorbing aspects of cognitive therapy and this became a major focus of her later stages of treatment. Cognitive therapy often involves several steps, such as the following (Friedberg, McClure, & Garcia, 2009):

1. Self-monitor thoughts
2. Understand the connection between thoughts and behaviors
3. Evaluate each thought for accuracy
4. Substitute more realistic thoughts for inaccurate ones

One of Anna's ongoing cognitive distortions was personalization, or her belief that others were purposely acting against her. The therapist asked Anna to keep a daily log of times she felt others made derogatory statements or were otherwise rude to her. The therapist pointed out how Anna's thoughts sometimes related to her avoidant behavior and depression. Anna might see classmates snickering and looking at her and think they were talking about her. Anna would then overgeneralize the incident to other people she knew and subsequently avoid certain social situations. She would become depressed as her social withdrawal increased. From Anna's log, the therapist identified other examples of how Anna's thoughts could lead to depressive behaviors.

The therapist then asked Anna to challenge negative thoughts directly. He asked Anna to examine evidence for and against each thought. If Anna could not find credible evidence to support her thought, then she was asked to find a more logical and realistic explanation (e.g., the girls are talking about something else). The therapist also helped Anna think about what to do even if someone acted rudely toward her. Anna's suspiciousness and depressive symptoms gradually declined over time.

Anna remained in outpatient therapy for about a year, after which time the therapist thought she was functioning well enough to end treatment. Some issues did remain unresolved, however. Mrs. Thompson remained adamant about the current family situation, continuing to ban Anna from seeing her father and brother. Anna felt occasionally sad about this but adapted well to her new lifestyle and now had some good friendships. Telephone contact with her 6 months after therapy revealed no recurrence of major depression or suicide attempt.

DISCUSSION QUESTIONS

1. Do you believe depression truly exists in preschoolers and school-age children? Defend your answer. What symptoms do you feel are most indicative of depression at different ages?
2. Why do you think more girls than boys display depression? Be sure to explore issues of socialization. Do you think women report being depressed more than men? If so, why might this be the case?
3. Why do you think males tend to choose more lethal methods for suicide than females?
4. What type of person is most likely to commit suicide by making the act seem like an accident? What do you suppose his or her motivation for doing so would be?
5. What questions would you most want to ask someone who seems depressed? How would you go about discovering whether the person is thinking about suicide and what would you do with this information?
6. Everyone gets depressed at one time or another. What life events cause you to feel sad or "down in the dumps"? What separates "normal" depression from "abnormal" depression? Was Anna's depression normal or abnormal? Why do you think so?
7. What are major ethical issues involved in giving medication to children or adolescents with depression? Given that depression is often a warning sign that something is wrong, explore how medication might prevent one from solving serious life problems.
8. How might you treat an adolescent with depression who does not want to talk with you? How might you change your treatment plan for a teenager with depression if he or she also used alcohol or other drugs, was the victim of maltreatment, or had symptoms of conduct disorder?

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Chapter 4

Early-Onset Bipolar Disorder

Symptoms

Dustin Lowell was a 14-year-old European American male brought to a child protective services (CPS) residential facility after his mother's arrest. Police arrested Dustin's mother, Natalie Chapman, on charges of drug possession and distribution and child neglect. She and Dustin lived together in a small home but neighbors said Dustin was alone and acting oddly. The police report indicated that Dustin sat on his front lawn in the middle of the night, blasted music at all hours, and threatened neighbors as they walked by. He had not been to school for at least 4 weeks and neighbors said they saw little of Ms. Chapman.

One of the neighbors contacted police, who found Dustin alone in the home with little food. He did not know where his mother was and could not remember the last time he saw her. Police officers said he looked gaunt and acted irritable and nervous. They eventually brought Dustin to the CPS unit for care and evaluation. Ms. Chapman was located a day later in a seedy downtown area and was arrested after police found her using and distributing methamphetamine.

Dustin's behavior at the CPS unit, a campus of several small group homes, was odd during his first few days. He was quite irritable, snapping at various staff members and other residents, though he did not threaten anyone. Dustin was also overactive. He seemed to have great trouble sleeping; staff members reportedly saw Dustin in the middle of the recreation room at 3:00 a.m. Dustin was fidgety, nervous, and had trouble concentrating. He had substantial energy and difficulty calming himself. Dustin's mood often fluctuated as well; he seemed docile one minute but irritable and anxious the next minute.

The staff psychologist, working in concert with two senior doctoral students in clinical psychology from the local university, evaluated Dustin. Dustin was reserved at first and offered little insight into his living situation or behavior. He did complete some self-report measures, however, regarding symptoms of posttraumatic stress disorder as well as related problems of dissociation,

trauma-related cognitions, depression, and anger. The doctoral students administered this assessment protocol to adolescents referred to the CPS unit to identify adjustment and other problems from maltreatment or transfer to the facility. Dustin's scores on these measures, however, were unremarkable.

The staff psychologist observed Dustin over the next few days to better understand his odd behaviors. She considered exposure to drug use, lingering symptoms of trauma-related stress, depression, and adjustment problems to the new facility as possible explanations. She eventually ruled out drug use because Dustin's behavior changed little during his stay on the unit and because a toxicology screen revealed no illicit substance use. She and other staff members regularly tried to speak to Dustin but he remained quiet, nervous, and distracted.

Dustin stayed at the CPS unit for 5 days, after which a foster family volunteered to house and care for him until CPS workers could find a long-term solution. The foster family consisted of a young couple, Mr. and Mrs. Boswell, and their 7-year-old daughter Emma. The couple recently completed training as foster parents and were eager to provide a stable, if temporary, home for Dustin.

A CPS social worker brought Dustin to the foster home to meet the Boswells but the initial meeting did not go well. Dustin entered the house and ran about, checking each room and quickly asking where he was to sleep. The Boswells were a bit startled at his energy but politely showed him his bedroom. Dustin entered the bedroom and started bouncing on the bed until the social worker asked him to stop. Dustin did so but appeared anxious and left to use the bathroom.

The social worker explained Dustin's recent history to the Boswells and encouraged them to speak with her should problems arise. That did not take long. At the dinner table that night, Dustin spoke endlessly of his recent experiences, a clear departure from his behavior at the CPS unit. He rocked back and forth in his chair and told of how his mother came and went with different people in the house and how he often feared for his safety. Dustin described one incident where he was in bed and heard voices "coming through the wall," as if they were ghosts. Mr. Boswell saw that his daughter was terrified at this story and asked Dustin to stop.

The Boswells were in bed when the next set of odd behaviors occurred. Mrs. Boswell awoke to the sound of a door slamming and went to Dustin's room to find it empty. She eventually found Dustin sitting in the front yard, rocking back and forth. She approached him but Dustin quickly stood up and yelled at her. Dustin said to leave him alone and began crying. He also said, oddly, that "they were coming to get him" and that Mrs. Boswell should go inside "or you'll get hurt." Mrs. Boswell was unsure if Dustin meant he would hurt her, so she retreated inside and informed her husband. Mr. Boswell was able to convince Dustin to come back inside and go to sleep.

The Boswell family noted other strange behaviors from Dustin over the next 7 days. Dustin's mood changed often, usually fluctuating from calmness to irritability and back again. His irritable moods were of special concern; he often yelled at the 7-year-old and constantly asked everyone to leave him alone. Dustin ate irregularly, seemed frantic at times, and had great trouble sleeping.

He refused to attend school, which meant someone had to stay home during the day to supervise him.

The last straw for the Boswell family came on the eighth day of their foster care. The family was working in the yard when they noticed that Dustin was missing. A frantic search of the house, yard, and neighborhood revealed no sign of him. The family alerted the CPS social worker and police, who eventually found Dustin sitting in the corner of a convenience store 2 miles from the Boswell home. A police officer said Dustin seemed incoherent and highly agitated. He returned Dustin to the Boswell home but Dustin immediately ran down the street. The police officer retrieved Dustin and brought him to the CPS unit. Dustin received a sedative to ease his agitation.

The psychologist delved further into Dustin's background to get a better handle on what might be causing his odd behaviors. She secured permission to access Dustin's school records. Dustin appeared to be a bright student but one who often missed school. His grades in elementary and early middle school were decent but his entry into high school this year involved excessive absenteeism and poor academic performance. The psychologist noted as well that Dustin's records indicated symptoms of possible attention-deficit/hyperactivity disorder (ADHD).

The psychologist then secured an interview with Natalie Chapman, Dustin's mother. This conversation revealed some fascinating information that helped explain some of Dustin's strange behaviors. This information, combined with observations and review of school records, led the psychologist to conclude preliminarily that Dustin displayed symptoms of early-onset bipolar disorder.

Assessment

The essential feature of bipolar disorder involves manic episodes that often occur with major depressive episodes. A manic episode is a "distinct period during which there is an abnormally, persistently elevated, expansive, or irritable mood and persistently increased activity or energy" (American Psychiatric Association, 2013, p. 127). Common symptoms during a manic episode include inflated self-esteem, decreased need for sleep, talkativeness, racing thoughts, distractibility, increased goal-directed activity or agitation, and excessive involvement in pleasurable activities that may lead to painful consequences. Examples of the latter include buying sprees, joyriding, or sexual indiscretions. Symptoms of a major depressive episode are described in Chapter 3.

Symptoms of bipolar disorder are less clear for adolescents than adults. Adolescents with bipolar disorder differ from the classic DSM criteria in 70% of cases (Ahn & Frazier, 2004). Adolescents with the disorder often do not show clear episodes of mania and depression (manic-depression) seen in adults. Their clinical picture instead usually involves irritable mood, inflated self-esteem, increased energy, distractibility, pressured speech, racing thoughts, and decreased need for sleep. A newer diagnosis in DSM-5 is meant to perhaps better capture adolescents such as Dustin. The main feature of disruptive mood dysregulation disorder is "chronic, severe persistent irritability" (APA, p. 156).

Dustin appeared to have many of symptoms of either early-onset bipolar disorder or disruptive mood dysregulation disorder. He was clearly irritable and agitated at many times and often distracted. The Boswells and the staff psychologist noted that Dustin had great trouble staying calm and maintaining conversations. The Boswells in particular felt they were "walking on eggshells around Dustin" and became afraid of "setting him off" by saying or doing the wrong thing. This apparently happened quite often with Emma, the 7-year-old. At other times, however, Dustin's mood seemed calm. Staff members at CPS and the Boswells told the psychologist they never could predict how Dustin would respond to their social gestures.

Dustin showed increased energy and decreased need for sleep. Recall that he often ran about and bounced on the bed, an odd behavior for a 14-year-old. Dustin appeared to have a history of excessive motor behavior as well; his school records indicated that a school psychologist once recommended a diagnosis of ADHD (hyperactive-impulsive type). Another key element of Dustin's problems was that he slept very little. Dustin said he slept only 4–5 hours a night and sat on the front lawn because it helped calm him.

Dustin did not show other symptoms of bipolar disorder to a substantial degree, however. He did not report racing thoughts and did not show pressured speech, though he did have odd speech at times. The police officer and the Boswells noted instances where Dustin spoke incoherently or oddly about "voices" or threats. The psychologist suspected that Dustin may have experienced racing thoughts, however, when he was distracted and could not focus on a conversation.

Further complicating the clinical picture for adolescents is that many mental disorders co-occur with bipolar symptoms. Common examples include prepsychotic conditions as well as substance use, sleep, anxiety, and ADHD (Joshi & Wilens, 2015). Dustin did not have a full-blown psychotic disorder such as schizophrenia but did display possible symptoms characteristic of this condition. His report of "voices," coming through the wall, and his unsubstantiated worry that others "were coming to get him" could indicate early signs of hallucination or delusion. Dustin did not report or show these symptoms on a regular basis, however. He had no substance use disorder.

Dustin certainly had symptoms of sleep and anxiety disorders. The staff psychologist did not formally diagnose Dustin with either type of disorder but the teenager clearly had trouble sleeping as well as worry and physical agitation. These symptoms were likely secondary to a diagnosis of bipolar disorder, however. Further discussion with school officials revealed that Dustin demonstrated classic symptoms of ADHD in elementary and middle school. These symptoms included overactivity, impulsivity, distractibility, inattention, fidgeting, and talkativeness.

Bipolar disorder has a strong genetic basis, so assessment should include family history and interview. The CPS staff psychologist, who interviewed Dustin's mother, discovered that Ms. Chapman had a long history of mood swings and substance use. Ms. Chapman said she grew up in "a smashed house" marked by constant fighting and drama. She began experiencing severe mood swings in her early 20s and eventually drank large amounts of alcohol to cope. Ms. Chapman

gave birth to Dustin when she was 23 years old but admitted that caring for her son was difficult. She said Dustin often had problems in school and that she was overwhelmed with having to care for a child. Her substance use worsened over the years to the point that she was heavily involved in the local drug culture. She never received a formal diagnosis of bipolar disorder but nodded in agreement when the psychologist listed possible symptoms. No information was available regarding Dustin's biological father.

Assessment of bipolar disorder can include behavior checklists and self-report measures of mood. The Child Behavior Checklist (Achenbach & Rescorla, 2001) is useful for distinguishing those with bipolar disorder from those with ADHD. Parent ratings on this checklist are higher on many scales for youths with bipolar disorder, including anxiety/depression, social and thought problems, and aggression (Diler, Uguz, Seydaoglu, Erol, & Avci, 2007). Another more specific parent report measure is the Child Bipolar Questionnaire that covers symptoms of mood and ADHD to derive a clear picture for a particular case (Papolos, Hennen, Cockerham, Thode, & Youngstrom, 2006).

Other important measures include the Parent Young Mania Rating Scale and Parent General Behavior Inventory-Hypomanic/Biphasic (Gracious, Youngstrom, Findling, & Calabrese, 2002; Youngstrom, Findling, Danielson, & Calabrese, 2001). Evaluations of parent–child interactions such as quarreling and poor affection may be instructive as well (Schenkel, West, Harral, Patel, & Pavuluri, 2008). Dustin's mother did not complete these measures, however.

Clinicians should look for several "red flags" that may indicate a particularly serious form of early-onset bipolar disorder. These red flags include early-onset depression, unusual depression, psychotic features, episodic aggressive behavior, and family history of bipolar disorder (Youngstrom, 2010). Dustin had many of these. He was moody and sometimes depressed, though he tended to be more energetic than lethargic. He may have had early psychotic features but the psychologist thought it was too early to know for sure. Dustin did not display physical aggression but did threaten his neighbors, Mrs. Boswell, and other CPS residents at times. Ms. Chapman's interview also revealed a likely family history of bipolar disorder.

Risk Factors and Maintaining Variables

Genetics is a key basis for bipolar disorder. Family studies reveal that first-degree relatives of those with bipolar disorder have the disorder themselves in 3–15% of cases. This is generally higher than the prevalence of bipolar disorder in the general population for adolescents (1%) and adults (3.9%). Risk of developing bipolar disorder is much greater in cases of early-onset bipolar disorder. Twin studies reveal much higher concordance rates for identical than fraternal twins. Early-onset bipolar disorder may relate most closely to changes on chromosomes 9, 12, 14, and 15 (Faraone, Lasky-Su, Glatt, Van Eerdewegh, & Tsuang, 2006; Kessler et al., 2005; Kloos, Weller, & Weller, 2008; Strakowski, DelBello, & Adler, 2015).

The CPS psychologist felt the strongest piece of evidence for diagnosing Dustin with bipolar disorder was a family history of mood swings, substance use, and symptoms of ADHD. Ms. Chapman later revealed more details that confirmed this diagnosis. Her parents threw her out of her house when she was 17 years old. Ms. Chapman said she and her mother constantly argued and often "set each other off." She further explained that her mother had an explosive temper that triggered her own wild mood swings and aggression. Ms. Chapman said her mood often fluctuated between irritability, elation, and depression. She found the only way to cope with these changes and with parenthood was substance use. Ms. Chapman also agreed that she displayed many symptoms of ADHD as a child. She was distraught to learn that Dustin had similar problems now.

Genetic influences likely set the stage for key brain changes in bipolar disorder. Bipolar disorder may relate to changes in the ventral prefrontal networks and limbic brain regions, especially the amygdala (Strakowski et al., 2012). These areas of the brain, in conjunction with other brain structures, influence inhibition and motor activity and thus the restlessness, movement, and goal-directed activity seen in people with bipolar disorder. These areas are intimately involved in emotion as well and may help explain sudden mood swings seen in people with bipolar disorder.

People with bipolar disorder have low levels of serotonin but higher than normal levels of norepinephrine. Rapid cycling in bipolar disorder relates to a less active thyroid as well. Youths with bipolar disorder also show many neurocognitive deficits in attention, planning, inhibition, and visuospatial memory. Youths with bipolar disorder may show sleep disturbances such as less rapid eye movement sleep, more awakenings, and longer periods of slow-wave sleep than controls. Some sleep deprivation may trigger manic episodes and especially rapid cycling (Baroni, Hernandez, Grant, & Faedda, 2012; Newberg, Catapano, Zarate, & Manji, 2008).

Dustin's specific neurobiology was unknown but he clearly had cognitive and sleep problems. He sometimes faded in and out of conversations or oddly began speaking about another topic. He was impulsive, as when he suddenly left the Boswells for the convenience store, and did not plan well. Dustin obviously had many sleep problems. He rarely slept through the night, slept only a few hours per night, and reported little dreaming, which is associated with less rapid eye movement sleep.

Psychological risk factors contribute to bipolar disorder as well. Youths with the disorder tend to have poor social and problem-solving skills and few friends. They experience teasing from others as well. Dustin's social skills were only fair. He did maintain conversations, albeit oddly, but often showed poor eye contact and kept his head down when speaking. His speech was sometimes muffled and he threatened others as well. Whether these problems caused or resulted from his disorder was unclear, however. Dustin's social problems could have resulted as well from poor parental feedback and poor social contacts from excessive school absenteeism (Pavuluri, Birmaher, & Naylor, 2005).

Children of parents with mood disorders such as bipolar disorder often show certain personality characteristics as well. Many show novelty-seeking—a trait involving impulsive, exploratory, and thrill-seeking behaviors (Althoff et al., 2012). Dustin enjoyed exploring his surroundings, as do many adolescents, but he was not a big thrill-seeker. His mother, however, displayed many thrill-seeking behaviors such as drug use and frequent sex. Other youths of parents with mood disorders show increased neuroticism and hostility (Ostiguy, Ellenbogen, & Hodgins, 2012). Dustin's anxiety and nervousness as well as verbal aggression toward others were evidence of these traits.

Youths with bipolar disorder often fight with their parents and siblings and have little warmth in their families. Dustin's relationship with his mother, though sporadic, was warm, however. The two rarely argued or fought, but this could have been due to the fact they did not interact much. Ms. Chapman's relationship with her parents, though, involved intense conflict, poor attachment, and violence. She expressed little warmth for her parents and described them as "cold" and "uncaring." She had not spoken to her parents in years and was unsure they were even alive.

Developmental Aspects

The developmental course of bipolar disorder involves the study of preschoolers, school-aged children, adolescents, and adults. Researchers generally identify preschoolers for study if at least one of their parents demonstrates symptoms of mania or bipolar disorder or severe mood disorder. Preschoolers in these studies generally show symptoms of mania and depression together, as in a mixed state. Many of these young children show frenetic motor activity such as excessive climbing or running about, fidgeting, and restlessness. Much of their motor behavior seems chaotic as well. Many preschoolers are active but goal-directed in some way, such as when playing a sport. Youngsters with symptoms of mania, however, often show motor behavior with little purpose (Demeter et al., 2013).

Ms. Chapman said Dustin was a "handful" as a preschooler—a problem that helped prompt her alcohol use. She said Dustin was always "on the go" and difficult to calm. He would climb on the furniture, get up early in the morning even after a late bedtime, "talk nonstop," and pester her constantly. Ms. Chapman noticed as well that Dustin had few friends in day care and said he had to leave one place because he was "too hard to handle." The psychologist asked Ms. Chapman about sports and games but Ms. Chapman said Dustin was never interested in team play. He preferred solitary activities, though this could have been because other children rejected him.

Preschoolers at risk for symptoms of mania also demonstrate impairment in school and social functioning (Whitney et al., 2013). They may have difficulty adjusting to the routines and rules of day care placements and have trouble controlling their emotions. Preschoolers normally develop a process of emotional control, however, so some children take longer than others to mature in this