Health Psychology

Child & Adolescent Mental Health

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Session Outline

- Defining abnormality
- Psychological Approaches
- Categorising Disorders
- Childhood Disorders
- Eating Disorders
- ADHD and Conduct Disorders
- Resilience
- Review

What Is Abnormal?

Can we decide what is abnormal on the basis of facts or is our view of what is abnormal based on some value judgment?

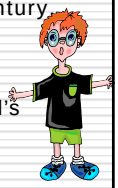
- It is difficult to give an exact definition because mental disorders can encompass so many aspects of functioning.
- A psychological disorder:
  - constellation of symptoms that create significant distress or impairment in school, family, relationships, or daily living.

Defining Abnormality

- Abnormality can be defined by events at the levels of:
  - The brain (by biological or structural abnormalities)
  - Person (by objective behaviors and subjective distress)
  - Group (in which abnormality is defined by the culture and the context of the behaviors).
- Obvious symptoms of abnormality
  - Psychosis
    - Obvious impairment in ability to perceive and comprehend events accurately, or gross disorganization of behavior
  - Hallucinations - Mental images so vivid they seem real
  - Delusions - Enriched false beliefs that are often bizarre
- Not so obvious
  - Depression, Anxiety, Repetitive thoughts/behaviors

Explaining abnormality

- In ancient Greece, Hippocrates attributed mental illness to imbalances in 4 fluids.
- In the Middle Ages and up through 17th century, mental illness was attributed to demonic possession or other work of the devil.
- In the early and middle 20th century, Freud's psychodynamic model was the standard for understanding abnormality.



Explaining abnormality

- Behaviour is judged abnormal not because actually it intrinsically abnormal but because it is deemed to be abnormal by the set of values held by society.
- e.g. ***Drapaetomania*** (***Wakefield, 1992***) an illness that afflicted slaves in the southern state of the USA; the main symptom of this was running away from the owner, which was treated by administering a beating!
  - Therefore, it is extremely difficult to avoid value judgments when deciding when someone's psychologically abnormal or disturbed.

Abnormality should be defined in terms of:

- Deviation from the norm
- Social conformity
- Cultural relativity
- Abnormality as coping

Psychological Approaches to Mental Health and Distress

- Focus on five frameworks:
  - Biological and medical
  - Behavioural
  - Psychodynamic
  - Humanistic
  - Systemic
- The frameworks can be seen as located at one of three levels of analysis:
  - Societal
  - Interpersonal
  - Individual.

Categorising Disorders

- 1st Edition *DSM* was published by APA (1952), based on psychodynamic theory.
- *DSM-IV* published in 1994 - tries to avoid relying on any one theory.
- The *DSM-IV* has 5 axes for categorising disorders, defining 17 categories of problems and almost 300 mental disorders
- It has been criticised on several grounds:
  - Introduced categories that define medical problems as psychological disorders.
  - No discrete boundaries for separating normality from abnormality.
  - Many disorders are not clearly distinct from each other.

Cultural bias!

DSM-IV

- Axis I: Clinical Disorders
  - Consider more short-term or treatable(?)
  - Depression, ADHD, Anxiety
- Axis II: PD and Mental Retardation
  - Clinical disorders that are longer lasting, more difficult to treat
- Axis III: General Medical Conditions
  - Head injury or substance use
- Axis IV: Psychosocial and environmental problems.
  - Divorce, family loss
- Axis V: Global Assessment of Functioning
  - 0-100 rating of how well person is doing

Some DSM-IV Categories

Category	Features	Examples
Infancy,Childhood, or Adolescent	Symptoms usually diagnosed in childhood	Autistic Disorder Tourette's Disorder
Substance-related	Effects of seeking or using drugs	Substance abuse
Eating disorders	Disturbances in body image, eating	Anorexia nervosa Bulimia nervosa
Impulse-control disorders	Inability to resist actions that may be harmful	Kleptomania, pyromania

Childhood Disorders 1

- ADHD
  - Predominately Inattentive type - day dreaming, poor focus
  - Predominately Hyperactive type - always on the go
  - Combined type
- Conduct Disorder and Oppositional Defiant Disorder
  - Show antisocial type behaviors, often challenging
- Learning Disorders
- Depression, anxiety..
  - Classified under adult - hard to differentiate in children
  - Internalising disorders are often missed

Childhood Disorders 2

- Autism
  - Stereotypical behaviors
  - Lack of theory of mind development
  - Related to disturbance in SHT and see overgrowth of brain as an infant
- Asperger's Disorders
  - High function autism (?)
  - Often gifted in some areas
  - Poor social skills and motor clumsiness

Abnormal Psychology: Eating Disorders

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DSM IV Categories of Eating Disorder

A. Feeding Disorder of Infancy or Early Childhood
B. Rumination Disorder
C. Pica
D. Anorexia Nervosa
E. Bulimia Nervosa

Characteristics of Anorexia Nervosa

DSM IV diagnostic criteria are as follows:

i. Refusal to sustain body weight at or above 85% of normal weight for height and age
ii. Intense fear of gaining weight or becoming fat
iii. Disturbed experience of body weight, and/or undue influence of weight or shape on self-esteem, and/or denial of severity of current low weight
iv. In postmenarcheal female, amenorrhea

DSM distinction between Restricting Type & Binge/Purge Type

Characteristics of Bulimia Nervosa

- More recent diagnostic category, introduced to DSM in 1987
- DSM IV diagnostic criteria are as follows:

i. Recurrent episode of binge eating (eating, in discrete period, large amount of food, with sense of loss of control)
ii. Recurrent inappropriate compensatory behaviour
iii. Binging & compensatory behaviour occur at least twice a week for at least three months
iv. Self evaluation unduly influenced by weight/shape
v. Not all criteria for Anorexia Nervosa are met

- DSM distinction between Purging Type & Non-Purging Type

Epidemiology of Eating Disorders 1

1. Incidence of Anorexia Nervosa

- Incidence around 1% (Fairburn et al., 1993)
- 2 out of 10,000 people diagnosed annually
- Onset in usually in adolescence, often following a period of stress (Nolen-Hoeksema, 1998)
- 9 out of 10 anorexics are female (Strober, 1986)
- In 12 to 18 year old girls, incidence of anorexia exceed 1 case for every 250 individuals (Carson et al., 1996)

Epidemiology of Eating Disorders 2

2. Incidence of Bulimia Nervosa

- Hoffman (1994) estimates that 2 to 3% of young women affected
- Yates (1989) estimates that 4% of young women affected
- More common in females than in males
- Age of onset usually between 16 – 18 years of age

Epidemiology of Eating Disorders 3

3. Prognosis

- Around 70% of sufferers eventually recover, but often only after 6 or 7 years of repeated relapses
- Anorexics and bulimics often suffer serious health problems:
  - Uncommon to be fatal in bulimia, though suicide rates elevated
  - Death from starvation or from associated complications, most often heart failure, occurs in 10 – 15% of anorexics (Nielsen et al., 1998)

Theories of Eating Disorders 1

Biological Theories

- Anorexia & bulimia tend to run in families (Strober, 1999)
- Concordance rates for bulimia 23%-56% in MZ female twins and 5-9% in DZ female twins (Holland, 1984).
- Theories of anorexia implicate hypothalamus (Blundell & Hill, 93)
- Hormones mediating hpt depleted in anorexia (Fava et al., 1989)
- Bulimia associated with reduced serotonin (Mitchel & deZwann, 93) and reduced norepinephrine (Fava et al., 1989), which some argue triggers craving for carbohydrates (Wurtman, 1984)

Theories of Eating Disorders 2

Psychological Theories

- Common psychoanalytical view is that anorexia represents defense against developing sexuality (Goodsit, 1997)
- Family systems theorists (Minuchin, 75) sees eating disorder as way of coping with dysfunctional family dynamics, such as:
  - Enmeshment
  - Over protectiveness
  - Rigidity
  - Lack of conflict resolution

Theories of Eating Disorders 3

Psychological Theories (Cont…)

- Conditioning theorists emphasise role of reinforcement in shaping pathological eating (Thompson et al., 1995; Fairburn et al., 1999)
- Cognitive theorists emphasise unrealistic beliefs about ideal weight conveyed by popular culture, showing that this is linked to frequency of eating disorders (Eagles et al., 95; Hoek et al., 95)

Therapeutic Approaches to Eating Disorders 1

Biological Interventions

- Initially often involve intravenous and/or forced tube feeding
- ? Value of antidepressant in reducing binging:
  - 67% reduction of binging found in Prozac
  - 33% reduction in control group (FBNC Study Group, 1992)
- Despite suggested value of Prozac in anorexia (Kaye et al., 1991) no drug shown to increase weight gain or change core features of anorexia (Attia et al., 1998; Johnson et al., 1996)

Therapeutic Approaches to Eating Disorders 2

Behavioural Interventions

- Usually involve hospitalised operant programs designed to produce weight gain, through earning “privileges” for weight gained
- Effective in achieving initial weight gain (Hsu, 1991)
- Less effective in sustaining weight following discharge (Wilson 95)

Therapeutic Approaches to Eating Disorders 3

Family Therapy

- Aimed to reshape family dynamics, though likely to also provide parents with enhanced operant skills
- Good maintenance of initial gains, with family therapy, at follow ups from 3 months to 5 years (Rosman et al., 1976; Eisler et al., 1997)

Abnormal Psychology: ADHD and Conduct Disorders

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Characteristics of ADHD

- ADHD is one of the most common reasons why children are referred to CAMHS (Popper & West, 1999)
- Temperamentally ADHD children tend to be disorganised, erratic tactless, obstinate & bossy
- Behaviourally, they show high level of haphazard & continuous movement, wearing out shoes and toys, and exhausting family, especially in structured settings
- Find difficulty sustaining friendships, making social errors and display sensation seeking behaviour (Melnick & Hinshaw, 1996)

Three Main Categories of ADHD 1

Specific Difficulties with Attentional Control

At least 6 of the following for 6 months or more:

i. Fails to attend to detail, making careless mistakes
ii. Difficulty sustaining attention to tasks or in play
iii. Seems not to listen when spoken to directly
iv. Fails to follow instructions to complete tasks
v. Avoids/dislikes tasks needing sustained mental effort
vi. Difficulty organizing tasks & activities
vii. Loses things needed for tasks & activities
viii. Easily distracted by extraneous stimuli
ix. Forgetful in daily activity

Three Main Categories of ADHD 2

Specific Difficulties with Hyperactivity/Impulsivity

At least 6 of the following for 6 months or more:

i. Fidgets with hands or feet or squirms in seat
ii. Leaves seat when expected to be seated
iii. Runs about or climbs excessively when inappropriate
iv. Difficulty engaging in quiet leisure activities
v. "On the go" as though "driven by a motor"
vi. Talks excessively
vii. Blurts out answers before questions are completed
viii. Difficulty awaiting turn
ix. Interrupts or intrudes on others

Three Main Categories of ADHD 3

Difficulties with both Attentional Control and with Hyperactivity/Impulsivity

- Simultaneously meets criteria for both 1 and 2
- In all cases:
  - Symptoms must have been in evidence before the age of 7 years
  - Symptoms must occur in at least 2 different settings
  - Symptoms must impair social, academic or occupational function

Characteristics of Conduct Disorder (& ADD)

- Some suggest that ADD is a precursor for CD, or an early manifestation of CD (e.g., Loeber et al., 1993))
- CD behaviours typically violate rights of others, & nearly always involve illegal activities
- Most often diagnosed in prepubescent and adolescent children, frequently following involvement of the justice system
- CD behaviours more deliberate & intentional than in ADHD
- CD often comorbid with substance abuse
- CD linked to antisocial problems in adulthood (Loeber, 1991),
- though 50% show remission across 1-4 years (Lahey et al., 1995)

Epidemiology of ADHD

- Despite differences from CD, at least 30% of ADHD children are comorbid for CD (Hinshaw, 1987)
- ADHD occurs in 4 – 12% of children aged between 6 and 12 years (Brown et al., 2001)
- ADHD diagnosis is four times more common in boys than in girls (Baumgaertel et al., 1995), though perhaps because in boys it involves more behavioual problems
- ADHD usually identified by age 3 or 4 (Barkley, 1987)
- 70% of sufferers experience problems as adults (Hart et al., 1995; Barkey et al., 1996)

Psychological Theories of ADHD

- Consequence of authoritarian upbringing (Bettelheim, 1973)
- Consequence of operant reinforcement
- Consequence of modelling (Ross & Ross, 1994)
  - Little compelling empirical evidence to support these accounts

Biological Theories of ADHD 1

A. Genetic Condition

- Relatives of ADHD children show increased rates (Biederman, 1992)
- Parent with ADHD - 50% of offspring ADHD (Biederman, 1995)
- MZ twins more concordant than DZ twins (Sherman et al., 1997)
- This elevated concordance also revealed in adoption studies (van den Oord et al., 1994)

Biological Theories of ADHD 2

B. Neurological Anomalies

- Frontal lobes are under-responsive (Rubia et al., 99; Tannock, 98); unusually small (Filipek et al., 1997)
- Reduced blood flow to frontal lobes (Sieg et al., 1995)
- ADHD children most impaired on frontal tasks (Barkley, 1997)
- Underactive portions of right hemisphere too (Riccio et al., 1993)

Biological Theories of ADHD 3

C. Environmental Toxins

- Little support for the ideas of Feingold (1975) that certain food additives cause ADHD
- Well controlled studies demonstrate inefficacy of Feingold diet in reliably reducing ADHD symptoms (e.g., Barkley, 1990)
  - However, maternal smoking during pregnancy increased risk of ADHD threefold (Millberger et al., 1996)

Therapeutic Approaches to ADHD 1

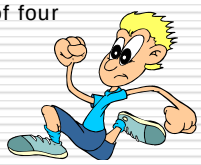
- Biological Interventions
  - Most common are Ritalin, Dexedrine and Cylert (prescribed to 80% of ADHD)
  - In 75% of cases provides ST improvement in concentration, goal directed & classroom activity & social interaction (Spencer, 1996)
  - Less evidence of LT benefits to academic performance (Weiss & Hechtman, 1993)
  - Problematic side effects (Dupaul et al., 1996), and contributes to drug abuse in school settings (Leleand, 1995)

Therapeutic Approaches to ADHD 2

- Psychological Interventions
  - Involve operant programs – systematic reward for on-task behaviours & penalise inappropriate disruptive behaviours
  - Implemented as token-based systems e.g.star charts and targets achieving tangible rewards (Fiore et al., 1996)
  - Includes formal parent training components and teacher training components for continuity.

Therapeutic Approaches to ADHD 3

- Combined Programmes
- Jensen et al., (2001) assigned 579 children to 14 months of treatment under one of four conditions:
  - Control (Community Care)
  - Medication (Ritalin)
  - Behavioural (Operant Program)
  - Both Medication and Behavioural



- Condition 4 superior over others

Resilience in Children

A.K.A. Sticks and Stones...

Definitions

- **1901**
  - Resil'ience, Resil'iency, act of springing back or rebounding.
  - adj. Resil'ient, springing back or rebounding.
- **1988**
  - Resilience(ri-zil'i-ans): recoil: elasticity, physical or mental.
  - adj. Resil'ient elastic, physically or in spirits

Definitions

"Although researchers may disagree on a single definition and also on the network of constructs surrounding resiliency, most researchers agree that resilient individuals share some outcomes."

(Jewel et al, 1999)

THE CAPACITY TO SURVIVE / BUFFER

In brief...

- The biological impulse to thrive and grow
- Characteristically - skills, beliefs or processes which allow some children to overcome adverse beginnings and go on to live successful lives
- Resilience is about the power to overcome adversity:
  - Physically
  - Emotionally
  - Cognitively

Risk Factors

Correlates of adverse life outcomes:

- Poverty
- Family breakdown
- Substance abuse
- Illness
- Stress

However 30-60% of children exposed to risk overcome or resist the dangers and go on to achieve successful, well adjusted lives.(Jew et al, 1999; Benard, 1995)

Against all odd?

Benard, 1997 - Longitudinal studies have shown that while the percentage of "high-risk" children developing various problems was higher than in the normal population, a greater percentage of the children "became healthy, competent young adults"

So... why do some children succeed despite the odds?

Questions

- Is resilience an ability?
- Does everyone have it?
- Learned or innate?
- Does it vary between individuals?
- Does it vary for an individual over different situations, over time or through different developmental stages?

- And, most importantly:
  - **Can it be taught, developed, or promoted?**

So what is resilience?!

Benard (1995) defined resilience as a "set of qualities" which develop out of an innate capacity "we are all born with".

- These "qualities" have been divided into personality traits and abilities:
  - Social competence
  - Problem-solving skills
  - Critical consciousness
  - Autonomy
  - Sense of purpose

Resilience traits

- **Social competence** (the ability to elicit positive responses from others, flexibility, empathy, communication and sense of humour)
- **Problem-solving skills** (ability to plan, resourcefulness, critical thought, creativity, reflectiveness)
- **Critical consciousness** (a "reflective awareness of the structures of oppression" plus strategies to overcome them)
- **Autonomy** (sense of identity, self efficacy, independence)
- **Sense of purpose** (aspirations, optimism, motivation, persistence and 'spiritual connectedness')

Cognitive Appraisal

- Cognitive appraisal theory proposed that individuals' responses to stress are influenced by their appraisal of a situation and the way in which the experience is processed, ***meaning is attached***, and the experience is incorporated into one's schemas

- ....Beliefs influence the choice of responses and strategies that resilient people bring to bear on stressful situations.
- These schemas are developed in the context of personality, ***environmental***, and developmental influences.

Protective factors

- "those traits, capacities, and personal and environmental resources that propel individuals in the direction of health, stability, and growth"
  (Masten, 1994, cited in Benard, 1997, 169)

- Protective factors can be:
  - Internal (personality, temperament, attitudes)
  - External (relationships, opportunities to participate)
  - Transactional

Protective factors are..

"Characteristics of persons and environments. Factors or processes are protective if they contribute to good outcomes in individuals at risk."
(Benard, 1995 & 1997)

- supportive relationships
- cognitive skills
- social skills
- positive self perceptions
- positive future orientation
- competence
- models and information
- belonging, responsibility & participation

Protective factors 2

- Supportive relationships (with adults/peers, high expectations)
- cognitive skills (problem solving, planning, critical reflection, adaptation)
- social skills (communication, friendships, conflict resolution)
- positive self perceptions (self-esteem, self-efficacy)
- positive future orientation (sense of purpose, hope, optimism, aspirations)
- competence (academic / sport)
- Models and information (role models, support)
- belonging, responsibility & participation

Developing resilience

"Whether young people develop depression or resilience depends largely upon their feelings of powerlessness or capacity… Feelings of powerlessness can be changed to those of capability by teaching youth the building blocks of resilience…. In short, resilience can be built as part of the developmental process." Grotberg (1999)

"Resilience and the development of strengths and resources occurs in interaction with the surrounding environment, notably families, schools, and social environments. Those environments that foster resilience and build strength all have similar attributes". (Bernard, 1997)

Key Resilience Texts

- Benard, B. (1995) Fostering Resilience in Children. In B. Cesarone (Ed), *Resilience Guide: A Collection of Resources on Resilience in Children and Families*. Champaign, Ill: ERIC Clearinghouse on Elementary and Early Childhood Education.
- http://resilnet.uiuc.edu/library/benard95.html

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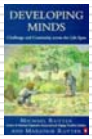
Useful references

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Resources

- Internet Links
  - www.mentalhealth.com – links to pages on specific disorders, offers assessments and possible treatments as well as detailing the latest research developments.
  - www.psych.org/clin_res/q_a.html - details answers to FAQ on DSM-IV.

- Review Questions
  - "Normality is the absence of abnormality". Discuss.
  - Why is diagnosing someone as "mentally ill" a controversial act?