Chapter 1
Perspectives: Abnormal or Exceptional?

One important question in the area of abnormal psychology is how to distinguish “normal” from “abnormal” behaviour. But as these two doors suggest, this is often interpreted as distinguishing between “normal” and “abnormal” people. Which door would fit for you?

Case Example: Troy

Thirteen-year-old Troy had never had a problem with separation, nor had he suffered from anxiety. But when the new school year started he began feeling tense and uneasy, and soon he refused to go to school altogether. Consequently, his mother stopped going to work in order to stay home with him. Troy began to have panic attacks characterized by the sudden feeling that he was going to die, along with palpitations, shortness of breath, trembling, and restlessness. He began refusing to leave his mother for any reason, and would follow her everywhere through the house. Finally, he began sleeping with his mother while his father went to sleep in Troy’s bed. The panic attacks became almost continuous.

Learning Objectives

1. Identify, define, and provide examples for the four elements of abnormality. Explain how cultural and societal norms play a role in definitions of abnormality.

2. Describe the field of abnormal psychology. Distinguish between mental health, mental illness, and abnormality. Summarize the DSM approach to abnormality.

3. Summarize key elements of a CYC conceptual model and highlight those elements that are particularly relevant in CYC work with young people experiencing mental health concerns. Define mental health literacy.

4. Summarize the CYC perspective on diagnostic labelling. Identify the strengths and limitations of using the DSM-5 in CYC practice.

5. Compare and contrast the psychological paradigms (both historical and modern) of abnormal behaviour.

6. Summarize ways in which CYC professionals may use the major psychological paradigms in their CYC practice.

7. Identify and describe the major psychological approaches to treatment for mental disorders.


9. Summarize the pros and cons of using psychotropic medications with children and youth.

Chapter Overview

Abnormal or exceptional? Disorder or trauma? Mentally ill or in pain and despair? In this chapter we examine the major differences between psychological and child and youth care (CYC) perspectives. This distinction is important, because in many ways a CYC approach to understanding young people’s emotional and behavioural disturbances or mental “disorders” is based on an alternative to the mainstream societal view of “aberrant,” “disturbed,” or “deviant” behaviours.

Consider the following statistics. According to Kessler et al. (2005), at least 18 percent of children and adolescents display serious mental disturbances and are in need of clinical treatment. And according to Health Canada’s (2002) Report on Mental Illness in Canada, the onset of most mental illnesses occurs during adolescence and young adulthood. It is estimated that, at any given time, approximately 15 percent of children and youth in Canada experience mental disorders that interfere with healthy development (Provincial Health Officer’s Annual Report, 2006). What is a mental disturbance? Does the term mental illness mean the same thing as mental disorder? Do you think Troy’s behaviour qualifies as an example of any of these? This chapter will clarify these familiar, but often misused, terms. It will also summarize the major paradigms used by both psychologists and CYC professionals to better understand the behaviour of those they work with. As you’ll see,
although there are similarities in the language and frameworks used in both fields, child
and youth care practitioners (CYCPs) have a unique view of what psychologists refer to as
“disordered behaviour.”

The CYC perspective is strength-based; it avoids the use of the medical model and
diagnostic labels, which pathologize youth behaviours. Accordingly, in this chapter we
stress that CYCPs see the world through an ecological lens, whereby the context of all
behaviours has significant meaning for the development of mental health issues. The
major approaches to the various intervention modalities that CYCPs can use in their
practice will be briefly introduced as well.

Each of the following chapters focuses on a particular group of disorders, or “excep
tional behaviours,” while following the same format throughout. For each group, we out
line (1) definitions of important concepts, (2) relevant criteria as defined and categorized
in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), (3) incidence, comor
bidity, and developmental issues, (4) major psychological paradigms of causation, (5)
CYC conceptual and causal models, and (6) the most common psychological and CYC
intervention approaches.

WHAT IS ABNORMAL BEHAVIOUR?

Generally, psychologists agree that disordered behaviour involves disrupted emotions,
behaviours, and/or thoughts. Mental health practitioners also recognize that disordered
functioning results in the experience of personal distress and can interfere with one’s abil
ity to achieve important personal goals. Everyone experiences periods of sadness, confu
sion, anger, and so forth, but these are typically normal, expected, short-term responses to
challenging events or experiences. For example, consider someone who’s been diagnosed
with a serious illness or has recently experienced the death of a loved one. We would
likely expect sadness, distress, and perhaps anger, as well as behaviours consistent with
such emotions. Under what circumstances would psychologists consider such distress or
behaviour “abnormal”? As you’ll see, there is no simple way to define or identify abnormal
behaviour.

Elements of Abnormality

Abnormality is that which is considered the opposite of normal. Defining and identifying
what is normal versus abnormal is not an easy task. Most definitions of “normal” include
what is expected, usual, or typical, including the idea of conforming to a standard. This
standard is associated with the concept of norms, socially based rules that define appro
priate behaviour in specific situations. One example of a norm in Canada is to shake hands
when you’re introduced to someone for the first time. Another is to arrive at scheduled
appointments on time. Behaviours that conform to these standards are considered normal;
behaviours that violate these standards (e.g., not extending a hand to shake when being
introduced or arriving an hour late for a lunch date) might be referred to as abnormal.

When it comes to defining any particular behaviour as normal or abnormal, however,
abnormality is not always an easy concept to characterize. Although there may be dis
agreement regarding definitions of abnormality, most would agree that there is no single
element or condition that defines abnormality. Instead, several characteristics are
considered to be possible indicators; it is the co-occurrence of these elements that increases the likelihood that a specific behaviour or condition will be defined as abnormal. Thus, psychologists consider various indicators or elements of abnormality when distinguishing between normal and abnormal. What are the specific elements of abnormality?

**Deviance.** Infrequency and social undesirability have been associated with abnormality and are related to two different forms of deviance: statistical deviance and social deviance. If a behaviour or emotional state is unusual or rare, some may consider it to be abnormal. This indicator of abnormality is referred to as statistical deviance. Specifically, if behaviour is unusual or not observed very often in the population, such infrequency may be used to define that behaviour as abnormal. Consider the case of Troy, and the fact that he sleeps in his mother's bed while his father sleeps in another room. In North America, most children are encouraged to sleep in their own beds from an early age (Cortesi et al., 2008); few 13-year-olds share a bed with their parents. Statistically, then, this behaviour is rare or unusual and some may define it as abnormal as a result.

Notice that not all rare behaviours or characteristics are defined as abnormal from a psychological perspective. For example, extremely high levels of intelligence (i.e., genius) are rare, but few would label these as abnormal. Similarly, although few people give up all their belongings and move to Africa to devote their life to helping those in need, such behaviour might be viewed with respect and admiration rather than as qualifying for consideration in the field of abnormal psychology. Thus, infrequency alone is not sufficient to define a behaviour or characteristic as abnormal in the psychological sense. In fact, some statistically deviant behaviour is actually considered desirable (e.g., extreme intelligence, athletic abilities, creativity) rather than requiring assessment and change. Therefore, although statistical deviance may be one element useful in defining abnormality, something else in addition to infrequency must be present in order to define a particular behaviour or characteristic as abnormal in the psychological sense.

Another indicator of abnormality is whether the behaviour and/or emotional experience are considered socially or culturally unacceptable. In other words, behaving in ways that violate social standards or deviate from the norms of society can result in a behaviour being labelled abnormal. This is referred to as social deviance. Norms tell us what is valued in a particular society and specify expected behaviour for particular situations. For example, Troy's refusal to attend school and his need to sleep with his mother are both examples of behaviours that deviate from what most Canadians might define as normal or from what most would expect in the behaviour of a 13-year-old male. However, different societies often have different norms or definitions of appropriate behaviour. For instance, other cultural groups consider “co-sleeping” as expected and even encourage such behaviour; in Japan and Korea, it is acceptable and not unusual for children to sleep with their parents until adolescence (Yang & Hahn, 2002). This highlights an important aspect of social deviance as a criterion for abnormality. Specifically, definitions of abnormality are relative to the social and cultural context in which they occur. We've noted that norms provide guidelines for acceptable behaviour. In doing so, they reflect what is valued or considered important in a culture. For example, in North America, where independence is greatly valued, children are encouraged to separate from their parents early in order to foster a sense of autonomy. Consistent with this value, children are expected to sleep alone at an early age. By comparison, in some collectivist cultures (e.g., those found in...
Asia and Africa; the Inuit of northwestern Canada), interdependency of the family unit is especially valued and co-sleeping in childhood is believed to support the development of strong bonds to others in the family (Cortesi et al., 2008). Thus, when considering definitions of abnormality in relation to social deviance, we must consider the values and beliefs of the larger social context or society in which we are observing a particular behaviour or characteristic. Definitions of abnormal and normal will depend on the values and beliefs that are predominant in the larger society.

Similar to our earlier discussion of infrequency, then, just because a behaviour or characteristic violates a social norm doesn’t mean that it’s labelled as abnormal or negative. As we’ve seen, different cultures have different definitions of what is valued and considered desirable. Thus, behaviour considered abnormal in one society may be considered normal in another. What is considered abnormal is relative, or considered in relation to the context or culture in which it is observed. Moreover, social norms reflect not what is true in an objective sense, but rather that group’s most current definition of acceptable behaviour. Thus, definitions of normalcy and abnormality not only differ across cultural groups but also change within any one cultural group. For example, consider same-sex orientation. Until 1973, the American Psychiatric Association classified homosexuality or same-sex orientation as a mental disorder and “abnormal.” As a result of changes in North American societal views regarding same-sex relationships, however, homosexuality was eliminated from the list of classified mental disorders and, therefore, is no longer considered abnormal in psychological terms. Thus, changing societal values and beliefs have resulted in changes with respect to definitions of abnormality in relation to same-sex orientation.

Even within a culture and a particular time period, different situations may have different norms. Accordingly, what is normal in one situation may be abnormal in another. For instance, we might consider acts of physical aggression to be normal if they occur between members of a football team on the playing field, but if the same physical acts occurred at a family barbecue, we might label them as deviant or abnormal. Thus, appropriateness to the situation is also an important consideration and, as such, definitions of abnormality are also relative to the situation. Is the behaviour expected in the specific circumstance? And, as we discuss later, definitions of abnormality are also relative to the stage of development.

**Personal Distress or Suffering.** A second indicator of abnormality is personal distress or suffering. Specifically, does the behaviour or emotion result in the individual experiencing significant personal pain? Distress is often what motivates an individual to seek treatment for symptoms. For example, if one is experiencing painful anxiety or depression, it’s not unusual to seek assistance in order to decrease such painful emotions. In Troy’s case, his symptoms of palpitations, shortness of breath, trembling, and feeling he was going to die are all associated with significant anguish. Notice how this example highlights the importance of the distress in relation to the appropriateness of the situation. For example, significant distress at the loss of a loved one would be expected, but such distress in the absence of a major life stressor or event is unexpected. It should be noted, however, that not all patterns of abnormal behaviour cause the individual distress. The behaviour viewed as abnormal may not create discomfort for the actor but rather for those around him or her. For example, a child exhibiting high levels of activity and difficulties inhibiting
inappropriate behaviour in a classroom may not be experiencing distress himself, but these behaviours are experienced as problematic by others who work or live with the child (e.g., teachers, parents, and peers).

**Impairment or Maladaptiveness.** A third indicator of abnormality is impairment or maladaptiveness. If behaviour or emotions interfere with an individual's ability to achieve important personal goals or to fulfill everyday responsibilities, or if the individual acts in ways that don’t contribute to personal well-being, this would indicate impairment of functioning. Specifically, emotional experiences or behaviours that interfere with educational or occupational goals, or with the development and maintenance of personal relationships resulting in isolation from others, are considered abnormal in the psychological sense. For example, in order to be diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD), there must be “clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning” (American Psychiatric Association, 2013, p. 60). In Troy's case, the fact that his feelings of anxiety and panic are interfering with his ability to attend school and are resulting in isolation from his peers would be considered important aspects in defining his behaviour and emotional experiences as abnormal.

**Risk to Self and Others.** A fourth indicator of abnormality is risk to self and others, or dangerousness. One obvious example of risk to self is suicidal thoughts or behaviours. Another is violent actions directed toward others. Does the individual behave in ways that create discomfort in others by making them feel threatened or distressed? This might also be associated with a definition of abnormality. For example, in the case of Conduct Disorder (discussed in Chapter 5), a youth demonstrates aggression toward people or animals, destruction of property, theft, and/or serious rule violations. If a behaviour or emotional experience puts the safety of the actor or others at risk, it's likely to be of particular concern for mental health professionals, and also very likely to be considered abnormal from a psychological perspective.

When you consider these elements of abnormal behaviour, it’s clear that “abnormality” is a vague label. As we noted earlier, no one element of abnormality is consistently or solely used to define any one behaviour or emotional experience as abnormal from a psychological perspective. Instead, in order for a behaviour or emotional experience to be considered “abnormal,” it usually reflects several of these elements. Distress, impairment, and risk are considered to be particularly significant in defining abnormality from a psychological perspective. And different elements may be more or less emphasized in different situations depending on the behaviour of interest. Thus, not all of these elements are equally relevant in each case of abnormality. And because abnormality is also a relative concept, definitions of abnormality change in relation to what constitutes abnormal behaviour at a particular time or within a particular culture. Our definitions of abnormality, then, change over time and are subject to cultural differences. Even within a particular culture or historical time period, people may disagree as to what constitutes an abnormal behaviour. Can you think of specific examples? Because abnormality is a relative concept, there's often disagreement as to whether a particular behaviour or set of emotions constitutes abnormality. Thus, consistent with the position of the World Health Organization (2001), discussions of abnormality and mental health and illness must consider the cultural differences, the role of subjective or personal judgments, and competing professional theories.
Perspectives: Abnormal or Exceptional?

Based on this discussion, it’s obvious that defining any one behaviour or characteristic as normal or abnormal is not an easy task. It’s also clear that, despite popular belief, it’s not possible to draw a clear distinction between “normal” and “abnormal.” In fact, the differences between what is normal and abnormal more often relate to a difference in severity/intensity, frequency, or duration of behaviour rather than a difference in the quality or type of behaviour. For example, if Troy had experienced a single panic attack that resulted in his being significantly distressed and staying home from school one day and sleeping with his mother one night only, he may never have been referred for treatment. The fact that his experience was severe, frequently occurring, and lasted for a long period or duration of time increased the likelihood that it would create significant distress and impair his functioning. So rather than thinking about normal and abnormal as a dichotomy in which a behaviour is either normal or abnormal, it’s more appropriate to think of abnormality as being a continuum or a matter of degree. Thus, the behaviour, feelings, and thoughts associated with abnormality don’t always differ from normal ones in their nature, but rather in how often they occur or how impairing they are to functioning. As a result, each of us can relate to emotions and actions that are associated with disordered behaviour. It’s important to keep this in mind as you read about the various psychological disturbances. It’s not unusual to see yourself or others you know reflected in some of these behaviour patterns!

Having identified the major elements of abnormality, we now turn to a discussion of how such behaviours have been explained throughout history. Before going on, however, consider the examples in the Think About It! exercise. Which of these behaviours would you consider to be abnormal? Which of the basic elements of abnormality would you use to define any one of these as abnormal?

Definitions of abnormality are relative to the situational context in which they occur. Would this behaviour be considered “normal” in a classroom?
WHAT IS ABNORMAL PSYCHOLOGY? THE PSYCHOLOGICAL PERSPECTIVE

Psychology is generally defined as the scientific study of behaviour and mental processes. Behaviour includes outward, observable actions (e.g., yelling, crying, and hugging). Mental processes refer to the workings of the mind (e.g., internal activities such as thinking, problem solving, feeling, and interpreting). The primary goals of psychology are to describe, explain, predict, and control various behaviours. Abnormal psychology is a branch of psychology that focuses on the scientific study of disorders of behaviour, mood, and mental processes. Therefore, abnormal psychology focuses on describing, explaining, predicting, and controlling (or changing) patterns of disordered, disrupted, disturbed, or abnormal behaviour or functioning (from a psychological perspective, we will use these terms interchangeably throughout the text). See Table 1.1 for examples of these goals in relation to the panic attacks discussed in Troy’s case.

How do psychologists define and view disturbances in behaviour, mood, and mental processes? In order to better understand definitions of such disruptions, we need to

<table>
<thead>
<tr>
<th>Table 1.1 Goals of Abnormal Psychology</th>
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<tbody>
<tr>
<td><strong>Goal</strong></td>
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<tr>
<td>Describe behaviour: What is a panic attack? What happens during an attack?</td>
</tr>
<tr>
<td>Explain behaviour: Why do panic attacks occur?</td>
</tr>
<tr>
<td>Predict behaviour: Who is most at risk for experiencing a panic attack? When are panic attacks most likely to occur?</td>
</tr>
<tr>
<td>Control/alter behaviour: How can we reduce the occurrence of panic attacks?</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td>Individual feels intense fear and apprehension and may experience sweating, shaking, chest pains, dizziness, accelerated heart rate, fear of dying, chills, and nausea</td>
</tr>
<tr>
<td>Genetic predisposition, severe stress, major life transitions, chemical imbalances</td>
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<tr>
<td>Those with a family history of the disorder, significant stress, loss of a loved one, history of childhood sexual or physical abuse, significant trauma</td>
</tr>
<tr>
<td>Cognitive behavioural therapy, behavioural (exposure) therapy, medication (antidepressants, anti-anxiety)</td>
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</table>
consider a definition of mental health. The World Health Organization (2001) defines mental health as a “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 1). Mental illness, in contrast, is a general term associated with behaviours and/or states that interfere with mental health (i.e., interfere with participation in productive activities, fulfilling relationships, and an individual’s ability to adapt to change and cope with challenges).

Based on these definitions, should we consider Troy’s behaviour “disordered”? What would a psychologist conclude? When it comes to understanding mental disturbance and disrupted behaviour from a psychological perspective, the concept of abnormality is particularly relevant. However, it’s important to note that abnormal behaviour does not equal mental disorder. Let’s examine the difference between these two terms.

The DSM-5 Categorical System

As we’ve seen, abnormal behaviour is a general term that relates to actions or emotions that violate societal norms, create distress, and interfere with functioning (the indicators of abnormality). By comparison, mental disorder is defined as a significant behavioural or psychological syndrome or behaviour pattern (associated with the indicators of abnormality) that relates to a very specific group of behaviours, emotions, and impairments. Examples include Bipolar Disorder, Obsessive Compulsive Disorder, and Conduct Disorder. Each of these disorders is defined by a particular pattern of behaviour (rather than a single behaviour or characteristic) that comprises many different actions or emotional experiences that interfere with the individual’s ability to function (socially, academically, emotionally, etc.) and/or results in significant distress for the individual. Thus, although certain behaviours can be possible indicators of a specific disorder, the two terms are not interchangeable.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a publication of the American Psychiatric Association (2013), provides detailed descriptions of all major psychological disorders currently recognized. The DSM-5 is used as a reference guide by mental health professionals around the world. Specifically, the manual is used to guide professionals in their work with those experiencing behavioural and/or emotional challenges. The manual identifies 22 groups or categories of disorders, each summarized in its own chapter. The specific disorders included in any one category/chapter are grouped together on the basis of similar symptoms and similar causes. Box 1.1 presents the 22 groups of disorders along with examples of specific disorders for each category.

How do mental health professionals use the DSM-5 in their work with people experiencing significant distress and/or impairment? Let’s take a closer look at what’s included in the DSM-5 for any mental disorder and how that information is used by psychologists, psychiatrists, and other mental health professionals.

DSM-5 Disorders: Diagnoses and Criteria

For any specific mental disorder identified in the DSM-5, there is a detailed summary of the symptoms that must be observed in order for someone to be diagnosed with the disorder. You may be surprised by the use of medical terms (symptoms, diagnosis) in a discussion of
mental disorders. However, because the DSM categorical system is based on medical model, mental disorders are viewed as being similar to physical illnesses and diseases that are associated with specific symptoms and require treatment. The specific symptoms of any disorder are referred to as diagnostic criteria, and outline the major features of a disorder. For example, Box 1.2 presents the diagnostic criteria for Gender Dysphoria, a disorder identified and summarized in the DSM-5.

You might also be surprised (and perhaps offended) to see Gender Dysphoria included in the DSM. As we saw in our discussion of the relative nature of definitions of abnormality, societal views regarding gender, sexual orientation, and sexual identity have changed significantly in recent decades, and the DSM criteria have changed in relation to shifts in these views. Did you know that in the past, having an identity as an LGBT person was

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**Box 1.1**

**DSM-5 Categories and Examples**

<table>
<thead>
<tr>
<th>DSM-5 Category/Chapter</th>
<th>Specific Disorder Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>ADHD, Autism Spectrum Disorder, Learning Disorders</td>
</tr>
<tr>
<td>Schizophrenia Spectrum and Other Psychotic Disorders</td>
<td>Schizophrenia, Schizoaffective Disorder</td>
</tr>
<tr>
<td>Bipolar and Related Disorders</td>
<td>Bipolar I Disorder, Bipolar II Disorder</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Specific Phobia, Panic Disorder, Social Anxiety Disorder</td>
</tr>
<tr>
<td>Obsessive-Compulsive and Related Disorders</td>
<td>Obsessive-Compulsive Disorder, Hoarding, Trichotillomania</td>
</tr>
<tr>
<td>Trauma- and Stressor-Related Disorders</td>
<td>PTSD, Acute Stress Disorder, Adjustment Disorder</td>
</tr>
<tr>
<td>Dissociative Disorders</td>
<td>Dissociative Amnesia, Dissociative Identity Disorder</td>
</tr>
<tr>
<td>Somatic Symptom and Related Disorders</td>
<td>Somatic Symptom Disorder, Conversion Disorder</td>
</tr>
<tr>
<td>Feeding and Eating Disorders</td>
<td>Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder</td>
</tr>
<tr>
<td>Elimination Disorders</td>
<td>Enuresis, Encopresis</td>
</tr>
<tr>
<td>Sleep-Wake Disorders</td>
<td>Insomnia Disorder, Narcolepsy, Parasomnias</td>
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<tr>
<td>Sexual Dysfunctions</td>
<td>Erectile Disorder, Female Orgasmic Disorder</td>
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<tr>
<td>Gender Dysphoria</td>
<td>Gender Dysphoria</td>
</tr>
<tr>
<td>Disruptive, Impulse-Control, and Conduct Disorders</td>
<td>Oppositional Defiant Disorder, Conduct Disorder</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>Substance Use Disorder, Gambling Disorder</td>
</tr>
<tr>
<td>Neurocognitive Disorders</td>
<td>Delirium, Major and Mild Neurocognitive Disorders</td>
</tr>
<tr>
<td>Personality Disorders (PDs)</td>
<td>Antisocial PD, Borderline PD, Narcissistic PD</td>
</tr>
<tr>
<td>Paraphilic Disorders</td>
<td>Pedophilic Disorder, Voyeuristic Disorder</td>
</tr>
<tr>
<td>Other Mental Disorders</td>
<td>Unspecified Mental Disorder Due to Another Medical Condition</td>
</tr>
<tr>
<td>Medication-Induced Movement Disorders and Other Adverse Effects of Medication</td>
<td>Tardive Dyskinesia, Antidepressant Discontinuation Syndrome</td>
</tr>
<tr>
<td>Other Conditions That May Be a Focus of Clinical Attention</td>
<td>Relational Problems, Abuse and Neglect</td>
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</tbody>
</table>
included in the *Diagnostic and Statistical Manual of Mental Disorders*? For example, homosexuality was defined as a psychiatric “disorder” that needed treatment. In 1973 and 1974, due to growing protest, the APA agreed to remove homosexuality from the manual. And yet, although homosexuality was declassified in the 1980 edition (the DSM-III), variations of the listing remained until 1986. In 1980, “Ego-Dystonic Homosexuality” was listed in the DSM-III as a disorder characterized by distress associated with homosexuality. This listing was removed from the DSM-III-R in 1987 in light of the argument that any distress associated with homosexuality was more the result of societal reaction (i.e., homophobia) to the behaviour pattern rather than one’s subjective experience of homosexuality. The fifth edition of the DSM introduces the term *Gender Dysphoria* to replace these earlier terms and emphasizes that the critical element in the definition of this “disorder” isn’t the gender identity itself, but rather the psychological distress and impairment that might be associated with the incongruence between one’s experienced/expressed gender and assigned gender.

By providing such a detailed description of each disorder and its symptoms, the DSM is used as a reference to guide *assessment* and *diagnosis* of those experiencing mental health issues. *Assessment* involves collecting relevant information about a person using a variety of means (e.g., observing their behaviours, questionnaires, interviews) in order to provide an overall picture of that person’s behavioural, cognitive, emotional, and overall functioning. By gathering this information, the mental health professional can identify behaviours, emotions, or thoughts that are interfering with functioning or creating significant distress (i.e., symptoms) and compare these to the diagnostic criteria in the DSM. If there is a match between the criteria outlined and the symptoms expressed by the individual, the person’s behaviour pattern can be assigned to a specific category of the DSM
This process of assigning one's behaviour pattern to a category of the DSM is referred to as diagnosis. Thus, the manual specifically describes each disorder in detail, summarizing the symptoms that must be present in order for someone to be diagnosed with that disorder.

Note that Criterion B in Box 1.2 requires that the individual be experiencing significant distress or impairment in relation to the symptoms summarized in Criterion A. This requirement is (associated with our earlier discussion of the major elements of a psychological view of abnormality) is included in the diagnostic criteria for every disorder in the DSM-5.

Before moving on to a consideration of a CYC approach to abnormal behaviour, test your understanding of some of the key concepts (i.e., the bolded terms) associated with a psychological approach to emotional and behavioural disturbances in the Test Your Understanding exercise. Can you identify the specific concept associated with each example?

A CYC APPROACH TO ABNORMALITY: UNDERSTANDING EMOTIONAL AND BEHAVIOURAL DISTURBANCES

Given the preceding discussion on the difficulties in defining abnormality, it's fitting to re-examine our choice of terms used to describe concerning behaviours related to mental health using a strength-based approach. For example, in CYC practice, one of the terms we might suggest using to describe young people’s “abnormal” behaviours or the emotional and behavioural disorders is exceptional. This term was developed through the study of learning disabilities in the field of children’s special education (Winzer, 2005). The term is philosophically consistent with a CYC perspective in that it avoids the negative labelling inherent in such words as psychopathology, abnormal, disturbed, and disorder. A child or youth with an exceptionality displays differences in his or her physical, intellectual, communicative, social, or emotional domains (Winzer, 2005).

Mental Health Literacy. The notion of mental health literacy (Jorm et al., 1997) is based on the assumption that in order to aid in the recognition, management, and prevention of mental health issues, members of society ought to have at least a basic knowledge of mental health. Such knowledge also helps to de-stigmatize mental health difficulties.

Children and youth practitioners (CYCPs) have an ethical and professional obligation to be knowledgeable about young people’s mental health issues and concerns.
That is, they need to be able to recognize the symptoms and signs of potential mental health difficulties and to respond to these appropriately and effectively. Well-informed helping professionals know how to obtain mental health information; they have a basic knowledge of risk factors, causes, and treatments; and they know where to access appropriate professional help. Indeed, CYCPs, as direct service professionals working with children, youth, and families, "are in an excellent position to recognize and respond to mental health emergencies" (Ranahan, 2010, p. 15).

There are many approaches to the assessment of, and intervention in, emotional and behavioural disorders in children and youth. These are articulated in CYC, counselling, behaviour management, and special education literature. The Reclaiming Children and Youth journal, for example, is an excellent resource for researching CYC approaches to exceptional behaviours.

**The Context of CYC Work.** CYCPs work in a wide variety of agency and program settings within many major systems: child and family services, health (including mental health), justice, community based, and education, to name just a few. CYCPs could also be doing street work or prevention work with homeless youth or sexually exploited young people. (We use the term child/youth sexual exploitation instead of juvenile prostitution to highlight the fact that adults having sex with minors constitutes child sexual exploitation/sexual abuse.) You might be a crisis worker responding to calls from the community to assist with a youth or family in crisis, or a family support worker teaching parenting skills and providing support to a young mother. You might be working with youth who are struggling with addictions in all these various systems. Your learning needs, how you approach your learning, and your perspective on the mental health concerns of the children, youth, and families with whom you’re engaged will vary and be influenced by the predominant ideologies of each system or setting. The expectations for your treatment approach, your level of involvement in case planning, and the ways you assist young people experiencing mental health concerns will vary as well. For example, if you’re working in a child and adolescent inpatient psychiatric facility, its predominant ideology will be based on the bio-medical conceptual model—one that provides a diagnosis and a plan for a cure or treatment of the mental illness (Stuart, 2009). The first line of treatment and the predominant intervention in this milieu will very likely be psychotropic medication—medications that alter perceptions, thoughts, emotion, and/or behaviour. There will likely be little choice in the conceptual model or treatment approach.

If you’re a CYCP working in a group home or residential treatment centre, you may have staff psychiatrists, psychologists, social workers, clinicians, or therapists giving you clinical advice about which therapeutic approaches to use with young people experiencing emotional and behavioural difficulties. The CYC staff team work with these youth during what’s been termed “the other 23 hours”—the hours that youth who live in managed care programs, residential care, or out-of-home care spend outside the therapist’s office (Brendtro, Whittaker, & Trieschman, 1969). If you’re working in a community-based mental health program, you may be responsible for developing the treatment plan for a youth’s seven-days/week, 24-hour care, and for reporting changes or concerns to an interdisciplinary team of doctors, psychiatrists, occupational therapists, nurses, and psychologists. If you’re a street outreach worker, you’ll need to provide advocacy, support, and referrals for youth experiencing mental health concerns. Whatever your role or level of responsibility and in whatever system you
may be working, as a CYCP you must be able to recognize signs and symptoms of youth mental health difficulties, and respond accordingly. Although you’re not qualified to make diagnoses (and this is not your role), you must be able to engage in a meaningful dialogue with collateral professionals, parents, and the young people themselves. Thus, you need to be familiar with paradigms or conceptual models, theories, interventions, referrals sources, psychotropic medications, signs and symptoms, and so on. That is your professional responsibility.

CYCPs must also be knowledgeable about the Mental Health Act in their respective jurisdictions. They need to be well informed about all the services offered in the local mental health system. This includes the Canadian Mental Health Association (CMHA) community-based programs, self-help and support groups, addiction services, crisis response services, emergency services, mental health assessment services, and all in-patient and outpatient child and adolescent psychiatric services. CYCPs need to understand how all the various systems (e.g., justice, health, community, child welfare and education) respond and intersect with regard to child and adolescent mental health issues. Knowledge of referral sources for these services, and of private mental health practitioners who provide ongoing therapy and support to young people and families experiencing mental health issues, is also key to effective CYC practice in the area of child and adolescent mental health.

**CYC Domains of Practice.** According to Carol Stuart (Stuart, 2009; Stuart & Carty, 2006), seven domains of practice or competencies are involved in child and youth care practice: self, professionalism, communication, normal and abnormal child and adolescent development, systems context, relationships, and interventions.

The first three domains (self, professionalism, and communication) are foundational (that is, the remaining four domains build on these and relate to the specific skills and knowledge required for CYC practice). The first foundation is the self, where the CYCP uses self-awareness to guide all interactions with others and ensures that personal values are congruent with professional values; the second is professionalism, where the CYCP identifies and resolves ethical dilemmas based on CYC values and strives to maintain a professional presentation and identity; and the third is communication, where the CYCP uses communication skills to express self and professionalism toward others, primarily clients and colleagues.

Your treatment approach is significantly influenced by your self; that is, your personal and professional experiences and opinions about the mental health concerns of the youth in your care. When considering the domain of self, you need to be mindful of your own life story (Bellefeuille & Jamieson, in Bellefeuille & Ricks, 2008). It's important to explore your own conceptual model or set of beliefs about what causes mental health issues in young people—a process that will help you, as the practitioner, clarify your understanding of how or why mental illnesses develop and affect some children and youth so profoundly. You must also recognize how your story influences your choice of preferred conceptual model. This process is sometimes called meaning making (Garfat & McElwee, 2007), which refers to how we make sense of what we observe based on our own context.

The competency domains of professionalism and communication are also critical to mental health literacy in CYC practice.

The four remaining competencies required for effective CYC practice (normal and abnormal child and adolescent development, systems context, relationships, and
interventions) overlap with each other. CYCPs must be able to assess the status of a child’s development and identify areas of competence and areas of developmental delay. They must then be able to apply this knowledge to the systemic context of the young person’s life. The assessment is applied to the planned interventions, which are executed by the practitioner. Most importantly, relationships are the foundation of the entire process from start to finish: from assessment through to interventions. “Children and youth as well as their families must trust and feel safe in their interpersonal interactions with CYC practitioners, [and] such safety and trust is developed through relationships” (Stuart & Carty, 2006, p. 26).

Refer to Figure 1.1 for a summary of these seven domains.

It’s evident that the domains of CYC practice are all highly interrelated. As Stuart and Carty (2006) point out, the central focus of CYC practice is first the child, youth, and/or family, and second (but also critically important) the quality of care and service CYCPs provide to help them with optimal mental health. The authors note that the domains of professional CYC practice in child and youth mental health are no different

![Figure 1.1 The Seven Domains of CYC Practice](image)

The seven domains of practice or competencies involved in child and youth care practice.

from those in any other sector that provides care for children youth and families. The emphasis may vary slightly and the interdisciplinary team will probably vary significantly in various settings, but competent CYC practice requires knowledge, skills, and abilities in all the domains, regardless of the context (Stuart & Carty, 2006).

**CYC and Diagnostic Labelling.** The use of diagnostic labels grew out of the special education field in the United States and is based on the medical model, or the biological–psychological paradigm (Winzer, 2005). In special education, diagnostic labelling is used to classify children in order to place them in appropriate settings and to secure funding. Labels can be seen as cues that help organize our knowledge of, and responses to, children’s and youth's exceptional behaviours. All labels carry with them certain expectations, some good, and some bad (Winzer, 2005).

The research on the use of diagnostic labels is inconclusive. Although there are always concerns about labelling bias, the research shows that stigma typically exists already, before the formal diagnostic label is applied, and that the label itself does not add appreciably to the stigma (Winzer, 2005). Moreover, the “mentally ill” or “mental disorder” label may help a child and family access help or services. Diagnostic labels while they can be stigmatizing, can also lead to proper treatment and recovery. Currently, however, in the special education field and in the CYC literature there is much distrust of the use of labels.

As Lavin and Park (1999) note, CYCPs need a good basic understanding of what the DSM diagnostic labels mean and how to distinguish between them—not only in order to understand the signs and symptoms of exceptionalities (a professional obligation in mental health literacy), but also to help “determine the modality, intensity and duration of the interventions” to use in treatment. Nonetheless, they also note, with strong criticism, that diagnostic labels tend to focus on the “child’s aberrant behaviour rather than the emotional turmoil that produces it” (Lavin & Park, 1999, p. 5). These authors identify this focus on the behaviour of the child as a pivotal issue for treatment: without an understanding of the context or background issues and/or by viewing behaviours from a strictly conceptual model, CYCPs run the risk of overlooking or minimizing the emotional elements that may be causing and perpetuating the behavioural difficulties (Lavin & Park, 1999). Larry Brendtro (1988) suggests that diagnostic labels are seldom helpful to CYC practitioners—that they’re antithetical to a CYC approach in that they stigmatize young people, which in turn negatively influences our responses to their behaviour and to them as individuals.

We point our finger, then control, treat and fix, as if we’re dealing with a disease. . . . ADHD, ODD, PDD, and so on: we have all of the “technical” labels, but are we trying to apply medicine and science where they do not belong? How can these diagnostic labels represent such unique, special and colourful minds? Confining children to categories constricts and changes our beliefs about them, and, consequently, our interactions with them. To understand each child for whom she/he is, we need to embrace “normalcy” rather than “pathology,” to be fluid instead of rigid and in our interventions we need to be simply genuine and caring human! (Brendtro, 1988, p. 1)

Indeed, many CYC writers and clinicians (e.g., Fewster, 2001) argue that diagnosing and labelling children has serious and undesirable consequences. Clearly, there is great
debate regarding the utility of labelling associated with diagnoses of children and youth. A summary of the advantages and disadvantages of the use of diagnostic labels is presented in Table 1.2. Consider the literature and then decide for yourself. Where do you stand on this important issue?

**Person-First Language.** A person is not a disorder; CYCPs use person-first language when working with young people with exceptionalities. For example, we don’t refer to the FASD child or the ADHD youth, but rather to a young person affected by FASD or the adolescent diagnosed with ADHD.

Person first language is the appropriate way to talk about disorders or disabilities. In talking about children with disabilities, we may hear or say things like, “He’s ADHD,” or “He’s a Down’s kid.” We have all heard and probably said these things without much thought. Person first language is the respectful way to talk about children’s disabilities that places the focus on the person and not the disability. To use person first language, simply say the person’s name or use a pronoun first, follow it with the appropriate verb, and then state the name of the disability. (Logsdon, 2015)

### Table 1.2 Pros and Cons of Applying Labels to Children and Youth

<table>
<thead>
<tr>
<th>Arguments for the Use of Labels</th>
<th>Concerns About the Use of Labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t discuss or identify problems without using labels</td>
<td>Labels permanently assign a diagnosis</td>
</tr>
<tr>
<td>Labels provide a common language for professionals</td>
<td>Labels don’t reflect an individual child’s needs</td>
</tr>
<tr>
<td>Labels help to access services and funding</td>
<td>Labels don’t reflect an individual child’s needs</td>
</tr>
<tr>
<td>Labels can simplify information for professionals and parents</td>
<td>Parents and professionals may disagree about the use of labels</td>
</tr>
<tr>
<td>Labels assist in diagnosis and in insurance coverage</td>
<td>Labels exclude things that are different and divide the normal from the deviant</td>
</tr>
<tr>
<td>There is no connection between labels and service delivery</td>
<td>A label only describes problems and deficits</td>
</tr>
<tr>
<td>Labels help others become more tolerant of a disability</td>
<td>People expect deviant behaviour from labelled individuals</td>
</tr>
<tr>
<td>Labels result in increased viability for those with special needs</td>
<td>People view a labelled individual differently</td>
</tr>
<tr>
<td>Labels are helpful to parents; they give a name to the disability and thus an explanation and control</td>
<td>An oversimplified label suggests an unhealthy child</td>
</tr>
<tr>
<td>Children suffer damage to self-esteem because of behavioural problems, not because of labels</td>
<td>Labelling negatively affects children’s self esteem</td>
</tr>
<tr>
<td>Labels help us identify those who need help</td>
<td>Categorizing encourages professionals to treat children as labels</td>
</tr>
<tr>
<td>Stigma precedes the label</td>
<td>Labels result in stigma</td>
</tr>
</tbody>
</table>

Cultural Respect. In the CYC approach to understanding child and youth exceptionalities, “helpers recognize that they need to develop an understanding of each individual they are working with, including that person’s personal, family, community and national history and how that history affects the present” (Hart, 2002, p. 107).

In culturally competent practice, CYCPs are knowledgeable about the culture of the young people with whom they are working. Cultural competence is a journey (not a destination) of learning about the cultures of the individuals they serve. The term cultural safety is similarly defined as “the state of being in which a child or young person experiences that her or his personal well-being, as well as social and cultural frames of reference, is acknowledged—even if not fully understood by the worker(s) claiming to be there to help him or her” (Fulcher, 2001, p. 2).

In Manitoba, for example, the majority of the children in the care of child and family services or involved in the justice system are of Aboriginal descent. To be effective in the justice or managed care system in this province, then, CYC practitioners ought to, at minimum, learn as much as they can about Aboriginal culture, and to acknowledge and address any biases they may have. They need to understand the present-day consequences of colonization and the consequent oppression and intergenerational trauma faced by Aboriginal people. They ought to have knowledge of traditional methods of healing where appropriate, including the sweat lodge and traditional medicines used in smudging, and to have access to Elders and cultural advisers.

Indigenous people have been particularly susceptible to cultural racism in both the allocation of resources for responsive health and social services and in the way services are delivered. Simply trying to understand where people from a different culture are “coming from” can be in itself a huge undertaking. Child and youth care workers seeking to pursue cultural safety in their own practice are encouraged to think about how each encounter is conceptually framed by a cultural context. (Fulcher, 2001, p. 152)

We know that there is a lack of culturally relevant services for Aboriginal mental health needs. There are also concerns about the use of Western labels for many mental illnesses, including depression, and the use of culturally appropriate questions to assess mental illness in Aboriginal young people.

Distinguishing between First Nations and Western understandings can be problematic and foster the process of othering. However, an understanding of distinguishing features from these two standpoint is essential to effectively address the priority Aboriginal peoples give to mental health and illness. Othering may marginalize Aboriginal peoples or render Aboriginal knowledge as a commodity to exploit, appropriate, or potentially misinterpret. Distinctions between Aboriginal and Western worldviews of mental health also run the risk of generalizing Aboriginal culture without considering individual and tribal differences or appreciating the dynamic nature of cultural worldviews, values, beliefs, and understandings. Nevertheless, to ignore Aboriginal worldviews about mental health and illness is unethical and immoral as Aboriginal peoples fight the legacy of colonization to regain a sense of balance and harmony within their collective historical identity. (Vukic et al., 2011, p. 660)
Perspectives: Abnormal or Exceptional?

Explanation and Intervention. In our work with young people, the way we understand the development of their exceptional behaviour ought to guide our choice of intervention. For example, if an ADHD diagnosis includes a biophysical explanation for the development of ADHD’s classic triad of behaviours (impulsivity, inattentiveness, and hyperactivity), we would look to a biophysical intervention, such as physician-prescribed medication or diet modification. Although a biological paradigm doesn’t usually fit well with the CYC approach, the use of psychotropic medications (as prescribed for ASD, ADHD, FASD, and so on) may indeed be warranted in some cases.

Evidence-Based Practice. CYCPs need to be accountable for the interventions they use in their practice. For most, this means providing evidence that the interventions have resulted in positive and measurable outcomes for youth. True evidence-based practice is supported by scientific evidence showing that it works. Many CYC interventions aren’t evidence-based per se, but have much anecdotal evidence of their success; the Life Space Crisis Intervention is one such approach (Stuart & Carty, 2006).

In an Ontario investigation of CYC and mental health, Stuart and Carty (2006) delineated several treatment models recognized by CYCP focus groups as evidence-based; the 10 most frequently identified were cognitive behavioural therapy; therapeutic crisis intervention; COPE; SNAP: Stop Now and Plan; CPI: Crisis Prevention Institute; NVCI; solution-focused therapy; Positive Parenting Program; TAP/C: Arson Prevention; Goldstein’s social skills; and pharmaceutical intervention.

Carol Stuart (2009) notes that she’s sometimes uncertain about whether the CYC field should fully adopt an evidence-based philosophy. Our interventions are intuitive and relational, and as such ought not to be strictly evidence based. Moreover, it’s difficult to determine whether an approach can be defined as evidence-based treatment, as this requires total consistency and control over the environment. Stuart explains that although we as a profession understand the importance of developing an evidence base about what we do, we need to retain the legitimacy of professional discretion, judgment, and individualized stories about approaches to our CYC work (Stuart, 2009).

To further consider the way labelling and language can alter our perceptions, read Troy’s Case: Revisited. Notice how the language we use to describe patterns of behaviour can alter our perceptions of that behaviour as well as our ideas about the person exhibiting it.

Troy’s Case: Revisited

Reread the opening case of Troy. What pathology- or deficit-based words might be used to describe him? What strength-based words might be used? Now ask yourself how you felt when reviewing each description of Troy. How might young people feel if they were to read some of the descriptions in their logs or case files?

Try this out by describing yourself in 25 words or less using pathology- or deficit-based terms: for example, I’m a procrastinator; I can’t lose weight; My car is a mess; I eat too much junk food; and so on. Now describe yourself in 25 words or less using strength-based terms: for example, I’m a good mother; I’m a caring person; I’m good at math; I’m a good friend. How did you feel when reviewing each description of yourself?
HOW MANY YOUNG PEOPLE STRUGGLE WITH MENTAL HEALTH DIFFICULTIES?

Mental illness will directly or indirectly affect all Canadians at some time in their lives, whether through a family member, friend, or colleague’s experience. Twenty percent of Canadians will personally experience a mental illness in their lifetime. Mental illness affects people of all ages, educational and income levels, and cultures.

According to Statistics Canada (2013), adolescents and young adults aged 15–24 experience the highest incidence of mental disorders of any age group in Canada. As illustrated in Figure 1.2, the number of people affected by any particular mental disorder varies significantly. For example, while schizophrenia affects 1 percent of the Canadian population, anxiety disorders affect more than 5 percent, causing mild to severe impairment. Of great concern is the fact that suicide accounts for 23 percent of all deaths among 15- to 19-year-olds (Statistics Canada, 2012).

Studies suggest that as many as 14–25 percent of children and youth in Canada experience significant mental health issues (Waddell et al., 2005). Most mental health problems can be detected prior to the age of 24, and 50 percent of these difficulties surface before the age of 14. Mental health difficulties contribute to problems with achievement and relationships at school. In severe cases, they prevent students from regularly attending class, but more often students simply struggle with these problems on a daily basis, leading to further social and academic functioning concerns. The problem is that most of the

![Figure 1.2 Estimated Prevalence of Mental Disorders in Canadian Children Under 15, 2001](image)

**Figure 1.2 Estimated Prevalence of Mental Disorders in Canadian Children Under 15, 2001**

The prevalence of mental disorders in Canadian children varies significantly depending on the disorder.

Source: Public Health Agency of Canada, 2009; Waddell et al., 2005.
children and youth who are struggling with mental health concerns will not say anything to anyone, and thus will not receive any support or intervention.

In each chapter of this text we provide statistics regarding current rates of the relevant disorder in Canada. Be aware that estimates vary significantly depending on the source, and that these estimates are constantly changing.

**MENTAL HEALTH DISTURBANCES AND DEVELOPMENT**

Definitions of abnormality are relative to the developmental norms for each age group. Thus, a behaviour or characteristic can be outside the norm within a particular developmental stage. This is especially relevant when considering definitions of abnormality for children and adolescents.

From a CYC perspective, when considering what is normal and what is not, we must recognize that almost all children and youth experience significant emotional and behavioural instability during pre-adolescence and adolescence (Winzer, 2005). CYCPs need to know how the various mental health concerns might manifest differently at the different developmental stages. For example, depression may be manifested as failure to thrive in infants, as defiance in preschoolers, and as anger, acting out, risk taking, and/or substance abuse in adolescents (Wilmshurst, 2004). CYC students and practitioners need a good understanding of developmental theories to use in their assessments.

As well, knowledge of child and adolescent development is a critically important domain of CYC practice. The sub-domains (Stuart & Carty, 2006; Stuart, 2013) included within the major domain of “normal and abnormal child and adolescent development” are the following competencies:

i. Knowledge of developmental theories
ii. Knowledge of patterns of growth and development
iii. An understanding of learning theory
iv. The ability to link developmental theory to pathology
v. Knowledge of medication and pharmacology

Let’s consider the case of Troy once more. As we discussed earlier, sleeping with one’s mother might be considered more acceptable and less abnormal for a 3- or 4-year-old than it would be for 13-year-old Troy. Accordingly, definitions of abnormality also consider the norms or expected standards of behaviour as they exist for particular age groups and what we might expect from those within a particular developmental stage. Refer to Table 1.3 for an overview of the age ranges that will be the focus of this text, and the terms that will be used to refer to each age group.

We also need to recognize that the characteristics or symptoms of adult mental health issues are different when manifested in children and youth. The DSM-5 acknowledges these differences on occasion as well. For example, the diagnostic criteria for Post-Traumatic Stress Disorder are different for those aged 6 and under, and the DSM
includes a specific set of criteria for this age range. In addition, the DSM includes a separate section on personality disorders, long-standing patterns of behaviour that are present continuously from childhood, adolescence, or early adulthood into adulthood. In order to be diagnosed with a personality disorder, there must be evidence of the behaviour pattern in earlier stages of development. For example, Antisocial Personality Disorder is characterized by frequent violations of the rights of others, including criminal acts. In order to be diagnosed with this disorder in adulthood, there must be evidence that the adult had a pattern of similar behaviour in childhood and/or adolescence, often being given a previous diagnosis of Conduct Disorder.

### COMORBIDITY

As we’ve discussed, psychological disorders and their symptoms are not clearly separated from normal functioning. In the same way, psychological disorders themselves aren’t neatly separated from one another. Similar symptoms (e.g., sleeping difficulties, impulsive behaviour) are included in the diagnostic criteria for many disorders’ it’s not unusual, then, for one person to meet the criteria for more than one disorder. Comorbidity refers to the co-occurrence of two or more disorders in one person. For example, an adolescent might meet the criteria (and be diagnosed) with both Major Depressive Disorder and ADHD.

Comorbidity represents a challenge both for the DSM as a categorical system and for practitioners. For the DSM, the fact that many symptoms are associated with various diagnostic categories (e.g., impulsivity is a criteria for ADHD, Antisocial Personality Disorder, Borderline Personality Disorder, and others) challenges the idea that mental disturbances fall easily into distinct categories. For the practitioner, comorbidity presents challenges regarding which pattern of disturbance (e.g., anxiety or depression) should be the priority of treatment.

Regardless of the challenges associated with comorbidity, and the fact that this term doesn’t fit with a CYC approach to conceptualizing youth behaviour, understanding this concept is an important component of CYCPs’ mental health literacy. Specifically, knowing how to recognize the most common co-existing disorders in children and youth can facilitate a practitioner’s work with youth and their supports.

Before examining the psychological explanations for what causes mental illness, consider the common myths about mental disorders presented in Box 1.3. Are you surprised by any of these myths? Are your beliefs about mental disorders consistent with the facts?

---

**Table 1.3 Developmental Age Ranges (as referred to in this text)**

<table>
<thead>
<tr>
<th>Chronological Age Range</th>
<th>Developmental Group and Associated Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 2 years</td>
<td>infants, toddlers</td>
</tr>
<tr>
<td>2 to 11 years</td>
<td>child, childhood</td>
</tr>
<tr>
<td>11 to 18 years</td>
<td>adolescence, adolescent, teen, youth</td>
</tr>
<tr>
<td>Birth–death</td>
<td>individual (this term is used to refer generally to anyone from any age range)</td>
</tr>
</tbody>
</table>
Explaning Mental Disturbances: Psychological Paradigms

Why do some people develop mental disorders while others do not? Various explanations for the development of mental disturbances have been offered throughout history. As in the case of defining abnormality, explanations of the causal factors, or etiology, of mental disturbances are relative to both the time and context in which they are observed.

Historical Views of Abnormality

While definitions of abnormality have changed throughout history, there have always been attempts to try to understand and explain abnormal behaviour. Early explanations for abnormal behaviour were based on ideas derived from philosophy, medicine, and religion. Following the emergence of the field of psychology around 1879, psychologists developed their own explanations for abnormal behaviour. We begin with a brief overview of historical explanations for abnormal behaviour, and then we’ll examine more current approaches to understanding abnormality.

Demonology, Early Philosophers, and the Middle Ages. Early views of abnormal behaviour are believed by some to have been based in demonology, which involved the idea...
that evil spirits or beings resided in or possessed the affected individual. Consistent with this early explanation for deviant behaviour, archaeologists have found Stone Age human skeletons with egg-sized holes in their skulls, and have interpreted these holes to be consistent with prehistoric views that abnormal behaviour was an indication of possession by evil spirits. This trephining (or trepanning)—cutting a hole in a person’s skull—is viewed by some as an assumption that such treatment would allow the release of demons that had possessed the person and were causing the abnormal behaviour. This treatment appears to have been widespread around the world (Kidd, 1946), and Aboriginal specimens with holes in the skulls have been found in British Columbia.

In ancient Greece, those exhibiting abnormal behaviour were often sent to temples for treatment by Aesculapius, the god of healing, who was believed to visit them while they slept, providing suggestions for cures in their dreams. Exercise, nutrition, and rest were also recommended. Those who weren’t cured were stoned and driven from the temple, highlighting the negative reactions to deviant behaviour.

But different explanations of abnormal behaviour were evident even in ancient Greece. Hippocrates disagreed with the demonological model and argued that illnesses of the body and the mind were a result of imbalances in bodily fluids, or humours (phlegm, black bile, yellow bile, and blood). For example, high levels of yellow bile were believed to result in irritability and anxiety. Although his original explanation for emotional disturbances has not been supported by scientific evidence, Hippocrates marked the beginning of a more natural explanation for abnormal behaviour in a time when supernatural explanations prevailed.

During the Middle Ages (476 c.e. through 1450 c.e.), belief in supernatural causes returned to the forefront when it came to explaining deviant behaviour and emotional disturbance. In relation to the teachings of the Roman Catholic Church, the belief in possession was revived, and behavioural disturbances were believed to be best treated by exorcisms, which included praying, beating, and other extreme treatments of the affected individual. In the later years of the Middle Ages, explanations for abnormal behaviour involved witchcraft and the belief that Satan was responsible for unfortunate events in society (e.g., drought, floods, illness) as well as emotional and behavioural disturbances in particular individuals (Zilboorg & Henry, 1941).

Despite this focus on supernatural explanations, natural causes (e.g., brain trauma, physical disease) were still used to explain many instances of disturbed behaviour. Asylums or mental hospitals were established for the mentally ill. The conditions in these hospitals were dreadful, and treatment of the patients was typically inhumane and not particularly effective. For example, Benjamin Rush, often considered the founder of American psychiatry, believed that a helpful approach to curing mental disturbance was to create significant fear in the patient; treatments involved convincing individuals that they were about to die and placing them in a box with holes and then lowering the box into a tank of water.

**A Humanitarian Approach.** The work of Philippe Pinel (1745–1826) marked the beginning of the humane and moral treatment of individuals exhibiting abnormal
behaviour and emotional disturbances. Pinel took charge of a Paris asylum (La Bicêtre) and began treating the patients as ill rather than as less than human. He allowed them to walk freely through the hospital and grounds (they had previously been shackled to walls with chains) and proposed the idea that they were normal people who would benefit from compassion and humane treatment. Unfortunately, however, this emphasis on humane treatment was more readily available for individuals of higher social classes. Nevertheless, it marked the start of humanitarian treatment of those classified as mentally ill.

Modern Psychological Approaches

Early demonological explanations and methods of treatment for abnormal behaviour seem very different from our current views. However, even early explanations considered the role of more natural, physical factors in explaining such phenomena. How do we currently explain abnormal behaviour? What is now believed to be the best way to help the individual suffering from symptoms of mental illness? The answers to these questions vary in relation to the paradigm one adopts. As illustrated in our discussion of historical views, abnormal behaviour can be considered from multiple paradigms.

A paradigm provides a conceptual framework or conceptual model that identifies relevant questions for scientific examination, specifies the best way to study these questions, and provides the assumptions that guide the development of acceptable explanations for a particular phenomenon (Kuhn, 1996). Any one paradigm or worldview can be associated with numerous theories, tentative, broad statements that explain a particular observation. For example, the biological paradigm views abnormal behaviour as arising from atypical biological processes. Numerous theories have been developed in relation to this paradigm, including the theory that low levels of the brain chemical serotonin explain depression, or that high levels of the brain chemical dopamine explain hearing voices or seeing things that are not actually present. Specifically, paradigms identify what should be observed, the kinds of questions to be asked, how these questions are to be structured and assessed, and how the results of scientific investigations should be interpreted. In examining various paradigms relevant to understanding abnormal behaviour, notice that each paradigm has its own major assumptions, explanations of typical/normal development and atypical/abnormal development, and clinical implications for assessment and intervention.

From a psychological perspective, predominant explanations include those offered from the biological, psychodynamic, behavioural, cognitive, and sociocultural paradigms. Although each of these paradigms or approaches is considered independently in our discussion of the psychological perspective, it is generally believed that no single paradigm can explain all instances of abnormal behaviour. Instead, a combination of biological, psychodynamic, behavioural, cognitive, and social factors interact with one another to produce and sustain the symptoms associated with various behavioural and emotional disturbances. This biopsychosocial perspective views abnormal behaviour in the context of factors in the body (biological), the mind (psychological), and the social context (sociocultural). Biological causes relate to genetics and physical functioning, psychological causes relate to experiences (learning) and related thoughts (cognitions) and feelings within an individual, and sociocultural causes relate to aspects of one’s social environment. This biopsychosocial approach prevails in Health Canada’s view of causal factors of abnormal behaviour, which acknowledges that “a complex interplay of genetic,
biological, personality and environmental factors causes mental illnesses” (Health Canada, 2002, p. 7).

Consistent with this view, and from a psychological perspective, the best approach to treatment involves utilizing a combination of strategies based on multiple paradigms. Thus, although the paradigms described below might be perceived to be competing and independent frameworks of abnormal behaviour, they are best considered as contributing one or more elements to the overall understanding and treatment of any disordered pattern of behaviour or emotion. Before turning to a discussion of modern paradigms, see Table 1.4 for an overview and comparison of the explanations and treatments associated with some of the historical views we've discussed as well as the major paradigms we will examine in the remainder of this chapter.

**Biological Paradigm** As discussed in our summary of historical perspectives, the belief that natural or physical factors might explain unusual behaviour and emotional experience is not a new one. This idea is also the basis of the biological paradigm. Since Hippocrates, there have been many renowned theorists, researchers, and physicians who have emphasized the relationship between mind and body. In the seventeenth century, Descartes proposed that the body and mind were separate entities, a position referred to as dualism. Recently, however, the limitations of this dualistic approach have been emphasized and made apparent in hundreds of scientific investigations. Specifically, countless examples illustrating the interaction of body and mind have been documented, resulting in a great emphasis on the role of biological factors in mental health and illness. Given this history, it's not surprising that the current approach to understanding disturbed behaviour is very much based on a medical model, a perspective that views abnormal behaviour as a symptom of an underlying illness or disorder. In fact, psychiatry is an area of specialization in medicine that is committed to the study and treatment of mental disorders. Therefore, a psychiatrist is actually a physician (not a psychologist) specializing in the treatment of behavioural and emotional disturbances. Psychopathology is a field of study that focuses on identifying the characteristics, causes, and treatment of mental distress and abnormal behaviour. Although it’s often used interchangeably with the term abnormal psychology, some view psychopathology as more of a psychiatric term with a greater

<table>
<thead>
<tr>
<th>Paradigm</th>
<th>Theories of Cause</th>
<th>Approach to Treatment</th>
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<tbody>
<tr>
<td>Supernatural</td>
<td>Demonic possession, evil spirits</td>
<td>Exorcism, trephining</td>
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<tr>
<td>Biophysical or biological</td>
<td>Physiological malfunction (genetics, nervous system biochemistry)</td>
<td>Physiological interventions (drugs, surgery, etc.)</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>Repression of unconscious childhood conflict, painful memories, and trauma</td>
<td>Increase awareness of unconscious conflicts and content</td>
</tr>
<tr>
<td>Behavioural</td>
<td>Faulty learning experiences (lack of reinforcement, overly punished)</td>
<td>Replace with new behaviours/ experiences</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Inaccurate cognitive structuring of experiences</td>
<td>Change thinking processes, negative thoughts</td>
</tr>
<tr>
<td>Sociocultural</td>
<td>Impact of social and cultural factors on individual</td>
<td>Assess and modify impact of environmental aspects</td>
</tr>
</tbody>
</table>
emphasis on *pathology* or disease and thus on the biological factors associated with mental distress and behavioural disturbance.

The influence of a biological approach to understanding mental disorder is reflected in the language often used to describe disrupted emotions and behaviour. In fact, referring to such disruptions as *illnesses* that are reflected in specific *symptoms* that can be reduced through *treatment* clearly illustrates the relevance of the medical model, the traditional approach to diagnosing and treating physical illnesses. This model emphasizes identification of dysfunction or deficiencies in the individual and treatment of these defects through various methods that alter biological or physical factors.

The relationship between biological processes and mental disorders has been investigated extensively. Research based on this biological approach to understanding abnormal behaviour has focused primarily on the role of genetic, biochemical, and neurological factors in disrupted behaviour.

**Heredity and Genetics.** Heredity plays a central role in determining various physical and psychological characteristics. *Genetics* is the science of heredity. The basic building blocks of heredity are *genes*, which are sections of *deoxyribonucleic acid* (DNA) along the *chromosomes* (rod-shaped structures found in all the cells of the human body). Figure 1.3 illustrates the relationship of these components. Each of us inherits this genetic material from our biological mother and biological father. Because genes contain codes that determine the development and structure of various cells in the body (including the brain), they have the potential to influence not only physical characteristics but also psychological characteristics. Throughout this text,
we'll see that numerous studies have shown that genes play a role in determining anxiety, depression, and other characteristics associated with abnormal behaviour.

**Brain Structures.** Various areas and structures of the brain play a role in regulating emotion and thought. For example, a structure deep within the brain, called the *amygdala*, has been found to be related to the experience of fear as well as rage. From a biological perspective, abnormalities in the size or activity of various structures (e.g., amygdala, thalamus, hypothalamus) might explain the abnormalities in emotional disturbances. The brain images presented in Appendix 2 show the location of various brain structures and areas that have been found to be important in the experience of thought and emotion.

Appendix 2 also shows the areas of the outermost part of the brain, the *cerebral cortex*, which includes the frontal, parietal, temporal, and occipital areas, or lobes. Different levels of activity in some locations of the cortex have been associated with disrupted emotional experience. For example, higher levels of activity in one location of the frontal lobe have been related to thinking repeatedly about negative events, creating feelings of sadness for the individual (Davidson, Jackson, & Kalin, 2000). In the following chapters we'll discuss specific mental disorders and consider the specific brain areas and structures that have been found to be associated with each condition; refer to Appendix 2 to see where these areas and structures are located.

**Neurotransmitters.** From a biological approach, another explanation for abnormal behaviours and emotional disturbance is an atypical level of certain neurotransmitters. Neurotransmitters are chemicals in the nervous system/brain that are responsible for communication between neurons, cells in the nervous system that send messages from one location to another. It has been suggested that particularly low or high levels of certain neurotransmitters (including norepinephrine, serotonin, and dopamine) might explain disturbances in emotion, perception, and behaviours. See Box 1.4 for a list of neurotransmitters often found to be associated with abnormal mood or behaviours.

**Psychodynamic Paradigm** In the *psychodynamic paradigm*, a major assumption is that psychopathology is the result of unconscious conflicts experienced by the individual. This approach was originally developed by Sigmund Freud (1946), a physician who proposed a dynamic model of the human psyche to explain emotional and behavioural experiences. In Freud’s *topographic model*, he identified three levels of awareness: (1) the *conscious*, consisting of memories, thoughts, and feelings of which we are currently aware

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**Box 1.4**

**Neurotransmitters Involved in Emotion and Behaviour**

<table>
<thead>
<tr>
<th>Neurotransmitter and Examples of Function</th>
<th>Role and Effects</th>
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<tr>
<td><strong>Dopamine:</strong> Associated with sensations of pleasure, reward; high levels associated with hallucinations (e.g., hearing voices, seeing things that aren't present)</td>
<td>Regulates emotions and reward behaviors.</td>
</tr>
<tr>
<td><strong>Serotonin:</strong> Regulates sleep and emotion; low levels associated with depression</td>
<td>Regulates sleep and reduces anxiety.</td>
</tr>
<tr>
<td><strong>Norepinephrine:</strong> Regulates emotions and arousal; low levels associated with depression</td>
<td>Regulates emotions and arousal.</td>
</tr>
<tr>
<td><strong>GABA</strong> (<em>gamma-aminobutyric acid</em>): Regulates sleep, reduces activity levels; related to sensations of relaxation</td>
<td>Regulates sleep and reduces anxiety.</td>
</tr>
</tbody>
</table>
Perspectives: Abnormal or Exceptional?

(1) the conscious, consisting of sensations, perceptions, voluntary actions, and conscious thoughts (e.g., aware you are hungry); (2) the preconscious, consisting of memories, thoughts, and feelings that can easily be brought to mind (e.g., what you had for dinner yesterday), and (3) the unconscious, those thoughts, memories, and feelings that can’t be easily called to mind but still exert significant influence on one’s behavior. Freud considered the unconscious to be the most significant level of awareness. For example, there are cases in which a person has experienced a significant trauma (e.g., being witness to a bank robbery) but can’t recall any details about the event. According to Freud’s topographic model, this information isn’t easily brought into one’s awareness but may emerge into one’s consciousness at a later time. More importantly, even though the individual is unaware of the event, he or she may experience anxiety in relation to the unconscious memory.

In addition to his topographic model, Freud proposed a structural model that identified three major components of the mind: the id, ego, and superego. The id is the only structure that is present at birth and is associated with providing the energy for the basic biological motives of hunger, thirst, warmth, affection, aggression, and sex. As such, the id operates according to the pleasure principle, seeking immediate gratification for its impulses. For example, a newborn is highly motivated by the hunger drive. Accordingly, it will cry and experience significant distress if this need is not gratified. The id, then, is instinctual or inborn, entirely unconscious, and primarily concerned with satisfying personal desires as immediately as possible, regardless of the consequences.

During the first two years of life and out of interaction with the environment, the ego develops. The ego operates largely at the level of conscious awareness and according to the reality principle. Specifically, it attempts to satisfy the demands of the id while considering the constraints of the realities of the situation. For example, although an infant may express a desire to be fed by crying loudly, the reality of the situation may be that the mother has to address the more immediate need of another child who has fallen and is hurt. In this case, the infant must wait for food and gratification of id impulses is delayed. Through these continual experiences in the environment, the ego develops and becomes able to manage both the selfish demands of the id and the demands or constraints of the environment.

The final structure of the psyche to develop is the superego. According to Freud, the superego is the moral branch of personality that represents the values and standards of society that have been internalized over the course of the individual’s interactions with parents and other socializing agents. Thus, the superego places restrictions on behaviors, thoughts, and feelings via the conscience, which is associated with feelings of guilt (about violating the rules of right and wrong that we’ve learned from those around us), and provides guidance with respect to standards to strive toward via the ego ideal, the ideas we have about what constitutes good behavior and admirable characteristics.

What role do these structures play in psychological health? According to Freud, the healthy individual has a strong ego that doesn’t allow the id or superego too much control over the personality. The healthy ego is able to effectively manage the demands of both the id and the superego and consider the constraints of the social environment. If an individual has an overly powerful id that dominates the ego, the result is selfishly driven behaviors that violate the rights of others and prevent the individual from successfully delaying gratification when necessary. By comparison, a superego that dominates the ego results in high levels of guilt and anxiety that are out of proportion to the reality of the situation.

If it sounds as though the three components of Freud’s model of the psyche are in a constant state of struggle with one another, then you have an accurate understanding of his view of
human personality. Freud believed that anxiety arises from this confrontation between personality components. A key job of the ego is to keep unacceptable id impulses out of conscious awareness: if we were to experience these, we’d feel extreme guilt or distress. Accordingly, if direct expression of id impulses is unacceptable or dangerous in the real world, another key function of the ego is to use **defence mechanisms**, the ego’s protective methods for reducing or avoiding anxiety by unconsciously distorting reality. See Table 1.5 for a summary and examples of important ego defence mechanisms that will be considered throughout this text.

Based on Freud’s theory of human personality, people are assumed to be irrational, naturally aggressive, anxious, self-centred, and typically unaware of the real motives that underlie their behaviour. Often criticized as maintaining a pessimistic and negative view of human nature, Freud’s theory remains controversial yet influential in discussions of abnormality. Despite a lack of scientific support for many of Freud’s original concepts and processes, his early emphasis on the parent–child relationships in the formation of character and the role of early experience in the development of disrupted emotions and personality has served as the inspiration for other theories that have been more consistently supported by research, including attachment theory and object relations theory, to which we now turn.

**Attachment Theory.** John Bowlby (1969) is well known for his development of attachment theory. Like Freud, he emphasized the great importance of the emotional bond that was formed between mother and infant, not only in humans but in other species as well. More recent psychodynamic theories also view **attachment**, the bond between mother and infant, to be one of the most significant events in one’s development. Generally, attachment theories emphasize how this early relationship between infant and mother serves as the basis of later emotional and social adjustment.

Karen Horney (1973) emphasized the relevance of early infant–parent relationships in the later development of abnormal behaviour and emotional disturbance. Specifically, when caregivers are insensitive and uncaring, the child may develop basic anxiety, which

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**Table 1.5 Examples of Common Ego Defence Mechanisms**

<table>
<thead>
<tr>
<th>Defence Mechanism</th>
<th>Specific Example</th>
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<tbody>
<tr>
<td><strong>Displacement:</strong> releasing or expressing feelings toward a substitute object because releasing these toward the real target would be dangerous</td>
<td>After being scolded by his teacher at school, Jeffrey pushes down another child in the playground</td>
</tr>
<tr>
<td><strong>Denial:</strong> refusing to accept the reality of an unpleasant or threatening situation</td>
<td>Jan says, “I don’t care what you say, my cat will come back to me” after her pet dies</td>
</tr>
<tr>
<td><strong>Regression:</strong> returning to earlier, less mature ways of behaving in order to cope with distressing events</td>
<td>Five-year-old Brian begins to suck his thumb again after his parents get divorced</td>
</tr>
<tr>
<td><strong>Rationalization:</strong> creating acceptable but inaccurate excuses for one’s own unacceptable behaviour</td>
<td>A student says to herself, “It’s not a big deal if I cheat on this test; everyone else is doing it!”</td>
</tr>
<tr>
<td><strong>Repression:</strong> pushing unacceptable content (memories, thoughts, impulses, desires, etc.) into the unconscious and out of conscious awareness</td>
<td>Fran, the victim of a crime and witness to her brother’s death, remembers nothing of the event or what she observed</td>
</tr>
</tbody>
</table>
is associated with feelings of isolation and helplessness. If the child feels anger toward her caregivers, that child may develop basic hostility, a form of anger that is pushed into the unconscious (because the thought is associated with fear that she may be punished if her anger was to be discovered by her parents); this repression is associated with feelings of anxiety and insecurity.

**Object-Relations Theory.** A second modern approach associated with traditional psychodynamic theory is object-relations theory. This theory emphasizes the importance of the symbolic representation (i.e., our thoughts and mental images) of significant others in our lives, particularly parents. Based on early emotional ties with others, the child forms long-lasting internalized beliefs about himself and other people. If a caregiver (usually the mother is emphasized) is rejecting or insensitive to her child’s needs, disrupted emotions and behaviours may be the consequence. As the child observes how his caregivers treat him and view him, he begins to view himself in the same way. This introjection or incorporation of the view we believe significant others have of us then serves as the basis for future interactions with others. For example, if a child has been treated by his parents as though he is incapable and unintelligent, the child will also think of himself as stupid or incompetent, acting as though the original attachment object or caregiver was still present and sending those messages. The consequence is the development of specific beliefs about oneself that will influence the child’s behaviour and social interactions with others. Thus, if the child believes his parents view him as incompetent, he will see himself as incompetent, and he may be drawn to relationships with those who also view him as incompetent because their view is consistent with his own. It’s easy to imagine how such a view of oneself might result in distressing emotions and unhealthy relationship with others.

**Behavioural Paradigm** As we’ve seen, psychodynamic theories emphasize the role of the unconscious, conflict between unseen components of the mind, irrational behaviour, and early attachment relationships in explanations of abnormal behaviour. In contrast, the behavioural paradigm emphasizes the importance of observable actions, immediate environment, and learning experiences in determining behaviour. According to this approach, the same learning processes that result in normal behaviour are also responsible for shaping abnormal behaviour. Three forms of learning are particularly relevant to understanding behaviour: classical conditioning, operant conditioning, and social or observational learning.

**Classical Conditioning.** Russian physiologist Ivan Pavlov and American psychologist John B. Watson are the two individuals most associated with the development of early behaviourism, the division of psychology that emphasizes the role of observable behaviour and learning in explaining behaviour. Pavlov (1926) was investigating salivation responses of dogs to the presentation of food. During his investigation, however, he ran into a problem: the dogs would begin to salivate as soon as the researcher entered the room, even before they had been presented with food. What was happening? Based on his later investigations, Pavlov discovered that the dogs had learned to associate the researcher with the food. Prior to their experience in Pavlov’s laboratory, the dogs would salivate to the presentation of the food (it is an inborn, biologically based reaction to do so). But because the researcher had been paired with the food on repeated occasions, the dogs had learned to associate the site of the researcher with the food, so began salivating to the site of researcher.
This form of learning discovered by Pavlov is now referred to as classical conditioning, the process by which paired presentations of two stimuli (objects or conditions) in the environment result in a response or reaction to one stimulus occurring also to a new or previously neutral stimulus. Such classically conditioned associations can help us better understand many of our automatic reactions to various stimuli in the environment. For example, imagine a child who has visited the dentist several times, and on each occasion has experienced painful procedures that result in fear and distress. As a result of the pairing of dentist and pain, the site of the dentist alone (or even the dental office waiting room) will result in feelings of distress and fear. We’ll examine more specific aspects of classical conditioning in greater detail in our discussion of anxiety disorders in Chapter 6.

Operant Conditioning. Harvard psychologist B. F. Skinner (1953) emphasized a different form of learning, operant conditioning, in explaining human and animal behaviour. According to this form of learning, people and animals engage in various behaviours, but it’s what follows the behaviour, the consequence, that influences the likelihood of that behaviour occurring again in the future. Some consequences, referred to as reinforcers, increase the likelihood of the behaviour occurring again. For example, if a child throws a tantrum and the caregiver gives a cookie to soothe the child, the child will likely exhibit similar outbursts in the future because such behaviour was followed by a desirable consequence. Other consequences, referred to as punishments, decrease the likelihood of the behaviour occurring in the future. If the same child throws a tantrum and the caregiver scolds the child or takes away something the child enjoys (e.g., a favourite toy), such consequences will likely decrease the likelihood of the behaviour occurring again.

Most people use various types of reinforcers and punishers in day-to-day life. Giving a dog a treat for performing a trick, giving a child a time-out for disruptive behaviour, or giving a friend the “silent treatment” because he or she has upset you in some way are all examples of how each of us might use consequences in an attempt to alter others’ behaviour. Such consequences can also be used to alter our own behaviour, as in taking a 20-minute break after 30 minutes of studying.

How might operant conditioning explain abnormal behaviour? Consider our previous example—a child throws a tantrum, followed by a parent giving him a treat or toy to soothe him. Such consequences serve to strengthen or increase the likelihood of this behaviour occurring again, resulting in repeated instances of disruptive behaviour. The role of punishments and reinforcers will be considered throughout the remaining chapters both as explanations of abnormal behaviour and in approaches to managing such disturbances.

Observational Learning. Albert Bandura conducted early experiments demonstrating that individuals acquired new behaviours not only through associations and consequences but also via modelling, in which we observe and then imitate the actions of those around us. In his classic Bobo Doll experiment, Bandura, Ross, and Ross (1961) had individual children watch a video of an adult model playing with an inflatable doll. He found that those children who observed a model behaving aggressively toward the Bobo Doll (i.e., hitting, kicking, and punching the doll) were more
likely to behave aggressively toward the Bobo Doll themselves when they were given the opportunity to play with it. You can probably think of several examples of behaviours you have acquired based on your modelling the actions of others. A child may pretend to “smoke” a pencil after watching her caregiver smoke a cigarette or push down her sibling after watching a wrestling match on television. In each instance, the child makes an observation first, and then imitates this action. In later chapters we explore how observational learning may serve as the basis for the development of abnormal or disruptive behaviours.

**Cognitive Paradigm** You may have noticed that the behavioural paradigm tends to view people as relatively passive in their learning experiences. Behaviours are assumed to result from experiences in the environment over which one may have little or no control. From a cognitive perspective, however, thoughts and beliefs are considered to be important factors in influencing emotional states. Therefore, rather than actual events being central to understanding the cause of abnormal behaviour and disrupted emotions, how we think about events and assign meaning to our experiences is vital in understanding abnormal behaviour. Specifically, if one seeks to understand behaviour, the thoughts, interpretations, expectations, beliefs, and attitudes of the individual must be examined.

One of the most influential cognitive theorists is psychologist Albert Ellis (1997). According to Ellis, feelings of anxiety, depression, and distress are not a function of events themselves but rather a result of our irrational beliefs about what these events signify. For example, consider a child who forgets to take his homework to school and says to himself, “See how stupid you are! You can’t even remember to take your homework in. You’ll never amount to anything!” Ellis would emphasize that such statements are irrational and that it’s unreasonable to interpret such an instance as evidence of such extreme deficits. Thus, although the actual event won't necessarily lead to distress, it's the interpretation of the event that is most relevant to the emotions and behaviours that follow.

Psychiatrist Aaron Beck (1979) also emphasizes the role of thought in disruptive emotions and distress. According to Beck, dysfunctional schemas and beliefs help to explain distressing emotions. A schema is a general cognitive framework that helps us organize and interpret information. For example, your schema for classroom might include desks, chairs, whiteboards, windows, and an instructor. Having this cognitive framework helps you interpret information and guides your behaviour: if you arrive at the room indicated on your class schedule for your first day of lectures and there are no desks, chairs, or whiteboards, you might assume you have the wrong room! Despite their function, however, schemas can result in a biased interpretation of circumstances and events around us and may fuel dysfunctional beliefs. Such schemas are formed as a function of our personal experiences. For example, if a child has been told repeatedly, “You’re so stupid!” or “You’ll never amount to anything!,” a schema of inadequacy may develop where the individual now assumes that he is insufficient and a failure. Associated with this general assumption, the individual develops specific beliefs such as “I don’t know how to talk to others” or “I’m ugly.” Even in the context of successes (e.g., receiving praise from a teacher for good performance), the individual will tend to focus on those events that are consistent with the schema (e.g., he did poorly on a sample quiz) and ignore those events that are inconsistent with the schema. This bias in perception and interpretation of events continues to support the irrational beliefs.

Once formed, these dysfunctional schemas are maintained through one’s consistent and automatic use of various cognitive distortions in which the individual alters his
perceptions of events and other self-relevant information to make them consistent with underlying negative assumptions and beliefs. One example of a cognitive distortion associated with distress is *magnification*, where the importance of a particular event is exaggerated beyond its actual significance. For example, consider a male adolescent who’s had an argument with a friend. Interpreting this event as a sign that he’ll never be able to resolve the disagreement or assuming that he’ll never have another friend again illustrates such magnification. It’s easy to imagine how such thoughts might create painful emotions. Additional cognitive distortions will be considered in later chapters.

**Sociocultural Paradigm**  
The paradigms from the psychological perspective we’ve considered tend to assume that individual characteristics (i.e., biological abnormalities, unconscious conflicts, personal learning experiences, and ways of thinking) serve to explain the occurrence of abnormal behaviour and emotional disturbances. According to the *sociocultural paradigm*, however, social and cultural factors must be examined in order to understand and explain abnormal behaviour. From this perspective, explanations for abnormal behaviour must consider conditions outside the individual exhibiting such disturbances.

**Culture.** We’ve discussed how norms or societal standards for behaviour relate to the concept of abnormality. Cultural ideas about sex, gender, ethnicity, and race can also influence behaviour and may result in differences in abnormality across various groups in a society.

For example, the rate of death by suicide in rural regions in China is higher among young females than males. This has been attributed to the difficulties faced by young women in Chinese society; suicide attempts in rural areas often use agricultural poisons with high lethality. This example is a clear illustration of the profound impact of social factors on suicide. (Kirmayer et al., 2007, p. 24)

In Canada, there are also variations with respect to abnormal behaviour in relation to social characteristics.

For Aboriginal people, suicide is an affliction of the young. From the ages of 10 to 19, Aboriginal youth on reserves are 5 to 6 times more likely to die of suicide than their peers in the general population. (Kirmayer et al., 2007, p. 1)

What social and cultural factors might explain such differences in suicide between different groups within the same society? Throughout this text we’ll examine various explanations for group differences in specific abnormal behaviours, including the role of poverty, abuse, education, and prejudice and discrimination. For now, it’s important to acknowledge that the sociocultural paradigm recognizes that abnormal behaviour isn’t solely a function of disturbances that reside within the individual. According to this approach, abnormal behaviours may be more a function of dysfunctional environments, and as such are best “treated” by changing conditions in the social context.

**Family.** Clearly, biological and psychological factors aren’t the only factors associated with increased risk for developing a psychological disorder. Various family factors, including conflict, communication strategies, discipline approaches, and neglect and abuse, have been found to increase the likelihood of developing specific emotional and behavioural disturbances. For example, families of children diagnosed with ADHD demonstrate
significantly higher levels of parenting stress and lower levels of perceived parenting competence (e.g., Anastopoulous et al., 1992). Lack of parental supervision, marital conflict, and violence in the home is associated with increased risk of child and adolescent antisocial behaviour (Loeber & Farrington, 2000; Reese et al., 2000).

Given the relationship of these social factors to rates of emotional and behavioural disturbances, how might they work together with the biological and psychological factors associated with such outcomes? The diathesis–stress model of psychological disorders proposes that biological, psychological, and social factors can create a vulnerability that might increase one’s likelihood of developing a particular disorder. For example, a genetic predisposition for Schizophrenia might be inherited from one’s parents. However, other vulnerabilities, including psychological (e.g., attentional difficulties) and social factors (e.g., parental conflict), will further increase one’s likelihood of developing the symptoms of Schizophrenia. Despite these vulnerabilities, however, it’s possible that a youth will never develop symptoms—until he is exposed to a significant stress, which can take the form of a biological (e.g., exposure to cocaine), social (e.g., death of a parent), or psychological (e.g., loss of self-esteem) trigger. A greater number of diatheses together with a greater number of stresses further increases one’s risk of developing a disorder. See Figure 1.4 for an overview of the diathesis–stress model.

Figure 1.4 The Diathesis–Stress Model
In this model, diatheses, or predisposing factors, together with stresses, or triggers in the environment, determine one’s risk of disorder.

A CYC LENS ON THE PSYCHOLOGICAL PARADIGMS: A HOLISTIC CONCEPTUAL MODEL
As we’ve seen, while some psychological paradigms don’t fit well with a CYC approach, many others do. Overall, each of the psychological models used to explain mental health has something important to offer CYC students and practitioners. Here we briefly review each to assess their goodness of fit from a CYC perspective.
Biological Paradigm  The biological paradigm, sometimes referred to as the medical, biological, or disease model, looks to biological causes to explain disorders, or exceptions. These include genetic predispositions, brain and neurotransmitter abnormalities, prenatal and birth factors, and environmental hazards (Kendall & Comer, 2010; Winzer, 2005). For example, geneticists have long recognized a link between DNA and behaviour (Winzer, 2005), and research has shown that child and adult temperaments (defined as biologically determined behavioural styles) are inherited. As well, neuroscience has established that the central nervous system and neurochemical activity are involved in all human behaviour. The neurotransmitters serotonin, dopamine, and norepinephrine have important roles to play in regulating behaviour, stress responses, aggression, addictions, and stress management (Winzer, 2005; Mate, 2008).

Neuroscience-based approaches to understanding troublesome behaviours explore ways to restore healthy brain functioning in youth struggling with trauma and other mental health issues. Although traditional biophysical treatments focus almost exclusively on administering psychotropic medications in order to stabilize crises and manage troublesome behaviours, insights into how the brain works have helped us learn much about the effects of trauma and the benefits of positive human connection (Brendtro et al., 2005). Neuroscience research is demonstrating that lasting change requires new programming of the brain with new connecting experiences. Such reprogramming requires corrective interpersonal attachments, the establishment of trusting relationships, healthy communication, and the opportunity to learn new strategies of emotional control and coping skills (Perry, 2014).

Psychodynamic Paradigm  According to Charles Sharpe (2001), the psychodynamic model is based on the theory that emotional and behavioural disorders are symptoms of internal, unobservable, unconscious conflicts between the components of the individual personality. Such unresolved conflicts were experienced in the early stages of childhood and have become reactivated in problem situations in adulthood. Freud's theories represent the primary examples of a psychodynamic theory; other psychodynamic theorists include Carl Jung, Alfred Adler, and Harry Stack Sullivan. Early methods focused on resolving inner conflict by uncovering these early childhood traumas (Brendtro et al., 2005), although such practitioners as Fritz Redl, August Aichhorn, and Anna Freud saw love as the primary unmet need of troubled children (Sharpe, 2007). Many aspects of the psychodynamic paradigm are important for CYCPs to understand. Freud's hypotheses that early childhood experiences can profoundly influence adult behaviour have endured over time (Kendall & Comer, 2010), and the idea that unconscious processes influence our conscious lives and behavioural actions remains undisputed. Early childhood trauma and attachment difficulties have indeed been found to influence the development of difficult behaviour and negatively affect relationships in adolescents and young adults. However, Freud's specific ideas about the sources of the conflict have not been supported by research over the years (Kendall & Comer, 2010). There is no compelling evidence, for example, that notions of the id, ego, and superego are relevant or even accurate as explanations for child and adolescent psychological difficulties (Kendall & Comer, 2010). And although the notion that sexual instincts and sexual drive determine development and behaviour hasn't been proven, Freud's ideas related to defence mechanisms remain important concepts.
**Behavioural Paradigm**  Behavioural approaches assume that all behaviour is learned (Sharpe, 2007). In this model, behaviours that are exceptional and that are associated with behavioural or emotional disorders are understood to be conditioned responses or habits that can be modified by the same principles of learning that govern all behaviour.

Behaviour theory holds that all human actions are the result of what we've learned or have been conditioned to do (McKenzie, 2008). Further, the behavioural paradigm emphasizes the observed behaviour of the child in the context of the environmental factors reinforcing the response (Kendall & Comer, 2010). By modifying influences in the environment, we can help change the undesirable behaviour patterns. To assist in behaviour change, then, CYCPs need to provide young people with corrective learning or different "conditioning" experiences.

Behavioural approaches have changed substantially over the years. While older practices focused almost entirely on eliminating deviant behaviours, current practices involve teaching pro-social behaviours through such techniques as aggression replacement training and social skills training. Moreover, there has been a shift from coercive and punishment-based methods to building positive behavioural supports (Brendtro et al., 2005). In other words, behaviourally based models now revolve around strength-based goals, making them a good fit for CYC practice.

As we discussed earlier, the behavioural model encompasses three types of learning: classical conditioning, operant conditioning, and observational learning (Kendall & Comer, 2010). CYCPs should have at least a cursory understanding of each, paying close attention to observational learning and social learning theory and their relationship to cognitive-behavioural interventions. CYCPs continually use learning theory in their practice, perhaps without naming it as such. Whenever you've administered a time-out or given a consequence to a child for misbehaving, you've applied concepts from the behavioural model and from learning theory.

Behavioural methods have always been used both formally and informally in out-of-home-care and other CYC settings. These methods involve using external rewards as a way to reinforce desired changes in behaviour. In social learning theory, a child is conditioned to behave by having certain behaviours rewarded and others punished. Behaviour is also learned by observing the behaviour of significant others. Therefore, any so-called “dysfunctional” behaviour could be learned behaviour. Domestic violence is a classic example of the application of social learning theory to explain behaviour. Research has shown that boys who witness their fathers perpetrating violence against women often grow up to be perpetrators of violence against women themselves, and girls who witness violence against their mothers may become later victims of violence (Ehrensaft et al., 2003).

**Attachment Theory.**  In any discussion of using a behavioural model in CYC practice, it's important to consider the relationship of attachment theory to learning theory. Sprinson and Berrick (2010) emphasize that the behavioural processes of modelling and reward are involved in the development of the child's attachment to his caregiver and thus in the construction of a working model of attachment (Sprinson & Berrick, 2010). Further, the repeated exchanges, or relational interactions, between child and care provider can be viewed through a behaviourist's lens, whereby both are learning how to regulate each other in the process of mutual reinforcement as the relationship develops (Sprinson & Berrick, 2010). As we know from attachment theory, the repeated...
reinforcement of these exchanges results in the development of or change in the child's **internal working model**; that is, the child's view of himself and of the world (Sprinson & Berrick, 2010). Once we understand the child's negative internal working model, we can respond to his efforts at re-enactment. For example, if the child yelled and swore at his caregivers in the past and they responded by yelling and swearing back or perhaps by hitting him, he may yell and swear at the adult in an attempt to duplicate these past responses from caregivers. He's trying to pull his current caregivers into that cycle, thus "re-enacting" the past cycle. Therefore, as the CYC team is observing this behaviour in order to understand its antecedents, contexts, and consequences, they can respond with interventions designed to challenge or interrupt the factors that have reinforced such negative behaviour (Sprinson & Berrick, 2010). It's easy to see, then, how attachment theory fits with a CYC perspective in the behavioural model.

Another model of attachment, Pat Crittenden's (2005) **dynamic-maturational model (DMM)**, outlines the various attachment strategies that individuals use to cope with stress, many of which include psychopathological responses. This model highlights the idea that "there is more to attachment than promoting security. Troubled people make meaning from their past experience and use it to protect themselves and their children as best they can, given their circumstances" (Crittenden, 2005).

Five central ideas underlie the DMM: (1) all patterns of attachment are self-protective strategies; (2) self-protective strategies are learned in interaction with attachment figures, most often one's parents; (3) psychological, emotional, and behavioural "symptoms" are functional aspects of a dyadic strategy (e.g., acting out, inhibition) or consequent to it (e.g., anxiety behaviours); (4) these strategies will change when they no longer fit the context; that is, symptoms of anxiety will disappear when one is no longer anxious; and (5) therefore, the focus of treatment should be the fit of strategy to context to yield maximum safety and comfort (Crittenden, 2005).

Viewing the development of emotional and behavioural disorders through an attachment theory lens represents a major paradigm shift for most of us, and fits well with a CYC perspective: it not only avoids negative labelling and stigma, but also highlights the relational aspect of exceptional behaviours. If we acknowledge the development of psychopathology as an adaptive self-protective or coping strategy and can identify the type of attachment strategy an individual may be using, we can then respond appropriately in our interventions.

**Cognitive Paradigm** The cognitive paradigm is based on the idea that an individual's cognitive functioning, or thinking patterns, contributes to his or her emotional or behavioural difficulties (Kendall & Comer, 2010). The fundamental premise of the cognitive model is that if individuals can change the way they think, they can change their emotional and behavioural responses to events.

Cognitive theories suggest that individuals are influenced in their actions by their conscious and unconscious beliefs about the world and themselves in the world. As we saw earlier, individuals develop schemas (similar to attachment theory's internal working model) that consist of their fundamental assumptions, beliefs, and values. The cognitive model focuses on dysfunctional cognitive (thinking) processes that are either cognitive distortions (maladaptive thinking patterns) or deficiencies (the absence of thinking altogether) (Kendall & Comer, 2010). One cognitive distortion is jumping to conclusions; for
example, assuming that a friend hasn’t returned your calls because she’s angry with you (rather than ill or really busy) before gathering evidence to support your conclusion. Feelings of sadness and behavioural withdrawal may result from such an assumption.

**Sociocultural Paradigm** As described earlier, the sociocultural paradigm examines how the influence of social and cultural factors may explain the development of abnormal or exceptional behaviours in young people. This sociocultural paradigm fits very well with a CYC perspective, in that such influences as mainstream cultural norms, dominant societal standards, and our ideas about sex, gender, ethnicity, and race all play a role in our understanding of what constitutes abnormal or exceptional behaviours in children and youth.

Most importantly, CYCPs will recognize the role of poverty, race, and ethnicity in becoming marginalized in society, and for many, the consequent mental health issues. In addition to socioeconomic disadvantage, the mental health problems of Aboriginal youth in Canada, particularly rates of substance use, depression, and suicide, “may at least partly reflect alienation and disenfranchisement from the land and a way of life that resulted from colonization by European cultures (Nevid, Rathus, & Greene, 2010, p. 62). Elders in Aboriginal culture often explain the development of mental health problems among young people, especially suicide and substance use, in relation to the collapse of their traditional culture brought about by colonization, and research has corroborated this (Nevid, Rathus, & Greene, 2010). One Anishinabe Elder explains depression in the following way:

> Before the White Man came into our world we had our own way of worshipping the Creator. We had our own church and rituals. When hunting was good, people would gather together to give gratitude. This gave us close contact with the Creator. There were many different rituals depending on the tribe. People would dance in the hills and play drums to give recognition to the Great Spirit. It was like talking to the Creator and living daily with its spirit. Now people have lost this. They can’t use these methods and have lost conscious contact with this high power. The more distant we are from the Creator the more complex things are because we have no sense of direction. We don’t recognize where life is from. (Nevid, Rathus, & Greene, p. 62)

Thus, the sociocultural model highlights the failure of other conceptual models to consider cultural variations in what are considered to be acceptable and unacceptable behaviour patterns. It is acknowledged in this paradigm that poverty, racism, and discrimination can cause psychological struggles, and that consideration of such contextual variables is essential to understanding all behaviour. Therefore, the sociocultural model fits well with a CYC holistic model of understanding exceptional behaviours.

After reviewing these conceptual models, you might conclude that not only have you used one or more of them—whether formally (when you use level systems, star charts, and consequences) or informally (when you challenge a youngster’s irrational or faulty thinking)—but that you’ve used them simultaneously. The fact is that these paradigms do overlap in the real world of CYC practice. Each of these models may guide your approaches and each may be helpful individually, depending on the needs of the children, youth, and families you’re working with. The diathesis–stress model, for example, fits very well with a CYC perspective, as it emphasizes that disorders stem from both precipitating and predisposing causes. A precipitating cause is an immediate trigger that instigates a person’s action or behaviour. A predisposing cause is an underlying
factor that interacts with the immediate factors to result in a disorder. According to this model, both causes play a key role in the development of a psychological disorder. In suicide, for example, a precipitating cause may be a breakup with a partner, and a predisposing cause might be longstanding clinical depression.

**Holistic/Ecological Model**  The attempt to explain all mental disorders with just one theory leads to reductionism; that is, an attempt to explain complex phenomena using only one idea or perspective. We’ve seen that most mental health issues in young people develop as a result of several coalescing factors, which is why it’s important to consider several theoretical perspectives when attempting to explain a particular mental health issue. An explanation of mental disorders that uses a combination of theoretical perspectives is known as a **multiple causality** approach.

In this approach, we consider all aspects of the possible causes of young people’s exceptional behaviours or mental health issues. Many clinicians and writers agree that, from the perspective of contemporary neuroscience and developmental psychology, the traditional psychiatric diagnostic system of the DSM, based as it is on a nineteenth-century medical model of disease, is out of date. Contemporary CYCPs (and many psychologists) instead embrace the holistic paradigm. Keep in mind, though, that within this paradigm there may always be something to be gained from applying aspects of a more traditional psychodynamic and/or a sociocultural perspective (Sharpe, 2001).

CYCPs’ use of the holistic model in assessing behaviour means that they consider the context of the young person’s family and his or her social environment. The **holistic model** acknowledges that the cause of exceptional or inappropriate behaviours may be related to a variety of factors contributing to a youth’s vulnerability, including illness, trauma, maltreatment, attachment issues, difficult relationships with peers, learning difficulties, and many other factors (Winzer, 2005).

This way of understanding exceptionalities is also known as the **ecological model**. The ecological model examines the overall pattern of relationships between a young person and all the variables in his or her environment: teachers, parents, caregivers, peers, and so on. Thus, it is a **relational** model. The ecological model suggests that problems in behaviour are not just the inappropriate actions of the child, but rather that undesirable behaviours are developed and maintained by difficulties in her interactions, reflecting a lack of “goodness of fit” between the child and the surrounding ecological system (Winzer, 2005).

Urie Bronfenbrenner, the primary author of the ecological or “systems” model, proposed two principles in working with vulnerable youth. First, **always involve adults directly in the life space of children and youth**. Secondly, **involve a child or youth in finding his or her own solutions to problems**. In these ways young people can avoid becoming disengaged from the community without ever having had the opportunity to make contributions to others (Brendtro, 2010). Bronfenbrenner’s two principles became the basis of all ecological and relational models used in CYC work with troubled and troubling children and youth (Brendtro, 2010).

Bronfenbrenner adamantly opposed diagnosing mental health issues in young people as “pathology” or “disease,” and instead focused on their immediate “circles of influence”: their family, peers, and school. So, as Brendtro summarizes, when CYCPs assess a child’s ecology in order to design positive interventions, the following two questions are most important:

1. What are the interactions (or “transactions”) between the child, family, peers, and school?
2. Does this “circle of influence” create stress or offer support for the child?
WHERE DO YOU STAND?

Consider the psychological and CYC perspectives we’ve discussed. Do you believe that any one of these perspectives can offer better explanations for exceptional behaviour than the others? If so, you’re not alone. Some psychologists, and some CYCPs, will also agree more readily with the assumptions of any one particular perspective. Generally, however, most practitioners acknowledge that each of these paradigms must be considered in order to achieve the most comprehensive understanding of abnormal behaviour. This eclectic or integrative approach (known in CYC practice as the ecological model) recognizes the importance of all paradigms in describing, explaining, predicting, and managing abnormal behaviour. Accordingly, each of us would be wise to consider explanations from a variety of perspectives. After considering abnormal/exceptional behaviour from both a psychological and a CYC perspective, try the Take Action! exercise and apply your knowledge of both explanations to Darren’s case. Where do you stand when it comes to the explanations for emotional and behavioural difficulties?

According to the ecological model, then, when the circles of influence are in balance, young people are in harmony with themselves and others. However, if their ecology is disrupted or in tension, they will experience conflict, difficulties, and maladjustment. The aim of CYC interventions in the ecological model, therefore, is to build a supportive ecology around the child (Brendtro, 2010).

**Take Action! Exercise: Darren’s Case**

Darren is a 17-year-old boy who was charged with sexually interfering with a female under the age of 13 one year ago. The police placed him in the Manitoba Youth Centre, where he was on remand awaiting assessment and trial. The forensic psychiatrist who assessed him accessed Darren’s school files and learned that he’d been diagnosed with Obsessive Compulsive Disorder (OCD) and Attention-Deficit Hyperactivity Disorder (ADHD), and had received medication (Ritalin) for the latter. His file notes also showed a Statement of Special Educational Needs, previous high-level support in school, and treatment from a speech and language therapist. The psychiatrist found no evidence of ADHD or OCD during the assessment. However, Darren did show evidence of specific learning difficulties, such as slow and laboured speech, difficulty in structuring sentences, and speaking in a fragmented fashion. He was open, honest, and matter-of-fact, and was observed to lack the ability to be strategic in his responses. The psychiatrist found that Darren appeared to lack insight into his behaviour and had no real awareness of right and wrong. Darren’s stepmother reported no concerns about his behaviour around children. When the psychiatrist contacted Darren’s school, they described him as a boy who lacked social skills and stayed near teachers at lunchtime in order to avoid being alone or bullied. Darren was sentenced to one year open custody and referred to mental health services.

What do you think? Which aspects of the psychological paradigms might inform your understanding of what’s happening with Darren? What information do you need to form a hypothesis? Are there aspects of both the CYC models and the psychology models that together would help inform your understanding of Darren’s behaviour?
HELPING CHILDREN AND ADOLESCENTS WITH EMOTIONAL AND BEHAVIOURAL DISTURBANCES

Troy's Case: Revisited

Troy became so incapacitated by his ongoing separation anxiety and his increasing panic attacks that his parents took him for an assessment at the child and adolescent psychiatric hospital. The psychiatrist recommended group-based cognitive behavioural therapy (CBT) and anti-anxiety psychotropic medications. Troy’s parents were reluctant to put him on the medication, but agreed to try CBT. Troy was referred to an outpatient program where youth participated in daily CBT therapy groups. Troy progressed very well in group and was able to learn to manage his anxiety symptoms. He returned to school and his panic attacks subsided. When he did experience a panic attack, Troy was able to successfully use the relaxation techniques he’d learned from the CYCP who ran the therapy groups at the outpatient program.

Psychological Approaches to Treatment

Various methods associated with the major psychological perspectives are used in an attempt to decrease symptoms of any particular disorder, with the general goal being to restore healthy functioning. As you read about the different strategies of treatment for each of the paradigms, notice the relationship between their ideas about what causes disordered behaviour (as discussed earlier in the chapter) and their recommendations for how to treat these disturbances.

Biological Paradigm

A biological approach to treatment for emotional and behavioural disorders primarily depends on the use of medications that alter the activity of neurotransmitters in the central nervous system. For example, anti-anxiety medications can be effective in decreasing the symptoms of anxiety and inducing feelings of relaxation and calm by increasing the sensitivity of neurons in the brain to GABA, an inhibitory neurotransmitter. Box 1.5 summarizes the general drug classes that will be discussed throughout the text, including the general mechanisms by which they exert their effects and the disorders they’re typically used to treat.

Although CYCPs aren’t responsible for prescribing medications for youth, understanding how they work and being able to identify their side effects and drug-interaction effects are an important component of mental health literacy. This is discussed at length in the CYC approach later in this chapter.

Psychodynamic Paradigm

In their review of the literature, Blagys and Hilsenroth (2000) identified seven features that distinguish psychodynamic therapy from other intervention approaches. First, the psychodynamic approach encourages the individual to explore and discuss his emotions, particularly those associated with distress. Second, attempts by individual to avoid his feelings of distress/anxiety are also examined. For example, if he fears public speaking, skipping classes or failing tests might be considered as attempts to avoid situations that trigger distress. Third, part of this process involves identifying recurrent patterns of behaviour. Fourth, psychodynamic therapy takes a developmental approach. This is associated with in-depth exploration of past experiences and how
Perspectives: Abnormal or Exceptional?

Prior events are associated with current behaviour patterns and emotional difficulties. In doing so, the aim is to help the individual live his life in the present rather than in the past.

Fifth, psychodynamic therapy emphasizes the importance of interpersonal relationships. The sixth feature includes an examination of the relationship between the individual who’s seeking assistance and the therapist. For example, if the individual fears his parents’ rejection and disapproval, it’s assumed that these concerns will be reflected in his interactions with the therapist (e.g., feeling fearful of sharing feelings of anger with the therapist because his father disapproved of the expression of anger). Seventh, psychodynamic therapists are willing to explore the dreams, fantasies, and daydreams of the individual more readily than those who adopt other approaches to intervention. The assumption is that this material is a rich source of information about what the individual values, what he seeks to avoid, and what is interfering with adaptive functioning.

The goal of psychodynamic therapy is not simply to reduce symptoms of disturbed functioning but to develop personal capacities and resources so that one achieves more satisfying relationships, gains a sense of competence, and face stressors with greater flexibility.

**Behavioural Paradigm** From a behavioural paradigm, if basic learning processes (i.e., classical conditioning, operant conditioning) are responsible for establishing dysfunctional and impairing emotional and behavioural patterns, approaches to treatment should use such processes to decrease symptoms and increase adaptive behaviours.

One important learning process used to decrease symptoms associated with various disorders is that of **exposure**. Specifically, being exposed repeatedly to a particular object, situation, or memory that triggers negative emotions (e.g., a dog) followed by the absence of negative outcomes (e.g., no dog bite) will result in the eventual decrease in fear triggered by that stimulus. From a behavioural standpoint, this extinction of or decrease in a particular emotional and/or physiological response results under the following conditions: (1) you are exposed to the stimulus you fear, (2) you feel the fear or distress associated with the stimulus, but (3) have nothing bad happen after the exposure. Exposure treatment is used extensively for anxiety and trauma- and stressor-related disorders.

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**Box 1.5**

**Medications Used in the Treatment of Youth Disorders**

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Examples of Mechanism of Action</th>
<th>Disorders Commonly Treated</th>
<th>Common Brand Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antianxiety drugs</td>
<td>Increase GABA sensitivity (an inhibitory neurotransmitter)</td>
<td>Anxiety, panic, and mood disorders</td>
<td>Valium, Xanax</td>
</tr>
<tr>
<td>(tranquilizers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood stabilizers</td>
<td>Alter sodium and potassium pump; increase GABA</td>
<td>Bipolar disorder</td>
<td>Depakene, Lithium</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Increase serotonin activity</td>
<td>Depression and anxiety disorders</td>
<td>Paxil, Zoloft</td>
</tr>
<tr>
<td>Psychostimulants</td>
<td>Increase dopamine activity</td>
<td>ADHD</td>
<td>Ritalin, Dexadrine</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Decrease dopamine activity</td>
<td>Schizophrenia</td>
<td>Haldol, Zyprexa</td>
</tr>
</tbody>
</table>

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Operant conditioning processes are also extensively used in the treatment of various psychological disorders. For example, providing reinforcements (e.g., verbal praise) following desirable behaviour (e.g., working hard on a school assignment) is an effective way to increase the likelihood of those behaviours occurring in the future. Although punishments might also be presented following undesirable behaviour, they’re generally less effective in changing behaviour and are also ethically questionable. The focus, then, is on how to use reinforcements to increase adaptive behaviour.

**Cognitive Paradigm** From a cognitive approach, thoughts and beliefs are considered to be important factors in influencing emotional states and related behaviour. Therefore, if you seek to change behaviour, altering thoughts is the optimal approach to treatment. The goals of cognitive therapy include increasing awareness of personal cognitive biases and how these negative thoughts contribute to negative emotional states. Keeping a thought record, in which one records the thoughts associated with specific daily experiences and notes how these thoughts result in particular emotions, is a common strategy used to increase this awareness. Together with a counsellor or therapist, the youth is encouraged to consider his or her automatic thoughts in various situations, evaluate the extent to which these are rational, and consider alternative thoughts in relation to situations that might be associated with negative emotions. By consistently challenging these dysfunctional cognitive beliefs, alternative interpretations become more likely to be used in the future, with negative emotions and dysfunctional behaviour decreasing as a result.

Because these cognitive approaches usually include behavioural exercises, they’re often referred to as **cognitive behavioural therapy (CBT)**. An abundance of research documents the effectiveness of cognitive behavioural therapy with a variety of disorders. As discussed later in this chapter, CBT fits well with a CYC perspective and is likely to be used by CYCPs in their practice. CBT interventions include strategies and techniques focused on enhancing problem solving, assertiveness training, cognitive restructuring, family communication skills training, relaxation, exposure, and increasing pleasant activities (Weersing, 2004). The primary focus of all these techniques is examining the relationship between thoughts, feelings, and behaviours and teaching effective coping responses to stress and negative emotions (Garber & Weersing, 2010).

**Sociocultural Paradigm** Sociocultural approaches to treatment emphasize altering the social and cultural factors involved in emotional and behavioural disturbances. From this perspective, including family in the treatment of affected young people is considered essential to the success of any intervention. **Family engagement** refers to the involvement of family members at various levels of intervention and treatment decisions and includes the process by which family members come to understand that their child/adolescent is in need of mental health care (Trunzo, 2006).

Engagement has been defined as a process that begins with a child being identified as experiencing mental health difficulties and ending with a child receiving mental health care. More specifically, engagement in care is described as beginning with the recognition of a child mental health problem by parents, teachers, or other adults within a child’s context. (McKay & Bannon, 2004, p. 906)

Engagement might initially include parents seeking services or accompanying the youth to a scheduled appointment; later it can include being involved in the assessment
of the child as well as in any treatment interventions agreed upon by mental health professionals together with family input. Such participation not only ensures that the family’s values and beliefs are considered, but also increases the likelihood that broader cultural factors will be considered when developing any approach to treatment.

By involving family and youth at all levels a system of care assures itself that the culture of the system will be impacted by the perspectives and the cultures of the families and youth in the community. (Penn & Savage, 2004, as cited in Chovil, 2009, p. 14)

For each disorder discussed in the remaining chapters of this text, we will explore strategies that seek to involve parents and other caregivers in meaningful ways so that they may best support the youth undergoing treatment.

**CYC Approaches for Youth Struggling with Emotional and Behavioural Disturbances**

Child and youth care is about caring and acting—about being there, thinking on your feet, interacting, and growing with children. It is rich, intense, difficult work that requires passion and commitment. (Krueger, 1991, p. 77)

As Brendtro et al. (2010) point out, many of the major psychological models used to understand the mental health issues and other problems of troubled youth operate from a deficit perspective. These authors note the popularity of five major approaches to working with troubled children based on Googling the word children with each of the following terms: behavioural, psychodynamic, neuroscience, ecological, and sociological. The resulting numbers of hits were as follows: behavioural (problems are seen as behavioural disorders), 270 000; psychodynamic (problems are seen as emotional disturbance), 131 000; neuroscience (problems are seen as brain disorders), 80 000; ecological (problems are seen as dis-ease in the ecology), 43 200; and, sociological (problems are seen as social maladjustment, 9420 hits (Brendtro et al., 2010).

This web search shows that there is much available online that tries to explain childhood social, emotional, and behavioural problems, but that all five models are negative and pessimistic, with the first three focusing on deficits in the child and the last two on deficits in the environment (Brendtro et al., 2005). Conversely, the authors found that a Google search for resilience and children produced 700 000 hits—more than the entire negative, or pathology based, labels combined.

As Brendtro et al. (2010) have suggested, we are currently engaged in a resilience revolution in how we see the worlds of troubled or at-risk young people—a paradigm shift from disordered to exceptional, from fixing flaws to finding strengths. Brendtro et al. (2010) examine each of the key theories about troubled children and youth and point out ways in which each now appear to be moving from a focus on deficits toward a focus on strengths.

**Strength-Based Relational CYC Practice**

We have a choice about how we wish to view the young people whom we assist. We can either view them as manifestations of pathology and deficit or we can view them as representing a degree of competence and skill. We cannot do both. Further, if we
choose to view them in terms of pathology, then the focus on problems that this perspective requires makes it much more difficult for us to recognize their strengths and resources . . . if we choose to view them as competent and resourceful, then our focus on strengths is more likely to obscure their deficits from our view. (Durrant, 1993, p. 12)

According to McWhirter et al. (2007), a youth being “at risk” denotes a set of presumed cause–effect dynamics that place an individual youth in danger of future negative outcomes. But in the risk–resiliency model, the term resilience refers to those at-risk youth who have good outcomes despite experiencing chronic stress and adversity (McWhirter et al., 2007).

Of course, resiliency is not a new idea in the area of emotional and behavioural disorders. Eleanor Guetzloe (1994) has outlined some themes of resiliency that have emerged from relevant research since the mid-1990s. Family environments that are considered to be unstable, hostile, or negative are characterized by external forces that can lead to mental illness or other serious problems in youth. These families can be described as dysfunctional; they may, for example, have substance abuse issues, and/or they may be neglectful or physically abusive of children. Or, as in the case of homeless youth, children may have no families at all. And yet Guetzloe notes that in some of these children at risk there is a surprising absence of mental illness; they seem to possess an inner strength that enables them to sustain healthy development and to maintain focus and hope. “Resilient children have endured poverty, abuse, neglect, parental divorce and separation, sexual assault, homelessness, living on the streets, illness, physical handicap, war, refugee camps, and the Holocaust. They have not only survived but prospered” (Guetzloe, 1994, p. 2).

Guetzloe (1994) further points out that many resilient children seem to have an entire cluster or pattern of “protective factors” instead of just one or two. The development of resilience seems to depend on the multiple “transactions” between the individual characteristics of a child/youth and the protective factors in the environment. Resilience depends on at least “four interacting trajectories in human development: biological, social, and environmental factors, and finally, a chance event.” Interestingly, these “same interacting and transecting trajectories can also contribute to the development of violent behavior, suicidal tendencies, and other serious problems” (Guetzloe, 1994, p. 4).

Guetzloe stresses that “certain components of resilience can be taught and reinforced, modeled and learned.” Whereas “learned helplessness” develops in the face of experiences where individuals learn that absolutely nothing they do will make a difference, this can be altered by showing these youth that their own actions will in fact make a difference. “Resilient children somehow know that their actions will work; less-resilient children can learn this through achieving success in school and in other environments” (Guetzloe, 1994, p. 5).

Guetzloe summarizes the resiliency protective factors noted by the research. They are as follows:

An “easy” temperament: Temperament refers to such attributes as activity level, feeding patterns, adaptability, intensity of reaction, and reflectiveness in meeting new situations. A child born with an easy temperament handles stress better than one with a difficult disposition and is more likely to receive assistance from others (which, in turn, is another protective factor associated with resilience).
The presence of an adult mentor: As we pointed out earlier in this chapter, one of the most important protective factors is a trusting relationship with an adult. Youth-serving programs, schools, and communities can provide these caring adults. Note that it’s very helpful to provide youth with mentors who have ethnic backgrounds and experiences similar to their own.

Informal sources of support: None of the resilient youth obtained help from mental health professionals, but they did seek help from peers, parents of peers, and older friends.

Activities and creativity: “All children, particularly those at risk, should be provided the opportunity to participate in art, crafts, music, drama, dance, and other activities aimed at fostering and enhancing creativity. . . . With a clear understanding that the phenomenon of resilience is complex and that specific interventions must be carefully selected with individual needs in mind, we can work toward a comprehensive system of positive interventions” (Guetzloe, 1994, p. 6).

Michael Unger, a leading researcher, author, and speaker about resiliency in children and youth, points out that “it is important that resilience be preserved as a concept that describes positive growth during adversity” (Ungar, 2008, p. 2). He also notes that risk and resiliency are “two sides of the same coin” (Ungar, 2008, p. 2), where risk factors refer to any force that threatens one’s normal development.

Unger distinguishes between strengths and resilience. Strengths encompass a roster of internal and external assets for the entire population. Simply put, the more assets a young person has, the more likely she is to succeed in culturally and socially acceptable ways over her life span. Resilience describes “the presence of these strengths when a population is exposed to multiple risks” (Ungar, 2008, p. 3).

Resilience can be understood as follows: first; the capacity of individuals to navigate the resources that sustain wellbeing; second, the capacity of individuals’ environments to provide resources; and third, the capacity of individuals, their families and communities to negotiate culturally meaningful ways for resources to be shared. (Ungar, 2008, p. 4)

Assessment

The following is a general introduction to strength-based assessment in CYC practice; the following chapters describe related assessment techniques for each identified mental health concern. The DSM-5 can be a very useful overall guide to the signs and behaviours that children and youth experiencing mental health issues will demonstrate and that you’ll need to understand, observe, and document.

In conducting their assessments, CYCPs need to know how to identify all the signs and symptoms of the mental health concerns described in this text. CYCPs should be familiar with the mental status examination (MSE) format, explained in Chapter 10. The MSE provides a guideline for practitioners’ observations about how a young person looks, feels, and behaves at the time of observation (Morrison, 2007) in terms of appearance, mood and affect, insight, judgment, and so on. Assessment can be defined at the gathering and synthesizing of information about, and with, a youth and his or her family in order to assist in planning effective interventions. Assessment is central to good child and youth care practice, and it is key to engaging in a focused and helpful way with youth in order to mutually plan successful interventions. Assessments need to be strength-based in child
According to Rudolph and Epstein, a strength-based assessment approach is based on four important assumptions:

Every child, regardless of his or her personal and family situation, has strengths that are unique to the individual; Children are influenced and motivated by the way significant people in their lives respond to them; Rather than viewing a child who does not demonstrate a strength as deficient, it is assumed the child has not had the opportunities that are essential to learning, developing, and mastering the skill; When treatment and service planning are based on strengths rather than deficits and pathologies, children and families are more likely to become involved in the therapeutic process and to use their strengths and resources. (Rudolph & Epstein, 2000, pp. 207–208)

Assessments also need to be trauma-informed in child and youth care. Depending on their education level and training, the sector within which they work, and their role in the organization, some CYCPs may be able to conduct clinical assessments. Generally speaking, however, in most jurisdictions, a thorough clinical mental health assessment ought to be conducted by a licensed clinical practitioner, who may or may not be a CYCP. The CYCP may need to refer the child, youth, or family for this type of more formal clinical assessment. Nonetheless, it’s important for the CYCP to remember that although trained therapists will make very important contributions to child and youth assessment and intervention, “it would be well to debunk the myth and mystique surrounding psychotherapy” (Brendtro, 2002, p. 82). Indeed, “sometimes an adult who is actively involved in the life experiences with a youth can engage in more genuine and helpful communications than can a therapist tethered to an office desk (Brendtro, 2002, p. 82).

Assessment in child and youth care is complex. It involves assessing any exposure to traumatic events as well as any potentially severe impact of trauma exposure across the domains of development (“Assessment of complex trauma,” n.d.).

Here are some key steps for conducting a comprehensive, trauma-informed, mental health assessment: Assess for a wide range of potentially traumatic events in the child/youth's history. Ensure that you determine when they occurred so that they can be linked to developmental stages. Assess for a wide range of symptoms, risk behaviours, functional impairments, and developmental difficulties. Gather information using a variety of techniques (clinical interviews, behavioural observations) and from a variety of perspectives (youth, caregivers, teachers, other providers, etc.). Always ensure to engage the child and family about what makes sense, what’s working, and the most useful next steps for intervention (“Assessment of complex trauma,” n.d.). As we discussed earlier, the CYCP’s belief system will invariably influence the way youth behaviour is viewed and how the data are interpreted. Depending on their training and frames of reference, any two professionals may interpret the same data completely differently. Even though we try to maintain objectivity, we know that our beliefs and values can significantly affect our picture of the child or youth. Such influences may result in inaccurate assessments, which will in turn affect how services are provided. A CYCP who looks for problems, weaknesses, or deficits will find them; therefore, searching for strengths, solutions, resources, and skills is always preferred (Rudolph & Epstein, 2000).

A strength-based assessment approach provides several advantages for CYC practitioners and the young people they assist. First, focusing on strengths allows practitioners to involve young people and their families in service planning in a positive way by highlighting what is
going well. Second, strength-based assessment provides a method for documenting a young person’s strengths and competencies and offers a way to establish positive expectations for the youth and family. Third, through strength-based assessment family members will be empowered to take mutual responsibility for decisions that will affect their child’s life (Rudolph & Epstein, 2000). Children and youth don’t want to be interrogated by adults; they want to feel that someone is listening to their story. All youth have the right to be fully involved in an assessment process that not only looks at their problems but also focuses on their strengths.

Artz and her colleagues stress that CYCPs need to know when a young person’s life circumstances call for a focus on assessing need and when they call for a focus on assessing risk (Artz et al., 2004). Nowhere is this distinction more critical than in the area of child and adolescent mental health. And yet, as Artz et al. (2004) point out, in CYC research and practice, risk and need are frequently collapsed. A needs assessment that is collapsed into a risk assessment tends to be deficit-focused; that is, concerned only with problematic conditions and behaviours rather than with strengths and potential. In CYC practice, strengths-based assessment is preferable to the other pathology-based models that focus on young people’s vulnerability. Further, having experts assess risk doesn’t necessarily help CYC professionals determine who needs services and what kinds of services are required. Nor does it help in predicting what will happen in a youth’s future without such services or support. Artz et al. (2004) thus emphasize that to facilitate appropriate service provision, accurate needs assessment is a must.

However, shifting the focus exclusively to needs assessment brings another challenge: some risks, especially the risk of harm to self and others, must take precedence over any other call for service and intervention. In planning effective intervention, then, both need and risk must be understood contextually.

Although CYCPs don’t traditionally use rating scales or other “paper-and-pencil” tests in their assessments, it’s important to familiarize yourself with the assessment scales in each area of CYC practice. Such familiarity will give you (1) an awareness of what clinicians and psychologists use in their own assessments, and (2) guidelines for both your observations and your formal and informal interview questions. Each chapter in this text therefore includes relevant and accessible rating scales.

The Youth Bill of Rights (see Box 1.6) was developed by Laura Burney Nissen (1994) specifically for young people in the juvenile justice system. These principles provide benchmarks for respect in assessment as the foundation of planning for positive outcomes. We encourage CYCPs to embrace these principles in their assessment practices.

**Indicators to Recognize** Parents, teachers, friends, CYCPs, and caregivers are often the first to recognize that a child or adolescent may be having concerning and/or significant difficulties with their emotions or behaviours. The Canadian Psychiatric Society provides general indicators that a formal mental health assessment may be useful or required; these are summarized in Table 1.6. In this text we highlight the specific indicators to recognize for the mental health issue presented in each chapter.

**Intervention**

In a relational CYC model the actual child-professional caregiver relationships may be the key to successful interventions with a child who has experienced severe early relationship disruptions. It is clear that a security enhancing practitioner or surrogate
Chapter 1

Parent who can look beyond a child's disruptive behaviours and emotional volatility to a child's strengths and developmental needs may promote the development of a secure attachment orientation in a child. (Curry et al., 2011, p. 6)

Research into the effectiveness of various psychotherapies and counselling techniques has concluded that, no matter which conceptual models or theories practitioners follow, the effectiveness of the chosen intervention depends most significantly on the quality of the relationship between client and therapist (Sharpe, 2006). Indeed, depending on the needs of individual children, in actual practice many approaches may be helpful (Sharpe, 2006). Thus, for youth who are facing adversity and a multitude of risk factors in their lives, the single most important opportunity for change is a positive and consistent relationship with a caring significant adult in their lives, whether that person is a grandparent, a

Box 1.6

Youth Bill of Rights

I have the right to . . .

- be viewed as a person capable of changing, growing, and becoming positively connected to my community no matter what types of behaviour I have exhibited
- participate in the selection of services that build on my strengths
- contribute things I am good at and other strengths in all assessment and diagnostic processes
- have my resistance viewed as a message that the wrong approach is being used with me
- learn from my mistakes and to have support to learn that mistakes don’t mean failure
- view past maladaptive or antisocial behaviours as a lack of skills that I can acquire to change my life for the better
- experience success and to have support connecting previous successes to future goals
- have my culture valued and to have services that honour and respect my cultural beliefs
- have my gender issues recognized as a source of strength in my identity
- be assured that all written and oral, and formal and informal, communications about me include my strengths as well as my needs
- surpass any treatment goals that have been set too low for me, or to have treatment goals that are different from those generally applied to all youth

be served by professionals who view youth positively and understand that motivating me is related to successfully accessing my strengths

have my family involved in my care and treatment in a way that acknowledges and supports our strengths as well as our needs

stay connected to my family no matter what types of challenges we face

be viewed and treated as more than a statistic, stereotype, risk score, diagnosis, label, or pathology

a future free of institutional or systems involvement and to services that most centrally and positively focus on my successful transition from institutions

service providers who coordinate their efforts and who share a united philosophy that the key to my success is through my strengths

exercise my developmental tasks as an adolescent—to try out new identities, to learn to be accountable, and to say I’m sorry for the harm I’ve caused others—all of which is made even more difficult if I’m labelled as a “bad kid”

be viewed and treated as a redeemable resource, potential leader, and success of the future.

Source: Adapted from Heckenlaible-Gotto, 2006.
teacher, an aunt, or a CYCP. As Urie Bronfenbrenner noted, “Every child needs at least one adult who is irrationally crazy about him or her” (Brendtro, 2006, p. 165).

Carol Stuart (2009) refers to planned CYC interventions as those that develop when we design activities and interactions to best meet young people’s identified needs and to support their individual goals and objectives. Thom Garfat (1998) defines intervention as “an intentional caring action, taken into one of the daily life systems of which the youth is a part, which facilitates a change in that system such that a context is created for the youth to have a different experiencing of herself and/or the meaning that she gives to her experiencing” (p. 168). Based on a qualitative analysis of the subjective experiences of both CYC practitioners and the youth they worked with, Garfat (1998) identified key characteristics of successful interventions. He recommends a framework for CYC assessment and intervention based on four key stages: noticing, reflecting, preparation, and intervention (Garfat, 2003).

### Behavioural and Cognitive-Behavioural Techniques for CYCPs

The fundamental assumption of the cognitive paradigm when applied to the exceptionalities of children and youth is that through intervention and training, young people’s thinking processes can be changed. The way we work with them depends on whether they exhibit a pattern of deficits or a distorted pattern. If there’s a deficit, CYCPs will teach them how to use cognitive skills and strategies, with the underlying assumption that young people either haven’t been taught particular cognitive skills or have learned them but use them incorrectly. If

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**Table 1.6 Behavioural Indicators Checklist: General Indicators of Mental Health Issues**

- Marked drop in school performance or increase in absenteeism
- Increased or excessive use of alcohol and/or drugs
- Marked changes in sleeping and/or eating habits
- Many physical complaints (headaches, stomachaches)
- Aggressive or non-aggressive consistent violations of rights of others: opposition to authority, truancy, thefts, vandalism, etc.
- Withdrawal from friends, family, and regular activities
- Depression shown by sustained, prolonged negative mood and attitude, often accompanied by poor appetite, difficulty sleeping, or thoughts of death
- Frequent outbursts of anger and rage
- Low energy level, poor concentration, complaints of boredom
- Loss of enjoyment in what used to be favourite activities
- Unusual neglect of personal appearance
- Intense fear of becoming obese with no relationship to actual body weight
- Uncharacteristic thrill seeking or sexual acting out
- Marked personality change or bizarre behaviour
- Comments about “feeling rotten inside,” wanting to “end things,” and soon no longer being a problem for others
- Hearing voices and/or talking to self

Source: Adapted from “Areas of care,” n.d.
there is a distortion, CYCPs will attempt to alter their perceptions, beliefs, and thinking patterns. This usually means helping youth shift from negative thinking patterns to positive self-talk patterns. Specific options for accomplishing this are explored in Chapter 2.

The cognitive-behavioural model combines elements of the behavioural and the cognitive conceptual paradigms. Cognitive behavioural therapy (CBT) emphasizes the learning process based on the influence of environmental factors while also focusing on the information or thinking process involved in the development of disorders. Much research supports the efficacy of the CBT model. Indeed, in the area of mental health for children and youth it’s considered the gold standard of evidence-based interventions, and as such is used frequently in CYC practice. The following chapters outline its use for each mental health disorder of children and youth.

The Role of Medication

Yes. Every single kid—it’s very rare that we’ll get a young person that is not on medication, and I’ve seen young people so over-medicated that they can’t even hold a conversation. They fall asleep halfway through the day. (Lambe & McLellan, 2009)

The use of psychotropic medications as a first-line treatment for children and youth diagnosed with psychological disorders is a significant issue, and of particular importance for those in the CYC field. Given that psychotropic drugs are inexact, unpredictable instruments at best, using these medications for children and youth is likely ill advised. And yet critics argue that physicians are increasingly prescribing these medications to children in order to treat what are merely the normal pains of daily living. In Canada, over 200 000 prescriptions for antidepressants were given to children and youth in 2003, representing a 75 percent increase in five years (Fewster, 2004).

Furthermore, many authors point out that once the DSM has established a child psychological disorder, the number of young people diagnosed as having that disorder inevitably expands. Children and youth once considered odd, difficult, melancholy, or unconventional have now joined the ranks of the mentally ill. ADHD is viewed by many as one such disorder: “Hyperactivity in children, for example, has become a hotly contested diagnosis. Aided no doubt by the availability of drugs like Ritalin and Adderall, the disease has crept outward from its core population of children who cannot concentrate, to children whose behaviours may be troublesome, but hardly abnormal” (Karp & Sisson, 2010, p. 122).

And as Fewster has argued for many years, once a psychiatric diagnosis has been established, pharmaceutical companies promote and market their medications for exclusive use in treatment. Indeed, the relationship between the pharmaceutical industry and psychiatry has been called into question by many authors and clinicians (Fewster, 2002), and there is no disputing the fact that marketing psychotropic medications for use with children is now a multimillion-dollar industry. In the United States, sales of antipsychotic drugs were estimated at $2.8 billion in 2003, and by 2011 that number had risen to $18.2 billion (“Are too many kids,” 2013). Recent data from the Centers for Disease Control and Prevention in the United States show that the ADHD diagnosis had been given to 15 percent of all American high-school age children, and that the number of children on medication for the disorder had soared to 3.5 million in 2003 from 600 000 in 1990. The rise of ADHD diagnoses and prescriptions for stimulants over the years has coincided with a hugely successful two-decade campaign by pharmaceutical companies to publicize ADHD and promote their meds to doctors, educators, and parents (Shwarz, 2013).
The long-term implications of psychotropic medications on children’s physical, emotional, and social development is unknown. Exposure to antidepressants and other medications may affect those areas of the brain having to do with stress, emotion, and the regulation of emotions (Foltz, 2008). As Foltz points out, there is an urgent need for more research on how these medications may affect a child or youth across childhood and adolescence. For example, in contrast to an average eight-year-old boy, the average teen boy experiences a dramatic increase in testosterone, yet if these two youth were each diagnosed with Bipolar Disorder, they would likely receive the same or similar medications—and it is not known how these medications may react with this or any other developmental event (Foltz, 2010).

As well, the effectiveness and overall safety of antidepressants with children and youth are, at best, highly questionable. In a U.S. FDA review of short-term, placebo-controlled antidepressant trials, only 3 of 15 studies demonstrated any superiority over the placebo. The increase in self-injurious behaviour and suicide ideation after taking antidepressants, and the increased likelihood of agitated, irritable, and impulsive behaviours (potentiating mania), have been well documented. In 2003, the FDA, Health Canada, and the MHRA all warned against the use of SSRIs in children and adolescents. Since 2004, a “black box warning” about potential suicidality in this age group was added to all antidepressant monographs (“Depression in children,” n.d.).

In children, SSRIs and other new anti-depressants produce a higher rate of behavioural and emotional adverse effects (such as: agitation, disinhibition, irritability and occasionally thoughts of self-harm). The largest drug-placebo difference in the number of cases of suicidal ideation and behaviour is greatest for the under-24 age group. For all ages, the risk is highest during the first few months of drug therapy, therefore, monitor patients closely during this time. (“Anxiety and depression,” 2010)

According to the Canadian National Youth in Care Network (NYICN) (Lambe & McLellan, 2009), the practice of using mood-altering and behaviour-modifying psychotropic medications as an intervention for young people who’ve been diagnosed with a mental health issue in the justice and child welfare systems is a serious issue. The NYICN conducted a study in which 41 young people aged 18 to 28, in and from care, were asked about the types of “chemical management strategies” that had been used with them. Seventy percent of the participants had been prescribed psychotropic medications while living in the system. On average, participants began taking medication at 13 years of age. Of the 70 percent who had been prescribed medications while in the system, 30 percent were still using psychotropic medications at the time of the interview. In addition, many children and youth did not have a say about whether they wanted to take the drugs or not.

Approximately 90 percent of caregiver or “intervener” respondents identified benefits of using medication to treat the symptoms of mental illness with the children and youth they worked with. They thought that the medications had minimized the disruption associated with such conditions as depression, anxiety, and panic attacks, and that those who had been prescribed medication for conditions such as ADHD had developed increased levels of concentration. Interveners shared their observations of how youth were able to participate with their peers and had successful and rewarding school experiences. The child/youth participants also acknowledged many benefits of using psychotropic drugs in the treatment of psychiatric disorders; for example, when medication had
alleviated disruptive or distressing symptoms they had experienced, they were in support of this method. They did, however, specify that when medication was required, it was most effective when used in combination with forms of counselling and psychotherapy. It’s important to note, then, that such medications do benefit some children and youth. Nonetheless, feedback about the consequences that arose from the overuse and misuse of psychotropics overshadowed all other commentary (Lambe & McLellan, 2009).

There are some advantages when they’re used. Some of the advantages are: to help with sleep patterns, to help with concentration in schools, to help as a mood stabilizer, to help with depression, to help control anxiety and panic attacks, etc. (Intervener, Ontario)

In my opinion, the advantages of using psychotropic medications are they help control some problems that occur. If it’s being prescribed by a doctor and under a doctor’s supervision, it should be okay. (Intervener, Atlantic)

Depending on the child and the severity of the behaviour, with some it would help with concentration with school work and day to day living so they are able to have a positive and successful future. (Intervener, Prairies)

According to the NYICN’s Drugs in Our System report (2009), youth feedback had indicated five main areas of serious concern: (1) psychotropics were prescribed immediately upon or shortly after their entry into the child and family services system; (2) informed consent from the young person was not required or requested; (3) workers had relied on medications as a quicker, easier, and cheaper alternative to “fix” emotional and behavioural struggles; (4) chemical management strategies were used as a means of controlling their behaviour, enforcing compliance, and restraining aggression; (5) the healing needs of participants had not been appropriately addressed through the use of psychotropics, and had resulted in dependency. The top five psychotropic medications prescribed to youth who’d been medicated while in systems care were Ritalin (34 percent), Paxil (17 percent), Dextrodrine (15 percent), Effexor (15 percent), and Prozac (15 percent). For the 41 young people who said they’d been medicated while in the out-of-home-care system, the top five psychiatric diagnoses reported were Attention Deficit Disorder (ADD) and Attention-Deficit Hyperactivity Disorder (ADHD) (41 percent), depression (39 percent), anxiety (15 percent), Bipolar Disorder (7 percent), and Obsessive Compulsive Disorder (7 percent).

I don’t like the idea of being force-fed meds at all. I think that it’s kind of perverted. It is. It’s a violation, like strapping me down and sticking me with a needle, I consider that raping me. Yes it is. You’re putting a chemical in my body. (17-year-old male)

I think they’re used as a control measure. I think it’s a way of dealing with issues, by not having to deal with issues. (22-year-old staff)

CYCPs need to decide for themselves where they stand on the issue of using psychotropic medications with children and youth. Gerry Fewster (2003) offers the following approaches to the question of whether to administer psychotropic medications in CYC work: Ask yourself whether you’d take the meds yourself, and whether you’d give them to your own children. Carefully articulate your stance on this issue, write it down, and revisit it occasionally. Be prepared to conduct research in order to offer alternative, drug-free interventions and to challenge those who argue that psychotropic medications are the only or the most effective treatment for children with difficulties. Ensure that you know all the potential side effects, and observe and document for these. Finally, ensure that
youths are well informed about the side effects as well as their right to refuse to take the medication (Fewster, 2004).

In the following chapters we describe the most commonly prescribed psychotropic medications used to treat each disorder CYCPs ought to examine this issue very carefully and determine their own position on it.

**Psychoeducation and Individual Counselling**  As discussed earlier, psychodynamic theories have had a significant influence on all therapeutic approaches, including individual and group counselling. Indeed, the classic CYC texts on therapeutic milieu and the need for external controls, predictability, and structure to calm the chaotic internal world of the “disturbed child” (Brendtro et al., 1969; Redl, 1966; Redl & Wineman, 1952) are based on the psychodynamic conceptual model. This model influenced the development of the theory of group care of children as well as Fritz Redl’s classic CYC concept of the “life space interview” or “life space crisis intervention” (LSCI), which uses informal, day-to-day situations as the space for therapeutic engagement with troubled youth. Group work with children has also been influenced by Bruno Bettelheim’s ideas about the therapeutic potential of this milieu.

The psychodynamic model stresses the importance of understanding the emotional and psychological development of children and young people, and can be used to explain what happens when development is disrupted in childhood (Sharpe, 2006). Therefore, it’s critical that CYC professionals working with vulnerable young people understand the psychodynamic paradigm.

Many of Freud’s theories are central to the writings of Fritz Redl, Redl and Wineman, Bruno Bettelheim, and other CYC pioneers (Garfat, 1987). As Thom Garfat has observed, “Trying to understand child and youth care without reading Redl and Wineman is like trying to understand algebra without learning addition, it’s that basic” (Garfat, 1987). Psychoeducation and strength-based individual counselling approaches are without a doubt one of the most effective and well-used approaches in the CYC intervention tool kit.

**Family Support Interventions**  CYCPs use a family-focused approach in their work. Families need to be included in every aspect of the therapeutic or healing relationship. And when family members are unable or unwilling to be involved in the young person’s case planning and healing process, the CYC will seek suitable alternative people in the youth’s support circle, or “ecology,” such as grandparents, aunts, teachers, and adult mentors. Being family focused and family driven is a core principle of CYC practice. It means that CYCPs will ensure that they afford families every opportunity to take an active decision-making role in the care of their own children. It also means that the family and the youth have a voice in defining what successful outcomes are. Having respect for a family’s unique set of needs, strengths, opinions, and beliefs is the foundation of the family-driven value ("Working definition of family driven care," 2008).

Child and youth care practitioners who engage with families are not family therapists in the normal or traditional sense of that term. Nor are they social workers, psychologists or some other human services professional, although many of the tasks, philosophies and skills across the various professions are quite similar. . . . We do not follow the models of other professions, although we learn from and in many cases contribute to them. We believe that in order to be an effective practitioner with families, the child and youth care worker must know and be fully grounded in our own profession and the way in which we consider family in our field. (Garfat & Charles, 2010, p. 6)
In the chapters that follow we introduce a wide variety of ways for CYCPs to engage with families. Although CYCPs are not trained family therapists, they do borrow family-intervention ideas from other professions, and so we’ll also discuss the family-therapy types of intervention that fit well with particular mental health concerns.

In providing support to families who are struggling with a child with a mental health issue, CYCPs might, for example, help young people within the family context in developing social skills, life skills, problem-solving skills, coping skills, relaxation skills, anger-management skills, and so on. They might also assist the family in learning or developing parenting skills or child-management skills.

According to Lahn Jones (2007), the reality is that many youth and families don’t want CYCPs to be involved in their lives. However, this reaction is minimized when CYCPs use a strength-based approach to their work with families. The CYC approach to family work means “being with [families] while they are doing what they do. It means the utilization of daily life events as they are occurring for therapeutic purposes” (Garfat, 2003, p. 43). CYCPs acknowledge families as being their own experts, recognizing that parents usually do want what is best for their children. Jones points out that youth behaviour is contextually anchored within the family, including any mental health difficulties that have been identified. When CYCPs are with the family, they can identify strengths and point out the exceptions to the identified problematic patterns while offering support, guidance, and alternative methods of coping (Jones, 2007, pp. 1–3).

Family group conferencing (FGC) is one highly successful method that CYCPs can use to actively engage families in a youth’s healing process. Although it was developed as a way to engage families primarily in the child protection and youth justice contexts, it can be adapted for any therapeutic context. FGC’s main objective is to give the entire family a voice and ownership in case-planning and decision-making processes. FGC is a culturally sensitive, strength-based approach to working with all families, but in particular, it helps empower marginalized families by bringing together family members to develop a plan of care for their child that addresses the concerns identified by a mental health professional (Desmeules, 2007).

The concept of FGC originated in New Zealand, and was based on concerns about the overrepresentation of Maori children in that country’s child welfare and juvenile justice systems. As such, FGC fits well in the Canadian context, where Aboriginal children are similarly overrepresented in our child welfare system.

Family conferencing embraces the principle of inclusion and shared leadership through consensus decision-making. It offers a model of service delivery that promotes family empowerment and self-reliance. The family system, once mobilized, is more powerful than professional services. It is the participation process that makes the plan created by the family come alive as a personal reality. (Desmeules, 2007, p. 6)

Box 1.7 lists some common CYC techniques for intervention with youth.

**Prevention: Advocacy, Community, and School-Based Strategies** Given that most school-aged children and youth spend most of each day within the school setting, schools are a very important venue for mental health service information and, potentially, program delivery (Mental Health Commission of Canada, 2013). The Mental Health Commission’s report, entitled *School-Based Mental Health in Canada*, highlights
the importance of schools in promoting universal mental health, in working toward stigma reduction, and in assisting in the early recognition of mental health problems (Mental Health Commission of Canada, 2012). The report recognizes the link between mental health and the academic performance of children and youth and recommends increasing “comprehensive school health and post-secondary mental health initiatives that promote mental health for all students and include targeted prevention for those at risk” (Mental Health Commission of Canada, 2012).

According to the Mental Health Commission, there are several unique advantages to offering mental health programming within the school setting. For example, class-wide programs may reach at-risk youth who would not otherwise access children’s mental health services; and during class-wide social-emotional learning instruction, high-risk students may benefit from observing their emotionally skilled peers model good coping behaviour and attitudes (Mental Health Commission of Canada, 2012). While school-based programming facilitates the identification of mental health difficulties when they first emerge, it also has the potential to maximize positive mental health development for all children and youth, not only for those who are on a negative trajectory (Rowling & Weist, 2004). Finally, the implementation of mental health promotion and prevention programming in schools is associated with improved emotional and behaviour functioning for all youth (Mental Health Commission of Canada, 2013).

Community-based intervention strategies encompass all the accessible mental health services offered in the community, including self-help groups. Every community ought to have crisis and mental health services for children, youth, and families available. An important responsibility of CYCPs is to be aware of all the relevant community-based services and to identify any gap in service availability and accessibility. If such gaps exist, CYCPs will work to promote awareness and to develop and implement the required resources. Promoting awareness of mental health concerns, working toward reducing discrimination and stigma, and improving accessibility to mental health information, resources, and services together represent an important role for CYCPs in the community.

Box 1.7
Techniques for CYC Intervention

Be familiar with the signs and symptoms of each DSM-5 disorder.
Use multiple data sources in assessment.
Use a strength-based assessment model: observe and document behaviours, noting triggers along with their severity/intensity, frequency, and duration.
Look for and use already existing, informal sources of support.
Identify resources, and harness what is going right in the ecology of the family.
Be relational.

Be family focused in your work; include young people’s significant others in your assessments and interventions.
Use family-support techniques, including family group conferencing.
Help young people make well-informed decisions about their treatment wherever possible, especially regarding the use of psychotropic medications.
Encourage and teach social skill building.
Think outside the box; be open to alternatives to traditional Western treatment by exploring holistic, alternative, and traditional Indigenous healing practices.
**Alternative Healing** Complementary and integrative medicine, also called alternative medicine, includes a wide array of mental health care practices not usually considered part of mainstream medicine. Naturopathy, natural psychology, and homeopathy, for example, are fields of practice used to treat many psychological difficulties. Such alternative healing approaches to mental health issues are premised on the belief that individuals can overcome mental health disorders with all-natural methods, without drugs, by using self-help strategies and making lifestyle changes. Nonconventional healing practices are most often used in conjunction with conventional/traditional medicine practices (AACAP, 2012). Since many families today opt for natural healing approaches in the treatment of mental health issues, CYCPs should be aware of the various options for holistic treatment in each area of mental health concern for children and youth. Families and older youth may be supported by CYCPs in investigating any of these approaches.

Alternative therapies include art therapies, music therapy, poetry and journalling, coaching and mentoring, neurofeedback, and biofeedback. A wide range of therapies are used with children and youth, including mindfulness-based stress reduction (MBSR), yoga, meditation, laughter therapy, music, art, play, diet, sleep, nutrition, exercise, spirituality, chiropractic care, body/energy therapies, relaxation techniques, massage, herbal therapies, folk remedies, acupuncture, self-help groups, and homeopathy (AACAP, 2012).

Biofeedback, reflexology, Reiki, shiatsu, and gemstone therapy are all used for energy work. Homeopathic medicine is a system based on the belief that “like cures like,” meaning that small, highly diluted quantities of medicinal substances are given to cure symptoms when the same substances, given at higher or more concentrated doses, would actually cause those symptoms.

Reviews of the literature suggest that alternative approaches are most often used for autism and ADHD in children, with nearly 50 percent of children with autism and 20 percent of children with ADHD being treated in this way (AACAP, 2012).

**Relational CYC Practice** CYC practice is, and always has been, relational, with all the pioneers in the field having enacted the relational model in their work. Relational CYC practice evolved, as the name suggests, from our historical focus on relationship in the days of poorhouses and orphanages, and even long before that (Garfat, in Bellefeuille & Ricks, 2008). After all, relationship has always been essential to any interpersonal healing.

The focus on relationships and the relational is not new. . . . Yet it seems that many look at a relational approach as if it was something invented by contemporary practitioners, eager to engage in intimate ways with young people and their families. . . . Relations and relationship have been a part of Child and Youth Care practice for as long as there has been written material and surely long before that as well. (Garfat, 2003, p. 1)

The term relational-based interventions (RBIs) (Hackney & MacMillan, 2008) is used to describe the CYC relational approach. In this approach, the focus of all CYC treatment interventions is to help young people see themselves as valuable, connected, and safe: “RBIs emphasize that how we respond to others, and how they respond to us, defines how we view ourselves as a people” (Hackney & MacMillan, 2008, p. 58). Hence, relational-based intervention has an attachment focus. Further, RBIs constitute treatment in and of themselves.
This means that the first and most important task of caregivers is to develop this valuing and respectful relationship that increases the safety and trust the young person has with us and gives them a new message about themselves. Most of the young people in our treatment programs do not see the safety or value in a relationship with us until they have been taught by our behaviour that there is. (Hackney & MacMillan, 2008, p. 59)

RBIs include any interventions that (1) demonstrate to young people that they are of value; (2) demonstrate and teach appropriate socio-emotional responses; and (3) provide young people with safety, structure, and security.

In addition to drawing upon principles of attachment, these three interrelated aims reflect the goal of resilience in young people by strengthening intrapersonal factors, such as feelings of self-worth, as well as building interpersonal skills and drawing upon available supports from the young person's environment, which . . . uses an ecological conceptual model base. (Hackney & MacMillan, 2008, p. 61)

Box 1.8 summarizes useful communication strategies that might facilitate your application of these treatment principles.

**WHERE DO YOU STAND?**

The CYC approach to understanding and intervening in the mental health concerns of young people can use aspects of all the major psychological paradigms. These paradigms can inform the CYC perspective, which highlights understanding young people's ecology and relationships and identifying their resiliencies and strengths. In some cases, diagnostic labels used in the DSM-5 are antithetical to the CYC approach, as with the “disruptive” behaviour disorders where context is either not adequately addressed or largely ignored. The strengths and resources of young people, or what is “going right” in their ecology, are not addressed in the DSM-5 diagnostic approach. As we'll see in later chapters, however, with other mental health issues of children and youth, such as autism, psychosis, and Schizophrenia, the DSM-5 and the medical model are important in informing our understanding.
Notwithstanding the critics of the DSM-5 in the CYC field, we believe that CYC professionals need to understand the DSM-5’s use of diagnostic labels regardless of the system within which they may be working. However, a strength-based, resiliency-focused, relational CYC approach to helping young people struggling with behaviours related to these diagnoses is still how we do what we do. It is the appropriate approach of a CYC professional regardless of the diagnostic label that has been applied or the ideological context of your work.

To evaluate your understanding of Chapter 1 concepts, try the Viewpoint Challenge exercise that revisits the cases of Troy and Darren one last time.

**Troy’s and Darren’s Cases: Viewpoint Challenge Exercise**

Reread the cases of Troy and Darren discussed in this chapter. How would the psychological and the CYC perspectives differ in their approach to better understanding Troy’s and Darren’s behaviour, respectively? Can you identify any similarities between the two perspectives? How do the approaches to intervention differ? What might be the major differences? What information would you need when you conduct your CYC assessment with Troy and with Darren? Which intervention approach might you try with each? Why?
- A review of the major psychological perspectives through a CYC lens demonstrates a variation in the degree to which each might be considered to have a good fit with a CYC orientation.
- The predominant CYC conceptual model used to explain exceptionalities is the ecological model, which emphasizes the role of contextual and relational factors in explaining troublesome behaviours. Of particular relevance from a CYC perspective is the role of resiliency, strengths, and the relational nature of CYC practice.

**Critical Thinking Questions**

1. Based on the psychological indicators of abnormality, do you think a clear distinction can be drawn between “normal” and “abnormal”? Explain.
2. What do you think about the use of the DSM-5’s diagnostic labels in CYC practice? How did you decide where you stand on this issue?
3. Why do you think CYC professionals prefer to use the term exceptionality or pain-based behaviours rather than abnormal or mentally ill to describe the emotional and behavioural disorders of children and youth?
4. Explain why it’s important to use person-first language and to be culturally respectful in your CYC practice.
5. Is the sociocultural perspective a good fit for CYC practice? Why or why not?
6. Do you agree that a CYC perspective is ecological? Why?
7. What do you think about the use of psychotropic medications with children and youth?
8. How do you think poverty, race, and ethnicity influence the development of exceptionalities or abnormalities?
9. Do you agree with the use of the term relational in describing the CYC approach? Why or why not?

**Key Terms**

- abnormality, xx
- abnormal psychology, xx
- assessment, xx
- attachment, xx
- behavioural paradigm (behaviourism), xx
- biological paradigm, xx
- biopsychosocial perspective, xx
- cerebral cortex, xx
- classical conditioning, xx
- cognitive behavioural therapy, xx
- cognitive distortions, xx
- communication, xx
- comorbidity, xx
- culturally competent, xx
- cultural safety, xx
- defence mechanisms, xx
- diagnosis, xx
- *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), xx
- diathesis–stress model, xx
- dynamic-maturational model (DMM), xx
- eclectic or integrative approach, xx
- ecological model, xx
- etiology, xx
Supplemental Readings


Online Resources

Discussion of misleading terms, www.huffingtonpost.com/allen-frances/can-we-replace-misleading-terms-like-mental-illness-patient-schizophrenia_b_7000762.html
Mental Health Commission of Canada's Youth Anti-Stigma Initiative, www.youtube.com/watch?v=lvknTTAV6Kk
Manitoba Mental Health Act, www.gov.mb.ca/healthyliving/mh/act.html
International Child and Youth Care Network, www.cyc-net.org
Child Trauma Academy, www.childtrauma.org
International Association for the Study of Attachment, www.iasa-dmm.org
Canadian Association of Naturopathic Doctors, www.cand.ca
Mood Disorders Association of Ontario, www.mooddisorders.on.ca
Dr. Bruce Perry and the neurosequential model, www.childtrauma.org
To hear Dr. Perry speaking, search his name at www.youtube.com.
Information on the DMM model, www.patcrittenden.com
To hear Dr. Crittenden speaking, search her name at www.youtube.com.