Two Broad Problem Types

- **Externalizing** – create difficulties in a person's external world
  - Tend to go together (e.g., substance use, delinquency, aggression)
  - More common among males
  - Often motivated by desire for excitement, not necessarily underlying unhappiness or psychopathology
  - "Undercontrolled" – characterized by lack of self-control;
    - Parental monitoring/control lacking

- **Internalizing** – primarily affect a person's internal world
  - Associated with experiencing distress
  - Tend to go together (e.g., depression, anxiety, eating disorders)
  - More common in females
  - "Overcontrolled" – characterized by inhibition, anxiety, self-punishment
  - Parents exert tight psychological control

The distinction between the two types is not absolute. A delinquent adolescent might also be depressed.

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**Externalizing Problems**

= “Risk Behavior”
= “Problem Behavior”

- Risky Driving
- Substance Use
- Crime
- Risky Sexual Behavior

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**Risky Driving**

- Highest rates of auto accidents, injuries, & fatalities = age 16-24
- Motor vehicle injuries leading cause of death for this age group?
Driver Crash Involvement: Fatality

Figure 13.1 Rates per 100,000: 2011

What do you notice?

Driver Crash Involvement: Injury

Figure 13.1 Rates per 100,000: 2011

What do you notice?

Driver Crash Involvement: Property Damage

Figure 13.1 Rates per 100,000: 2011 (NHTSA, 2012)

What do you notice?

Risky Driving

Possible Reasons?

1. Driver inexperience – rates drop dramatically after 1 year experience
2. Taking risks
3. Lack of parental monitoring
4. Cultural norms glorify speeding/racing; Belief that friends approve of risky driving
5. Driver characteristics
Shope’s Model of Young Driver Crash Risks (2002, p. 15)

Prevention: Two Approaches

1. Driver Education
   - Does not improve accident rate

2. Graduated Driver Licensing (GDL)
   - Addresses variety of risk factors, restrictions imposed
   - Learning license – supervised driving
   - Accidents 20-40% lower; fatalities 40% lower

Substance Use

- Another common form of risk-taking
  - Alcohol
  - Cigarettes
  - Illegal drugs (e.g. marijuana, cocaine, LSD, ecstasy…)

- Rates of substance use vary across Western countries (WHO, 2008)

Alcohol Use

Figure 13.3
World Health Organization analysis of 41 countries; Weekly alcohol use among 15 year olds
Cigarette Use

Figure 13.4

Marijuana Use

Figure 13.5

World Health Organization analysis of 41 countries; Cigarette use at least once per week among 15 year olds

World Health Organization analysis of 41 countries; Marijuana use at least once per week among 15 year olds

Some stats

• Substance use rates continue to rise past age 15 to emerging adulthood
  – 40% US high school seniors used alcohol and 31% reported binge drinking in past month
  – 19% cigarette use (at least once) 19%
  – Marijuana use (at least once) 23%
  – Other forms of substances relatively low

• Among 8th grade students, nearly 4 out of 10 (39%) reported some alcohol use in their lifetime, and 16% self-identified as a current (past 30-day) drinker!!!
• The earlier one begins to drink the greater the risk of abusive consumption.

Substance Abuse by Age

Figure 13.6

Source Johnston et al., 2008

• Peaks in early 20's
• Alcohol use highest
• Time of unstructured socializing (e.g., college)
Sequence of Substance Use

- Typical sequence of 4 stages
  1. Drinking beer and wine
  2. Smoking cigarettes and drinking hard liquor
  3. Smoking marijuana
  4. Using “hard” drugs (e.g., cocaine, LSD)

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Discussion Stop

- Some people have interpreted the "gateway drug" theory as indicating that if adolescents could be prevented from using alcohol and cigarettes, they would also be less likely to use marijuana and hard drugs
- Do you think this is true, or would they be more likely to use other drugs if their access to alcohol and cigarettes were curtailed?
- Which drug represents the gateway?

Alcohol as The Gateway Drug

- Weltes et al. 1985: Unless alcohol was used first, there was very small likelihood that any other drug would be used later in life
- Kirby et al. 2012 US 12th grade study
  - alcohol use the first step (i.e., “gateway”) in the temporal ordering of substance use; alcohol use predicted use of tobacco, marijuana, and other illicit drugs
  - drug use follows a progression from licit to illicit

Kandel’s drug sequencing hypothesis:
Drug involvement begins with the most socially acceptable drugs, alcohol, and cigarettes (stage 1), proceeds to marijuana use (stage 2), and finally to illegal drugs (stage 3).
Reasons for Use

<table>
<thead>
<tr>
<th>Type</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>Curiosity &quot;to see what it's like&quot; once or twice</td>
</tr>
<tr>
<td>Social</td>
<td>Use during social activities with one or more friends</td>
</tr>
<tr>
<td>Medicinal</td>
<td>To relieve unpleasant emotional state such as sadness, anxiety, stress</td>
</tr>
<tr>
<td>Addictive</td>
<td>Dependency either physical or psychological</td>
</tr>
</tbody>
</table>

Which adolescents use more frequently? Which adolescents tend to be healthier psychologically? What are implications of each type of use? What types of prevention strategies might work best for each type?

Reasons for Use: Personality

<table>
<thead>
<tr>
<th>Type</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>Sensation seeking (disinhibition and experience seeking)</td>
</tr>
<tr>
<td>Social</td>
<td>Sociability and extraversion</td>
</tr>
<tr>
<td>Medicinal</td>
<td>Shyness and social anxiety Shyness X Sociability interaction</td>
</tr>
</tbody>
</table>

- Santesso et al.: Best predictor of substance use and related behaviors (absenteeism, truancy etc) among US and Cdn University students was sensation seeking

Delinquency & Crime

Delinquency – when “juveniles” commit crimes:

1. **Status** Offences – only a violation of the law because committed by juvenile
   - E.g., Failure to attend school, buying alcohol, etc
2. **Index** Crimes – serious crimes at any age
   - Violent Crimes (assault, rape, etc)
   - Property Crimes (robbery, theft, etc)
3. **Non-index** Crimes – less serious offenses such as gambling, disorderly conduct

Age and Crime: Males

![Figure 13.7](image)

Year: 1842

Year: 1977

What pattern do you see? What factors might account for this pattern?
Two Types of Delinquency

(Moffit, 2003; Wilson & Herrnstein, 1985)

**Life-course-persistent delinquents (LCPDs)**
- Pattern of problems from birth on up
- Originate in neuropsychological deficits (temperament, learning disabilities)
- Likely to grow up in high risk environment (low income, parents have problems)
- Criminal activity continues after adolescence, more later life problems (financial, substance use, etc)

**Adolescent-limited delinquents (ALDs)**
- No signs of problems in infancy or childhood
- Period of occasional criminal activity between ages of 12–25 (e.g. vandalism, illegal drug use)

Discussion: Moffit’s ALDs

Why do adolescents with no history of behavior problems in childhood suddenly become antisocial in adolescence?

How are they able to spontaneously recover from an antisocial life-style within a few short years?

Preventing Crime & Delinquency

- Prevention programs for children who show signs of risk for LCPD and for adolescents engaging in serious delinquency
- Varied Strategies

Two problems with prevention programs:
1. Participation is typically non-voluntary or against one’s will; do not see themselves as having problem
2. Prevention comes too late (in adolescence) after behavior patterns have been established
   - Resources go to where problem is most obvious but not root

Success of Multisystemic Therapy

- Intervene at several levels: home, school, neighbourhood
- Parent training, job training, vocational counseling, development of neighborhood activities and centers – directing the energy of delinquents in positive directions

![Bar chart](image-url)
Model of factors related to risk behaviours

“Socialized” vs. “unsocialized” delinquent

Culture and Risk Behavior

Death Rates

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Levels of Depression

- Depression is an enduring period of sadness:
  - Depressed mood:
  - Depressive syndrome:
  - Major Depressive Disorder:

- Most common internalizing problem in adolescence
- Rates of depressed mood rise steeply from age 10-17 then decline in late teens and 20s

MDD Checklist

- Depressed/irritable mood most of the day
- Lack of pleasure; reduced interest in activities
- Weight loss or gain
- Insomnia or oversleeping
- Slowed motor movements
- Low energy or fatigue
- Feelings of worthlessness or guilt
- Difficulty concentrating, making decisions
- Recurrent thoughts of death/suicidal ideation

*Five or more from the above for 2-week period

Causes of Depression

- Depressed mood = conflict with friends or family; disappointment or rejection in love; poor performance in school
- More serious forms of depression = both genetic and environmental influences

Diathesis-stress model

- Preexisting vulnerability or potential for problems (likely genetic; e.g., higher concordance in identical than fraternal twins)
- Expression of vulnerability from environmental conditions (e.g., stress)

Diathesis-Stress model

What sort of stresses bring out the diathesis for depression in adolescents?
Are there gender differences in depression?
Treating Depression with CBT

CBT recognizes that depression is characterized by negative attributions, and a belief that the situation is permanent and uncontrollable.

- Catastrophizing
- Filtering
- Personalizing
- Overgeneralization
- Emotionalizing
- All-or-none thinking

Suicide: Facts

- Common cause of death ages 15-19 after motor vehicle accidents and homicide (US)
- Americans grades 9 to 12, 24% report thinking of suicide, 3% attempt
- Suicide rate for US teens is 4 times the rate in the 1950s
- Higher rates in Canada and the U.S. than other countries (high where guns are available)
- Rates are higher in White adolescents and emerging adults; highest among Native American youth
- Females 4 times more likely than males to attempt; males more likely to succeed
- Attempts: Higher rates of depression in females
- Actual suicide: Males use more deadly methods (guns, hanging)

Suicide: Risk Factors

- Risk factors:
  - Depression
    - Usually when symptoms are abating (more energy, can plan)
  - Family disruption
    - Conflict/abuse, neglect, chaotic and disorganized
    - Often family disruption worsens months before suicide
  - Substance abuse problems
    - Self-medication
  - Relationship problems outside family
    - Rejection from peers, academic failure
  - Result of series of difficulties over time
    - Not in response to single stressful event
    - Rare there are no warning signs over months/years

Identify, debate, correct irrational ideas:

1. Is there any evidence for this belief?
2. What is the evidence against this belief?
3. What is the worst that can happen if you give up this belief?
4. What is the best that can happen?

Relapse is less likely after CBT treatment than drug treatment.
Eating Disorders

- Anorexia Nervosa – intentional self-starving
- Bulimia Nervosa – binge eating and purging

Puberty and body changes
- changes the way teens think about their own bodies and how others respond

Evidence of cultural roots
1. ED more common in cultures that emphasize thinness as the ideal
2. More common among upper and middle socioeconomic classes
3. Occurs most often among females in teens and early 20s when cultural pressures to conform to ideal is strongest
4. Girls who read magazines like “Seventeen” are more likely to strive for thinness
- Females most likely have other internalizing problems exist (e.g., depression, anxiety)

Resilience: Protective Factors

- Most adolescents who grow up in high-risk environments exhibit resilience – good outcomes despite difficult circumstances
- What are some protective Factors that promote resilience?

How can adolescents help themselves?
Emerging adulthood has been proposed as a key period for the expression of resilience because unlike children and adolescents, they have the ability to leave a high risk family environment. Unlike older adults, they have not made the commitments that will structure their adult life (Arnett, 2004).

**What decisions/opportunities exist during emerging adulthood that could promote resiliency?**