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Editorial

Does adolescents' psychopathology change in times of change?

Adolescent psychopathology is integrally shaped by the daily contexts in which they grow and develop. We experience many societal changes during the last decade (such as immigration; economic crisis, delay of markers of adulthood and a prolonged dependence on parental support), which may result in a change in the pattern of psychopathology. Further, comorbidity, especially with depression and anxiety, has become the rule and makes it increasingly difficult to design therapeutic approaches which apply for these youth. This calls upon new diagnostic tools which go beyond the diagnosis (e.g. the symptom level) and help in planning and conducting a treatment as well as evaluating its outcome. Changes in parental behavior are also noteworthy during recent decades with increasingly more inappropriate parenting; it needs to be explored whether this has an impact on psychopathology of the offspring. It is yet unclear in which way the new media have changed the psychic structure or led to new disorders. Further, we need to be more sensitive to gender- and culture-specific issues in all questions concerning psychopathology in adolescence. In the following, I will present research pointing to these changes and will discuss some of the consequences of these changes for psychopathology, treatment and future research.

1. Changes during adolescence and the window of vulnerability

To grasp the importance of adolescence psychopathology, it is crucial to understand this developmental period. Adolescence typically is defined as beginning at puberty, a physiological transformation that gives boys and girls adult bodies and alters how they are perceived and treated by others as well as how they view themselves. Body changes were frequently related to depressive mood, especially in girls (Brooks-Gunn, Graber, & Paikoff, 1994). A further central concern are identity issues, as identity formation is a core developmental challenge for adolescents (Erikson, 1968). Adolescents' attempts to establish more mature, egalitarian relationships with their parents often result in conflictual, stressful interactions (Branje, van Doorn, van der Valk, & Meeus, 2009). Adolescents' relationships with peers likewise change dramatically, as marked by the emergence of more intimate friendships based on trust and loyalty and the involvement in romantic encounters (Noakes & Rinaldi, 2006). Peer rejection is considered as quite stressful (Sentse, Lindenberg, Omvlee, Ormel, & Veenstra, 2010), and these stressors may add to the stress experienced in parent-adolescent relationships, a finding replicated in adolescents from many countries in the world (Persike & Seiffge-Krenke, 2014). In addition, several studies substantiated an increase in depression in adolescent girls involved in romantic relationships and, further, a change in externalizing behavior as a function of dating involvement (Zimmer-Gembeck, Siebenbruner, & Collins, 2001). Thus, although body changes, identity concerns, changes in close relationships and romantic involvement are normative, they can bring considerable stressors and thus compromise health.

In recent years, there is concern about how the social media might alter close relationship, resulting in larger and less intimate peer networks (Tong, Van Der Heide, & Langwell, 2008). Cyberbullying has enormous health consequences; the anonymity of the offender and the large group of the silent audience makes it difficult to protect an individual adolescent. Parent-child relationship are also altered by new media; adolescents are increasable at home, but" far away". Family meals became less frequent (Betts, Gullone, & Allen, 2009), and a distant parenting style and dysfunctional emotion regulation have been found as predictors of adolescent depression (Berge, Wall, Neumark-Sztainer, Larson, & Story, 2010).

Adolescence is also a time for first experiences of various kinds: being out of direct control of parents, exploring alcohol and drugs, staying away from home, first sexual experiences and, for some, the transition from school to work. In the process of taking these developmental steps towards independence, adolescents make decisions and develop habits of lifelong implications for their health and well-being. Patterns begun during adolescence, both enhancing and compromising behavior, often carry through adulthood (Tiede Call et al., 2002; Schulenberg, Sameroff, & Ciccetti, 2004). Drugs and drinking are a concern in many families caring for an adolescent.

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Adolescence is not only a time of change in the individual adolescent, changes in parenting behavior and societal changes further add to the challenges adolescents have to cope with (Bynner, 2002; Laursen & Collins, 2004). Compared to earlier decades, current life conditions for adolescents in most Western, industrialized countries, particularly in Europe and North America, were characterized by extended years of schooling and new career options (Arnett, 2004; Furlong & Cartmel, 1997). Growing occupational uncertainties are a concern for many youth in Western industrialized countries (Schoon & Silbereisen, 2009). Adolescents in other parts of the world may be experiencing political unrest, face unclear future options or live in poverty (Pat-Horenczyk et al., 2009; Tiede Call et al., 2002). Adolescents in many countries may be confronted with new kinds of job opportunities and limitations. In addition, they may be unable to receive support from adults (Côté, 2002), who, due to rapid societal changes, may not be in a position to adequately provide knowledgeable guidance. Cross-cultural research established that adolescents in many parts of the world have become much more worried about their educational progress, because success in school largely determines their professional outcomes (Seiffge-Krenke et al., 2012).

The health implications of these changes are enormous. Adolescents who struggle with the challenges and develop psychopathology may not only be compromised in their current health, psychopathology is associated with adverse outcomes in terms of education, social integration, economic prospects and future health. To give two examples: Adolescents who develop an internalizing disorder are at higher risk for early school leaving (Melkevik, Nilsen, Evenson, Reneflot, & Mykletum, 2016) with a higher risk of economic hardship and dependency on parents or the welfare system. Adolescents with externalizing symptoms and problematic alcohol use have, in the long run, a higher probability of criminal outcomes in young adulthood (Aebi, Giger, Plattner, Winkler Metzge, & Steinhausen, 2013) and difficulty to leave the non-adaptive track.

2. Decrease or increase in psychopathology?

Adolescence is also a transitional phase for the development of psychopathology. Many symptoms appear for the first time during adolescence (such as personality disorders and eating disorders); other symptoms intensify (such as depression) and many continue into emerging adulthood (Roberts, Roberts, & Xing, 2007). Thus, there is stability and change in psychopathology during the adolescent period. Continuity and change coexist in the same developmental period.

Although the co-occurrence of stability and change in adolescent psychopathology has been established since decades, the societal, economic and familial changes indicated above give space to the question whether overall psychopathology (or specific disorders) in adolescence have increased or decreased during recent years.

Research on the prevalence of mental disorders affecting adolescents has expanded during recent years, but an answer to this question is not easy, due to several reasons. For one, prevalence rates, as a rule, are given for children and adolescents together, as the current diagnostic tools like DSM V or ICD 10, and most questionnaires like CBCL or YSR, are developed for the ages 6 to 18. Thus, most research does not allow for an independent estimating of prevalence rates for adolescents. Second, indicators of stability and change such as mean level change or rank-order consistency have frequently been used interchangeable in diverse studies. Third, the diagnostic tools used are heterogeneous and make the findings frequently incomparable. For example, the administration of a clinical interviews (such as CAPI) and of self-report questionnaires (such as YSR or BDI) render different results with prevalence rates based on clinical interviews being as a rule, higher than those based on self-report measures.

Polanczyk and coworkers (2015) conducted a meta-analysis to calculate the worldwide prevalence of mental disorders in children and adolescents. Based on a systematic literature review on 41 studies from 27 countries from every world region, they reported a pooled prevalence of 13, 4% (range 11–18%). Specifically, the world wide prevalence for anxiety disorder was 6, 5% for depressive disorder was 2, 6%, for attention deficit hyperactivity disorder was 3,4% and for disruptive, antisocial disorder was 5,6%. These findings matches with earlier research of the Achenbach group which uses the Youth Self-Report (YSR; Achenbach, 1991), limited to adolescent samples in 24 countries (Rescorla et al., 2007). Of note, both these findings refer to community samples and are based on questionnaire data.

The question remains, however, whether the overall psychopathology scores during adolescence have increased or decreased during recent years or whether, on the base of more or less stable overall prevalence rates, there are subtle changes in specific disorders. The findings are mixed. Although the overall rate of self-reported psychopathology during adolescence has not changed, as nationwide (see, for example, Barkmann & Schulte-Markworth, 2012) and cross-cultural comparisons over time show (Rescorla, Ivanova, Achenbach, Bergovac, & Chahed, 2012), there seemed to have occurred, on the clinical level, changes in specific disorders: traumatic diseases, eating disorders, self-harm, antisocial and delinquent behaviors are on the increase, but not in all countries. In Sweden and the Scandinavian countries, for example, antisocial behavior and delinquency have decreased the last 15 years (Dodge, Coie, Lynam, 2006) and some aggressive behaviors required a reclassification.

Despite the prosperity in the West, increases in the prevalence rates in certain mental health problems of adolescents such as depression, suicide, and eating disorders were seen during the last half of the 20century (Tiede Call et al., 2002). Similarly, reviews of trends in psychopathology across adolescence in the 21. century showed increases in rates of depression, panic disorders, agoraphobia, and substance abuse; with anxiety disorders and depression showing continuity towards emerging adulthood (Costello, Copeland, & Angold, 2011). Judging from hospital statistics, self-harm has greatly increased in frequency in adolescents, with further rise seen in female adolescents in Germany, the US and in the UK since 2000 (Hawton, Saunders, & O'Connor, 2006; Plener, Liba, Keller, & Fegert, 2009). In recent years, an increase of identity pathology has been noted in several disorders, most noticeably in personality disorders (Schmeck, Schlüter-Müller, Foelsch, & Doering, 2013), Thus, in the framework of seemingly overall stable total prevalence rates, there seem to be subtle changes in certain disorders and, what is more, changes in the symptomatic expression within certain disorders. Cyberbullying, binge drinking, date rape and extreme forms of self-cutting seem to suggest a change towards