Developmental Psychopathology

FROM INFANCY THROUGH ADOLESCENCE

THIRD EDITION

Charles Wenar

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DEVELOPMENTAL PSYCHOPATHOLOGY
From Infancy through Adolescence

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PREFACE

PROGRESS IN DEVELOPMENTAL PSYCHOPATHOLOGY

It is gratifying to note how quickly the 1990 edition of *Developmental Psychopathology* has become dated. This is a sure sign of vitality. However, we are dealing with more than sheer energy—we are dealing with progress. This revised edition provides comprehensive coverage of these exciting new developments:

Developmental psychopathology—conceptual and empirical advances. The basic premise of the developmental approach to understanding childhood disorders was established as symbiotic relation between normal and abnormal development, each nourishing the other and neither being a comprehensive account of development without the other. Our own formulation of psychopathology as "normal development gone awry" epitomizes this interdependence. Once this basic idea was established, however, such phrases sounded too general to be satisfactory. What was needed was a more *differentiated conceptualization* of how the interdependence operated to result in normal development on the one hand, and psychopathology on the other. The concepts of *risk* and *protective factors* currently fill this need. It is the dynamic interplay between the two that determines whether development will follow a normal or deviant course and, in the latter case, if there will be a return to normality.

Empirically there is now sufficient data to chart the *developmental pathways* of a number of psychopathologies. Such pathways provide information as to which variables at which developmental periods deviate from their normal course as well as the nature of such deviations. Often there is also information concerning risk factors responsi-

ble for the deviations. Our knowledge of protective factors however is still limited.

Finally, there has been some progress in understanding the *models* that account for deviant development. *Precocity* has been added to the traditional psychopathologies of timing—fixations, lags, and regression—while the idea that deviant development is *qualitatively different* from normal development appears more frequently than before.

Multideterminism. The previous edition marked the shift from thinking in terms of a single cause for a given psychopathology to thinking in terms of multiple causes. All too often, however, this shift resulted in a mere listing of possible determinants as if such a list were a satisfactory solution to the etiological mystery. Currently, there are a number of attempts to *integrate* the data in terms of the relative importance of the etiological variables as well as the interaction among them. At times this integration is conceptual, at times statistical, and, in the ideal cases, a combination of the two.

Understanding specific disorders. As would be expected, this edition documents the conceptual and empirical progress in understanding specific disorders, e.g., the importance of *theory of mind* for autism, of *coercion theory* for conduct disorder, and for *attachment theory* for depression and abuse.

BROADENING THE SCOPE OF DEVELOPMENTAL PSYCHOPATHOLOGY

In addition to making progress, the scope of developmental psychopathology has been broadened. The following topics receive particular attention in the current edition.

Comorbidity. The co-occurrence of two or more psychopathologies was once regarded as an irritating methodological confound to be swept under the rug of research. Now investigators realize that comorbidity frequently occurs and needs to be understood in its own right. Because the realization came so recently, however, there is much to be learned about the nature and reasons for comorbidity.

Multiculturalism. The sheer number of ethnic minority children has forced clinical child psychologists to pay special attention to them and their mental health needs. Much of the literature concerns providing services congruent with their particular ethnic background. However, there is also a growing interest in the implications of cultural diversity for the question of what constitutes normal and deviant development.

Problem behavior. While not new, the trend of broadening clinical child psychology to include nonpsychopathological conditions continues. For example, *emotional maltreatment* has been added to physical and sexual abuse, and *depressed mothers* to the list of deviant parenting. While not falling within traditional diagnostic categories, the children

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are sufficiently distressed and dysfunctional to be of concern to the clinical child psychologist.

Assessment. Two major developments in assessment are the appearance of *DSM-IV*, providing criteria for diagnosing mental disorders in infants, children and adolescents, and the revised definition of *mental retardation* published by the American Association on Mental Retardation. (The former will be presented in terms of the DSM-IV Draft Criteria [3/1/93] since the DSM-IV itself was not yet published.)

FOR THE STUDENT

The goal of the present edition has not changed—namely, to enable the student to "think developmentally" about childhood psychopathologies. However, visual material has been added for the first time along with summary charts of particularly complex findings. Review articles are often cited so students can have access to more detailed presentations of research than is possible within a given chapter. Also there are references to literature on topics which, while important, had to be excluded because of space limitations.

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Finally, I am grateful to the many reviewers of this edition. I was impressed by their thoughtfulness and thoroughness and profited greatly from their comments. In particular, I would like to thank the following individuals: Michael Alessandri, San Jose State University; Karen Bierman, The Pennsylvania State University; Ronda J. Carpenter, Roanoke College; Byron Egeland, University of Minnesota; Jon B. Ellis, East Tennessee State University; Per F. Gjerde, University of California

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And then there is Solveig, my loving helper, who is in a class by herself.

CHARLES WENAR

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THE DEVELOPMENTAL APPROACH

Chapter Outline

You are a clinical child psychologist.[1] *A mother telephones your office frantic over the sudden personality change in her boy. "He used to be so sweet and then, out of the clear blue sky, he started being sassy and sulky and throwing a fit if anybody asked him to do the least little thing. What really scared me was last night he got so mad at his brother, he ran at him and started hitting him with all his might. His brother was really hurt and started screaming, and my husband and I had to pull them apart. I don't know what would have happened if we hadn't been there. I just never saw anybody in a rage like that before."*

[1] This and subsequent sections will concern the experiences of a hypothetical clinical child psychologist. However, the experiences themselves might apply to any professional who is involved with the mental health of children. All names are fictitious.

What is the first question you ask?

You are at a cocktail party and, after learning that you are a clinical child psychologist, a former star-quarterback-turned-successful-business-executive takes you aside. After some rambling about "believing in sexual equality as much as the next fellow," he comes to the point. "Last week my son turned to my wife and announced that when he got old enough, he was going to become a girl. When my wife asked him where he got a crazy idea like that, he said that he thought boys were too rough, and he liked to be with girls more. I know he's always been a 'mama's boy,' but I'll be damned if I want any son of mine to have one of those sex changes done on him."

What is the first question you ask?

You are a clinical child psychologist conducting an initial interview with a mother who has brought her daugh-

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ter to a child guidance clinic. "She has always been a sensitive child and a loner, but I thought she was getting along all right—except that recently she has started having some really strange ideas. The other day we were driving on the highway to town, and she said, 'I could make all these cars wreck if I just raised my hand.' I thought she was joking, but she had a serious expression on her face and wasn't even looking at me. Then, another time she wanted to go outside when the weather was bad, and she got furious at me because I didn't make it stop raining. And now she's started pleading and pleading with me every night to look in on her after she has gone to sleep to be sure her leg isn't hanging over the side of the bed. She says there are some kind of crab creatures in the dark waiting to grab her if her foot touches the floor. What worries me is that she believes all these things can really happen. I don't know if she's crazy or watching too much TV or what's going on."

What is the first question you ask?

The first question is the same in all three cases: *How old is your child?*

OVERVIEW

Our general concern is with time—or, more precisely, with change over time.

Our specific charge is to understand psychopathological disturbances of childhood.

Our procedure will involve placing various psychopathologies within a developmental context and examining them as instances of *normal development gone awry.*

The three vignettes illustrate this procedure. Whether the described behaviors are regarded as normal or pathological depends upon when they occur in the developmental sequence. All three are to be expected in toddlers and preschoolers but would be suspect at later ages. It is not unusual for a docile infant to become a willful, negativistic, temperamental tyrant during the "terrible twos." If the child were 10, however, his attack on his brother may well represent a serious lapse in self-control. In a like manner it is not unusual for preschool boys to believe that they can grow up to be women because they have not grasped the fact that sex remains constant throughout life. If an adolescent boy seriously contemplated a sex change, this would be cause for parental concern and professional attention. And finally, ideas of omnipotence and a failure to clearly separate fantasy from reality are part of normal cognitive development in toddlers and preschoolers; their presence from middle childhood on suggests the possibility of a serious thought disturbance and an ominous lack of reality contact.

The vignettes also provide us with our first clue to understanding child psychopathology as normal development gone awry: psychopathology is behavior which once was but no longer can be considered appropriate to the child's level of development. This was one of Freud's most brilliant and influential insights. The general thesis that adult disturbances have their roots in childhood continues to be a pervasive etiological hypothesis accepted even by those who reject all other aspects of Freudian theory. We shall make use of the same developmental hypothesis but apply it within childhood itself. As we examine various psychopathologies, we shall discover that there are many variations on this theme of psychopathology as developmentally inappropriate behavior; therefore we shall constantly be seeking the specific *developmental model* that best fits the data at hand. We shall also come across some unexpected exceptions for which the model itself does not seem to hold.

At the applied level, the developmental approach underlies the child clinician's deceptively simple statement, "There's nothing to worry about—most children act that way at this age, and your child will probably outgrow it"; or its more ominous version, "The behavior is unusual and should be attended to, since it might not be outgrown." A considerable amount of information concerning normal de-

velopment must be mastered before one can judge whether the behavior at hand is age-appropriate, as well as whether a suspect behavior is likely to disappear in the course of a child's progress from infancy to adulthood. In addition, the child clinician must know which frankly psychopathological behaviors stand a good chance of being outgrown with or without therapeutic intervention and which are apt to persist.

Incidentally, to state that behavior is outgrown is not as much an explanation as a label for ignorance. While certain psychopathologies tend to disappear with time, exactly what happens developmentally to cause their disappearance is not known. In fact, the phenomenon has rarely been investigated. The best we can do is to recognize that "outgrown" is a nonexplanation.

Before we set out to understand child psychopathology as normal development gone awry, there are a number of preliminary matters to be attended to. First, we must present a *general developmental model* in order to examine various characteristics of development itself. Then we must select those *variables* that are particularly important to the understanding of childhood psychopathology and trace their normal developmental course. Our vignettes, for example, suggest that the variables of self-control, sexual identity, and cognition should be included in the list. We shall also have to select the *theories* that will contribute most to the developmental approach. Next, we shall turn to a descriptive account of the *behaviors comprising childhood psychopathology,* since these are the behaviors we must understand in terms of our developmental perspective. And, finally, we must examine *longitudinal studies* that have followed groups of normal and disturbed children into adulthood, since these studies will provide a general guide as to which psychopathologies are apt to persist and which are likely to be outgrown.

A General Developmental Model

Our general developmental model includes the time dimension along with intrapersonal, interpersonal, superordinate, and organic variables. These five categories will be referred to as *contexts.*

Time Since our general concern is with change over time, our task would be simpler if there were agreement as to how change should be conceptualized. There is not.

Some psychologists anchor change in chronological time. Gesell is a prime exemplar, since he links crucial behavioral changes to chronological age. In tracing the child's relation to the parents, for example, he describes age 6 as a time of high ambivalence toward the mother, cravings for affection being followed by tantrums and rebellion. Age 7 is calm and inward, the child being companionable, sympathetic, anxious to please. Age 8 is stormy again, with the child demanding the mother's attention while being exacting, rude, and "fresh," while 9 marks a return to self-sufficiency, eagerness to please, and affectionate behavior. And so it goes (Gesell et al., 1946).

A different way to conceptualize change is in terms of *stages* of development, Piaget's cognitive theory and Freud's psychosexual theory being two prominent examples. Stage theories are more concerned with change itself than with chronological age. Typically they make two assumptions: stages represent qualitative reorganizations of behavior rather than "more of the same"; and the sequence of stages is unalterable. Thus, something new emerges at each stage, and the order of emergence is fixed. For both Piaget and Freud, the question "How old is the child?" is not as important as "What stage is the child in?" Fortunately for the clinician, the stages they depict can be assigned chronological age guidelines.

The conceptualization of change over time

is of more than academic interest. A characteristic of stage theories is that they often regard the transition between stages as a time of increased tension, unrest, and even reversion to less mature behaviors. The psychosexual stages have this characteristic, while Piaget describes the child's return to immature ways of thinking during cognitive transitions. Even Gesell, whose maturational theory does not include specific stages, describes development in terms of periods of unstable expansion alternating with ones of stable consolidation. All such conceptualizations stand in contrast to radical environmentalism, which claims that stability or instability is primarily the consequence of the experiences the child is having. The important point for us is that normal development may entail built-in times of stress and upset; the transitions from infancy to the preschool period and from middle childhood to adolescence, for example, are two potentially stressful periods. Knowing when disturbed behavior is part of normal growth helps the clinician decide when to tell a parent, "Most children act like that, and yours is likely to outgrow it."

There is another aspect of the time dimension. Our developmental approach implies that in order to evaluate the meaning and import of an event in a child's life, it is essential to know not only *what* happened but also *when* it happened. To illustrate: a lengthy separation from the mother may have few adverse effects in early infancy before an attachment to her has developed but may trigger a dramatic reaction of protest and extreme withdrawal after an attachment has been formed. Being hospitalized becomes progressively less upsetting between 2 and 12 years of age and also may have different meanings, the younger children being distressed over separation, the 4- to 6-year-olds fearing mutilation or death or viewing hospitalization as punishment. Whether obese adults regard their body with disgust or not depends, among other things, on whether they were obese during adolescence, a period when body consciousness is at a height.

It is also widely believed that events happening in the first few years of life have a more lasting effect on development than events happening subsequently. However, this so-called critical-period or sensitive-period hypothesis has not gone unchallenged and is viewed with a certain amount of skepticism (see Clarke and Clarke, 1977). While the controversy over the critical or sensitive period will play only a minor role in our presentations, we will not accept either hypothesis as a universally valid principle of human development. Rather, we prefer to test its validity in regard to the particular aspect of development under discussion.

The Intrapersonal Context The intrapersonal context will figure most prominently in our discussions of psychopathology, since it contains the greatest amount of developmental data. However, here, as with the context of time, we are confronted by the problem of how best to conceptualize the individual child. Once past the obvious variables of age and sex, in what direction should we go? Traditional behaviorists would persuade us to deal exclusively with manifest behavior and to avoid all mentalistic or inferential concepts; Freudians urge us to examine the child's ego strength and monitor the battles between id and superego; Piaget reminds us not to neglect egocentrism and the balancing act between assimilation and accommodation; Erikson points to the centrality of ego identity; and Werner insists on the importance of differentiation and hierarchical integration. (The technicalities of the various theories need not concern us here. However, it would be helpful to have the kind of general familiarity with the major developmental theories to be found in introductory texts in child development. See, for example, Berk, 1991.)

The choice among conceptualizations has

important clinical implications. The behavioral viewpoint leans toward a statistical and social approach to psychopathology. Since there is nothing in behavior itself which designates it as abnormal, the judgment must be based on its infrequency or on the fact that a given society chooses to label certain behaviors as psychopathological. In another society the same behavior might go unnoticed or even be regarded as a special gift.

The psychoanalysts, on the contrary, maintain that behavior is important only as it furnishes clues to the child's inner life; psychopathology is not a matter of behavior per se, but of the meaning of such behavior. The frequency of masturbation in adolescence, for example, is not as important as the stage-appropriateness of the fantasies which accompany masturbation.

Because our primary goal is to understand rather than to champion a particular conceptualization of the intrapersonal context, we shall utilize various theories only as they throw light on the psychopathology at hand. Such eclecticism assumes that no one theory offers a satisfactory account of all of childhood psychopathology, while various individual theories are apposite in accounting for specific disturbances.

The Interpersonal Context Interpersonal variables are concerned with interactions among individuals. Of all such interactions, the parent-child relationship will figure most prominently in our discussions since it is assumed to be the most important in determining normal or deviant development and has been most thoroughly investigated. We will be interested in different normal patterns of parenting and the children's behaviors associated with them as well as in such pathological extremes as neglect and physical and sexual abuse. Peer interactions also play a significant role in normal and deviant development, although their importance has only recently been recognized. Here we will deal with such positive relations as popularity and friendship and their negative counterparts such as rejection and isolation. While sibling and teacher-child relationships fall within the interpersonal context, their relation to psychopathology has rarely been investigated.

The Superordinate Context Superordinate variables deal with aggregates of individuals taken as a unit, such as the family, the group, social class, culture. The study of the family as a unit, for example, has yielded a number of provocative hypotheses concerning the difference between normal and disturbed functioning. The group will concern us when we discuss the contribution of the gang to delinquent behavior and substance abuse. Cultural differences lie at the heart of our discussion of ethnic minorities and the stresses they must cope with. The role of social class in general and poverty in particular in producing psychopathology will also concern us.

The Organic Context The organic context involves various characteristics of the human body that are relevant to understanding deviant development: genetic material, variables involved in the body's structure and functioning with particular emphasis on the brain, and factors determining those innate individual differences called temperament.

The organic context should not be equated with the psychological representation or experience of the body; this belongs in the intrapersonal context. The two are clearly distinct: many physiological processes do not and cannot have any representation in consciousness; in the case of phantom limbs, pain is still felt in a toe that has been amputated; severe psychopathology may be marked by somatic delusions, such as believing that one's bowels are turning into stone.

The effects of psychological disturbances on

the organic body will be central to our examination of the eating disorders of bulimia and anorexia nervosa. Reversing the direction of influence, we will be concerned with the psychological consequences of physical illness and brain damage. We will also be concerned with the role genetic factors play in various psychopathologies and in various forms of mental retardation, one of which—Down syndrome—will be discussed in detail.

Interaction

We have been discussing the contexts as static entities. In reality, they are constantly interacting. The context of time interacts with all other contexts, which in turn interact with one another. Parents who are 25 years old when their daughter is born are not at the same stage in their development as they will be at 40 when she enters adolescence. In a like manner, the casual, improvised peer group of the preschool period differs from the adolescent clique, which vies with parents as the arbiter of taste in clothes, music, language, and social behavior. Being a member of the lower class in the socially stable 1950s had a different meaning than it did in the 1960s when riots and protests made the plight of the urban poor a matter of national concern. The social ferment of the 1960s has had other effects as well. The family as a social institution is being markedly changed by parents' willingness and need to place toddlers and preschoolers in day-care facilities, by the increasing number of working mothers, by the emphasis on negotiable rather than assigned parental roles, and by the increase in divorce and single-parent families. Our society has become increasingly tolerant of early sexual experiences and of couples living together without being married, while the emphasis on doing "your own thing" has broadened the spectrum of acceptable behavior. All these changes have an impact on what parents and professionals alike regard as normal or deviant development.

The changes described above are well known. Not so well known is the fact that the concept of childhood itself is changing. In the pioneer days, children were workers and miniature adults; since they were born into sin, their parents were advised—often by the clergy—to beat the devil out of them. Quite a different image from our present one, with its emphasis on the uniqueness of childhood and the importance of child-centeredness on the part of the parents. (For a more detailed account, see Abramowitz, 1976). To cite another example: in 1874 a brutally abused, starving, and mutilated child named Mary Ellen received legal protection from her parents only after she had been legally defined as an animal so that the laws against animal cruelty could be applied to her. This is a far cry from the current concern for children's rights; in Sweden, for example, corporal punishment is against the law and a child has the right to have a parent arrested for spanking him or her.

Just as the concept of childhood is changing, so is the concept of childhood psychopathology. Some changes have come from within the profession, such as Kanner's delineation of early infantile autism in 1943; others have resulted from social forces, such as the elimination of homosexuality as a psychiatric disturbance in 1974 which was spearheaded by pressure from gay activists groups, or the increasing interest in a multicultural perspective which was necessitated by the increasing number of minority children. The social ferment of the 1960s forced professionals to recognize that poverty vastly increases the risk of a variety of psychopathologies, thereby changing the course of the mental health movement from an individual to a community orientation. (See Chapter 17. For a comprehensive historical account, see H. E. Rie, 1971.) Thus, there is nothing final about the list of psychopathologies that will be introduced in Chapter 3. The list has changed and will continue to change in response both to theoretical and em-

pirical progress within the profession and to social pressures and values outside the profession. In fact, a consistent application of our developmental model requires that this be so.

In sum, our model entails the interaction of variables both at a given point in time and over time. This continual and progressive interaction among variables is called the *transactional* approach (Sameroff and Chandler, 1975). The model itself is presented schematically in Figure 1.1.

SPECIFIC MODELS OF CHILDHOOD PSYCHOPATHOLOGY

The model we have presented is designed to be general and comprehensive. It is intended to serve as a means of organizing what might otherwise be a bewildering array of variables used to account for a given psychopathology. It also is sufficiently general to embrace the specific models of psychopathology that we are about to present.

There are, at present, a variety of models of childhood psychopathology. While having distinctive features, the models are not necessarily incompatible. Some share common features. Others are complementary or tangential. Still others represent irreconcilable differences. Each has merit; none is totally satisfactory. Moreover, few efforts have been made to integrate them all, as there is tacit agreement that such a unification lies far in the future. Therefore we must reconcile ourselves to living with diversity and partial truths. In our own presentation of models, we will concentrate on those features that will be relevant to our subsequent discussion of various psychopathologies. For a more comprehensive coverage of models of psychopathology than we shall give, see Bootzin, Acocella, and Alloy, 1993.)

The term "model" is best interpreted as a frame of reference, since it has little of the precision and explanatory potency of models in the physical sciences, such as a model for the structure of the atom or the DNA molecule. Each model has its own concepts, often couched in terms of a specialized vocabulary, its own assumptions concerning which are relevant variables, its own view of etiology and remediation, and its own stand on the nature of scientific inquiry. In addition to its expected functions of organizing existing facts and generating new ones, a model of psychopathology must also serve the pragmatic function of being useful to the professionals concerned with understanding and remedying childhood disturbances.

The Medical Model

The medical model belongs in the organic context. Historically it was a step forward in the scientific study of psychopathology because it replaced the demonology of the Middle Ages. However, by its subsequent exclusion of all other etiological factors in the nineteenth century it became a roadblock to progress. Currently, the organic emphasis is more temperate and buttressed by a more substantial body of empirical findings than it was 100 years ago. The present-day medical model consists of two components. The first involves the general etiological hypothesis that certain psychopathologies result from organic dysfunctions. The second involves classifying and interpreting psychopathological behavior in the same way as physical diseases, namely, in terms of diagnostic entities.

Organic Etiology There is evidence that organic factors play a major role in certain kinds of adult schizophrenia and depression and in certain kinds of mental retardation and schizophrenia in children. Organic factors have also been implicated in the etiology of autism and in certain kinds of antisocial acting-out behaviors, hyperactivity, and learning disabilities in children, although the evidence varies in definitiveness. Thus, the list of psychopathologies having a possible organic etiology contin-

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