Jhomas M. Achenbach

Second Edition

# DEVELOPMENTAL LPSYCHOPATHOLOGYL

## DEVELOPMENTAL PSYCHOPATHOLOGY

Second Edition

## Thomas M. Achenbach

Departments of Psychiatry and Psychology University of Vermont



John Wiley and Sons, Inc.

New York

Chichester

Brisbane

Toronto

Singapore

Copyright © 1974 and 1982, by John Wiley & Sons, Inc.

All rights reserved. Published simultaneously in Canada.

Reproduction or translation of any part of this work beyond that permitted by Sections 107 and 108 of the 1976 United States Copyright

Act without the permission of the copyright

owner is unlawful. Requests for permission or further information should be addressed to the Permissions Department, John Wiley & Sons.

#### Library of Congress Cataloging in Publication Data:

Achenbach, Thomas M. 1940 – Developmental psychopathology.

Bibliography: p. Includes indexes.

1. Child psychopathology. 2. Adolescent psychopathology. I. Title.

RJ499.A32 1982 618.92'89 82-2838 ISBN 0-471-05536-0 AACR2

Printed and bound in the United States of America by Braun-Brumfield, Inc.

20 19 18 17 16 15 14 13 12 11

## **PREFACE**

In the first edition of this book, I tried to convey the basic concepts of a developmental approach to psychopathology. Although the relevance of these concepts seemed obvious, they were not generally evident in efforts to help troubled children. Since then, the study of child and adolescent disorders has become more sophisticated. New data have challenged old myths and unfounded assumptions, while specialized knowledge of several disorders has increased. These are signs of progress.

On the other hand, the flurry of activity evoked by certain topics often masks a need for closer links between the study of particular disorders and development in general. Interest in a momentarily fashionable disorder rises to a crescendo and then fades away, not because the problems are solved but because another disorder comes into vogue. An example is the shift of interest to childhood depression from what has been variously called minimal brain dysfunction (MBD), hyperkinesis, and attention deficit disorder. Although intensive research helped to dispel certain myths about MBD-hyperkinesis-attention deficit disorder, this research might have made a more basic contribution if it had shown how the disorder (if there is one) relates to other aspects of development rather than viewing it largely as a circumscribed disease entity.

The specifics of such disorders are discussed in Chapter 11, but the general point is that children and adolescents are programmed for change. They are continually changing in many ways at once. A developmental perspective shows specific disorders in relation to the individual's previous experience, the developmental tasks the individual faces, other problems and competencies the individual displays, and what is likely to happen in later developmental periods. For now, this perspective tells us more about where to look than what to find. But, even when interest inevitably shifts from one disorder to another, a developmental perspective may help us find links from which to forge a more enduring and unified approach to childhood and adolescent disorders.

However, a developmental perspective on psychopathology does not offer a ready-made theory or set of answers. Because disorders of childhood and adolescence are so diverse and multidetermined, we need help from multiple theories, none of which provides all the answers. Many of the theories, therapies, and findings considered in this book do not reflect a "developmental" approach. Yet, in

viii PREFACE

some areas, these "nondevelopmental" efforts may be the best we have at the moment. One of the challenges of a developmental view of psychopathology is to integrate various kinds of truth into a comprehensive picture of development and its deviations. Because we cannon yet weave all the important strands into a single, seamless whole, we must avoid dogmatic judgments about what is or is not "developmental."

This book is intended for readers acquainted with the basic concepts of general psychology, abnormal psychology, or developmental psychology. Chapters 1 to 7 deal mainly with the application of basic concepts to developmental psychopathology in preparation for more intensive concentration on specific disorders and interventions in Chapters 8 to 14. Chapters 15 to 17 presuppose familiarity with key concepts, specific disorders, and interventions. The book is organized so that it can be used as a main text in courses for advanced undergraduates, graduate students, and clinical trainees, but most chapters are sufficiently self-contained to be used alone.

For this edition, I have had the benefit of critiques from diverse perspectives on both development and psychopathology. I am deeply indebted to Professors William Kessen of Yale, Brendan Maher of Harvard, Fred Rothbaum of Tufts, and John Weisz of the University of North Carolina, who provided invaluable commentaries on the entire manuscript. I am also deeply indebted to Professor Barry Nurcombe, Director of Child, Adolescent, Family, and Community Psychiatry at the University of Vermont, who critiqued portions of the book, who debated the rest of it with me, and who facilitates the inquiry needed to advance our knowledge of the developmental course of psychopathology. To my wife, Susan, I offer my gratitude for the sacrifices this kind of effort entails.

Thomas M. Achenbach

## CONTENTS

1.	A DEVELOPMENTAL APPROACH TO PSYCHOPATHOLOGY	:
	Theories and Concepts Structure of the Book	1
	Summary	3
2.	HISTORICAL CONTEXT	10
	Early Theories of Mental Disorders	10
	The Twentieth Century	15
	Summary	29
	Suggested Reading	31
3.	PERSPECTIVES ON DEVELOPMENT	32
	The Biological Perspective	32
	The Cognitive Perspective	37
	The Social-Emotional Perspective	44
	The Educational Perspective	48
	Developmental Periods	50
	A Developmental Framework	66
	Summary	71
	Suggested Reading	72
4.	BASIC ISSUES IN DEVELOPMENTAL	
	PSYCHOPATHOLOGY	74
	On Doing Your Own Thing	74
	Conceptual Models for Psychopathology	78
	The "Whole Child" Issue	82
	Subcultural or Individual Deviance?	83
		-

ix

X CONTENTS

	What's Wrong?	86
	Etiology	86
	Prognosis: Curable or Incurable?	88
	Taxonomy	89
	Summary	94
	Suggested Reading	95
5.	SCIENTIFIC STRATEGIES	96
	Discovery and Confirmation	96
	Theories and Hypothetical Constructs	101
	Concepts of Causation	102
	Research Methods	103
	Explanation, Prediction, and Control	112
	Summary	116
	Suggested Reading	117
6.	GENETIC FACTORS	119
	Views on Human Behavioral Development	119
	Mechanisms of Genetic Transmission	122
	Genetic Contributions to Development	130
	Behavior Genetics	132
	Human Behavior Genetics	136
	Estimating Human Heritability	140
	Heritability of Personality	145
	Genetic Screening	149
	Summary	149
	Suggested Reading	150
7.	NEUROBIOLOGICAL DEVELOPMENT AND	
	DYSFUNCTIONS	152
	Prenatal Development	153
	Prenatal Risks for Neurobiological Development	155
	The Birth Process	159
	Postnatal Development	163
	Postnatal Risks for Neurobiological Development	171
	Some Disorders with Presumed Organic Etiologies	176
	Psychophysiological Disorders	184
	Some Psychophysiological Disorders of Childhood	186
	Psychopharmacology	191
	Summary	196
	Suggested Reading	198

CONTENTS xi

8.	INTELLECTUAL DEVELOPMENT AND		
	RETARDATION	200	
	The Assessment of Intelligence	203	
	Validity of IQ Tests	213	
	Long-Term Stability and Change in IQ	217	
	Organic Abnormalities Causing Retardation	220	
	Nonorganic Pathological Conditions Assumed to Cause		
	Retardation	224	
	Cultural-Familial Retardation	229	
	The Roles of Environment	239	
	Care and Education of the Retarded	248	
	Summary	255	
	Suggested Reading	257	
9.	PSYCHOANALYTIC APPROACHES TO		
	DEVELOPMENT AND		
	PSYCHOPATHOLOGY	259	
	Freud's First Theory of Neurosis	259	
	Freud's Revised Theory of Neurosis	265	
	The Ego and the Mechanisms of Defense	269	
	Later Trends in Ego Psychology	271	
	Erik Erikson's Theory of Psychosocial Development	274	
	Anna Freud's Developmental Profile	277	
	Other Outgrowths of Psychoanalytic Theory	281	
	Clinical Applications of the Psychoanalytic Approach	283	
	Types of Neurosis	284	
	Research on Psychoanalytic Views of Neurotic		
	Disorders	299	
	Research on Psychoanalytic Views of the Causes of		
	Neurosis	302	
	Research on the Effects of Psychoanalytic Treatment	311	
	Summary	312	
	Suggested Reading	313	
10.	BEHAVIORAL APPROACHES TO		
	DEVELOPMENT AND		
	PSYCHOPATHOLOGY	315	
	Conditioning	316	
	Early Behavior Modification	317	
	Later Developments	321	
	Wolpe's Psychotherapy by Reciprocal Inhibition	324	

xii CONTENTS

	Operant Approaches	330
	Aversion Therapy	335
	Implosive Therapy	337
	Social Learning Theory: Modeling and Imitation	340
	Cognitive-Behavioral Approaches	343
	Behavior Modification in Natural Environments	345
	Behavioral Approaches to Fears and Somatic Dysfunctions	349
	Evaluation of Behavioral Approaches	357
	Summary	362
	Suggested Reading	363
11.	DISORDERS OF SELF-CONTROL,	
	LEARNING, AND AFFECT	364
	Hyperactivity	365
	Enuresis	386
	Encopresis	392
	Disorders of Learning	394
	Disorders of Affect	398
	Summary	411
	Suggested Reading	413
12.	PSYCHOTIC AND OTHER PERVASIVE	
	DEVELOPMENTAL DISORDERS	414
	Early Interest in Childhood Psychosis	414
	Prevalence of Childhood Psychosis	417
	The DSM-III: Pervasive Developmental Disorders	418
	Infantile Autism	420
	Schizophrenia and Other Severe Disorders	439
	Treatment	452
	Summary	462
	Suggested Reading	464
13.	THE DEVELOPMENT OF AGGRESSIVE	
	AND DELINQUENT BEHAVIOR	465
	The Development of Aggression	466
	Patterning and Prevalence of Aggressive and	
	Delinquent Behavior	473
	Moral and Prosocial Development	476
	Juvenile Delinquency	480

CONTENTS	xiii

	Differences among Delinquents	482
	Socialized-Subcultural Delinquency	485
	Unsocialized-Psychopathic Delinquency	494
	Disturbed-Neurotic Delinquency	500
	Juvenile Delinquency among Girls	502
	Treatment	506
	Differential Treatment	513
	Prevention	516
	Summary	518
	Suggested Reading	519
14.	DRUG ABUSE	521
	Types of Drugs and Their Effects	522
	Licit Drugs	524
	Illicit Drugs	525
	Psychosocial Characteristics of Drug Abusers	533
	What should be done about Drug Abuse?	537
	Prevention of Drug Abuse	542
	Summary	544
	Suggested Reading	546
15.	TAXONOMIC ASPECTS OF	
	DEVELOPMENTAL PSYCHOPATHOLOGY	547
	The Diagnostic and Statistical Manual of Mental	
	Disorders	547
	The GAP Taxonomy	551
	Multivariate Approaches	553
	Other Approaches to Taxonomy	572
	Summary	574
	Suggested Reading	576
16.	DIAGNOSTIC ASSESSMENT OF	
	PSYCHOPATHOLOGY	577
	Assessment of Infant Development	579
	Assessment of Cognitive Functioning	580
	Assessment of Personality	585
	Assessment of Family Functioning	601
	Behavioral Assessment	603
	Assessment of Organic Dysfunction	614

ĸiv	CONTENTS

	Cultural Influences on Assessment	618
	Summary	620
	Suggested Reading	622
17.	ISSUES IN THE PREVENTION AND	
	TREATMENT OF PSYCHOPATHOLOGY	623
	Nondirective Play Therapy	623
	Group Therapy	626
	Conjoint Family Therapy	627
	Psychoeducational Approaches	631
	Community Mental Health Centers	636
	High Risk Groups	639
	Evaluating Interventions	644
	Summary	649
	Suggested Reading	650
EPI	LOGUE: WHERE DO WE GO FROM HERE?	652
REF	ERENCES	657
sou	URCE NOTES	731
NAN	ME INDEX	737
SUB	JECT INDEX	757

CHAPTER 4

## A Developmental Approach to Psychopathology

"This is a book about a field that hardly exists yet." So began the first edition of Developmental Psychopathology. It is both gratifying and frustrating to undertake a revision: Gratifying because more sophisticated research is expanding our knowledge of the developmental aspects of psychopathology; frustrating because the burgeoning literature on child and adolescent psychopathology continues to reflect problems that prompted me to write the first edition. It is also frustrating because the sheer volume of literature makes it harder to do justice to all the important findings while still exposing the gaps in our knowledge and pursuing alternative conceptions that go beyond current findings.

In stressing a developmental approach, I must point out that it is more a way of looking at problems than a total solution to the problems. Unlike the "simple and sovereign" theories of an earlier day, a developmental approach to psychopathology does not offer all-encompassing terminology or explanations. Instead, it poses questions about the developmental course of adaptive and maladaptive behavior, and it offers guidelines for answering these questions. As we will see, no one set of variables and no one theory holds all the answers.

There is not now (and probably never will be) a *single* developmental theory of all psychopathology. Instead, the role of a developmental approach is to help us understand troublesome behavior in light of the developmental tasks, sequences, and processes that characterize human growth. A developmental approach can shed light on all phases of the life cycle, but the dramatic changes occurring from birth to maturity make it especially crucial for understanding problems of childhood and

adolescence. The following case history illustrates the need for developmental perspectives.

#### JERRY C., JR.

Jerry was Mr. and Mrs. C's only child. He was born while Mr. C. was away on assignment as a foreman for a nationwide construction company. Mrs. C. was quite ill during pregnancy and the birth was difficult, but Jerry was reported to be in good condition at birth. Jerry's arrival was welcomed by his mother, who longed for company during her husband's frequent absences. Mr. C. was less happy about the birth but did favor naming Jerry after himself. Mr. C.'s career had been a sequence of ups and downs in which promotions earned through seniority were revoked after he disappeared on drunken binges.

Young Jerry was an exceptionally easy baby, usually quiet, placid, and affectionate, and his early development appeared normal. He crawled at eight months and walked at 14 months. His mother devoted a great deal of time to him, absorbing herself completely in caring for him when she became depressed during her husband's absences.

When Jerry had not begun speaking by the age of three, he was taken to a pediatric clinic for a complete medical checkup. Jerry was extremely upset by the medical procedures, but no organic abnormalities were found. An attempt at psychological testing failed because Jerry was too distractible to attend to the tasks. Intelligible speech was completely absent. Speech therapy was tried, but was given up after it appeared to have no effect.

Because Mrs. C. was also concerned about other children's teasing and refusal to play with Jerry, she applied to a child guidance clinic. She was put on the clinic's waiting list, but the family moved away from the area before she was given an appointment.

When Jerry was five, a school official inquired as to why he was not attending kindergarten. Confronted with the need for action, Mrs. C. brought Jerry to the pediatric clinic of another hospital. Here she was told he was retarded, that this was incurable, and that he should be taken to a state institution. Mrs. C. was extremely upset by this suggestion and applied instead to another child guidance clinic. The clinic had a seven-month waiting list, but Mrs. C. persevered.

By the time the C.'s were given an appointment at the clinic, Jerry had begun to speak and appeared able to read a number of words. Interviews with Mrs. C. showed that, while she was very threatened by the possibility of retardation, she had long recognized that her son was not normal. Jerry was not a problem at home. But, besides failing to speak, he showed little interest in other children, did not engage in games, and spent much of his time either watching TV or rolled up in a ball under a table in his favorite corner of the living room. Mrs. C. reported that Jerry displayed a phenomenal memory for TV commercials. To support her contention that he was not retarded, she also said that he read street signs along familiar routes. However, she acknowledged that his speech was difficult for anyone but her to understand.

When Jerry was first seen at the child guidance clinic, he was noted to be a solidly built boy, big for his age, with a pale, puffy, expressionless face, and very bright blue eyes. He showed no reluctance to separate from his mother. In the playroom, he walked around looking at various toys and uttering sounds in a singsong manner. When spoken to, he repeated the sounds of the therapist's voice, but words were almost entirely unintelligible. However, after several interview sessions, the therapist began to recognize words consistently distorted by the substitution of certain sounds for other sounds. Jerry mechanically read aloud and repeated words he saw printed in the building, such as "Fire Exit." He demonstrated a moderate-sized reading vocabulary by reading words printed by the therapist and words he found on the labels of games and toys.

Jerry soon made up his own abbreviation for the therapist's name, repeated it often at home, and seemed eager to come for his weekly appointments. However, he never engaged in conversation, tending instead to repeat over and over the therapist's name, his own name, TV commercials, and the names of places he had visited. His speech was often interrupted with peals of laughter. He also repeated words of the therapist, but scrupulously avoided using the first-person pronouns "I" and "me" and referred to himself only as "Jerry." He avoided looking the therapist in the eye and, though he seemed to like being hugged and tickled, he stood very rigidly and felt like a heavy inanimate object when the therapist lifted him.

Jerry showed exceptional speed, sensory-motor coordination, and dexterity on a nonverbal formboard test in which the child is to replace wooden geometric shapes in their proper openings. On a vocabulary test requiring the child merely to point to a picture corresponding to a word spoken by the examiner, Jerry obtained an IQ equivalent of 100, despite so little interest in the task that the examiner had to hold him and continually prod him to attend. When induced to draw a human figure, he drew one that scored slightly below average for his age according to standardized norms.

During therapy sessions, Jerry usually picked out a toy vehicle and lay rolling it on the floor, humming or echoing barely recognizable TV commercials. He occasionally drew maps of places he had visited and named the various streets on the maps. Sometimes he set up simple scenes with dolls in the doll house. Information from Mrs. C. showed that these were usually reenactments of rather routine events at home. Certain deviations from routine, such as the therapist's failure to wear a necktie, upset Jerry so much that he would not accompany the therapist. Jerry kept repeating, "Daddy leave necktie in Florida," a reference to a time when his father mentioned having left a necktie where he had been staying during his last job. Attempts to probe with Jerry his association between the tieless therapist and his father elicited only repetitions of "Daddy leave necktie in Florida." When the therapist donned a tie, Jerry resumed his usual cooperative behavior. Other changes in routine seemed to have no effect.

Since it appeared that at least some of Jerry's abilities were in the normal range, the therapist sought a school placement for him. His mother was asked to place him in groups of children whenever possible—such as Sunday school—in order to see how well he could mix with his agemates. While he seemed happy in these situations, he was content to watch the other children and did not interact with them in any way. Since the family could not afford private schooling, the public schools were asked to provide a homebound teacher who visited Jerry's home several times weekly. Arrangements were then made with an especially cooperative kindergarten teacher to have the homebound teacher accompany Jerry to a kindergarten class for an hour a day. Jerry expressed eagerness to go to school and the homebound teacher, who had never been comfortable with Jerry, soon asked to withdraw.

In kindergarten Jerry played by himself and did not partake of group activities, although he did conform to the teacher's instructions and occasionally surprised her with his reading skill and knowledge of maps. After a year of negotiations with the school system, Jerry was admitted to a special class for the emotionally disturbed. Here his social isolation continued, but he showed some academic progress.

Meanwhile, Jerry's father quit his job and deserted the family, although he occasionally called from distant places or reappeared unexpectedly, always promising to mend his ways. Mrs. C. tried to make a new life for herself without her husband, but she now had to depend on public welfare, which barely provided subsistence for her and Jerry. Jerry responded to his father's disappearance by becoming preoccupied with mailboxes and telephones, the sources of the occasional messages from Mr. C. He also talked of Mr. C. and showed affection whenever he reappeared. Jerry's speech and academic skills continued to improve slowly, but, after several years in the special class, it appeared that he was destined to remain significantly handicapped academically as well as socially. He was especially unable to take everyday responsibilities such as crossing streets.

Jerry is not typical of all children needing help, but he illustrates the need for developmental understanding.

### **Obtaining Help**

Unlike adults, children almost never seek mental health services for themselves. Jerry would not have been seen for assessment or treatment if his mother had not sought it. He played no part in making the arrangements; his mother simply took him to the clinic. It was Mrs. C.'s perseverance during the seven-month wait for an appointment, rather than any discomfort on Jerry's part, that resulted in his eventually being seen. This is typical: Mental health services are usually sought for a child because of an adult's discomfort, and not the child's. And the adult's discomfort often results from an accumulation of problems rather than a single event.

Greater initiative is usually needed to get mental health services than other services for children—Mrs. C.'s odyssey included two hospitals, a speech therapist, contacts with school officials, and the waiting lists of two child guidance clinics before Jerry received treatment. Had she lived in other areas of the country, she might never have obtained services for Jerry. Once assessment and treatment finally began at the second clinic, she and Mr. C.—whenever he was available—had to accompany Jerry for interviews with a social worker during Jerry's weekly sessions over a period of two years. Parent motivation is thus a primary factor in continuing as well as obtaining treatment.

Most children lack realistic concepts of mental health services and many actively resist being taken for help. Their preconceptions are often conveyed by their parents. In Jerry's case, his mother had told him that the clinic was a "school," ostensibly to allay his anxiety.

When brought to a mental health professional, children do not readily assume the "patient" role that enables workers with adults to begin by asking clients about their problems. Young children are typically reluctant to leave their parents and go with a stranger, especially in the quasi-medical atmosphere of many mental health settings. It may have been significant that Jerry did *not* seem reluctant to separate from his mother, despite an unhappy previous experience with medical examinations and his general lack of social experience.

Even children suffering subjective discomfort are seldom able to tell a strange adult about it and its possible causes. Mental health workers must adapt to children's communication level and must rely on direct observations of their behavior and on data from other observers, such as parents and teachers. Because office contacts seldom elicit representative samples of children's behavior, it is usually essential to obtain data on behavior in other settings as well.

## **Family Functioning**

Because they are so dependent on their family, children's behavior is usually a more direct function of their family situation than adults' behavior. No families are without problems. Mrs. C.'s depression, Mr. C.'s erratic behavior, and the threatened, and then actual, breakup of the C.s' marriage were bound to affect Jerry. Did they cause Jerry's problems?

Jerry's gratifications and frustrations were intimately tied to those of his parents. Their ways of communicating, interacting, and meeting stress taught Jerry most of what he knew about human behavior. On the other hand, Jerry's birth changed the balance of his parents' marital relationship. When Jerry's abnormalities became apparent, Mrs. C. may have become so concerned that she withdrew from her husband, who then reacted with progressively more infantile behavior. Any biological vulnerabilities on Jerry's part may have been aggravated by the reactions he elicited from his parents. Rather than family problems directly causing Jerry's problems, it is thus more likely that a sequence of transactions between Jerry's characteristics and those of his parents shaped his behavior.

#### **Developmental Level**

Another essential difference between the study of child and adult psychopathology is the importance of developmental milestones. Mrs. C. first sought help when Jerry failed to speak by the usual age. Although she had previously noticed differences between him and other children, the contrast between his lack of speech and the speech of his agemates became so compelling that she could no longer deny the need for action. When no organic cause was found for his lack of speech, it was his failure to achieve another milestone expected for all children, entry into school, that prompted further action.

The onset of speech is a milestone established by the observed uniformity of

children's development. School entry is a milestone established by social custom. Both types of milestones are important for children's adaptive development. Jerry's delayed speech may have resulted merely from slow, but not defective, maturation of the speech areas of his brain. He may have begun talking later than average simply because of this one unusual characteristic of his biological makeup. Yet, his failure to talk at the typical age had broad ramifications for his social and intellectual development. Being ostracized by other children for his lack of speech may have caused him to withdraw from social relationships. This, in turn, could hinder development of the cooperative and competitive skills necessary for dealing with others. His handicap may also have evoked further overprotection from his mother, who desperately needed someone to hold close while her husband was absent and her marriage crumbling.

Failure to achieve the developmental milestone of school entry at the usual time has consequences of its own. Most children who start school late will be bigger than their classmates, which can lead to being ostracized. They may therefore develop coping strategies, such as withdrawal or physical force, that hinder further adaptation. When Jerry entered kindergarten, he was already bigger than his classmates. He was further distinguished by his lack of social skills and the special attention of the homebound teacher and regular teacher.

Just as a child's deviation from developmental norms is an important factor in getting parents to seek help, precise comparison with developmental norms is an essential part of diagnostic assessment. Jerry's poor speech led the physician in the second pediatric clinic to diagnose Jerry as mentally retarded and to recommend referral to an institution for the retarded. However, subsequent assessment showed that his sensory-motor functioning, understanding of words, and drawing skills were within the normal range for his age. Uniform mental retardation was not, therefore, an appropriate diagnosis, despite Jerry's deviant speech and social functioning.

Although the question of mental retardation may sometimes arise in the assessment of adults, adults already have a long history of development that includes important developmental milestones. This history usually indicates the adult's attained level of development.

While it was not clear why Jerry's speech and social behavior were so deviant, he seemed to have the cognitive ability to acquire academic skills. Unlike adult treatment, which aims to facilitate self-understanding and remove discomforting symptoms, interventions with children must help them reach developmental milestones and acquire needed skills without which they will be forever handicapped, no matter what the other outcomes.

## **Diagnostic Assessment**

Traditional diagnostic practices are oriented toward identification of diseaselike entities in adults, such as schizophrenia and hysteria. Yet, children's problems