Thomas M. Achenbach

Second Edition

DEVELOPMENTAL PSYCHOPATHOLOGY

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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

some areas, these "nondevelopmental" efforts may be the best we have at the moment. One of the challenges of a developmenttal 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

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CHAPTER 1

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