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EDITION

PSYCHOPATHOLOGICAL DISORDERS OF CHILDHOOD

QUAY & WERRY

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PREFACE TO THE THIRD EDITION

The considerable difference in the organization of this third edition as compared to earlier editions is a function of the continuing expansion of knowledge in the field of child psychopathology. Accumulated information as to the characteristics, correlates, and consequences of the major "broad-band" disorders necessitated that these disorders be discussed in separate chapters. Thus, data from epidemiological and follow-up studies previously considered in separate chapters have been incorporated into these chapters.

While efficacy data remain scarce, a chapter in psychotherapies has been added which reviews the extant literature and highlights research problems in the area as well. The chapter on community interventions is entirely new and has been expanded to deal with prevention as well. A new chapter on social and ecological factors in childhood disorders has also been added. Only the chapter on residential treatment remains much as it was in the second edition; very little has happened in this area in recent years.

Our original focus on critical review of the research literature continues. Fortunately, the quality of research, as well as its quantity, continues to improve. Case descriptions and uncontrolled "research" are fading from the scientific scene as well they should.

Finally, research into the role which biological factors may play in all disorders is clearly on the upswing and is likely to come even more to the fore in the late 1980s.

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HERBERT C. QUAY

INTRODUCTION

Scientific understanding is, in large measure, the ability to describe precisely the functional relations between entities or events. The ability to set apart such entities or events from one another and to describe their properties in terms of observable phenomena is a precursor to understanding the relations between them. In abnormal psychology, the entities (disorders) that need to be understood in terms of their etiologies, responses to differing forms of treatment, and prognoses have not been easy to describe. The complexities and dynamic nature (especially in children) of human behavior and the crude state of our observational techniques have all contributed to the difficulty of describing (and measuring) those disorders that must form the essential elements of a science of childhood psychopathology.

Furthermore, the need for a classification of disorders as well as the process of classification of children has often come under attack. Since there has historically been little agreement as to what disorders in fact exist and perhaps even less agreement on the utility of diagnosis, the whole enterprise has sometimes been considered to be of doubtful utility if not actually damaging to children. There has, however, been a marked resurgence of interest in the classification of psychopathological disorders in both adults and children in the last decade and an increasing recognition of the need for a taxonomy of disorders.

Blashfield (1984) has enumerated the following purposes that can be served by a good classification system: (1) It may provide a *nomenclature* necessary for communication among people working in the field—a basic set of terms is needed to describe the various disorders of concern. (2) It may also furnish a basis for *description and information retrieval.* Knowing that a child has a certain disorder should tell one about the likely symptoms, prognosis, and best treatment. We must note, however, that the descriptions and the information retrieved are almost always less than ideal in both quantity and quality as regards psychopathological disorders. (3) A good

classification system may also provide a basis for making *predictions*. Knowing that a child has a particular disorder should enable us to predict that he or she should have other concomitant behavioral features, perhaps as yet unobserved, and is likely to manifest certain forms of behavior in the future. Again, we note that our predictive ability falls far short of perfection in the case of most disorders of childhood and adolescence. (4) Finally, and in our view most importantly, a system of classification can provide the basic concepts for *theory formation* about etiology, pathology, prognosis, and response to treatment. We cannot research disorders that we cannot describe and set apart from other disorders. As we noted above, we can never arrive at a scientific understanding of any specific disorder until we can describe it accurately and determine how it is different from other disorders.

Historically, there have been two competing points of view in regard to the classification of psychopathological disorders. The "class or categorical model" common in pathology holds that the disorder is either present or absent; it cannot vary in amount, and all, or nearly all, symptoms must be present before the disorder itself can be considered to be present. This view also holds that disorders are mutually exclusive; a person cannot be both psychotic and neurotic at the same time. On the other hand, the "quantitative model" conceives of a disorder as a group of symptoms with the number of symptoms present being the measure of the intensity of the disorder. This model assumes that symptoms form a dimension or continuum of disorder and that all individuals have a place on this dimension; that is, all persons possess the disorder to a lesser or greater degree. This quantitative or dimensions model also recognizes that, since the basic dimensions are independent, an individual can have, at the same time, features, to a greater or lesser degree, of more than one disorder. (See Blashfield, 1984; Lorr, 1961.)

CRITERIA FOR EVALUATING A CLASSIFICATION SYSTEM

The degree to which a classification, or taxonomic, system of behavioral abnormality will serve those purposes just described is a function of the extent to which it satisfies the criteria by which any system for the classification of behavior must be evaluated. First and foremost, those features said to constitute the category or the continuum must be clearly described and operationally defined. Then it must be demonstrated that those features exist as a cluster of covarying characteristics, observable with regularity in one or more situations by one or more methods of observation. Without the reasonably objective definition of those characteristics delimiting the patterns and without empirical demonstration that they generally occur in company with one another, the stage is set for the system to fail on most of the remaining criteria.

Another critical requisite is reliability. The assignment of an individual to a discrete category or to a place on a continuous dimension must be reasonably consistent. Agreement should occur between different ways of measuring the disorder or between clinicians viewing the individual at the same

time. Assignment of the individual to a category or a relative position on a dimension should also be stable over reasonable time intervals. Since reliability sets a ceiling on validity, questions about reliability are extremely critical for any classification system.

An additional important criterion is validity. This is a complex concept and can be assessed in different ways. At the very least, however, the patterns should be discriminable from one another and should demonstrate coherent relationships with variables other than those initially used to define them. Validity will finally determine the extent to which the system can adequately serve those functions of nomenclature, information retrieval, description, prediction, and theory building.

There are three other criteria that, while not so crucial, are nevertheless of concern. Completeness is a factor to be considered. A system of describing child psychopathology should not consistently be embarrassed by the occurrence of clearly pathological children who do not fit any of the existing patterns. At the same time, parsimony is equally desirable. Whereas the ultimate in completeness may be a system in which a multitude of subgroups are defined by a single symptom or characteristic, the best classification system should have no more subcategories than are necessary to produce maximum reliability and validity.

Finally, as nearly as possible, the patterns should be mutually exclusive. Ideally, cases should be assignable to one category only. While the complex nature of human behavior sometimes may make one wonder about the feasibility of assigning an individual to one and only one subgroup, multiple assignments obviously lessen the degree of orderliness that classification initially seeks to enhance.

CLINICALLY DERIVED CLASSIFICATION SYSTEMS

Historically, diagnostic categories have evolved out of the observations of clinicians working with disordered individuals on a day-to-day basis where the immediate requirements have seldom permitted systematic investigation. The clinician notices the regularity with which certain characteristics apparently occur together and conceptually "abstracts these out" as comprising a diagnostic entity. These various entities then gain some degree of consensual validation, again in the clinical setting, and subsequently become codified into a classification system. One of the more persistent difficulties is that the development of these clinically derived systems is essentially hypothesis formation, and few such systems have escaped the direct transmutation of hypothesis into accepted dogma. Usually it is authority, not proof, that is the benchmark.

DSM-III

The most widely used classification system for psychopathological disorders in North America is set forth in the *Diagnostic and Statistical Manual,* third edition (DSM-III), published by the American Psychiatric Association in

1982. This system is the "official" one in the United States and its categories are used for reporting of disorders to government health agencies, for categorizing the mentally ill in various official reports, for other administrative purposes, as well as for treatment and research. In addition to providing descriptions and diagnostic criteria for major syndromes (Axis I) and minor (Personality and Specific Developmental) disorders (Axis II), the system also provides for listing of information as to concomitant physical disorders (Axis III), associated stresses (Axis IV), and premorbid level of functioning (Axis V).

With respect to DSM-III as a classification system for psychopathological disorders of childhood, we are most concerned with the categories of Axis I devoted to "Disorders usually first evident in infancy, childhood, or adolescence" (pp. 35-99).

We note here that criticism of this section of DSM-III is not new; there was considerable published criticism even before the final version appeared in print (e.g., Garmezy, 1978; Schact & Nathan, 1977; Zubin, 1978). These early critiques dealt with a variety of issues including whether or not the various syndromes constituted mental disorders and/or medical conditions, the issue of medical control of diagnosis and treatment, and the effects of labeling. Most of these concerns were subsequently discussed by Rutter and Shaffer (1980) in the context of a much broader critique of the published version (see also Achenbach, 1980). Millon (1983) has responded to many of the criticisms raised. While these issues may be relevant to both the clinical and administrative uses of DSM-III, as may a host of problems associated with Axes II, III, IV, and V (see Garmezy, 1978; Rutter & Shaffer, 1980), the critical scientific question, and our major concern, has to do with the adequacy of Axis I DSM-III as a taxonomy of psychopathology in childhood and adolescence.

An analysis of the childhood and adolescence section of DSM-III as a classification system for childhood disorder is complicated by the fact that any of the adult disorders may also be used to diagnose children and adolescents. Thus, while no disorder of depression appears in this section, depression in children may be diagnosed using any one of the adult depressive disorders.

Table 1.1 sets out the major disorders (disorders with physical manifestations excluded) and provides a very brief listing of major characteristics associated with each. A more detailed description of many of the disorders will be found in later chapters. We will return to a detailed evaluation of DSM-III after a brief discussion of two other clinically derived systems.

WHO Multiaxial Classification

Another clinical approach to classification has been developed for the World Health Organization (Rutter et al., 1969; Rutter, Shaffer, & Shepherd, 1975). This system also looks upon the process of diagnosis as involving not only classification with regard to the nature of the disorder itself but

TABLE 1.1 *Major Diagnostic Categories of Axis I of DSM-III (Descriptions Abridged)*

Attention Deficit Disorder

Attention Deficit Disorder with Hyperactivity

Developmentally inappropriate inattention, impulsivity, hyperactivity

Attention Deficit Disorder without Hyperactivity

Developmentally inappropriate inattention, impulsivity but without gross motor overactivity

Conduct Disorder

Conduct Disorder, Undersocialized, Aggressive

Physical violence, thefts outside the home, failure to establish normal affective bonds

Conduct Disorder, Undersocialized, Nonaggressive

Chronic violation of rules, running away, lying, stealing, failure to establish normal affective bonds

Conduct Disorder, Socialized, Aggressive

Physical violence, thefts outside the home, evidence of social attachment

Conduct Disorder, Socialized, Nonaggressive

Chronic rule violations, running away, lying, stealing, evidence of social attachment

Anxiety Disorders of Childhood

Separation Anxiety Disorder

Excessive anxiety on separation from major attachment figures or familiar surroundings

Avoidant Disorder of Childhood or Adolescence

Persistent and excessive shrinking from social contact with strangers interfering with social functioning

Overanxious Disorder

Excessive worrying and fearful behavior not focused on a specific situation or objection

Other Disorders of Infancy, Childhood, or Adolescence

Reactive Attachment Disorder of Infancy

Poor emotional and physical development due to inadequate caretaking

Schizoid Disorder of Childhood or Adolescence

Defect in capacity to form social relationships, very limited peer relations

Elective Mutism

Continuous refusal to speak despite ability to speak and comprehend

Oppositional Disorder

Disobedient, negative, and provocative opposition to authority figures

Identity Disorders

Uncertainty about goals, career, friendships, sexual orientation and behavior

Pervasive Developmental Disorder

Infantile Autism

Lack of responsiveness to others, gross impairment in communication skills, bizarre responses to environment, developing before 30 months of age

Childhood Onset Pervasive Developmental Disorder

Profound disturbance in social relations and multiple oddities of behavior developing after 30 months but before 12 years

with regard to the associated intellectual level, biological factors, and associated or etiological psychosocial influences.

Excluding psychotic disorders, this system recognizes eight major categories and eight subcategories of specific developmental disorders that are seen as true psychopathological disorders rather than deviations from normal development as in DSM-III; this system also recognizes categories of psychosomatic disorder and personality disorder and a set of other clinical syndromes that include confusional states, tics, and anorexia nervosa. Here the three categories of greatest interest are Hyperkinetic Syndrome (a subcategory of Specific Developmental Disorders), Conduct Disorder, and Neurotic Disorder; brief descriptions of these are also provided in Table 1.2.

It is interesting to note that this system recognizes that legally delinquent behavior may arise "naturally" out of a cultural milieu and, thus, may not necessarily be abnormal; in fact, there is no equivalent category to the two socialized conduct disorders of DSM-III.

The WHO system is also the only approach that does not try to differentiate disorders of anxiety, dysphoria, and social withdrawal into subcategories with the recognition that: "Most neurotic disorders in children are less differentiated than are neuroses in adults, and even when disorders could be specified as some particular subvariety of neurosis, it was uncertain whether this subdivision had much clinical meaning or much predictive value" (Rutter et al., 1969, p. 47).

International Classification of Diseases (ICD-9)

Although this system does not, on principle, provide for different classifications for different age-groups, there are provisions for disorders that occur only at particular age periods. The ICD-9 provides for five categories (excluding a category of psychosis with origin specific to childhood, which is found in the adult section) of disorders relevant to children and adolescents. There are nine subtypes of neurotic disorders that are described similarly for adults, children, and adolescents, eight special symptoms or syndromes including most of the disorders listed under the specific developmental disor-

TABLE 1.2 *Major Diagnostic Categories of the World Health Organization Classification System (Descriptions Abridged)*

Hyperkinetic Syndrome
Poorly organized and poorly regulated extreme overactivity, distractibility, short attention span and impulsiveness, mood fluctuations and aggression
Neurotic Disorder
Includes states of disproportionate anxiety and depression, obsessions, compulsions, phobias, hypochondriasis, and "conversion hysteria"
Conduct Disorder
Includes some types of legally disturbed delinquency and nondelinquent disorders of conduct (e.g., fighting, bullying, destructive behavior, cruelty to animals). The behavior must be abnormal in its sociocultural context.

ders (Axis II) of DSM-III, and nine adjustment reactions of a transient nature. There are also three categories, Disturbance of Conduct, Disturbance of Emotions Specific to Childhood and Adolescence, and Hyperkinetic Syndrome of Childhood, that are of greater interest here and are listed and briefly described in Table 1.3.

The Common Elements

By and large, all of the major clinical approaches provide for separate categories covering attention-deficit (or hyperkinetic), undersocialized aggressive, socialized aggressive, and anxiety-withdrawal-dysphoria disorders.

TABLE 1.3 *Major Diagnostic Categories of ICD-9 (Descriptions Abridged)*

Hyperkinetic Syndrome of Childhood

Simple Disturbance of Activity and Attention

Short attention span, distractibility, overactivity without conduct disturbance

Hyperkinesis with Developmental Delay

Hyperkinesis associated with speech delay, clumsiness, delay in academic skills

Hyperkinetic-conduct Disorder

Hyperkinesis associated with conduct disturbance but not developmental delay

Disturbance of Emotions Specific to Childhood and Adolescence

With Anxiety and Fearfulness

May include school refusal, elective mutism

With Misery and Unhappiness

May include eating and sleep disturbance

With Sensitivity, Shyness, and Social Withdrawal

Relationship Problems

May include sibling jealousy

Other or Mixed

Unspecified

Disturbance of Conduct Not Elsewhere Classified

Unsocialized Disturbance of Conduct

Defiance, disobedience, quarrelsomeness, aggression, destructive behavior, tantrums, solitary stealing, lying, teasing sibling

Socialized Disturbance of Conduct

Holds values of delinquent peer groups to whom they are loyal; stealing, truancy, staying out late at night

Compulsive-conduct Disorder

Disorders specifically compulsive in nature, kleptomania

Mixed Disturbance of Conduct and Emotions

Behaviors of either unsocialized or socialized conduct disorders but with considerable emotional disturbance, anxiety, misery, or obsessive neurotic delinquency

With regard to "hyperactivity," DSM-III places emphasis on the attention deficit and subdivides according to whether or not hyperactivity is an accompanying feature. The WHO system considers hyperkinesis as a separate subcategory of developmental disorders, whereas ICD-9 recognizes three separate hyperkinetic syndromes. There is clearly little agreement among these approaches as to the categorization of attentional deficits and motor overactivity.

There is some agreement in regard to the separateness of undersocialized and socialized conduct disorder, though DSM-III recognizes unaggressive subtypes of both, and ICD-9 provides for both compulsive and neurotic forms of conduct disturbance.

With respect to anxiety, dysphoria, and social withdrawal, DSM-III provides for two subcategories involving anxiety and one involving shyness, while ICD-9 differentiates between disorders involving anxiety and fear, misery and unhappiness, and shyness and social withdrawal. The success with which a syndrome involving anxiety, social withdrawal, and dysphoric mood can be empirically differentiated into three, or even two, subcategories is not at all certain, as will be indicated later in this chapter.

An additional comparison of the various features of DSM-III and ICD-9 may be found in Werry (1985). Finally, mention may be made of two other clinically derived approaches, that of the Group for the Advancement of Psychiatry (1966), which has been superseded by DSM-III, and the California I-level System (see Sullivan, Grant, & Grant, 1957; Warren, 1969), which has been limited in its applicability to juvenile delinquents (see Chapter 15).

MULTIVARIATE STATISTICAL APPROACHES TO CLASSIFICATION

Those espousing a quantitative view of behavior disorders have approached the problem of classification in a way that has obviated many of the difficulties associated with the clinical method. This approach utilizes statistical techniques that isolate interrelated patterns of behavior; it was first used by Ackerson (1942) and Hewitt and Jenkins (1946), who analyzed case histories of problem children for the conjoint appearance of certain behavioral characteristics. Although their methodology was unsophisticated by today's standards, the findings of Hewitt and Jenkins (1946), the more definitive of the two early investigations, have been generally supported by later research.

These investigators began with a pool of 500 case records of children who had been referred to a Chicago child guidance clinic for some behavioral problem. They noted the presence or absence of 45 behaviors in each of the case records and then calculated the joint occurrence of each. A further analysis of the intercorrelations among the behavior traits was then performed by visual inspection. The purpose of this analysis was to determine

those traits that occurred together, thus forming clusters or syndromes of deviant behavior. Three primary behavioral syndromes were identified and were labeled the unsocialized aggressive, the socialized delinquent, and the overinhibited child.

Fifty-two children were classified as unsocialized aggressive, 70 as socialized delinquent, and 73 as overinhibited. The number of multiple classifications was small but, as these figures reveal, only about two-fifths of the 500 children could be designated as representative of any of the three major syndromes. This failure to be able to classify over three-fifths of the sample illustrates a problem that arises when one uses behavior dimensions as if they were discrete categories—a problem that will be discussed in greater detail later in this chapter. Nonetheless, Hewitt and Jenkins (1946) were successful in establishing that a variety of problem behaviors were subsumable by only three patterns—one of behavioral inhibition, anxiety, and withdrawal, and two of differing forms of aggression.

A much later study by Peterson (1961), which has served as a model for much additional work, is an excellent illustration of the use of a more sophisticated methodology. Peterson began by carefully considering the need for an adequate sampling of the many behaviors of children that could be considered deviant. This sampling was an important step, since behavior traits not included obviously could not appear in any patterns that might be isolated. Over 400 representatively selected case folders from the files of a child guidance clinic were inspected, and the referral problems of each child were noted. Eliminating overlap and selecting on the basis of relatively frequent occurrence, 58 items descriptive of deviant behavior were chosen and compiled into a checklist. A sample of 831 grammar school students in kindergarten through sixth grade were then rated by their teachers on this problem checklist.

The intercorrelations among all the items were obtained and this matrix of intercorrelations was subjected to further study by means of factor analysis. This statistical technique enables one to isolate clusters of behaviors (or other variables) that are interrelated and thus form a coherent behavioral dimension. A factor loading, which is a numerical expression equivalent to a correlation, reveals the extent to which a particular behavior is related to the dimension.

Peterson's (1961) results indicated that the interrelations among the 58 items could be resolved into two independent clusters, which he called "conduct" problem and "personality" problem. Thus, Peterson demonstrated that the vast majority of problem behaviors in public school students could be accounted for by two major dimensions: essentially one of aggression and one of withdrawal. Furthermore, each child could be placed somewhere on these two dimensions according to the number of problem behaviors related to the dimension that the child manifested. It is important to note that in this instance children differ in quantity but not in quality; the normal and abnormal differ only in degree.

Advantages and Disadvantages of Statistical Approaches

In the building of a classification system, the statistical approach clearly obviates two of the basic weaknesses characteristic of the clinical approach. First, empirical evidence is obtained showing that the dimension in fact exists as an observable constellation of behavior. Second, as will be discussed later in this chapter, the relatively objective nature of most of the constituent behaviors utilized in the statistical analyses permits reliable measurement of the degree to which a child manifests the dimension.

This approach is not, however, without pitfalls of its own. One criticism, which has been applied to the technique of factor analysis in general, is that "If something does not go into the analysis, it cannot come out." This simply means that a dimension not represented by its constituent behavior traits in the analysis cannot possibly emerge from the analysis. Neither can a dimension be identified unless there is an intercorrelation of *some* subset of behaviors, since this intercorrelated subset, in fact, constitutes the dimension. Such intercorrelation depends, at least in part, on the sample in which the behaviors are observed. In the Peterson (1961) study, for example, a dimension of behavior that might have been labeled "psychoticism" was not found. There clearly is such a syndrome (see Chapter 5), and its failure to emerge was a function of the fact that there were no behaviors related to it in Peterson's checklist, and there were no children manifesting the syndrome in the samples studied. Clearly, Peterson's method did not permit a dimension of psychoticism to emerge in his analysis. But such problems are by no means fatal to the development of a classification system; those deviant behaviors to be studied can be selected carefully for inclusiveness, and different samples of children can be systematically studied.

An additional criticism of the factor-analytic technique that is sometimes voiced is that the factors that emerge are dimensions of behavior—not types of individuals. This is true and, as we have already pointed out, Peterson's two dimensions are sets of behaviors that all children possess to varying degrees: a child is rarely "all problem" or "no problem."

A somewhat more serious and more complex problem for the establishment of descriptive systems based on multivariate statistical analyses has been the degree to which the methods of data collection and the settings in which the data are collected influence the results. Are the dimensions that result from different methods really the same? Categories arising from the analysis of behavior ratings may or may not be the same as those arising from the analysis of life history data even though they look the same. There is always some possibility that the method may produce the result. Peterson (1965a), for example, has suggested that the interpretive biases of those doing the ratings may be more reflected in the factors arising from behavior ratings than is the actual behavior of those being rated. It is also clear that the situation in which the behavior is observed influences whether the behavior does, in fact, occur. Yet, as Achenbach and Edelbrock (1978) have suggested, determining which ratings are predictive of other important variables is more important than trying to obtain high levels of agreement between raters.

Although it may be necessary to develop a particular method to assess a given behavior dimension as it may be observed in a particular setting (e.g., classroom), this complicates, but in no way invalidates, the meaningfulness of the dimension. It is the relationship of factorially derived dimensions of behavior, however measured, to etiological and treatment variables that give the dimensions psychological relevance. Clearly multivariate statistical approaches, although not without some associated difficulties, are the methods of choice for the construction of a descriptive behavioral taxonomy for disorders of childhood and adolescence. The techniques and results of multivariate studies have been reviewed earlier from somewhat different perspectives by Achenbach and Edelbrock (1978), by Dreger (1982), and by Quay (1979).

The analysis presented here is based on 61 studies spanning almost 40 years in which descriptors of behavior have been analyzed and factor loadings reported. Data have been obtained by behavior ratings, behavior observations, analyses of case histories, peer ratings, and self-reports. Informants have included parents, peers, teachers, child-care workers, corrections personnel, and mental health professionals. Samples have ranged in age from 3 to 18 years, both sexes have been included, and sample sizes in some studies have gone well into the thousands. Subjects have come from normal public school classes, special classes for the behaviorally disordered and learning disabled, retarded, and deaf, and institutions for delinquents, as well as hospitals and clinics.

It is important to recognize that matching the results of the different studies is not, by any means, perfectly straightforward. To determine whether or not one investigator's conduct disorder factor is the same as another's undersocialized aggressive factor, especially when the two contain few of the same variables in common, requires judgment on the part of the reviewer. Such judgment can, of course, be influenced by preconceptions of what ought to be. Since labels vary, the matching of factors from the various studies has been done on the basis of the actual behavior subsumed by the factors and only secondarily on the basis of the factor titles assigned in the original study.

A dimension most reasonably labeled Undersocialized Aggressive Conduct Disorder has emerged almost without exception. As can be seen from Table 1.4, the most frequently (those appearing in one-third or more of studies reviewed) associated behaviors are those generally considered as aggressive, disruptive, and noncompliant. It is of interest to note that both hyperactivity and restlessness frequently appear in this pattern. The association of the *behavior* of "hyperactivity" (not the putative *syndrome*) with this undersocialized aggressive conduct disorder dimension provided some of the evidence against the notion of the independent existence of a syndrome with motor overactivity (rather than attentional problems) as the central characteristic (see Chapter 4). It is also noteworthy that stealing has not been found at all central to this dimension, a finding which stands in contrast to the fact that "theft outside the home involving confrontation with