Amy Beth Taublieb

The Psychopathology of Childhood and Adolescence

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Preface

During my thirteen years of teaching undergraduate psychology courses, I was often called on to teach a class in child and adolescent psychopathology. Because much of my clinical practice is devoted to working with young people, this class was always one of my favorite teaching assignments. I was often frustrated, however, when looking for a good textbook to order for my students. Most of the books that were available assumed a developmental perspective. This approach would have been acceptable if crucial clinical topics had been addressed more than superficially. The only books that did contain the relevant clinical information were psychiatry textbooks, which unfortunately were not suitable for an undergraduate course. As I was bemoaning this situation to a publishing company representative at a psychology convention exhibition booth, he responded (I think halfheartedly), "Why don't you write one?" And so the story began.

As a clinician, I recognized the importance of integrating the clinical and developmental perspectives in this book. Indeed, a major part of my motivation for writing this textbook was to provide students with a sound clinical perspective. Writing, however, is a continuous process of learning, modification, and compromise, and my original "hard-line" clinical perspective metamorphosed into the developmentally informed clinical perspective presented here. Much of the content is based on the recently released *DSM-IV,* so this book is up to date in terms of its presentation of clinical material. Clinical information, however, is not limited to lists of diagnostic criteria. Each disorder is discussed in terms of clinical presentation, etiology, diagnostic criteria, assessment, epidemiology, and treatment approaches. Further, the symptoms of each disorder are conceptualized along the continuum of pathology to show how they vary according to the developmental stage of the child or adolescent patient. Further, to make this theoretical material more real to the reader, the chapters contain illustrative case studies.

Although the writing is extremely user-friendly, the tone is not at all condescending or superficial. Complex concepts are presented in a manner a lay reader can easily comprehend,

but the book is by no means too simplistic for graduate students, medical students, nursing students, or professionals. A glossary of these key terms which are boldfaced in text, is provided at the end of the book. "Think About It" boxes present the reader with thought-provoking questions based on issues in recent research and clinical practice.

All of this material is presented within a developmental context, with particular emphasis on how the various psychopathologies present themselves in children and adolescents. Because of this integrated approach, the reader does not have to choose between the clinical and developmental perspectives. Indeed, current trends in teaching in this field do not support the idea that the two different perspectives are mutually exclusive.

The text is written so that students do not have to take prerequisite courses in psychology. Thus, this book can be used across different disciplines, not just in psychology courses. In addition, to meet the needs of students for independent study, the pedagogical devices allow the reader (student, professional, or lay parent) to assimilate the material without formal class instruction.

To assist the instructor in using this text, a companion *Instructor's Manual* is available. The manual includes a bank of test questions, which have been tested on my own students; lecture suggestions with project/discussion ideas, supplemental resource materials; and when relevant, a discussion of potential pitfalls, concepts which, in my experience, have been difficult for students to grasp.

One Final Point

I hope that I have provided the reader as well as the instructor with a textbook that competently addresses the clinical and developmental issues relevant to the psychopathology of childhood and adolescence. The quality of this book has benefited from opportunities to "test-market" revisions on several undergraduate classes. Input from students as well as from many reviewers has contributed to making the final product a better one. I believe that this unique book will meet the needs of students at various levels, instructors, professionals who work with young people, and interested lay readers. To determine how well this text succeeds in these endeavors (and how it can better meet such needs in subsequent editions), I require feedback from you. If you are so inclined, please take a minute to drop me a line or give me a call with your reactions. Feedback from its readers can help the book continue to improve and achieve its maximum potential.

Acknowledgments

It seems appropriate to acknowledge those professionals whose input and expertise helped this text become a finished product. First and foremost, it was Catherine Woods (Acquisitions Editor at Longman) who read a prospectus and a sample chapter and was willing to take a chance with a first-time author and a controversial project. Her support and guidance were omnipresent throughout the project and will be remembered long after the first edition computer disks have been filed away! Catherine Woods' assistant Erica Smith also deserves acknowledgment for her efficient management of all the necessary details, which, at times, I am sure were more bothersome than rewarding! Finally, acknowledgment is due to the reviewers who offered their input at the various stages of manuscript development:

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Clearly, it was the thoughtful feedback of these professionals that contributed to the creation of the final product you hold in your hands.

Amy Beth Taublieb

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Chapter one
Conceptualization of the Psychopathology of Childhood and Adolescence

Introduction

When you hear the phrase "psychopathology of childhood and adolescence," what are some of your associations? Some people imagine a "crazy" child, screaming hysterically behind the thick doors of an insane asylum. Maybe you envision a sociopathic substance abuser in a maximum security prison, obsessively contemplating his next heinous crime. Or perhaps you focus on a recent newspaper report of a preteen suicide, and you wonder how anyone could be so depressed that she would desire to terminate her life. Indeed, the word *psychopathology,* especially when applied to children and adolescents, evokes powerful, emotionally laden imagery.

As we begin a formal study of the topic, however, we need to depend less upon free associations to define the topic and more upon factually based principles. First, look at this definition of the term *psychopathology:*

1. The science dealing with the causes and development of mental disorders.
2. Psychological malfunctioning, as in a mental disorder.

This definition from *Webster's New World Dictionary of the American Language* is adequate if it is assumed that there is an accepted definition of "mental disorders" or "psychological malfunctioning." If we agree on definitions of those two terms and apply these definitions to children and adolescents, the term *psychopathology of childhood and adolescence* is appropriately defined.

Like the term *psychopathology,* however, the phrases *mental disorder* and *psychological malfunctioning* both have several images associated with them. How can we arrive at a single definition we can use in rigorous scientific inquiry? Yet one consistency that does seem to prevail is the equating of *psychopathology* with what is considered to be "abnormal behavior."

Conceptualization of Abnormality

But are there agreed-upon definitions for *abnormal behavior?* Is there agreement as to whether any given behavior in which a child or adolescent engages is to be classified as abnormal? Is there a single set of criteria upon which all such decisions can be based?

There is, at least, general agreement that certain behaviors are "just plain weird." Some children and adolescents who demonstrate behaviors that others find to be aversive or strange are perceived as a bit odd or perhaps even abnormal. But what criteria can we use to classify a particular behavior as abnormal? The ideal set of criteria could be used to evaluate any behavior, and every evaluator would come to the same conclusion with respect to normalcy.

In fact, however, the current manner in which abnormal behavior is conceptualized depends on the particular theoretical framework(s) employed. Whether a professional is working with a troubled adolescent or an agitated 5-year-old, what is deemed to be abnormal depends on the theoretical perspective from which the case is approached.

Accuracy of Diagnosis

In order to properly evaluate any approach to defining abnormality we need to know whether the method can accurately detect the presence of psychopathology. For any given clinical situation, there is a range of four possible outcomes (see Table 1.1). Correct classifications can fit into one of two categories: diagnosing pathology when it is present (**true positive**) or correctly determining that no pathology is present (**true negative**). Similarly, erroneous classifications can fit into one of two categories: diagnosing pathology when none is present (**false positive**) or diagnosing an absence of pathology when it is actually present (**false negative**). As we explore various theoretical approaches to defining abnormality, we will evaluate their validity in different situations.

Table 1.1 Outcomes of Diagnosis

	Diagnosis	
Reality	**Pathology**	**No pathology**
Pathology	**True positive (accurate)**	**False negative**
No pathology	**False positive**	**True negative (accurate)**

The Statistical Approach

The statistical approach to defining abnormality involves assessing the probability that a given behavior will occur. Based upon the mathematical assumptions of the Central Limit Theorem, the statistical approach envisions all behaviors in terms of the frequency of their occurrence. This probability is represented by a frequency distribution referred to as the **normal** or **bell curve.** Figure 1.1 represents a frequency distribution, illustrating how often certain behaviors are likely to occur. The horizontal axis lists the behaviors in question, and the vertical axis represents the frequency with which the specific behaviors actually occur. Clearly, those behaviors represented along the middle of the curve are more frequent, while those represented at either end occur considerably less often. At either extreme of the curve, the behaviors can be conceptualized as also being more "extreme." Behaviors represented at the two extremes (at a greater distance than two standard deviations from the mean) are generally considered to be abnormal.

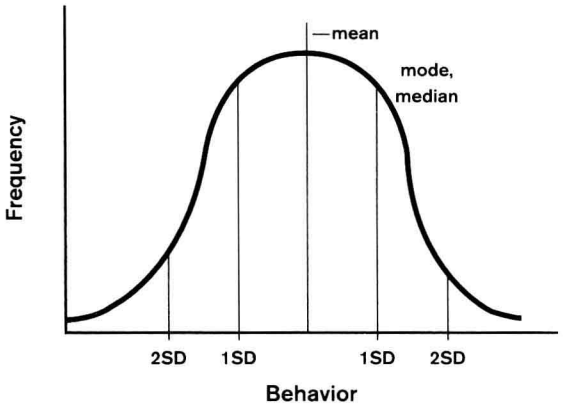

figure 1.1 Bell Curve: Frequency Distribution of Certain Behaviors
Behaviors represented at the two extremes are considered abnormal.

How can we use this information in the conceptualization of psychopathology in childhood and adolescence? To illustrate, consider 3-month-old Jenny, who cries whenever she is hungry. Is this behavior abnormal? More specifically, where is this behavior represented on the normal curve? We may not know the exact percentage of 3-month-old baby girls who cry when they are hungry, but we can safely assume that such behavior is very nearly universal. We can predict that this "hunger-crying" behavior would fall in the middle of the curve. Statistically speaking, then, the behavior in question would *not* be considered abnormal. By definition a frequently occurring behavior has a high probability of occurring in the population.

In contrast, consider 15-year-old John, who exhibits identical behavior. That is, whenever John feels hungry, he cries loudly, often screaming in a high-pitched voice. We know that such behavior is rare among healthy 15-year-olds in our population. Therefore, this example of "hunger-crying" behavior would fall in the tail of the frequency distribution—it occurs quite infrequently. Statistically speaking, then, a 15-year-old boy who cries whenever he is hungry would be considered to be "abnormal"; such behavior is relatively rare.

Other situations, however, are ambiguous. For example, the developmental literature reports that most children have a sense of gender identity at about 36 months of age. Thus, statistically speaking, we can say that it is normal for a child to be able to articulate his or her gender on or around the third birthday. Consider, however, the case of 2-year-old Pete, who is able to convince the clinician of a firm sense of gender identity. Operating from within a firm statistical framework, we would have to consider Pete's premature development of gender identity abnormal as its frequency is rather low.

Now consider the case of 2-year-old Ashley, who has no interest in stuffed animals or dolls. Rather, she carries a silver spoon from her grandmother's house, and she even sleeps with it. The developmental literature states that the majority of young children become attached to a special toy, usually a doll or animal, by 18 months of age. Ashley has never had such a relationship with a traditional toy. Statistically speaking, her behavior would be deemed abnormal.

Still another example is 8-year-old Brian, who has an IQ of 140. Using the statistical approach to defining pathology, Brian would be considered abnormal in this area, as his score