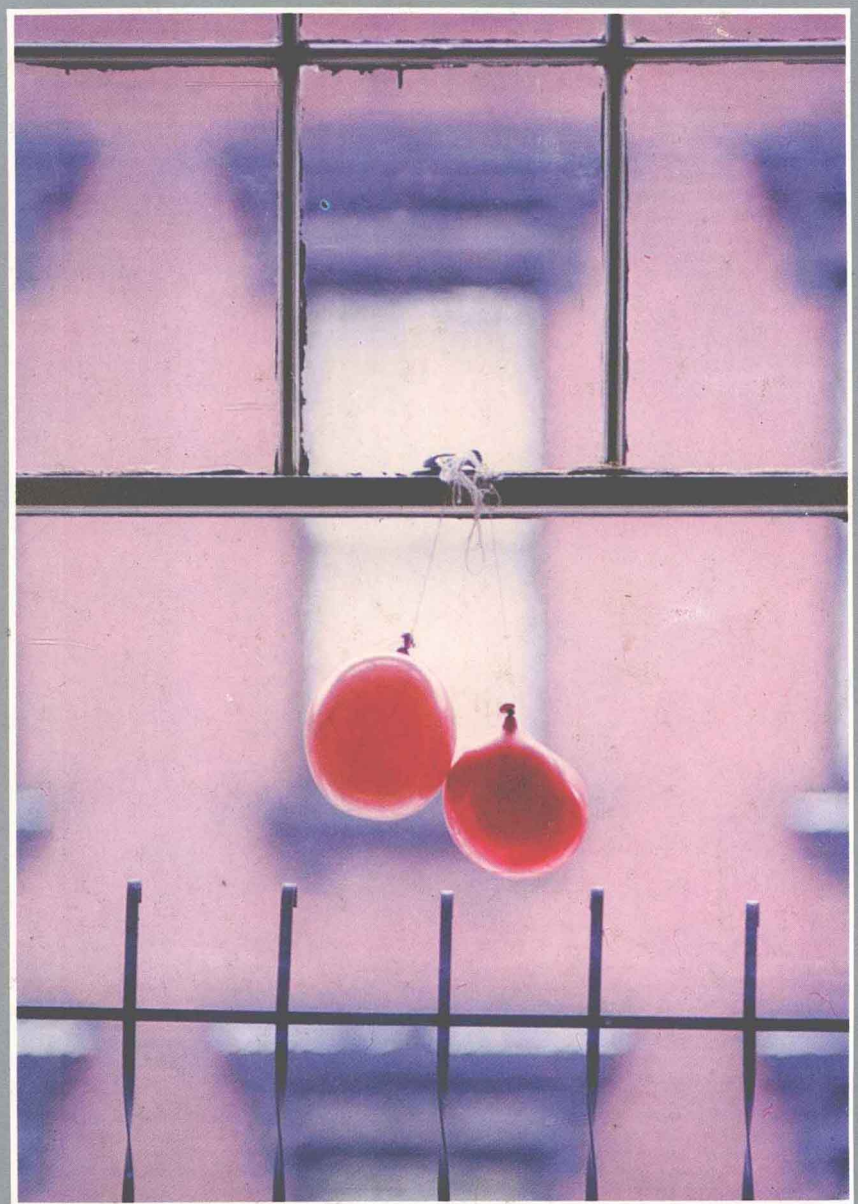
Understanding Child Behavior Disorders

Second Edition



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Understanding Child Behavior Disorders

An Introduction to Child Psychopathology

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PREFACE

It is gratifying that classroom use of the first edition of this textbook was sufficient to justify the preparation of a revised version. The second edition offers updated and expanded coverage in a number of areas and presents the most recent theories and research developments. As before, the book is a text for courses on child psychopathology, abnormal child psychology, exceptional and maladjusted children, child adjustment and behavior problems, and educational psychology. Some familiarity with introductory psychology or child psychology provides a helpful background for the use of this text, but is not absolutely essential. Throughout the book, we have attempted to avoid unnecessary technical terms when possible and to concentrate on clear and straightforward explanations. As a further aid to students, unfamiliar key terms are defined at the beginning of each chapter. Students should read these brief definitions before beginning a chapter, and should review them afterward to ensure that they understand the material.

This book's coverage and orientation reflects the varied professional backgrounds of the authors. Donna Gelfand was trained as a clinical psychologist and later specialized in developmental psychology. She first taught psychology at San Jose State University, and for many years has taught at the University of Utah. William (Bill) Jenson earned a master's degree in experimental psychology and a Ph.D. in child psychology. Following postdoctoral training in clinical psychology, he directed a child and family treatment unit of a community mental health program. He is now a faculty member in educational psychology at the University of Utah. Clifford Drew teaches in the special education and the educational psychology departments at the University of Utah, where he has published 13 textbooks and specializes in research design, mental retardation, and public policy issues. Thus we each contribute somewhat different perspectives on childhood psychological problems. Together, we represent the views of researchers, teachers, and practitioners in diverse fields.

Our shared commitment is to a level-headed, rational approach to the study and treatment of children's problems, based on the best, most definitive research available. This means that we give greater weight to replicated findings from well-controlled research studies of the origin, nature, prognosis, and treatment of behavior disorders than to more subjective clinical case studies, while recognizing that the latter also prove informative. This book reflects our belief that in addition to sensitive clinical observations, probing and objective research is the best means for understanding children's disturbances and ultimately for treating and preventing them. Inevitably, a research orientation favors some theories and treatments over others that are less empirically based. For example, social learning theory and behavior therapy have particularly lent themselves to rigorous research scrutiny. However, no contemporary theory or type of treatment is completely successful or free from flaws, and even the most seemingly misguided have some strengths. We aim for good, impartial scholarship rather than favoritism to any particular orientation. We have tried conscientiously to present all schools of thought accurately and fairly, and to criticize each according to objective criteria.

Users of the first edition will note that this revision covers most of the original topics, but in a modified order. Instructors can assign chapters in any order they prefer, but will find that for users'

convenience we now introduce the history and explanations of child psychopathology first and then review the various disorders before presenting material on research methods, classification, assessment, and treatment. Each chapter stands alone, because the book is designed for use by teachers like ourselves who prefer to vary the order of class presentation from time to time. New material in this edition is noted in the following summary:

Chapter 1, the introduction to the book, features new historical material, a further explanation of criteria used to judge deviance, and a new section on comparisons between adult and child psychopathology.

Chapter 2, on theories of psychopathology, reviews the major explanations and presents recent critiques.

Chapter 3, on sociocultural factors in child disturbances, presents new data on the effects of early malnutrition, lead poisoning, poverty, discrimination, parental conflict and divorce, and child physical and sexual abuse and neglect.

Chapter 4 reviews the effects of stress on children's functioning and presents new research on disorders such as school refusal, childhood depression, suicide, and physical illnesses with psychological components.

Chapter 5 describes attention deficit disorder with hyperactivity, conduct disorder, and delinquency, presenting the results of many new studies.

Chapter 6 is a notable feature of our book because it deals exclusively with smoking, drinking, and other illicit drug use—their prevalence according to the latest statistics, their prevention, and their treatment.

Chapter 7 also covers material not typically found in such texts, including sleep, speech, and toileting problems, as well as eating disorders such as anorexia nervosa and bulimia that have gained recent prominence.

Chapter 8 will be of special interest to educational psychologists, for it deals with recent advances in the understanding of learning disabilities.

Chapter 9, on mental retardation, thoroughly covers etiology and treatment in addition to preventive measures.

Chapter 10 has been described by reviewers as one of the best, most informative chapters in the book. Childhood psychosis and pervasive developmental disorders, especially autism, are described by author Jenson, who has done research, clinical care, and teaching on these topics for many years.

Chapter 11 uses clear, understandable language to describe the rationale underlying research methods and the research designs and procedures themselves. Applications to clinical topics are emphasized, such as use of nonexperimental paradigms.

Chapter 12 covers classification of child disorders, especially the widely used DSM-III system. Approaches are compared on various important criteria.

Chapter 13 introduces child assessment methods, ways of evaluating them, and their appropriate use. Contemporary methods are described, such as child interviews, behavior checklists, and self-monitoring techniques.

Chapter 14 considers the child's developmental level as a factor in the choice of treatment interventions. Major approaches to treatment are described in some detail.

Chapter 15 reviews innovations in child assessment and treatment, presenting up-to-date coverage of children's legal and human rights; new treatment approaches featuring children's regulation of their own behavior; the use of developmental psychology theory and research on child diagnosis and therapy; and the latest programs for the prevention of child psychopathology. The effects of alternative child care patterns such as day care are also reviewed.

The preceding summary presents some new aspects of the present revision and emphasizes features such as the descriptions of prevention efforts that set this textbook apart from most others. As an aid to instructors, a manual including test questions is available upon adoption of the text.

We hope to convey a sense of intellectual cu-

riosity and respect for and enjoyment of the ingenuity and rich variety of contributions of many researchers and theorists. Insofar as we have succeeded in this effort, we thank the people who have so generously read portions of the manuscript and offered their very useful revision suggestions. They, of course, are not responsible for any mistakes appearing here. We particularly thank Paul Goddard, Linda James, Nancy Worsham, Eric J. Cooley (Western Oregon State College), Janet R. LeFrancois (Converse College), A. J. Pappanikou (The University of Connecticut), Paul Michael Ramirez (Hunter College), Lee A. Rosén (Colorado State University), Thomas Schevers (Northeastern Illinois University), and Mary Anne Siderits (Marquette University).

A word about writing style is necessary. This edition continues our practice of alternating between "she" and "he" when referring to a hypothetical person. This is our response to the social and grammatical problems posed by the traditional English-language practice of referring to everyone in the masculine gender. That customary form now sounds sexist, but no alternative has as yet received widespread acceptance. We hope that readers will bear with us during this time of grammatical transition.

The advent of personal computers has allowed us to type this manuscript ourselves and largely without the assistance of secretaries. Nevertheless, we wish to thank office staff members who have helped us in many ways at crucial times. Thanks are due to Christine Rydalch, other office staff members, and our helpful and efficient editors, Jane Knetzger, Jean Ford, and Jeanette Ninas Johnson.

Writing a book (or even preparing a new edition) places considerable stress on busy authors with otherwise full schedules, as well as on their families. Spouses are good sports, although they sometimes make unhelpful observations such as "I want you *never* to do this again." But they relent and we take on other writing assignments. We couldn't have completed this project without you, Sid, Kathy, and Linda. Thanks for your support and willingness to let us work on this book when there were other important things to do.

D. M. G.
W. R. J.
C. J. D.

CONTENTS

chapter

1

Introduction

KEY TERMS

Continuity Hypothesis. The view that, unless successfully treated, childhood problems will persist rather than be overcome.

Delusion. A false belief, such as that one's thoughts are controlled by microwave transmissions or that one is a holy or historical personage.

Growth Hypothesis. The view that childhood psychological problems are typically outgrown or overcome without recourse to professional treatment.

Hallucination. A compelling but false perception, such as that worms are crawling on one's skin or that disembodied voices are belittling one.

Identity Crisis. Erik Erikson's concept that in adolescence the person undergoes a stressful transition and develops a new adult character.

Psychopathology. A general term referring to any type of emotional, social, or cognitive disturbance severe enough to require professional attention.

Psychosis. A serious psychological disorder often involving delusions, hallucinations, thought disturbances, impaired social functioning, and bizarre emotional reactions.

Syndrome. A constellation of problem behaviors that together constitute a psychological disorder; for example, the delusions, thought disturbances, social impediments, and other symptoms of psychosis.

HISTORY OF CHILD PSYCHOPATHOLOGY

Child Care before the 18th Century

Today, children's rights to proper care are guarded and respected. In previous times, however, the level of care and consideration accorded children was generally low by today's standards. For millennia Europeans tolerated the suffering of abused and neglected babies and the tormenting of the mentally retarded and insane. Our ancestors might not have understood present-day professional attention to children's disturbed behavior, or *psychopathology*. Concern for physical survival and spiritual well-being outweighed niceties such as children's rights to autonomy and humane care.

In the past, interest in studying and treating children's disturbed behavior paled in comparison to protecting them from omnipresent threats to their lives. Although most parents were concerned and responsible, they must have realized that many of their children were doomed to an early death. As one author has observed:

> The statistics available from the eighteenth century in England and on the continent are terrifying in the inevitability of the death of children: The century had almost closed before children born in London had an even break of surviving until their fifth birthday, and before 1750 the odds were three-to-one against a child completing five years of life. (Kessen, 1965, p. 8)

Why did children die in such huge numbers? Threats such as grinding poverty and recurrent famines, wars, and epidemics made life precarious, most especially for the young, who were the weakest and among the most expendable of all. Foolish sentimentality could endanger the whole family, so poor parents were forced to be harshly realistic. Babies were closely confined and tightly wrapped in swaddling bands, ostensibly to ensure that their limbs grew straight. Swaddling kept them quiet and out of harm's way while the older family members worked. Because so many babies died, parents may have resisted forming emotional attachments to them (Tuchman, 1978). Or perhaps parents grieved over their children's deaths as keenly as they do in our time, but there is no record of it. High infant mortality rates do not necessarily cause parents to avoid bonding with children (Pollock, 1983). Nevertheless, in the unyielding world of pre-18th-century Europe, sentiment seems to have had little place among the less privileged, and relationships within most families were more functional than obviously affectionate (Shorter, 1975). Children were needed to transmit the family name, to help provide family subsistence, and to care for parents in their old age. Spouses were needed to ensure the viability of the family, and love matches were virtually unknown at any level of society.

Two or three centuries ago, European babies were likely to be seriously neglected or abandoned by poor or unmarried mothers. In 18th-century Paris, parents deposited one-third of all babies at foundling homes, and more came from the countryside despite a law prohibiting transporting babies into the city to abandon them. Desperately poor parents may have been trying to save their infants' lives by delivering them to charitable institutions where they might receive adequate food and shelter. Most of the babies died anyway. In Dublin between 1775 and 1800, 10,272 infants were admitted to foundling homes, but of this vast number only 45 survived (Kessen, 1965, p. 8). Starving and ill, they endured unsanitary, crowded conditions, a meager and nutritionally inadequate diet, and deadly contagious diseases.

The babies who remained with their parents also had high mortality rates. Prior to the late 18th century, less than about a third of the babies born survived the first year of life (Borstelmann, 1983). The practice of sending babies away to live in the care of wet nurses took its toll. Families who could afford it hired wet nurses who lived in the country to breast-feed their babies and raise them until they were 4 or 5 years old. These very poor women accepted the babies of richer families long after their own babies had grown and they could no longer breast-feed. They solved the problem by feeding their charges a despicable mixture of gruel made from cereal, water, and a little sugar if possible. They lived in cold, dark huts, and some

babies' diapers went unchanged for hours, chilling them. Many died of malnutrition, disease, and neglect (Beckman, 1977). Of course, some of the more capable nurses provided reasonably good care. Nevertheless, it is puzzling why parents would expose their babies to the perils of wet nursing. One reason was their belief that having sexual relations would curdle a mother's milk and sicken her baby, and an alternative was to hire a wet nurse for the baby (Pollock, 1983). Other mothers were unable to nurse their own babies and a wet nurse was necessary. Undoubtedly, most parents were doing what they considered best for their children by placing them with experienced wet nurses in supposedly wholesome country surroundings.

Responsible parents expressed their concern about their children's welfare in the forceful measures they used to ensure their children's conformity to religious and social commandments. Many children were caned or whipped into obedience, immersed in ice water, confined in dark cupboards, and threatened with abandonment or abduction (deMause, 1974). Disobedient children were thought to be in imminent peril of hellfire and damnation, and could endanger their parents' salvation as well, so all the resources of family, church, and community were devoted to their reform. In the 16th century, babies who persistently cried and were unsoothable were thought to be possessed by demons and were sometimes put to death on the advice of Christian church leaders (deMause, 1974). Concerns about social acceptance and salvation were paramount, and they guided disciplinary practices.

It is possible that modern writers have overemphasized the rigor of the earlier child-rearing practices (Gordon, 1978; Pollock, 1983). Diaries of upper-class parents in the 17th to the 19th centuries showed great love for and enjoyment in their children. Lady Anne Clifford (1590-1676) wrote about her ill 2-year-old: "The Child had a bitter fit of her ague again, insomuch I was fearful of her that I could hardly sleep all night, so I beseeched GOD Allmighty to be merciful to me and spare her life" (Clifford, 1923, p. 54). It must be recalled, though, that the diarists tended to come from more recent historical periods and from the highest social classes. Thus they were not representative of earlier periods or of the bulk of the population.

Stern discipline was the norm and might not have represented parental rejection or indifference. In fact, Kagan (1978) has argued that today's children are more vulnerable to lack of love than in the past, when children were viewed less sentimentally. Now children's behavior problems and emotional disturbances are often attributed to insufficient parental affection (Kagan, 1978). It may be that "sufficient parental affection" is impossible to attain because children always crave more than they receive. Thus modern people may have an insatiable craving for unqualified love and regard from others, and the inevitable frustration of this unrealistic need makes them feel unfairly deprived. Feeling neglected may be characteristic of middle-class children who have less parental supervision now than was the case in their grandparents' time. The present divorce rate of 50 percent, high maternal employment rates, and strict grading by age in educational and recreational settings all decrease children's opportunities for experiencing the instructive and enjoyable aspects of their parents' company. Some psychologists (Bronfenbrenner, 1979; Winn, 1983) have asserted that the rise of peer influences at the expense of parental ones is causing increasing child problems, such as a lack of internalized values and controls, which may result in drug misuse, drinking, smoking, and sexual activity. As a consequence, it is difficult to tell whether modern children are more psychologically advantaged than were the children of the past.

The Beginning of Modern Attitudes toward Children

In the 18th century, attitudes toward children became more positive and humane. Children were increasingly valued for their innocence, charm, and playfulness. The English philosopher John Locke (1632-1704) taught that children are not born perverse, but mentally resemble a blank slate *(tabula rasa)* to be developed through suitable education and experience. Thus adults need

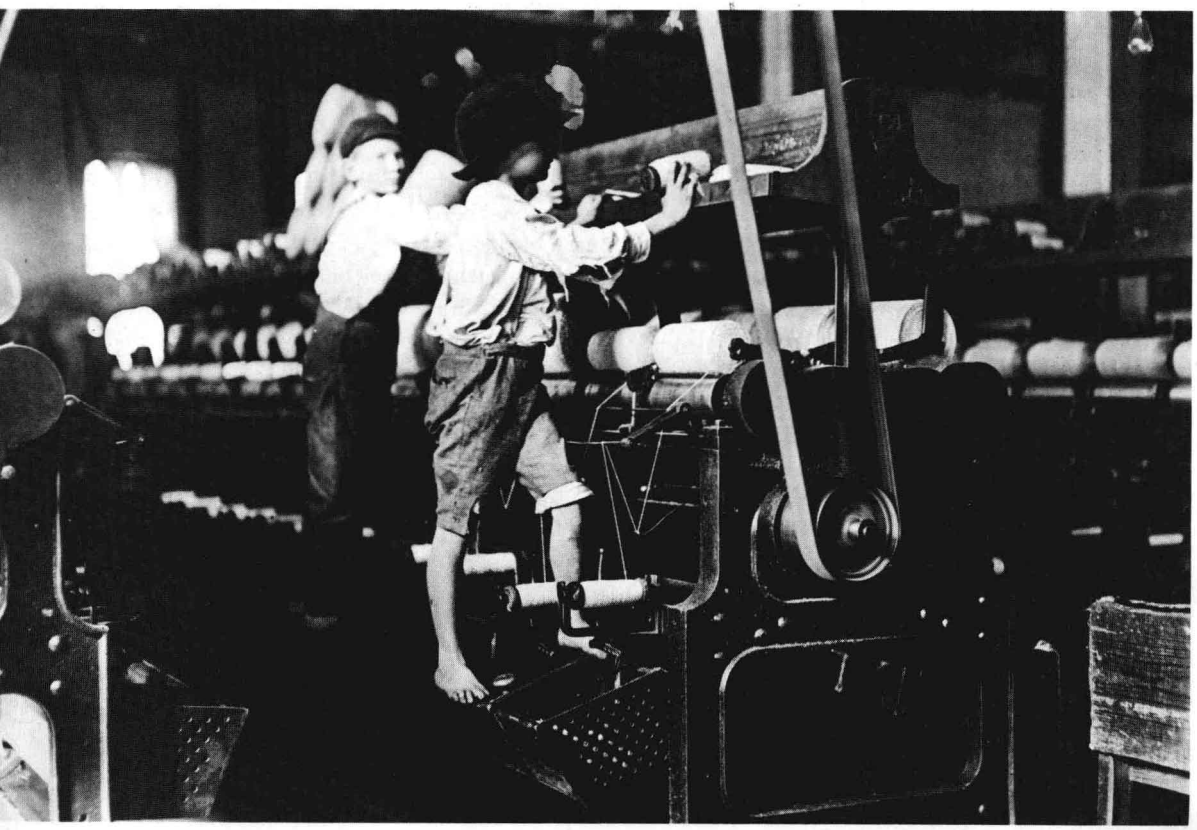
not combat the child's evil nature through cruelty, since the child is not innately corrupt. Later, the French philosopher Jean Jacques Rousseau (1712-1778) promoted the glorification of childhood by writing that children have a natural tendency toward healthy growth in both body and spirit. Accordingly, children were thought to require only developmentally appropriate instruction and a clean, healthful, and nonrestrictive environment in order to develop optimally. Only the malevolent influences of adults' cruelty and teachers' ignorance of their pupils' limited capacities were believed to interfere with healthful, normal development. Accordingly, educated parents began to view their children more positively and affectionately and to perceive them as innocent rather than as depraved.

Ironically, the later growth of industry (1750-1850) threatened the health of impoverished child workers, of whom there were many:

> According to the 1870 [U.S.] census about one out of every eight children were employed. By 1900 approximately 1,750,000 children, or one out of six, were gainfully employed. Sixty percent were agricultural workers; of the 40 percent in industry over half were children of immigrant families. (Bremner, 1971, p. 601)

Poor immigrant and rural children put in 12- to 15-hour days in the mines, mills, farms, and manufacturing plants. The typical 19th-century urban workplace was dangerous and unsanitary. Child workers were found to be useful in factories, where they were paid less than adults and where their small stature enabled them to work in restricted places at dangerous jobs such as cleaning or oiling machinery while it was still in operation.

In the 19th century, poor children labored long hours in hazardous conditions before child labor laws were enacted. Working them hard and paying them little was viewed as "good business" and morally correct.



Children even worked in the dark, cold, damp English mines, where they were harnessed to carts like animals to haul coal. Clad in rags and underfed, the mine children were beaten when their energy flagged. The working conditions of black and Native American slave children in the Americas were as bad or even worse. Profit was king, and the children's welfare was not considered by the businessmen. To their credit, some clergy and concerned citizens spoke out against this inhumane treatment of children, and eventually managed to outlaw the worst abuses; however, reform came slowly.

It is a human tendency to blame others in order to explain their misfortunes, and the peasant immigrants and their scruffy, undersized offspring were natural targets for such prejudice. Many well-educated and wealthy people drew a parallel between evolutionist Charles Darwin's principle of the survival of the fittest in the animal kingdom and their own prosperity, which they attributed to their own genetic superiority. In contrast, they viewed the poor, uneducated, and ill as genetically unfit and unworthy of education, decent employment, or medical treatment. The fact that some of the poor were defenseless children did not inspire the rich to help them. This selfishness was rationalized by the assertion that it was better for them to die young than to grow up to breed additional generations of the socially dangerous and unfit. Such an interpretation is indefensible genetically, historically, and morally, but it prevailed in law and practice. Consequently, children who were impoverished, orphaned, or abandoned were left to live or die by their own devices. Today we realize that some childhood behavior disturbances do have a genetic basis or genetic contribution, but we recognize that no social class or ethnic group is genetically inferior—or superior—to any other.

The Rise of Mental Testing and the Study of Child Psychopathology

Formal education is a relatively recent historical development. No schools existed in Europe before the 15th century. School attendance was considered inappropriate for females until the 18th and 19th centuries, and compulsory school for all children began only in the later 19th century (Aries, 1962). With the advent of compulsory education, it became evident that some children were not progressing normally, but the nature of their incapacity was not understood. In 1909, the French Minister of Education charged the psychologists Binet and Simon with developing standardized tests to identify children who lacked the intellectual ability to cope with the regular school curriculum. Children thus identified were given special education in the schools if their deficiency was minor or were institutionalized if their retardation was more severe. Institutions for the retarded were not viewed as dead-end placements, but aimed to equip the children to return to regular community life (Rie, 1971). The test devised by Binet and Simon was a great success; it was translated into English and eventually revised to become the Stanford-Binet Intelligence Test. A more recent revision of this test remains in use today. These mental status tests were among the first systematic assessments of children's developmental disorders.

Other types of juvenile psychological abnormalities were also recognized by 19th-century writers. Prominent German and English physicians such as Friesinger and Maudsley provided sketchy descriptions of various childhood adjustment disorders. Mental retardation or deficiency was distinguished from *psychosis*, which was defined as a broad category including hyperactivity, antisocial-aggressive behavior, generalized anxiety, suicidal behavior, and schizophrenic reactions (Rie, 1971). In all, just two disorder categories were recognized: mental deficiency and insanity (psychosis).

Perhaps because of the great popularity of Darwin's evolutionary theory, 19th-century psychiatrists believed that most forms of deviance had a hereditary basis. Family heredity was thought to account for desirable as well as undesirable characteristics, and the power of social influences was little appreciated. Francis Galton's discovery of disproportionately large numbers of eminent persons in certain prominent English families was widely considered to prove the hereditary basis of intellectual and personality charac-