Essentials *of*

Child and Adolescent Psychopathology

Linda Wilmshurst

Alan S. Kaufman & Nadeen L. Kaufman, SERIES EDITORS

Second Edition

WILEY

Table of Contents

- Title Page
- Copyright
- Series Preface
- Part I: The Foundations
- Chapter 1: Introduction to Child and Adolescent Psychopathology: Development, Theories, and Influences
  - Practical Applications: Case Study Illustrations of Child and Adolescent Psychopathology
  - Distinguishing Normal from Abnormal Behavior
- Chapter 2: Issues in Child and Adolescent Psychopathology: Ethical Issues in Research and Practice
  - Relationship between Ethical Guidelines and Laws
  - Ethical Issues in Assessing, Treating, and Conducting Research with Children
  - Research Methods in Child Psychopathology
  - Developmental Considerations in Clinical Child Research
- Chapter 3: Issues in Clinical Decision Making: Diagnosis, Assessment, and Treatment of Childhood and Adolescent Disorders
  - Goals of Assessment and Diagnosis
  - The Nature of the Child's Problem: Issues in Diagnosis
  - The *DSM-5*: Issues and Trends
  - Issues in Assessment: How the Clinician should Evaluate the Problem

- Child Treatment Interventions

Part II: Neurodevelopmental Disorders

Chapter 4: Intellectual and Developmental Disabilities
- Intellectual Disabilities
- Developmental Disabilities: Autism Spectrum Disorders (ASD)
- Etiology

Chapter 5: Attention-Deficit/Hyperactivity Disorder (ADHD)
- Clinical Description and Associated Features
- Etiology (Causes)

Chapter 6: Specific Learning Disabilities
- Clinical Description and Associated Features
- General Prevalence Rates and Course
- Learning Disabilities and Social Skills Deficits
- Learning Disabilities and Subtypes
- Specific Reading Disability: Dyslexia
- Specific Learning Disability of Written Expression: Dysgraphia
- Specific Mathematics Disability: Dyscalculia
- Nonverbal Learning Disabilities (NLD)
- Developmental Coordination Disorder (DCD): Dyspraxia

Part III: Internalizing Disorders
- Internalizing Disorders

Chapter 7: Anxiety Disorders and Obsessive-Compulsive and Related Disorders
- Anxiety Disorders
- Separation Anxiety Disorder

- Selective Mutism
- Phobias and Fears
- Social Anxiety Disorder (Social Phobia)
- Panic Attacks and Panic Disorder
- Agoraphobia
- General Anxiety Disorder
- Obsessive-Compulsive and Related Disorders

Chapter 8: Disorders of Mood: Depression and Bipolar Disorder

- Major Depressive Disorder (MDD) and Persistent Depressive Disorder (PDD)
- Disruptive Mood Dysregulation Disorder
- Bipolar Disorders

Chapter 9: Somatic Symptom and Related Disorders

- Somatic Symptom Disorder
- Conversion Disorder
- Illness Anxiety Disorder

Part IV: Disruptive Behavior Disorders

Chapter 10: Disruptive Behavior Disorders

- Oppositional Defiant Disorder (ODD)
- Conduct Problems and Conduct Disorder
- The Category of Disruptive Behavior Disorders

Part V: Later-Onset Disorders

Chapter 11: Feeding and Eating Disorders

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa

Etiology Of Eating Disorders
Assessment and Treatment of Eating Disorders
Binge-Eating Disorder (BED)
Chapter 12: Substance-Related Disorders
Substance Use Disorder
Substance-Induced Disorders
Part VI: Special Topics in Child and Adolescent Psychopathology
Chapter 13: Trauma- and Stressor-Related Disorders
Adjustment Disorders
Attachment Disorders
Reactive Attachment Disorder (RAD)
Disinhibited Social Engagement Disorder (DSED)
Prevalence and Course of the Attachment Disorders
Posttraumatic Stress Disorder
Chapter 14: Children of Diverse Cultures
Introduction
The Impact of Culture on Child Psychopathology
African Americans
Latino/Hispanic Americans
Asian Americans and Pacific Islanders
American Indians
Assessment
Treatment
Appendix A: Codes of Ethical Conduct
Appendix B: References for Assessment Instruments and Resources
Structured and Semistructured Clinical Interviews
Rating Scales and Self-Report Measures

- Intellectual/Cognitive Functioning and Adaptive Behavior
- Resources

Appendix C: Individuals with Disabilities Education Improvement Act of 2004 (IDEA 04)

References

Index

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Essentials of Child and Adolescent Psychopathology

Second Edition

Linda Wilmshurst

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Series Preface

In the *Essentials of Behavioral Science* series, our goal is to provide readers with books that will deliver key practical information in an efficient, accessible style. The series features books on a variety of topics, such as statistics, psychological testing, and research design and methodology, to name just a few. For the experienced professional, books in the series offer a concise yet thorough review of a specific area of expertise, including numerous tips for best practices. Students can turn to series books for a clear and concise overview of the important topics in which they must become proficient to practice skillfully, efficiently, and ethically in their chosen fields.

Wherever feasible, visual cues highlighting key points are utilized alongside systematic, step-by-step guidelines. Chapters are focused and succinct. Topics are organized for an easy understanding of the essential material related to a particular topic. Theory and research are continually woven into the fabric of each book, but always to enhance the practical application of the material, rather than to sidetrack or overwhelm readers. With this series, we aim to challenge and assist readers in the behavioral sciences to aspire to the highest level of competency by arming them with the tools they need for knowledgeable, informed practice.

Essentials of Child and Adolescent Psychopathology, Second Edition, provides an overview of child and adolescent disorders that begins with a look at the foundations of the discipline and the unique historical influences that played a role in the evolution of the field. This updated version of the book includes all of the changes

in the criteria and conceptualization of disorders that can be found in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association [APA], 2013). The book is divided into six parts. In Part I, readers are introduced to child and adolescent characteristics (e.g., family, school, economics, culture) that shape developmental pathways toward normal or deviant behaviors, and the role of theoretical perspectives in guiding our understanding of the underlying processes. Current trends and issues in the areas of professional ethics, research, assessment, diagnosis, and treatment are also addressed. Part II contains three chapters (intellectual and developmental disabilities, attention-deficit/hyperactivity disorder, specific learning disabilities) that focus on disorders representing a range of neurodevelopmental impairments and functioning from global (global developmental delay) to more specific deficits (executive functioning deficits).

The focus in Part III is on the internalizing disorders (anxiety and obsessive-compulsive and related disorders, disorders of mood and somatic symptom and related disorders), whereas Part IV discusses externalizing disorders, such as oppositional defiant disorder and disorders of conduct. Disorders that most likely have onset in later childhood or adolescence, such as eating disorders and substance-related disorders, are presented in Part VI. The final section, Part VII, contains two chapters devoted to special topics: trauma- and stress-related disorders and children of diverse cultures. Finally, the book provides three additional appendices that contain important information, regarding ethical codes of conduct, references for assessment instruments and resources, and the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 04).

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Part I
The Foundations

The following three chapters provide the basic foundations for understanding child and adolescent psychopathology. In the Introduction, readers will discover how child and adolescent psychopathology evolved as a unique discipline and the growing pains that were evident in achieving the early milestones, historically. Through the use of case examples, readers will gain an increased appreciation of important developmental considerations that are required in order to make clinical decisions regarding where a child's behavior is best represented on the normal versus abnormal continuum based on important information available from developmental expectations and theoretical perspectives.

The second chapter provides important information regarding ethical issues and challenges that practitioners face in their work with young children and adolescents, whether this takes place in a clinical or research setting. Issues of confidentiality can be daunting as practitioners attempt to determine who is the legal guardian for children under 18 years of age (or the age of majority in the state where the clinician is practicing), especially in cases where information regarding the custodial parent may not be readily accessible. The chapter ends with an important discussion about common risks and protective factors that can influence the trajectory of child development.

Finally, in the third chapter, readers are introduced to issues in diagnosis, assessment, and treatment as they relate to different systems of classification (empirical versus categorical), and how the recently revised *DSM-5*

has attempted to address these issues. Different methods of clinical assessment will be discussed, as well as issues of obtaining parental consent and child assent for individual assessments.

Chapter 1
Introduction to Child and Adolescent Psychopathology

Development, Theories, and Influences

Recognition of clinical child psychology as a unique discipline has only emerged in the past 30 years, despite auspicious beginnings. The end of the 19th century ushered in an era of social reform that addressed the need to protect children's rights concerning health and education, to provide protection within the judicial system, and to free children from working within the adult workforce (Culbertson, 1991). In the wake of this movement, child labor laws and mandatory education became a reality. At the turn of the 20th century, Lightner Witmer established the first psychology clinic to treat children with learning disabilities, and by 1909 more than 450 cases had been seen at the clinic. However, Witmer fell out of favor with his colleagues, because of his refusal to adopt Terman's revision of the Stanford-Binet tests of intelligence and his reluctance to accept Freud's theories on behavior disorders.

William Healey, an English-born psychiatrist who shared America's enthusiasm for Freud's theories, opened the first child guidance clinic in Chicago in 1909. By 1933, 42 child guidance clinics were in operation at a wide variety of locations, including juvenile institutions, courts, hospitals, schools, and universities. As the popularity of the child guidance clinics grew, the emphasis shifted from

delinquency to problems evident at home and at school, with a primary interest in parent–child difficulties.

The underlying philosophy of the time was that the source of children's problems could be found in parenting and the family (Horn, 1989, p. 27). In 1948, 54 child guidance clinics came together to form the American Association of Psychiatric Clinics for Children (AAPCC). According to Horn, this marked a shift from identification to training and treatment; a movement riddled with debate over standards, roles, and status among psychiatrists, psychologists, and social workers. For a summary of the timelines in historical perspective, refer to Rapid Reference 1.1.

Despite the popular rise of the child guidance clinics, the field of clinical child psychology encountered many roadblocks that delayed the establishment of child psychopathology as a unique discipline until only 30 years ago. One reason for the delay was the fact that theories of child development were firmly entrenched in the controversy over nature versus nurture.

Rapid Reference 1.1

Early Milestones in the History of Child Psychology

1892	American Psychological Association founded; G. Stanley Hall is first president.
1896	L. Witmer founds first psychology clinic, at the University of Pennsylvania, for children with learning disabilities and academic problems.
1897	Witmer's clinic offers four-week summer course in child psychology.
1905	Binet-Simon Intelligence Scale for measuring mental abilities in children published in France.
1907	Witmer establishes a residential school for retarded children and founds the first clinical journal, *The Psychological Clinic*.
1908	H. Goddard establishes first clinical internship program at Vineland Training School (New Jersey).
1909	Beers, supported by psychologist W. James and psychiatrist A. Meyer, founds the National Committee for Mental Hygiene, later renamed the National Association of Mental Health (NAMH).
1909	W. Healey establishes the first child guidance center, the Juvenile Psychopathic Institute (Chicago), to treat and prevent mental illness in juvenile offenders; later named the Institute for Juvenile Research.
1909	G. Stanley Hall invites Sigmund Freud to lecture on psychoanalysis at Clark University.
1910	Goddard translates the Binet-Simon Intelligence Test for use with “feebleminded children” at the Vineland School.
1911	A. Gesell appointed director of Yale's Psychoeducational Clinic; renamed Clinic of

	Child Development.
1912	J. B. Watson publishes *Psychology as a Behaviorist Views It*.
1916	Terman's Stanford-Binet Intelligence Test is published.
1917	APA section of clinical psychology is founded.
1920	Watson and Raynor demonstrate that fear can be conditioned in a child called Albert.
1922	NAMH funds eight pilot child guidance clinics established in various cities.
1926	Piaget publishes *The Language and Thought of the Child*.
1928	Anna Freud publishes *Introduction to the Technique of Child Analysis*.
1930	Kanner joins Johns Hopkins University and opens first pediatric psychiatric clinic, Harriet Lane Pediatric Clinic.
1932	M. Klein authors *The Psychoanalysis of Children*.
1935	Kanner publishes first textbook on child psychiatry.
1937	Adolescent psychiatric ward opens at Bellevue Hospital.
1944	Kanner describes autistic behaviors and attributes illness to “refrigerator mother.”
1945	Studies by R. Spitz raise concerns about negative impact of institutional life on children.
1948	American Association of Psychiatric Clinics for Children (AAPCC) is formed as 54 child guidance clinics come together.
1950s	Behavior therapy emerges as a treatment alternative for child and family problems.

1951	Bowlby publishes on attachment.
1952	American Psychiatric Association (APA) publishes the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The *DSM* contains two disorders of childhood: Adjustment Reaction and Childhood Schizophrenia.
1953	The American Academy of Child Psychiatry is established.
1968	*DSM-II* published and adds “hyperkinetic reaction of childhood.”
1977	Thomas and Chess publish work on the nine categories of temperament.
1980	*DSM-III* is first version of *DSM* to make specific developmental recommendations regarding childhood disorders.
1984	Sroufe and Rutter introduce domain of child psychopathology as offshoot of developmental psychology; *Developmental Psychopathology Journal* is introduced.
1999	Clinical Child Psychology established as the 53rd division of American Psychological Association; renamed Society of Clinical Child and Adolescent Psychology (2001).

Note: See Nietzel, Bernstein, & Milich, 1994, and Slaff, 1989, for details.

Toward the end of the 19th century, there was a growing belief that mental illness had a biological basis, and Emil Kraepelin's (1856–1926) textbook published in 1883 argued that physical ailments could cause mental dysfunction. The disease model was a mixed blessing, with some practitioners intent on finding a cure, whereas others feared that diseases could be transmitted to others or passed on genetically to offspring. Fear and

misunderstanding resulted in the placement of adults and children with mental retardation and mental illness in institutions for the next half-century.

CAUTION

The nature (heredity) and nurture (environment) debate has waged for centuries. John Locke, the 17th-century English philosopher, proposed that children came into the world as a blank slate (*tabula rasa*), and it was the parents' responsibility to fill the slate with the proper environmental controls and discipline. By contrast, the 18th-century French philosopher Jean-Jacques Rousseau envisioned the child as a flower that would grow and flourish, naturally, in a *laissez-faire* approach. Caring, nurturing, and opportunity were the parents' gifts to the growing child. Most psychologists today appreciate the interaction of both heredity and environment.

DON'T FORGET

Henry Goddard is credited with establishing one of the largest training schools for the mentally retarded. However, the belief system upon which the school was constructed did much to harm attitudes about the mentally retarded. Goddard's beliefs were summarized in his fictional book that chronicled two sets of offspring of Martin Kallikak: (1) descendants from his union with a barmaid, who were plagued by feeblemindedness, delinquency, and alcoholism, and (2) descendants of his union with a “nice girl,” who all became respectable citizens.

Another roadblock to the establishment of clinical child psychology as a unique discipline was the shift in emphasis from treatment to identification. Psychologists became increasingly involved in intellectual assessments of children and adults for placement in education and the military. By 1918, psychologists had screened more than 2 million potential candidates for the army.

Abnormal behavior in children continued to be interpreted from the vantage point of adults, and thus childhood maladjustment was described in adult terms and treated with adult treatment methods (Peterson & Roberts, 1991). By the mid-1930s, child guidance clinics were firmly entrenched in linking child problems to adult problems. After years of viewing children's problems from the vantage point of adult psychopathology, the current trends are to refine our understanding of how many characteristic features of these child and adolescent disorders differ from adult disorders. Since the 1970s, several journals have emerged that are exclusively devoted to research about child and adolescent clinical concerns (e.g., *Journal of Clinical Child Psychology, Journal of Abnormal Child Psychology, Journal of the American Academy of Child and Adolescent Psychiatry, Journal of Child Psychology and Psychiatry and Allied Disciplines*).

In the mid-1980s, the field of clinical child psychology witnessed the evolution of yet another stage of development. At this time, the domain of developmental psychopathology (Sroufe & Rutter, 1984) emerged as an offshoot of developmental psychology, complete with its own journal, *Development and Psychopathology*. Within this framework, atypical behavior is conceptualized as deviating from the normal developmental pathway.

DON'T FORGET

Conceptually, because normal and abnormal behaviors stem from the same developmental principles and are part of the same continuum, increased emphasis is placed on having knowledge of normal behavior (its stages and underlying processes) as a precursor to abnormal behaviors.

Organizational principles of developmental psychopathology define a system that considers human development as *holistic* (the interactive and dynamic concept of the total child) and *hierarchical* (movement toward increasing complexity; Cicchetti & Toth, 1998). Increased emphasis has been placed on determining processes that can inhibit (protective factors) or escalate (risks) the development of maladaptive behaviors.

Practical Applications: Case Study Illustrations of Child and Adolescent Psychopathology

The following cases will serve as an introduction to some of the practical issues faced by clinicians working with children and youth and provide a framework for better understanding the importance of considering developmental contexts and environmental influences in understanding child psychopathology.

The Cases of Jason, Winnie, and Brian

The psychologist is asked to observe three children in Mrs. Skill's fourth-grade classroom: Jason, Winnie, and Brian. All three children have been rated as demonstrating the

following behaviors: has problems sustaining attention, loses things necessary for tasks, is easily distracted, is forgetful, is restless, doesn't seem to listen, is disorganized, doesn't complete assignments, and demonstrates poor follow-through. The psychologist's observations of the children verify information obtained from the teacher rating scales. A review of the children's cumulative folders reveals that all three children scored within the average range on the Otis-Lennon group intellectual screening test given during the previous third-grade school year.

Question: Is a diagnosis of attention-deficit/hyperactivity disorder (ADHD) an appropriate classification for Jason, Winnie, or Brian? Why?

According to the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*; APA, 2013), all three children demonstrate many symptoms associated with ADHD. The psychologist has verified the teacher's ratings of these behaviors through classroom observation, has reviewed the school records, and is fairly comfortable ruling out any contributing intellectual difficulties. Furthermore, these problems have been documented on an ongoing basis.

What's missing from this picture?

In order for the psychologist to diagnose whether the three children have ADHD—or rule out the possibility of ADHD in favor of a different diagnosis (a process called *differential diagnosis*)—information is required from several key sources, including the home and school environments. What is missing, therefore, is information from the child's home environment. The psychologist schedules interviews with all three parents to obtain additional information.

The Case of Brian

According to Brian's mother, Brian has “always been this way.” His mother describes Brian as a “space cadet” who constantly misplaces things and often gets distracted when trying to do his homework. Brian eats standing up and is always on the go. His mother adds that Brian is just like his father, who is also restless, active, and distracted. Brian seems very capable (his mother and teacher both feel he is a bright boy), but he has problems completing assignments because of his distractibility. Everything seems to take his attention away from the task at hand.

After talking to the mother, the psychologist develops a *case formulation* (a hypothesis about why the problem behavior exists and how it is being maintained). The case formulation is based on information obtained from the family history, consistency in Brian's behaviors across situational contexts (home and school), and the longevity of the problem (he has always been that way). The psychologist is now more confident in suggesting that Brian does have ADHD, probably the Predominantly Inattentive Presentation, and discusses possible interventions with Brian's parents.

Based on all of the information, the psychologist makes a provisional diagnosis for Brian of ADHD, Predominantly Inattentive Presentation.

The Case of Winnie

Winnie's mother arrives at the interview out of breath and very anxious to hear about her daughter. Her mother describes Winnie as a “real worrier” and admits that she is that way herself. Winnie has always been very timid, and as an infant she was cautious, fearful, sensitive to noises and touch, and “slow to warm up to others.” Socially, Winnie has a few close friends. Homework is a painful process, as perfectionistic tendencies get in the way of completing

assignments, because Winnie keeps erasing her work. Because of the extent of her fears and anxieties, Winnie is often overwhelmed by tasks and appears inattentive, distracted, and forgetful.

Winnie's provisional diagnosis is general anxiety disorder (GAD), but the psychologist also needs to rule out possible obsessive-compulsive disorder (OCD).

The Case of Jason

Jason's foster mother arrives at the interview with her social worker. This is Jason's fourth foster placement in the past 2 years. Jason has been in his current foster placement for the past 6 months. According to the social worker, Jason was a witness to family violence from an early age. Jason's family was well known to Social Services, and Jason has been in care several times in the past for reported neglect and possible abuse. Shortly after Jason and his brother rejoined their parents 2 years ago, Jason's father shot his mother and then himself, while Jason and his younger brother slept in an adjoining bedroom. Jason has been receiving play therapy for the past 2 years. Jason continues to have trouble sleeping and is often agitated and restless. In relationships, his behavior vacillates between being overly inhibited (shy and withdrawn) or disinhibited (socially precocious). His ability to sustain his attention and concentration is impaired, and he is often forgetful and appears disorganized.

Jason's provisional diagnosis is chronic posttraumatic stress disorder (PTSD), but an attachment disorder (reactive attachment disorder [RAD] or disinhibited social engagement disorder [DSED]) and ADHD also need to be ruled out.

Summary of the Three Child Study Cases

Although the three children demonstrated similar symptoms in the classroom and in the home environment (pervasive across situations), only one of the three children was likely demonstrating ADHD.

Given high rates of *comorbidity* (disorders occurring together) in childhood disorders and the fact that many disorders present with similar symptom clusters, the need for developing a case formulation based on information from multiple sources cannot be overemphasized.

The Case of Matthew

The next day, the psychologist is asked to observe another child in the fourth grade: Matthew, an 11-year-old who is repeating the fourth grade. Matthew has a behavior problem, and his emotions often escalate out of control. This day is no exception. When the psychologist observes Matthew in the classroom, he demonstrates a full-blown temper tantrum, throwing himself on the floor, kicking, and crying.

The psychologist makes an appointment to meet with Matthew's father. She leaves the elementary school and stops on her way home to pick up her 3-year-old daughter, Rachel, at the daycare center. To the psychologist's dismay, Rachel is lying on the floor, kicking and screaming because another child took her favorite toy from her.

When the psychologist meets with Matthew's father, he states that Matthew's behavior problems have been ongoing from an early age. Matthew can be aggressive, moody, and irritable. Tantrums are frequent and often unpredictable. Matthew is oppositional and defiant at home and at school, and he often refuses to comply with even the smallest request. Often Matthew seems to deliberately annoy others.

Question: Are the temper tantrums produced by Matthew and Rachel indicative of a disruptive behavior disorder?

Disruptive behavior disorders, classified as conduct disorder (CD) and oppositional defiant disorder (ODD) by the *DSM-5* (APA, 2013), are highly prevalent in children and adolescents. Of these disorders, ODD is represented by a constellation of symptoms of aggression, anger, and disobedience. Children with ODD have recurrent displays of negative behaviors toward authority that are defiant, disobedient, and hostile (APA, 2013). Matthew's provisional diagnosis is ODD or depression.

The Case of Rachel

The psychologist's 3-year-old daughter throws tantrums at the daycare center when she is frustrated. These tantrums have been increasing in frequency for the past 6 months. Talking to the daycare staff, the psychologist finds out that one particular child, Arty, seems to trigger these tantrums in her daughter. Arty joined the daycare center about six months ago. Rachel does not throw tantrums at home and is a relatively easy-to-manage child. The psychologist is aware that, developmentally, tantrum behavior in toddlers normally peaks at around three years of age. The daycare center staff members are not concerned and see Rachel's behavior as reactive to increasing frustration. The provisional diagnosis is a developmentally appropriate response to frustration.

DON'T FORGET

Although Matthew and Rachel displayed the same behavioral response to frustration (temper tantrums), when viewed within a developmental context, tantrums are a normal expression of frustration at 3 years of age but more deviant behavior at 11 years of age.

Distinguishing Normal from Abnormal Behavior

Although many of the professional skills and competencies required to distinguish normal from abnormal behavior are shared by clinicians who serve adult and child populations, several unique skills and competencies distinguish these two populations as separate clinical fields.

Determining whether a behavior pattern is normal or abnormal requires, at a minimum, a fundamental understanding of normal expectations and the range of behaviors that constitute the broad limits of the average or normal range. In order to determine whether a behavior falls outside of the normal range, clinical judgment is often based on a series of decision-making strategies. One way of measuring how the behavior compares to normal expectations is the use of "the four Ds" as a guideline to evaluating the behavior: *deviance, dysfunction, distress*, and *danger* (Comer, 2013).

Rachel, the psychologist's 3-year-old daughter, was previously observed throwing a temper tantrum at the daycare center. Consider the severity of Rachel's tantrum behavior in relation to the tantrum behavior of another 3-year-old child, Arty.