

Part I

Basic concepts and processes

1

Normality and abnormality in the context of human development
Basic definitions

The difference between a word and the right word is like the difference between lightning and a lightning bug.

MARK TWAIN

A word is not a crystal, transparent and unchanging; it is the skin of a living thought and may vary greatly in color and content according to the circumstances and time in which it is used.

OLIVER WENDELL Holmes (Justice of the US Supreme Court)

Scholars of several disciplines use different terms to refer to children’s psychological problems. The quest for a global descriptor that is accurate and that avoids stigma has so far been unsuccessful. In fact, there is probably not even a euphemism that enables its users to avoid debatable analogies and connotations that they would probably prefer not to evoke. This chapter is devoted to definitional issues, starting with the definitions of pathology and disease. Problems with all of the terms in common use to describe children’s and adolescents’ psychological problems are highlighted. Many of the issues raised in this chapter recur in subsequent chapters on the classification of mental illness and the physiological basis of child and adolescent psychopathology. Estimates of the total prevalence of psychopathology appear near the end of the chapter, followed by remarks about the notion of recovery in the context of mental illness.

Pathology; disease

Although the concepts of mental illness and disease have existed since ancient times, it is only in the past 200 years that coherent attempts have been made to differentiate transitory problems associated with the stressful experiences suffered by most

people from full-blown conditions that merit more enduring concern and professional care. The German psychiatrist, Karl Kahlbaum, renowned in his own time but almost unknown since, is credited with introducing, in 1863, the idea that the concept of mental illness should include the course of the illness, its effect on the individual’s psychological well-being, the developmental stage at which it occurred and any accompanying conditions to which it might be secondary. Kahlbaum also applied these ideas to the study of children’s mental disorders, especially early forms of psychosis (Kahlbaum and Berrios, 2007; Millon, Grossman and Meagher, 2004). His delineation of mental illness and health, with considerable refinement, has become an integral part of mainstream thinking about child psychopathology.

The word “pathology” is composed of two Greek words that refer to illness and to knowledge or understanding. This term is used to refer to the gathering of knowledge about the causes and effects of disease or diseases. Psychopathology is, thus, the science of the diseases that affect a person’s psyche or mind. The *Oxford English Dictionary* (Simpson and Weiner, 1989) lists several alternative definitions of the noun “disease,” all of which could arguably be considered descriptive of the major psychological problems of childhood:

4 Normality and abnormality: basic definitions

absence of ease; uneasiness, discomfort; inconvenience, annoyance; disquiet, disturbance; trouble. (For long *Obs.* but revived in modern use with the spelling *dis-ease*.)

a cause of discomfort or distress; a trouble, an annoyance, a grievance. *Obs.*

a condition of the body, or of some part or organ of the body, in which its functions are disturbed or deranged; a morbid physical condition; “a departure from the state of health, especially when caused by structural change.” Also applied to a disordered condition in plants.

an individual case or instance of such a condition; an illness, ailment, malady, disorder.

any one of the various kinds of such conditions; a species of disorder or ailment, exhibiting special symptoms or affecting a special organ.

fig. A deranged, depraved, or morbid condition (of mind or disposition, of the affairs of a community, etc.); an evil affection or tendency.

The term *disorder* is very closely related to the term *disease*. Although the original meaning of the word “disorder” is confusion or lack of order, that noun in the context of psychological problems signifies “an illness that disrupts normal physical or mental functions” (Simpson and Weiner, 1989).

Not all of these definitions inherently imply that a psychological illness has the exact characteristics of a physical illness, although the term psychopathology inevitably evokes that association. The *medical model* is often attributed to Freud, who was indeed a physician and who became interested in studying and treating the problem of hysteria among women in Vienna in the 1920s. He described the hysteria as a disease and described his “talking cure,” which might involve, for example, allowing a sufferer to express grief over a traumatic event, as a treatment to be administered by a “doctor.” This delighted many of his contemporaries who had previously believed that mental illness was biologically caused and incurable.

The *medical model* is the prevailing mode of thinking and communicating by and among many if not most professionals in the mental health field. It has become common in everyday conversation to refer to individuals suffering from psychological distress as “sick.” Critic David Elkins has remarked that many psychologists use medical model language so readily that they do not realize that they are doing so, being no more capable of articulating the model than fish are capable of explaining what water is (Elkins, 2009).

However, there are fervent objections to the medical model, with the most vociferous articulated by proponents of the anti-psychiatry movement in North America and the Critical Psychiatry Network in the UK. The best-known opponents of the medical model are the late Scottish psychiatrist R. D. Laing (e.g., Laing, 1960) and late Hungarian-born American psychiatrist Thomas Szasz. Szasz, for example, objects to applying the concept of “disease” to difficulties of human thoughts, emotions and relationships. He would prefer that we referred to such psychological difficulties as *problems in living*. A disease, Szasz insists, is caused by a bodily lesion that a physician can identify and treat, as by medication or surgery. Problems in living do not work this way, he argues. He offers the analogy of a television program that is not of high quality. A technician or repairman could do nothing to improve it. Szasz argues that members of the health professions cannot improve the quality of human interactions by working on the “wiring.” They propagate this myth, he insists, because their professional status is maintained and enhanced by this kind of thinking. Unfortunately, he continues, the medical model restricts the freedom of many individuals afflicted by problems in living and stigmatizes them unnecessarily (Bracken and Thomas, 2010; Szasz, 1974, 2007). Along similar lines, the late French philosopher and social critic Michel Foucault maintained that, over the past two centuries, society has been targeting the mentally ill as objects of abuse who can be isolated, repressed and punished, replacing the lepers who filled the roles

of outcasts in earlier eras (Foucault, 2006). There has been similar criticism of the “medicalization” of child psychiatry. For example, Timimi (2002), a child and adolescent psychiatrist who works for the British National Health Service in Lincolnshire, compares “biomedical” child psychiatry to a religious cult, a cult that practices racism and sexism and imperialistically imposes Western values on non-Western peoples. Disputing the very existence of the disease entities that occupy the time of contemporary child psychiatrists and psychologists, Timimi advocates a diagnosis-free helping process in which therapists and their clients exchange, as equals, their personal narratives and the feelings they arouse. Needless to say, Szasz, Timimi and those who share their views reflect only the opinion of a vociferous minority, whose opinions are repudiated by most of their colleagues. More will be said in the next chapter about the historical evolution of the medical model and about ideas pertaining to the causation of psychological disorders during the childhood years.

Mental or psycho-

The adjective “mental” in “mental illness,” “mental disorder,” “mental health,” and even “mental hygiene” has been the subject of almost as much controversy as the nouns that the adjective is used to describe. The prefix “psycho-” similarly implies that the location of psychological distress is in the mind or psyche. However, any such dichotomy of mind and body is incongruent with what has been known for a long time about the ways in which physiological processes affect thinking and behavior. The dynamic interplay of biological and mental processes has been known since ancient times. The rejection in modern medical science of any artificial distinction between the two is sometimes attributed to the influential psychiatrist Adolf Meyer (1866–1950), who taught that human beings are integral organisms. Their thoughts and emotions can affect biological function down to the cellular and biochemical level. Conversely, processes

at the lowest biological levels can affect thoughts and emotions (Cicchetti, 2006).

Georgaca (2013) observed that many people with mental illness find it comfortable to believe and assert that their problems are of physiological origin. They see doing so as legitimizing their problems and relieving themselves of responsibility for them. On the other hand, anything they might then say about their problems may be understood by other people as the result of the distorted thinking of a “sick” person.

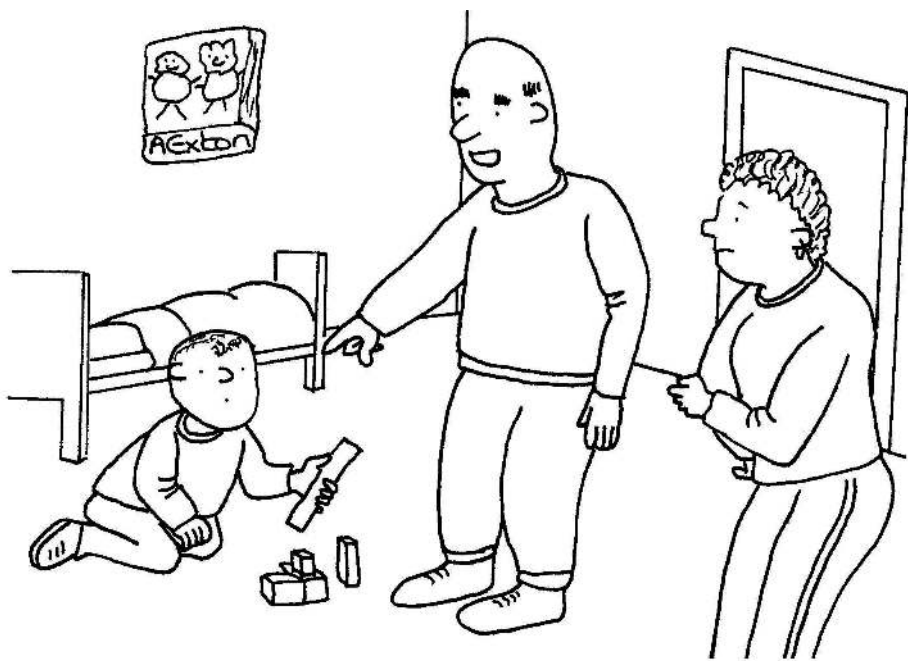
Atypical or abnormal

The concept of normality and its opposite, abnormality, can be interpreted in a number of different ways, each conveying different metaphors and each having advantages and disadvantages. Abnormality can be understood, first of all, statistically: What is quantitatively unusual or atypical is considered abnormal. This does, of course, have the advantage of objectivity; all that is needed is information about the frequency in the population of the behavior in question. Invocation of the adjective “atypical,” however, can also be construed as a glorification of the typical. Some infrequent behaviors can be innocuous, even positive. Creative genius, for example, is rare. It is surely inappropriate to consider a child who cultivates musical, artistic, literary or mathematical talents as abnormal, however few such children might be.

Furthermore, there may be nothing inherently wrong or dysfunctional with behaviors that characterize a minority. The classic example of this is homosexual behavior, which, after a generation-long battle within the mental health professions, is no longer considered abnormal per se. Hence, although many authors use the terms *atypical development* and *atypical behavior*, few do so wanting to reinforce the tyranny of the majority in any way. It is important to note that, as with much of the terminology discussed in this section, the adjective “abnormal” has acquired a negative connotation in common parlance that is not inherent in its dictionary definition.



Figure 1.1 Homosexuality is no longer regarded as a mental disorder.



“You’ll have to excuse George: he suffers from perfectly normal child disorder.”

Figure 1.2 “Symptoms” must be understood against the backdrop of normal human development.

Discarding the notion of atypical or abnormal in the strict statistical sense in favor of a definition based on what society defines as abnormal does not constitute much of an improvement because many cultures may regard some behaviors or traits as deviant for reasons that are arbitrary or even wrong from a moral standpoint. Even though the behaviors need not interfere with either the lives of the individuals who display them or the functioning of society, the sanctions imposed by the culture may create maladjustment for the stigmatized group. Homosexuality is, again, the classic example.

Abnormal as maladaptive

Mealey (2005) proposes an evolutionary definition of normality/abnormality in which traits, behaviors or attributes that reduce an individual's chances of adaptation, survival and reproduction are considered abnormal. He extends this concept to traits, behaviors and attributes that may not necessarily affect the likelihood of survival, adaptation and reproduction of the people who exhibit them but which interfere with the potential of other people to survive, adapt and reproduce. As an example in child psychopathology, he cites conduct disorder, which violates the rights of other children and/or adults even though it may enable the child diagnosed with conduct disorder to achieve some misguided objective of their own.

This evolutionary definition is somewhat different from a medical definition of abnormality, which refers to some part of the human organism not working properly. Related to it is the notion that the dividing line between normal and abnormal should be drawn on the basis of danger to the person or to those around him or her (Comer, 2006). This concept is not invoked very frequently because many forms of child psychopathology, disabling as they may be, constitute no real danger to anyone but those who suffer. This is especially the case for anxiety and depression, which are very common.

Emphasizing the dysfunction in daily living that results from a disorder or condition has been widespread since Freud, who, in response to a question, stated that *lieben und arbeiten* (love and work) are the defining features of adaptation, happiness and mental health. In reflecting on how this idea might be applied to adjustment and maladjustment during childhood, eminent American child psychologist David Elkind suggested adding the element *spielen*, play, as the work of children (Elkind, 1988). Elkind is a fierce opponent of young children being pressured into precocious academic achievement and adult roles. However, it is certainly reasonable to consider schooling from the start of formal education as the major work of children. Given the importance of relations with other children for adjustment from that stage on, schooling and relationships might well be considered the childhood analogues of work and love in the adult psychoanalytic literature. Whatever disrupts success in those two domains might be considered pathological.

Development, not individuals, seen as abnormal, atypical or pathological

It is important to reflect upon exactly what is considered maladaptive, abnormal or atypical – children or their development. A basic precept of the emerging interdisciplinary field of developmental psychopathology is that the focus should be on development. Development can be considered abnormal, atypical or dysfunctional if it fails to achieve its purpose, which is to bring about adaptation to the environment and maturity (Cicchetti, 2006). The field of developmental psychopathology is based on the centrality of developmental processes in the conceptualization of mental illness and mental health. One of its core assumptions is that much can be learned about normal functioning by studying abnormal functioning and that, vice versa, studying abnormal developmental patterns can help elucidate the nature

8 Normality and abnormality: basic definitions

of normal developmental patterns (Cicchetti, 2006; Rutter and Stevenson, 2010).

Developmental psychopathology has been defined as “the study of the origins and course of individual patterns of behavioral maladaptation” (Sroufe and Rutter, 1984, p. 18). Developmental psychopathologists focus on the interplay between normal and abnormal development. Individuals can “cross the line” between normal and abnormal in either direction at many different points in life. The maladaptive symptoms evident at the moment at which they surface must be understood in broader perspective as elements of a process that has been going on for a long time and that will continue. The onset of a disorder is unlikely to be the one-to-one, linear result of some traumatic event, although a traumatic event may be its trigger (Perret and Faure, 2006). Therefore, it is important for researchers to study the development of individuals throughout the lifespan, focusing particularly on important transition points. Developmental psychopathologists are interested in comparing the *trajectories* of development for individuals who are and who are not experiencing psychological difficulties. They seek to learn why individuals who have experienced different background conditions and processes may end up in the same state (*equifinality*) and why individuals who start out at essentially the same point and seem initially to be developing in the same ways turn out differently at the end (*multifinality*). In illustrating the concept of a developmental trajectory, Sroufe (1997) offers the metaphor of a growing tree. Its various branches share a common trunk, representing the species-wide programming for development, which then subdivide and grow in their own directions. However, they might meet again, at some later stage. A developing child may follow a trajectory consisting only of successful adaptation to the successive crucial tasks that are encountered at different stages. Another individual’s trajectory may start and continue with unsuccessful adaptation. Individuals following a trajectory that starts with successful adaptation at the early stages of development but continues into a failure to adapt

at later stages are likely to come to the attention of mental health professionals. However, the opposite trajectory – starting with a failure to adapt that is overcome at later stages – is highly informative, though often overlooked, as will be discussed shortly.

In the few decades since the emergence of developmental psychopathology as a movement and way of thinking, considerable progress has been made in tracing across time and developmental stages the course of many forms of adjustment and maladjustment. Still, much less is discussed about resistance to disease than about susceptibility to it. This is true of both physical and mental diseases throughout the lifespan. *Resilience* or *resiliency* refer to the capacity to achieve good adaptation despite being exposed to risk factors. The study of the processes associated with resilience is especially important in developmental psychopathology. Resilience has emerged as a distinct area of enquiry in the past 40 years, although as a research field it is minuscule in comparison to the largely opposite processes by which a child comes to display a mental health problem. Much of the initial impetus for studying the *protective factors* that may explain why some children who are exposed to many of the *risk factors* that often lead to mental illness came from the identification of some individuals who failed to develop adult schizophrenia despite clear signs that they are at risk because of genetic endowment or parental history of psychosis. The late American psychologist Norman Garmezy coined the term *invulnerable* to refer to this phenomenon (Garmezy, 1991). Hopefully, researchers will continue the legacy left by his pioneering work, equipped with the scientific knowledge and tools that have emerged in recent years in the areas of behavioral and molecular genetics (see Chapter 4).

Developmental psychopathologists emphasize the study of human development across the lifespan. They emphatically refute the contention that an individual’s destiny is fully shaped in the early childhood years although they very definitely recognize the importance of those years. Instead, they argue that an individual is affected by

experiences that occur at all points in life (Perret and Faure, 2006; Sroufe et al., 1999). Despite its emphasis on development across the lifespan, the developmental psychopathology movement has done much to facilitate a conceptualization of psychopathology that is suitable for children. It has disseminated a depiction of children not as junior adults but as organisms that are undergoing active growth and change and who are adjusting to a social environment that is itself undergoing change in most cases. It has been several centuries since childhood has been regarded by most of Western society as a distinct period characterized by its own challenges and miracles. We no longer think of children as adults-to-be needing a bit of care before they can assume their places at work in the fields beside their parents and older members of their communities. Instead, we now provide schools and other institutions to foster their development in a variety of ways. However, it unfortunately remains important to invoke quite frequently the fact that conceptual schemes designed to organize the mental health field in general may not fully fit the trials experienced by children and adolescents. Also overlooked all too frequently is the fact that the developing minds and bodies of children are not likely to react to treatments of all kinds in the same ways that adult bodies and minds do.

At the same time as it has raised awareness of the importance of developmental processes, the field of developmental psychopathology has raised the methodological standards of the research that is needed before ideas are accepted and rejected. It has done so by placing a premium on longitudinal research, especially longitudinal research that encompasses multiple causal factors, both genetic and environmental, as well as multiple outcomes. Influential longitudinal studies of child psychopathology have been conducted not only in large cities of the United States and the UK but also in such places as the Hawaiian island of Kauai (Werner, 1989), the Isle of Wight, off the southern coast of England (Rutter et al., 1976) and the island nation of Mauritius in the Indian Ocean (Raine et al., 2010).

Developmental psychopathologists might not object to the diagnosis of a disorder in a child at a particular moment in time. However, they have done much to remind us that the moment in time at which the diagnosis occurs is just that – a moment in time. That diagnosis might be just one part of the data that should be considered in studying the developmental trajectory of an individual in distress and in gathering the information needed to help bring that individual back onto a trajectory of adaptation to successive developmental tasks. Other data that might inform the demarcation of a developmental trajectory might consist of overt behaviors, information about interpersonal relationships and internal mental representations of the self and of the social environment (Perret and Faure, 2006; Sroufe et al., 2000).

Developmental psychopathologists revere the natural processes of human development but do not resist efforts at changing them to assist individuals or groups of individuals who are experiencing challenges in adapting to their environment. In fact, they regard intervention as a learning opportunity. By changing one element in a sequence of events, much can be learned about the effects of the phenomenon that has been modified. The eminent American developmental psychologist Uri Bronfenbrenner influenced the field by proposing that “if you want to understand something, try to change it” (Bronfenbrenner, 1979; Perret and Faure, 2006).

Although prediction in the field of child psychopathology remains a very imprecise endeavor, the longitudinal studies that have emerged in the past century have greatly enhanced understanding of the comings and goings of the psychological disorders that affect too many children and adolescents. Among the important first fruits of the developmental psychopathology movement are the findings that certain forms of disorder, such as disruptive behavior disorders (see Chapter 12) tend to be more or less debilitating and more or less stable depending on the ages at which they first appear. The challenge facing the next generations of theorists

10 Normality and abnormality: basic definitions

and practitioners is not only how to continue and refine this longitudinal research but also to discover how to use the findings to alter the course of psychopathology over the childhood and adolescent years.

How common is child psychopathology?

Prevalence refers to the number of people in a sample or population who are affected by a particular disorder. Incidence rates indicate the number of new cases that are diagnosed within a specified time frame, often 1 year. One of the reasons why it is difficult to estimate the population prevalence of child psychopathology is the divergence in the ways in which psychopathology can be defined, as discussed in the previous sections of this chapter. Another difficulty is the fact that many children suffer from psychological problems that never come to the attention of professionals. Therefore, although data on the use of professional time for the mental health problems of children and youth are interesting for other reasons, they do not provide the best estimates of the rate of psychopathology. Better answers come from studies in which large samples of the child population are screened for indicators of psychological problems. Population estimates can be derived, first of all, by tallying the numbers of children who can be diagnosed as suffering from a particular disorder. As will be discussed in Chapter 3, the result will depend on the diagnostic criteria used. For example, many children may be very sad but their sadness does not reach the level or the chronicity needed to formally diagnose them as having major depression. Therefore, there are advantages to estimating the prevalence of psychopathology according to the known prevalence of some of the behaviors that are linked to it, such as suicide or substance abuse.

The time span studied is an important variable in the interpretation of prevalence data. It is of some interest to find out how many children display signs of psychopathology at a particular moment

in time. It is, however, probably more important to determine how many will experience mental health problems over their lifetime or significant parts of it. This is studied more rigorously by following the same children over a period of years in a longitudinal study, avoiding a number of possible pitfalls in a *cross-sectional* study – one in which children of different ages are studied at one specific moment. Furthermore, only a longitudinal research strategy can help distinguish between transitory difficulties that will usually disappear with maturity and stable problems that all too often persist over a lifetime.

Another issue to be considered is the age at which the study begins; relatively few longitudinal prevalence studies begin at birth or during the preschool years (Beyer and Furniss, 2007). This is one of the reasons why relatively little is known about the manifestation of several forms of disorder in very young children. Finally, it is important to remember that a study of the prevalence of child psychopathology, like any other study, can be no better than its measures and sampling procedures. The sample must be representative of the population. The measures, be they interviews or questionnaires, must be valid. Interviews are often more accurate because an interview can probe in detail the responses provided, revealing more subtle forms of psychological difficulty. Another important methodological feature is the scope of the problem behaviors being studied. As discussed in Chapter 3, there is considerable overlap among the various psychological disorders. The researcher must take this into account and not simply measure the individual disorders (Rutter and Stevenson, 2010). Because many of the influential longitudinal studies are by now over 50 years old, *era effects* must be considered in interpreting the statistics reported. The historical period when the study began may or may not have been one of particular political upheaval or stress. In many cultures, awareness of psychological problems has increased over time, which might increase the likelihood of respondents reporting them in a truthful manner. In general, child and adolescent mental disorders appear to have increased over the

past 50 or 60 years. The reasons for this are not fully understood. New discoveries about the disorders and better training of professionals may account for much or most of the change. However, the increasing complexities and stresses of modern life may have some effect, as may some unknown change in the environment (Maughan, Iervolino and Collishaw, 2005).

The prevalence rates of specific disorders are discussed in the subsequent chapters devoted to them. However, it may be useful at this point to note that the prevalence rates for the disorders vary greatly. The more common forms of child psychopathology – anxiety, depression, attention deficit and disruptive behavior disorders – each affect at least one child in fifteen to twenty, whereas most other diagnosed disorders each affect less than 1 percent of the child population (e.g., Faravelli et al., 2009). For that reason, the chapters in this book are not of equal length: More in-depth treatment is provided to the more common disorders.

It is also useful at this point to provide some global estimate of the prevalence of child psychopathology. The influential Great Smoky Mountains Study in the United States conducted with children from 9 to 16 years, using a rigorous interview methodology, indicated that almost 37 percent of children suffer from some form of psychological disorder at some point during that 7-year period. Just over 13 percent could be diagnosed as having a disorder at a given 3-month time point within the range covered by the study (Costello, Compton et al., 2003). A similar prevalence rate of almost 13 percent was reported in the UK for children of 13–15 years old but the prevalence rates for younger children were somewhat lower (Ford, Goodman and Meltzer, 2003). Studies in many countries, including, for example, Brazil and Russia, indicate very similar prevalence rates (Ford, Goodman and Meltzer, 2003; Goodman, Slobodskaya and Knyazev, 2005). Importantly, in longitudinal studies that begin during childhood and continue into adulthood, such as the influential

Dunedin longitudinal study conducted in New England, it has been found that most adult mental health disorders first occur during the childhood and adolescent years (Beyer and Furniss, 2007; Kim-Cohen et al., 2005). In brief, child psychopathology is far from rare.

Recovery and the “politics of hope”

If psychological problems can be seen as diseases, it is logical to speculate about the likelihood of recovery from them. Up until very recently, experts felt it important to distinguish between conditions that were likely to be lifelong and conditions that might be transitory. As will be detailed in the chapters that follow, longitudinal studies have often revealed that many of the disorders that affect children and adolescents are remarkably stable. Although experts are very wary of generating false hope and keenly aware of “miracle cures” that are quickly debunked, research in several areas has revealed what appear to be total cures for conditions once deemed incurable. The most outstanding example is a 2013 study by Fein (2013) about thirty-four individuals previously diagnosed with autism spectrum disorder who no longer show any symptoms of the disease. Small as this sample is, it lends credence to isolated case studies indicating recovery from autism that have appeared in the years since the disorder was first identified (see Chapter 17). This publication can be considered a landmark, leading many mental health experts to become less reluctant to use the “r” word (recovery; Ozonoff, 2013). Already, there is lively debate in the field about how to define recovery. It is unclear at this stage whether “recovery” implies the total absence of the original disorder, of any diagnosable mental disorder or even of the types of psychological problems that are quite common but that do not correspond to the criteria for any disorder. As more professionals recover from their anxieties about talking about recovery, some clarity about what recovery might mean will hopefully emerge.