

Abnormal Psychology in Child Development

Howie Fine
Birkbeck College



1

Session Outline

- Defining abnormality
- Psychological Approaches
- Categorising Disorders
- Childhood Disorders
- Learning Disabilities
- Autism
- Learning Disabilities (Academic)
- Eating Disorders and Gender Identity Disorder
- ADHD and Conduct Disorders
- Malingering
- Review

2

What Is Abnormal?



Can we decide what is abnormal on the basis of facts or is our view of what is abnormal based on some value judgment?

- It is difficult to give an exact definition because mental disorders can encompass so many aspects of functioning.
- A psychological disorder:
 - constellation of symptoms that create significant distress or impairment in school, family, relationships, or daily living.

3

Defining Abnormality



- Abnormality can be defined by events at the levels of:
 - The brain (by biological or structural abnormalities)
 - Person (by objective behaviors and subjective distress)
 - Group (in which abnormality is defined by the culture and the context of the behaviors).
- Obvious symptoms of abnormality
 - Psychosis
 - Obvious impairment in ability to perceive and comprehend events accurately, or gross disorganization of behavior
 - Hallucinations - Mental images so vivid they seem real
 - Delusions - Enriched false beliefs that are often bizarre
- Not so obvious
 - Depression, Anxiety, Repetitive thoughts/behaviors

4

Explaining abnormality

- ❑ In ancient Greece, Hippocrates attributed mental illness to imbalances in 4 fluids.
- ❑ In the Middle Ages and up through 17th century mental illness was attributed to demonic possession or other work of the devil.
- ❑ In the early and middle 20th century, Freud's psychodynamic model was the standard for understanding abnormality.



5

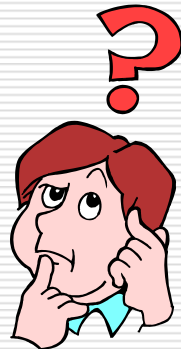
Explaining abnormality

- ❑ Behaviour is judged abnormal not because actually it intrinsically abnormal but because it is deemed to be abnormal by the set of values held by society.
- ❑ e.g. ***Drapaetomania*** (*Wakefield, 1992*) an illness that afflicted slaves in the southern state of the USA; the main symptom of this was running away from the owner, which was treated by administering a beating!
 - Therefore, it is extremely difficult to avoid value judgments when deciding when someone's psychologically abnormal or disturbed.

6

Abnormality should be defined in terms of:

- ❑ Deviation from the norm
- ❑ Social conformity
- ❑ Cultural relativity
- ❑ Abnormality as coping



7

Psychological Approaches to Mental Health and Distress

- ❑ Focus on five frameworks:
 - Biological and medical
 - Behavioural
 - Psychodynamic
 - Humanistic
 - Systemic
- ❑ The frameworks can be seen as located at one of three levels of analysis:
 - Societal
 - Interpersonal
 - Individual.

8

Categorising Disorders

- ❑ 1st Edition *DSM* was published by APA (1952), based on psychodynamic theory.
- ❑ *DSM-IV* published in 1994 - tries to avoid relying on any one theory.
- ❑ The *DSM-IV* has 5 axes for categorising disorders, defining 17 categories of problems and almost 300 mental disorders
- ❑ It has been criticised on several grounds:
 - Introduced categories that define medical problems as psychological disorders.
 - No discrete boundaries for separating normality from abnormality.
 - Many disorders are not clearly distinct from each other.

Cultural bias!

9

DSM-IV

- ❑ Axis I: Clinical Disorders
 - Consider more short-term or treatable(?)
 - Depression, ADHD, Anxiety
- ❑ Axis II: PD and Mental Retardation
 - Clinical disorders that are longer lasting, more difficult to treat
- ❑ Axis III: General Medical Conditions
 - Head injury or substance use
- ❑ Axis IV: Psychosocial and environmental problems.
 - Divorce, family loss
- ❑ Axis V: Global Assessment of Functioning
 - 0-100 rating of how well person is doing

10

Some DSM-IV Categories

<u>Category</u>	<u>Features</u>	<u>Examples</u>
Infancy, Childhood, or Adolescent	Symptoms usually diagnosed in childhood	Autistic Disorder Tourette's Disorder
Substance-related	Effects of seeking or using drugs	Substance abuse
Eating disorders	Disturbances in body image, eating	Anorexia nervosa Bulimia nervosa
Impulse-control disorders	Inability to resist actions that may be harmful	Kleptomania, pyromania

11

Childhood Disorders 1

- ❑ ADHD
 - Predominately Inattentive type - day dreaming, poor focus
 - Predominately Hyperactive type - always on the go
 - Combined type
- ❑ Conduct Disorder and Oppositional Defiant Disorder
 - Show antisocial type behaviors, often challenging
- ❑ Learning Disorders
- ❑ Depression, anxiety..
 - Classified under adult - hard to differentiate in children
 - Internalising disorders are often missed

12

Childhood Disorders 2

□ Autism

- Stereotypical behaviors
- Lack of theory of mind development
- Related to disturbance in SHT and see overgrowth of brain as an infant

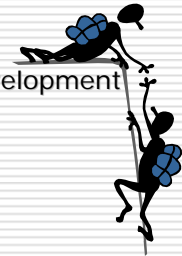
□ Asperger's Disorders

- High function autism (?)
 - Often gifted in some areas
 - Poor social skills and motor clumsiness
-

13

Learning Disabilities

The Psychology of Child Development
Howie Fine
Birkbeck College



14

Definition of Learning Disabilities

- Significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behaviour, and manifest during the developmental period

DSM IV Diagnostic Criteria

- Significantly below average intellectual functioning, with an IQ of approximately 70 or below on an individually administered IQ test or, for infants, a clinically based judgment of significantly below average intellectual functioning
-

15

Some points about intelligence

1. Intelligence is not knowledge, though it is associated with the capacity to acquire knowledge
 2. Though people may differ in terms of specific abilities, it is general intellectual ability, or g , that is critical in the definition of Learning Disabilities
 3. DSM criteria presuppose that assessment is carried out using an IQ test that has standard deviation of 15
-

16

Definition of Learning Disabilities 1

- ❑ Significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behaviour, and manifest during the developmental period
- ❑ DSM IV Diagnostic Criteria
 2. There must be deficits or impairments in the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group in at least two of the following areas: communication, self-care, home living, social / interpersonal skills, use of community resources, self-direction, functional academic skills, work leisure, health and safety
 3. These criteria must both be met before the age of 18

17

Vineland Adaptive Behavior Scale Items

Age in Years	Adaptive Ability
2	Says at least 50 recognizable words Removes front-opening coat, sweater, or shirt without assistance
5	Tells popular story, fairy tale, lengthy joke, or plot of television program
8	Keeps secrets or confidences for more than one day
11	Orders own meal in restaurant Uses the telephone for all kinds of calls without assistance
16	Looks after own health

18

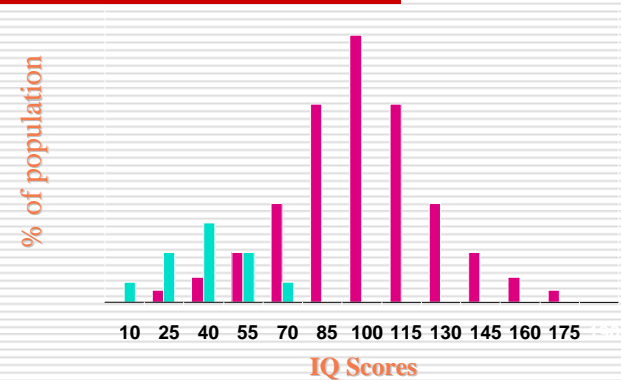
Classes of Learning Disabilities Severity

Approach taken in DSM IV

Level	IQ	% of cases
Mild	50 – 70	80
Moderate	35 – 49	12
Severe	20 – 34	7
Profound	< 20	1

19

Causes of Learning Disabilities 1



20

Causes of Learning Disabilities 2

- Therefore it is important to distinguish....
- 1. Cultural-familial etiology (75% of cases)
- 2. Specific organic pathology etiology (25% of cases)

21

Cultural-Familial Causes of LD

- The basis debate is the nature vs. nurture dispute concerning the basis of individual differences in intelligence:
- Evidence of Environmental Influence:
 - i. Twins & large families have lower IQ scores
 - ii. Maternal behaviours linked with IQ variation
 - iii. IQ correlates with socio-economic class
- Evidence of Genetic Influence:
 - Twin studies show IQ correlation patterns such as:
 - MZ twins = 0.85: DZ twins = 0.56: Siblings = 0.55

22

Specific Pathologies Causing LD 1

- Genetically-based Conditions
 - Dominant Gene Inherited Disorders
 - i. Tuberous sclerosis
 - Recessive Gene Inherited Disorders
 - i. Phenylketonuria (PKU)
 - ii. Tay-Sachs Disease
 - iii. Fragile X Syndrome
 - Non-Inherited Genetic Conditions
 - i. Down's Syndrome

23

Specific Pathologies Causing LD 2

- Environmentally-based Conditions
 - Prenatal Environment
 - i. Maternal infection (e.g., Rubella)
 - ii. Toxic exposure (e.g., Fetal Alcohol Syndrome)
 - iii. Antibody attack (e.g., due to blood RH factor)
 - Prenatal Environment
 - iv. Neural trauma
 - v. Anoxia
 - Postnatal Environment
 - vi. Childhood infection (e.g., encephalitis, meningitis)
 - vii. Toxic exposure (e.g., to lead or heavy metals)
 - viii. Head trauma

24

Therapeutic Approaches to LD 1

□ **Primary Prevention**

- i. Information campaigns to reduce risks of LD
- ii. Screening & genetic counseling
- iii. Legislation designed to reduce risks of LD postnatally

□ **Secondary Prevention**

- i. Special dietary regimes for PKU sufferers
- ii. Immediate transfusions for RH incompatible babies

□ **Intervention**

- i. Behaviour modification
 - ii. Skills training
-

25

Therapeutic Approaches to LD 2

□ Three main elements in skills training:

1. Modelling
 2. Guiding
 3. Reinforcement
-

26

Autism



The Psychology of Child Development
Howie Fine
Birkbeck College

27

History of Autistic Disorder

- Delineated by Leo Kanner (1943) - studied a sample of 11 children
- Introduced to DSM III in 1980
- Now appears in DSM-IV as one of four conditions:
 - Pervasive Developmental Disorders
 - Rett's Disorder
 - Child Disintegrative Disorder
 - Asperger's Disorders



28

Autistic Disorder vs Learning Disabilities

- ❑ Associated with no visible signs of organic pathology and with normal motor development
- ❑ Approximately 75% of autistic children score below 70 on standard IQ tests
- ❑ However, autistics show variable performance across IQ subtests, while mental retardation is usually associated with uniformly low scores
- ❑ In some cases, autistic children show specific areas of exceptional ability

29

Key Features of Autistic Disorder 1

- ❑ Extreme autistic aloneness
 - Remarkable inattention to social stimuli
 - Seems present from birth (Hutt & Ounsted, 1970)
 - Results in failure to develop social relationships or even to engage in co-operative play (Hobson & Lee, 1998)
 - Yet have capacity to discriminate different individuals (Dissanayake & Crossley, 1996)

30

Key Features of Autistic Disorder 2

- ❑ Lack of speech for communication
 - All have difficulty and around 50% of autistics never learn to speak (Volkmar et al., 1994)
 - Most who do speak do not use speech for communication
 - Common language anomalies include:
 - ❑ Echolalia
 - ❑ Rigidity & concreteness
 - ❑ Neologisms
 - ❑ Pronoun reversal

31

Key Features of Autistic Disorder 3

1. Extreme autistic aloneness
2. Lack of speech for communication
3. Good relationships with objects
4. Stereotyped ritualistic behaviours
5. Insistence of sameness
6. Occasional islets of exceptional ability

32

Incidence of Autistic Disorder

- ❑ Affects at least 2 in 10,000 children (Folstein & Rutter, 1988)
- ❑ May affect as many as 20 in 10,000 (APA 2000)
- ❑ Four times more common in boys than in girls, though this is reversed in very low IQ samples (Volkmar et al., 1993)
- ❑ Diagnostic criteria require that symptoms are evident before age of 36 months, though most commonly the problems emerge at a much earlier age (APA 2000)

33

Theoretical Perspectives on Autism 1

1. Psychodynamic theories

- ❑ Kanner (1943) - Refrigerator Parent theory
- ❑ Bettelheim (1967) - Implicated childhood trauma
 - However, careful empirical investigations have refuted the idea that parenting style causes autism e.g. Cox et al. (1975); Wing (1976)

34

Theoretical Perspectives on Autism 2

2. Biological perspective

- Evidence of neurological damage
 - ❑ Autistic children have higher incidence of birth complications
 - ❑ Rate of autism increased 10 fold by Rubella infection
 - ❑ Around 30% of autistic also develop epilepsy
 - ❑ EEG often abnormal in autistic children (Hutt et al., 1964)
 - ❑ Autistic men have increased brain size (Piven et al., 1996)

35

Theoretical Perspectives on Autism 3

2. Biological perspective (cont...)

- Evidence of genetic involvement
 - ❑ Identical twin of autistic child has 82% chance of autism, & fraternal twin has 10% risk (Folstein & Rutter, 1978)
 - ❑ Family with one autistic child has 215 times baseline risk of a second child having autism (Ritvo et al., 1989)
 - ❑ Recent research suggests involvement of 15th chromosome (Cook et al., 1989)

36

Theoretical Perspectives on Autism 4

3. Cognitive perspective

- ❑ Autistics lack the *second order representational capacity* required to develop *theory of mind* (Leslie, 1978)

37

Therapeutic Approaches to Autism 1

❑ Biological therapies

- Antipsychotic medication has been used to reduce stereotypic behaviours in autistic children
- Ritalin has been used to reduce hyperactivity in autistics
- Anticonvulsants used to control epilepsy in autistics
- Antidepressants have been used to reduce mood-mediated withdrawal in autistics
- ❑but no medication has proven effective in treating the key symptoms of autistic disorder

38

Therapeutic Approaches to Autism 2

2. Behaviour Therapy

- Introduced by Ivor Lovaas in the 70s & 80s
- Involves programs that run for at least 40 hours per week for at least two year
- A method for very early intervention which builds on child's strengths in visual processing and memory for routines.
- Core mechanism is the operant shaping of spectrum of communicative and social skills, with heavy (at least initial) reliance on tangible reinforcers such as food
- Lovaas emphasises child's need to feel successful

39

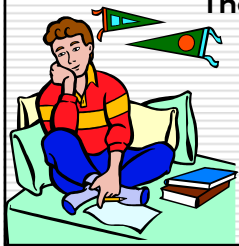
Prognosis in Autistic Disorder

❑ Without behaviour therapy prognosis is poor

- 50% of autistics institutionalised as adults, with only 5 – 17% making fair adult adjustments (Lotter, 1978)
- Childhood IQ is best predictor of adjustment
- With intensive behaviour therapy prognosis is better:
 - ❑ Of 19 children given 40 hours per week operant intervention for two years at early age, Meachin et al (1993) found:
 - Average IQ gain was nearly 30 points
 - 50% went on to regular schools
 - 40% were indistinguishable from their peers

40

Learning Disabilities (Academic)



The Psychology of Child Development
Howie Fine
Birkbeck College

41

Characteristics of Learning Disabilities

- Delay or deficit in a specific area of communicative ability, motor ability, or academic skills, that is not due to mental retardation, autism, or a demonstrable physical disorder
- Defined as a shortfall in this area of performance, relative to reasonable expectation based on an individual child's general level of intellectual ability, and educational experience
 - Therefore average performance in a skill may still be evidence of learning disability in high IQ well educated child
 - ...and an individual with LD may still show additional evidence of a more specific academic learning disability

42

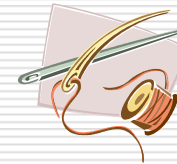
Three Main Classes of Learning Disabilities

1. Communication Disorders
 - i. Expressive language disorder
 - ii. Receptive language disorder
 - iii. Phonological disorder
 - iv. Cluttering
 - v. Voice disorder
 - In at least 50% of cases these conditions co-occur with disorders such as anxiety (Baker & Cantwell, 1987)

43

Three Main Classes of Learning Disabilities

2. Motor Skills Disorder
 - Developmental Coordination Disorder involves impairment in the development of motor coordination, that is inconsistent with general ability, and is not caused by known physical disorder

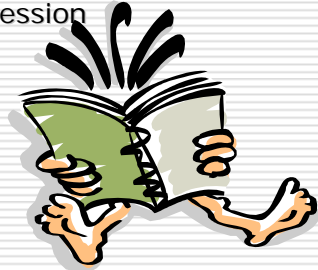


44

Three Main Classes of Learning Disabilities

3. Learning Disorders

- i. Reading disorder
- ii. Disorder of written expression
- iii. Mathematical disorder



45

Diagnostic Criteria for Learning Disorder

- ❑ Reading achievement (or achievement in writing/maths), as measured by individually administered standardised test of reading accuracy or comprehension (or of writing/maths ability) is substantially below that expected given the person's chronological age, measured intelligence, and age-appropriate education

- ❑ This significantly interferes with academic achievement or with activities of daily living

46

Epidemiology of Reading Disorder

- ❑ Affects between 5 - 15% of population (Popper & West '99)
- ❑ Incidence rate is similar for boys & girls (Wadsworth et al '92)
- ❑ Problems may be more pronounced with English than with other languages (Paulesu et al., (2001)
- ❑ Only 50% of affected individuals undertake postgraduate studies! (Shapiro & Lentz, 1991)
- ❑ Around 30% do not complete full set of GCSE's (Wagner et al., 1990)
- ❑ Compromised career aspirations common (Polloway et al., '92)

47

Proposed Causes of Reading Disorder 1

1. Perceptual Anomalies

- ❑ Affected children show difficulties recognising rhyme (Bradley & Bryant, 1985)
- ❑ Have difficulty distinguishing similar phonemes, like "da" & "ga" (Kraus et al., 1996)
- ❑ Have difficulty distinguishing similar letters, like p & q, or b & d
- ❑ Have difficulty with rapid visual processing of non-verbal material also (Eden et al., 1995)

48

Proposed Causes of Reading Disorder 2

2. Neurological Dysfunction

- ❑ Rhyme detection tasks fail to produce normal activation of left temporal cortex in affected children (Rumsey et al., 1992)
- ❑ Autopsies of dyslexics reveal microscopic anomalies in location, number and organisation of neurones on posterior language area of cortex (Galaburda et al., 1994)

49

Proposed Causes of Reading Disorder 3

3. Genetic Mediation

- ❑ Parents and siblings of affected children show increased rate of reading disorder (Popper & West, 1999)
- ❑ Twin studies show heritable component (Pennington, 1995)
- ❑ When one identical twin has reading disorder, probability of other twin having this nears 100% (Vandenberg et al., 1986)

50

Treatment of Reading Disorder

1. Readiness Skills

- Letter discrimination
- Phonetic analysis
- Letter-sound correspondence

2. Traditional Linguistic Approaches

- Instruction in listening and comprehension
- Close supervision of reading aloud exercises

3. Operant Behavioural Techniques

- To increase motivation to engage with training
- To reduce behavioural obstacles to progress

51

Abnormal Psychology: Eating Disorder & Gender Identity Disorder

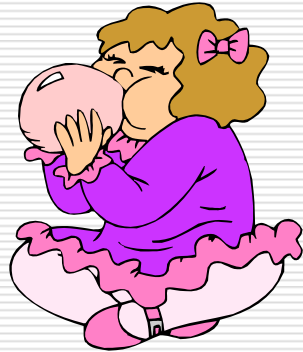


The Psychology of Child Development
Howie Fine
Birkbeck College

52

DSM IV Categories of Eating Disorder

- A. Feeding Disorder of Infancy or Early Childhood
- B. Rumination Disorder
- C. Pica
- D. Anorexia Nervosa
- E. Bulimia Nervosa



53

Characteristics of Anorexia Nervosa

DSM IV diagnostic criteria are as follows:

- i. Refusal to sustain body weight at or above 85% of normal weight for height and age
- ii. Intense fear of gaining weight or becoming fat
- iii. Disturbed experience of body weight, and/or undue influence of weight or shape on self-esteem, and/or denial of severity of current low weight
- iv. In postmenarcheal female, amenorrhea

DSM distinction between Restricting Type & Binge/Purge Type

54

Characteristics of Bulimia Nervosa

- More recent diagnostic category, introduced to DSM in 1987
- DSM IV diagnostic criteria are as follows:
 - i. Recurrent episode of binge eating (eating, in discrete period, large amount of food, with sense of loss of control)
 - ii. Recurrent inappropriate compensatory behaviour
 - iii. Binging & compensatory behaviour occur at least twice a week for at least three months
 - iv. Self evaluation unduly influenced by weight/shape
 - v. Not all criteria for Anorexia Nervosa are met
- DSM distinction between Purging Type & Non-Purging Type

55

Epidemiology of Eating Disorders 1

- 1. Incidence of Anorexia Nervosa
 - Incidence around 1% (Fairburn et al., 1993)
 - 2 out of 10,000 people diagnosed annually
 - Onset is usually in adolescence, often following a period of stress (Nolen-Hoeksema, 1998)
 - 9 out of 10 anorexics are female (Strober, 1986)
 - In 12 to 18 year old girls, incidence of anorexia exceed 1 case for every 250 individuals (Carson et al., 1996)

56

Epidemiology of Eating Disorders 2

2. Incidence of Bulimia Nervosa

- ❑ Hoffman (1994) estimates that 2 to 3% of young women affected
- ❑ Yates (1989) estimates that 4% of young women affected
- ❑ More common in females than in males
- ❑ Age of onset usually between 16 – 18 years of age

57

Epidemiology of Eating Disorders 3

3. Prognosis

- ❑ Around 70% of sufferers eventually recover, but often only after 6 or 7 years of repeated relapses
- ❑ Anorexics and bulimics often suffer serious health problems:
 - Uncommon to be fatal in bulimia, though suicide rates elevated
 - Death from starvation or from associated complications, most often heart failure, occurs in 10 – 15% of anorexics (Nielsen et al., 1998)

58

Theories of Eating Disorders 1

Biological Theories

- ❑ Anorexia & bulimia tend to run in families (Strober, 1999)
- ❑ Concordance rates for bulimia 23%-56% in MZ female twins and 5-9% in DZ female twins (Holland, 1984).
- ❑ Theories of anorexia implicate hypothalamus (Blundell & Hill, 93)
- ❑ Hormones mediating hpt depleted in anorexia (Fava et al., 1989)
- ❑ Bulimia associated with reduced serotonin (Mitchel & deZwann, 93) and reduced norepinephrine (Fava et al., 1989), which some argue triggers craving for carbohydrates (Wurtman, 1984)

59

Theories of Eating Disorders 2

Psychological Theories

- ❑ Common psychoanalytical view is that anorexia represents defense against developing sexuality (Goodsit, 1997)
- ❑ Family systems theorists (Minuchin, 75) sees eating disorder as way of coping with dysfunctional family dynamics, such as:
 - Enmeshment
 - Over protectiveness
 - Rigidity
 - Lack of conflict resolution

60

Theories of Eating Disorders 3

Psychological Theories (Cont...)

- ❑ Conditioning theorists emphasise role of reinforcement in shaping pathological eating (Thompson et al., 1995; Fairburn et al., 1999)
- ❑ Cognitive theorists emphasise unrealistic beliefs about ideal weight conveyed by popular culture, showing that this is linked to frequency of eating disorders (Eagles et al., 95; Hoek et al., 95)

61

Therapeutic Approaches to Eating Disorders 1

Biological Interventions

- ❑ Initially often involve intravenous and/or forced tube feeding
- ❑ ? Value of antidepressant in reducing bingeing:
 - 67% reduction of bingeing found in Prozac
 - 33% reduction in control group (FBNC Study Group, 1992)
- ❑ Despite suggested value of Prozac in anorexia (Kaye et al., 1991) no drug shown to increase weight gain or change core features of anorexia (Attia et al., 1998; Johnson et al., 1996)

62

Therapeutic Approaches to Eating Disorders 2

Behavioural Interventions

- ❑ Usually involve hospitalised operant programs designed to produce weight gain, through earning "privileges" for weight gained
- ❑ Effective in achieving initial weight gain (Hsu, 1991)
- ❑ Less effective in sustaining weight following discharge (Wilson 95)

63

Therapeutic Approaches to Eating Disorders 3

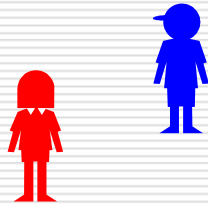
Family Therapy

- ❑ Aimed to reshape family dynamics, though likely to also provide parents with enhanced operant skills
- ❑ Good maintenance of initial gains, with family therapy, at follow ups from 3 months to 5 years (Rosman et al., 1976; Eisler et al., 1997)

64

Dimensions of Gender

- A. Biological Gender
- B. Gender Role
- C. Sexual Orientation
- D. Gender Identity



- In Gender Identity Disorder (GID) gender dimension D is *incongruent* with dimension A

65

Theories of Gender Identity Disorder 1

Nurture

- Good evidence that parents of those who develop GID permitted and maybe reinforced gender inappropriate behaviour at young age (Green, 1987; Zuckerman & Green, 1993)
- One explanation for this is that parents actually wanted child of different gender – no supporting evidence (Zuckerman, 1994)
 - Parents explanation is usually that child insisted on engaging in this pattern of behaviour

66

Theories of Gender Identity Disorder 2

Nature

- Daughters of mothers who took synthetic progestin when pregnant show tomboyish behaviour (Ehrhardt & Money, 1967)
- Sons of mothers who took female hormones when pregnant show less stereotypically male play behaviour (Yalom et al., 1973)
- Best evidence comes from the case of John Thiessen (Colapino 97)
- In 1967, an anonymous baby boy was turned into a girl by doctors at Johns Hopkins Hospital.
 - For 25 years, the case of John/Joan was called a medical triumph — proof that a child's gender identity could be changed — and thousands of "sex reassignments" were performed based on this example. But the case was a failure, the truth never reported.
 - <http://www.pfc.org.uk/news/1998/johnjoan.htm>

67

Therapeutic Approaches to GID 1

Modification of Gender Identity

- Most unwilling to engage in such approach (Tollinson & Adams, 79)
- Only three documented successful cases (Barlow, 73; 79; 84)

68

Therapeutic Approaches to GID 2

Sex Reassignment Surgery

- Typically only given after strict criteria have been met, such as:
 - Living in opposite gender role successfully for 1 or 2 years
 - Showing psychological, social and financial stability
 - Successfully negotiating hormone based approaches
- 97% of female to male, and 87% of male to female, transsexuals report satisfaction with surgery 1 year later (Green & Fleming, 1990)

69

Abnormal Psychology: ADHD and Conduct Disorders



The Psychology of Child Development
Howie Fine
Birkbeck College

70

Characteristics of ADHD

- ADHD is one of the most common reasons why children are referred to CAMHS (Popper & West, 1999)
- Temperamentally ADHD children tend to be disorganised, erratic tactless, obstinate & bossy
- Behaviourally, they show high level of haphazard & continuous movement, wearing out shoes and toys, and exhausting family, especially in structured settings
- Find difficulty sustaining friendships, making social errors and display sensation seeking behaviour (Melnick & Hinshaw, 1996)

71

Three Main Categories of ADHD 1

Specific Difficulties with Attentional Control

At least 6 of the following for 6 months or more:

- i. Fails to attend to detail, making careless mistakes
- ii. Difficulty sustaining attention to tasks or in play
- iii. Seems not to listen when spoken to directly
- iv. Fails to follow instructions to complete tasks
- v. Avoids/dislikes tasks needing sustained mental effort
- vi. Difficulty organizing tasks & activities
- vii. Loses things needed for tasks & activities
- viii. Easily distracted by extraneous stimuli
- ix. Forgetful in daily activity

72

Three Main Categories of ADHD 2

Specific Difficulties with Hyperactivity/Impulsivity

At least 6 of the following for 6 months or more:

- i. Fidgets with hands or feet or squirms in seat
- ii. Leaves seat when expected to be seated
- iii. Runs about or climbs excessively when inappropriate
- iv. Difficulty engaging in quiet leisure activities
- v. "On the go" as though "driven by a motor"
- vi. Talks excessively
- vii. Blurts out answers before questions are completed
- viii. Difficulty awaiting turn
- ix. Interrupts or intrudes on others

73

Three Main Categories of ADHD 3

Difficulties with both Attentional Control and with Hyperactivity/Impulsivity

- Simultaneously meets criteria for both 1 and 2
- In all cases:
 - Symptoms must have been in evidence before the age of 7 years
 - Symptoms must occur in at least 2 different settings
 - Symptoms must impair social, academic or occupational function

74

Characteristics of Conduct Disorder (& ADD)

- Some suggest that ADD is a precursor for CD, or an early manifestation of CD (e.g., Loeber et al., 1993)
- CD behaviours typically violate rights of others, & nearly always involve illegal activities
- Most often diagnosed in prepubescent and adolescent children, frequently following involvement of the justice system
- CD behaviours more deliberate & intentional than in ADHD
- CD often comorbid with substance abuse
- CD linked to antisocial problems in adulthood (Loeber, 1991),
- though 50% show remission across 1-4 years (Lahey et al., 1995)

75

Epidemiology of ADHD

- Despite differences from CD, at least 30% of ADHD children are comorbid for CD (Hinshaw, 1987)
- ADHD occurs in 4 – 12% of children aged between 6 and 12 years (Brown et al., 2001)
- ADHD diagnosis is four times more common in boys than in girls (Baumgaertel et al., 1995), though perhaps because in boys it involves more behavioural problems
- ADHD usually identified by age 3 or 4 (Barkley, 1987)
- 70% of sufferers experience problems as adults (Hart et al., 1995; Barkey et al., 1996)

76

Psychological Theories of ADHD

- Consequence of authoritarian upbringing (Bettelheim, 1973)
- Consequence of operant reinforcement
- Consequence of modelling (Ross & Ross, 1994)

- Little compelling empirical evidence to support these accounts

77

Biological Theories of ADHD 1

A. Genetic Condition

- Relatives of ADHD children show increased rates (Biederman, 1992)
- Parent with ADHD - 50% of offspring ADHD (Biederman, 1995)
- MZ twins more concordant than DZ twins (Sherman et al., 1997)
- This elevated concordance also revealed in adoption studies (van den Oord et al., 1994)

78

Biological Theories of ADHD 2

B. Neurological Anomalies

- Frontal lobes are under-responsive (Rubia et al., 99; Tannock, 98); unusually small (Filipek et al., 1997)
- Reduced blood flow to frontal lobes (Sieg et al., 1995)
- ADHD children most impaired on frontal tasks (Barkley, 1997)
- Underactive portions of right hemisphere too (Riccio et al., 1993)

79

Biological Theories of ADHD 3

C. Environmental Toxins

- Little support for the ideas of Feingold (1975) that certain food additives cause ADHD
- Well controlled studies demonstrate inefficacy of Feingold diet in reliably reducing ADHD symptoms (e.g., Barkley, 1990)
 - However, maternal smoking during pregnancy increased risk of ADHD threefold (Millberger et al., 1996)

80

Therapeutic Approaches to ADHD 1

- Biological Interventions
 - Most common are Ritalin, Dexedrine and Cylert (prescribed to 80% of ADHD)
 - In 75% of cases provides ST improvement in concentration, goal directed & classroom activity & social interaction (Spencer, 1996)
 - Less evidence of LT benefits to academic performance (Weiss & Hechtman, 1993)
 - Problematic side effects (Dupaul et al., 1996), and contributes to drug abuse in school settings (Leleand, 1995)

81

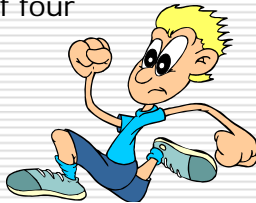
Therapeutic Approaches to ADHD 2

- Psychological Interventions
 - Involve operant programs – systematic reward for on-task behaviours & penalise inappropriate disruptive behaviours
 - Implemented as token-based systems e.g. star charts and targets achieving tangible rewards (Fiore et al., 1996)
 - Includes formal parent training components and teacher training components for continuity.

82

Therapeutic Approaches to ADHD 3

- Combined Programmes
- Jensen et al., (2001) assigned 579 children to 14 months of treatment under one of four conditions:
 - Control (Community Care)
 - Medication (Ritalin)
 - Behavioural (Operant Program)
 - Both Medication and Behavioural
- Condition 4 superior over others



83

Malingering

- Malingering - People who exhibit symptoms of psychological disorders are suspected or accused of faking the disorders to avoid their work or life responsibilities, or to get attention for themselves.
- DSM-IV - The essential feature is *intentionally* producing false or grossly exaggerated physical or psychological symptoms, motivated largely by *external* incentives such as avoidance of unpleasant duties or obtaining financial compensation or drugs.
- Presenting symptoms less likely to be symbolically related to underlying emotional conflicts, as they are in dissociative and somatoform disorders.
- In malingering, there is no effort to harm anyone else to get attention for yourself (Munchausen's by proxy)

84