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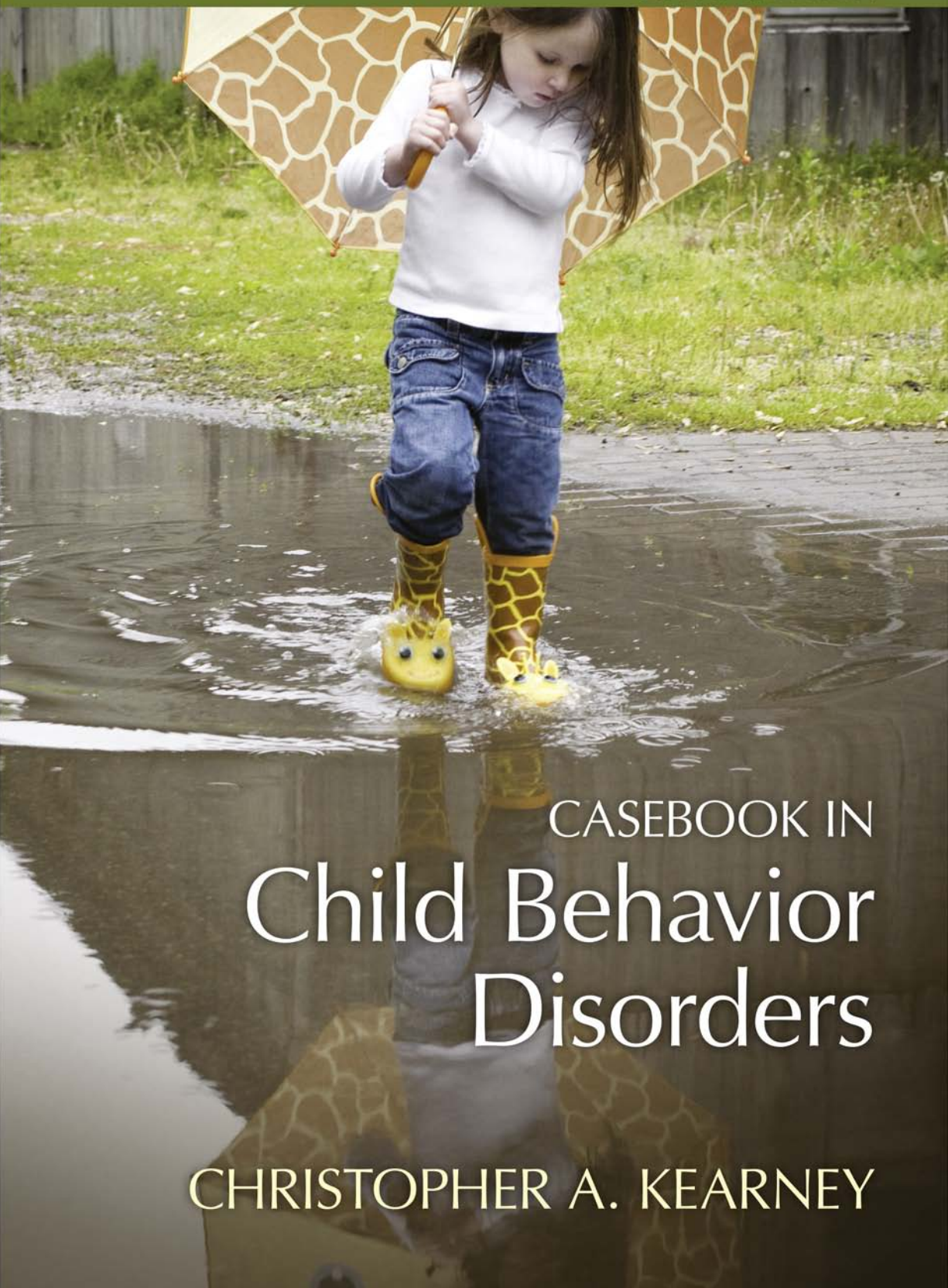

CASEBOOK IN Child Behavior Disorders

CHRISTOPHER A. KEARNEY

Casebook in Child Behavior Disorders

SIXTH EDITION

CHRISTOPHER A. KEARNEY
University of Nevada, Las Vegas

Australia • Brazil • Mexico • Singapore • United Kingdom • United States

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To my clients and students

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Preface

With the explosion of knowledge about childhood behavior disorders comes a heightened sense of responsibility to appreciate the problems these disorders create for children, their parents, and others who address these children. One goal of this casebook is to synthesize current thinking about childhood behavior disorders with the cases of specific children and their significant others, whether at home, school, or in other settings. My purpose is to show how the lives of the children and their families are both painful and disrupted on a daily basis.

Representing the Breadth of Children's Psychopathology

I present a wide variety of cases to illustrate the continuum of psychopathology in youth. The cases represent internalizing and externalizing disorders and mixed symptomatology (diagnoses?). Cases in Chapters 1, 14, and 15 purposely omit diagnoses, so instructors can discuss possibilities. Instructors can access case solutions in a special supplement. A student can derive a clinical picture for each case by reading about symptoms, major assessment methods, risk factors and maintaining variables, developmental aspects, and treatment strategies. These sections represent types of information professionals find most important when addressing a particular case. Each case concludes with questions to stimulate student review or group discussion. The breadth of these cases is reflected as well by the fact that children's presenting symptoms often differ from DSM-5 criteria and by substantial differences in treatment outcome.

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Real Cases Can Be Used in Different Settings, in Different Ways

This casebook was primarily designed for undergraduate and beginning graduate students in psychology, but the text is written so people of other disciplines and interests may find the material useful and appealing. The cases are based on actual case histories or composites of cases seen by different mental health professionals. The names and some of the details of the cases were changed to protect the confidentiality of the people involved. Resemblances to actual people are coincidental because details were altered.

An Empirical Approach

This casebook generally reflects an empirical approach derived from a cognitive-behavioral-family systems orientation. This does not imply, however, that other forms of treatment are invalid for a certain population. An intricate combination of biological and other interventions is often needed to successfully resolve a particular case of child-based psychopathology.

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About the Author

Christopher A. Kearney is distinguished professor of psychology at the University of Nevada, Las Vegas. He is also the director of the UNLV Child School Refusal and Anxiety Disorders Clinic in Las Vegas. Dr. Kearney received his B.A. from the State University of New York at Binghamton and his M.A. and Ph.D. from the State University of New York at Albany. He completed his internship at the University of Mississippi Medical Center. Dr. Kearney's research focuses primarily on the classification, assessment, and treatment of school refusal behavior and internalizing disorders in children and adolescents. He has also worked with adults with severe developmental disorders. Dr. Kearney has authored several books on anxiety disorders and school refusal behavior in youth; in addition, he has written numerous journal articles and book chapters. Dr. Kearney is a fellow of the American Psychological Association and the recipient of the Harry Reid Silver State Research Award and Distinguished Teaching Award from the University of Nevada, Las Vegas.

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Chapter 1

Mixed Case One

Symptoms

Michael Rappoport was a 9-year-old European American male referred by his parents to an outpatient mental health clinic. Michael was in fourth grade at the time of his initial assessment. His parents, Mr. and Mrs. Rappoport, referred Michael for what they described as "difficult" and "unruly" behavior. During the telephone screening interview, Mrs. Rappoport said Michael was not listening to her or to his teacher, was failing subjects at school, and was occasionally aggressive toward his 5-year-old sister. She hinted that the family was experiencing conflict and financial problems since Mr. Rappoport lost his job several weeks before. The Rappoports were scheduled for an intake assessment session that week but the family either postponed or failed to show for their appointment three times before attending.

A clinical psychologist who specialized in childhood behavior disorders interviewed Michael and his parents separately. The psychologist interviewed Michael first and found him to be polite, social, and responsive to most questions. Michael went into detail about his pets, soccer team, and neighborhood friends. When asked why he thought he was at the clinic, however, Michael shrugged and said his parents did not like him very much. He said his parents often yelled at him and that his father "hits me when I'm bad." The psychologist asked Michael how his father hit him and how often this occurred, but Michael again shrugged and did not answer.

The psychologist then asked Michael about behaviors his parents considered bad. Michael said he would often run and hide in his room when his parents fought, which was often, and that his mother did not like running in the house. He was usually in trouble for failing to do his homework and for getting poor grades in school. Michael struggled with most of his subjects. He also said he and his little sister "didn't get along."

Michael complained his teachers "yell at me for everything." His teacher often reprimanded Michael for not staying in his seat, paying attention, or completing homework assignments. Michael said the work was too difficult for him,

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especially reading assignments, and that he could not concentrate on them. He usually had to sit close to his teacher during the day because of these problems and often missed recess to complete past work.

The psychologist noticed, as the conversation turned to misbehavior, that Michael's mood became more downcast and his interaction with her more withdrawn. Michael cried at one point and said he often felt "lonely and sad." He felt deprived of time with friends at school and was embarrassed to bring his friends to his house to play. He was sad that his parents often fought and worried about what would happen in the future. Michael denied thoughts about harming himself but did muse about what his parents would think if he were dead.

The psychologist concluded her initial interview with Michael by asking him what he would like to see different in his life. Michael said he wished his father were out of the house because of the constant fighting there. Michael said he wished he did better in school and could avoid trouble. The psychologist asked Michael if he wanted to feel differently as well but Michael simply shrugged.

The psychologist then interviewed Mr. and Mrs. Rappoport. The two were clearly irritated with one another. Mrs. Rappoport apologized for the earlier scheduling postponements and indirectly blamed her husband. Mr. Rappoport rolled his eyes in response and said, "Let's get on with this." The psychologist asked both parents what brought them to the clinic. Mr. Rappoport shrugged but Mrs. Rappoport quickly listed a series of problems regarding Michael.

Mrs. Rappoport said Michael was "impossible to control." He was argumentative, boisterous, and noncompliant. Mrs. Rappoport complained that Michael would not listen to instructions and would often yell obscenities at her when she asked him to do something. Michael would also run around the house during a tantrum, which occurred almost every day. His tantrums—which included yelling, crying, and punching something—often occurred after parental commands or when Mr. and Mrs. Rappoport were "discussing something." Michael would often end up in his room or be spanked by his father after these tantrums. This did little to control his behavior, however. In addition, Michael was becoming aggressive with his 5-year-old sister—he was caught slapping the child on several occasions. Michael could no longer spend time alone with her.

Mrs. Rappoport said Michael was doing poorly at school. He was failing almost all subjects and had problems with reading and spelling. This was somewhat surprising because Michael was a good student up to the middle of third grade (last year). Michael was difficult to control in the classroom, often throwing tantrums and complaining the work was too difficult. He often refused to do his homework and had to sit near his teacher so she could better monitor his behavior. Michael's academic problems and misbehavior grew so bad that his teacher, Mrs. Greco, suggested a referral to special education. Mr. and Mrs. Rappoport strongly resisted this suggestion, however.

Mrs. Rappoport finished her comments about Michael by saying he was often sullen and sometimes "quirky" in his behavior. Michael would often cry when upset and withdraw to his room. He was also concerned about contracting AIDS (acquired immune deficiency syndrome). One of Michael's classmates returned to class following a bout with hepatitis and this triggered a fear of

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AIDS and other diseases in Michael. He thus washed his hands about 10 times a day to prevent possible contagion.

The psychologist then asked Michael's parents about other family matters. Mrs. Rappoport again did most of the talking and said her husband recently lost his job and that the family had financial problems. She admitted that she and her husband fought "sometimes" but did not feel this led to Michael's misbehavior. She insisted that the focus of the interview and later therapy be on Michael, who was displaying the most problematic behavior. Despite several gently prodding questions, she and her husband did not provide more detail regarding their marriage or disciplinary style.

The psychologist spoke with Michael's teacher, Mrs. Greco, with parental permission. She said Michael was a relatively good student during the first month of the year but that his grades and behavior worsened since then. Mrs. Greco said Michael was struggling with many of his assignments even though he was intelligent and could easily do the work if motivated. This seemed particularly true for assignments involving extensive reading and writing. Mrs. Greco said she never recommended Michael for special education, as claimed by Mr. and Mrs. Rappoport, but did feel that Michael's parents needed to take a more active role to address their son's academic problems. She also speculated that Michael's parents, who were difficult to address in their own right, were a primary cause of many of Michael's problems.

Mrs. Greco said Michael's misbehavior was becoming intolerable as well. She complained her student was often noncompliant, inattentive, and disruptive. She described how Michael refused to do assigned work by throwing papers, crying, and stomping his feet around the room. She thus sent him to the principal's office about once a week. Michael was overactive and needed reminders to sit in his seat. He demanded a substantial amount of attention from Mrs. Greco, who said her ability to attend to the rest of her class was suffering.

The psychologist felt Michael and his family had several problems that needed treatment. Michael had a combination of internalizing, externalizing, and academic problems. His family was marked by substantial conflict and intense life stressors. Potential maltreatment from corporal punishment was also an issue the psychologist believed she would have to explore further.

Assessment

The general purpose of assessment, or collection of information on children and their families in a clinical setting, is to answer three basic questions:

1. What is the behavior problem?
2. Why is the problem continuing to occur?
3. What is the best treatment for the problem?

These questions may seem straightforward but are sometimes difficult to answer. This is especially so in a complicated case like the Rappoports'.

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The first question—"What is the behavior problem?"—might raise several additional questions. Is there an actual behavior problem that needs to be addressed? Was Michael referred for treatment because his behavior was truly abnormal or because he upset his parents and teacher? Some of his behaviors might be developmentally appropriate for a 9-year-old. What if a child's behavior problem understandably results from family variables such as conflict, disarray, maltreatment, or negative parent attitudes? What if the "behavior problem" lies more with the family than with the child? Michael's sadness may have been due to his parents' fighting. A psychologist does not automatically assume a child is the one who needs the bulk of attention during treatment.

Deciding upon the behavior problem can also be difficult if one person such as a child says no problem exists and other people such as parents disagree. A therapist should look for behaviors that clearly interfere with a child's daily functioning. Several of Michael's behaviors did so and therefore needed to be addressed. If a child does have behavior problems, then a decision must be made as to which behaviors are most severe and should be addressed first. Different symptoms from different disorders overlap in many youths referred for treatment. Michael certainly had several overt symptoms but his acting-out behaviors might have been linked to more serious internalizing problems such as anxiety or depression.

The second question to be answered from an assessment—"Why is the problem continuing to occur?"—is fraught with difficulty as well. A therapist must determine what *maintains* each behavior problem in a child. These maintaining variables, as mentioned throughout this casebook, include sensory reinforcement, attention, escape from aversive situations, and tangible rewards such as money. Different variables maintain different behaviors, as may have been true for Michael. His tantrums and aggression toward his sister could be a way to get attention; his handwashing could be a way to escape or reduce worry about contamination; his noncompliance could be a way to solicit bribes from his parents.

These questions—"What is the behavior problem?" and "Why is the problem continuing to occur?"—refer to form and function of behavior. Knowing the form *and* function of a child's behavior makes answering the last major question easier; that is, "What is the best treatment for the problem?" Suppose Michael's most severe behavior problem was his tantrums at home and school (form). Eliminating this behavior problem might help reduce other behavior problems such as general noncompliance. Suppose also that Michael's tantrums were motivated by attention from parents at home but escape from work at school (function). Michael's parents might wish to ignore his tantrums at home but Michael's teacher might wish to work through his tantrums at school and not allow him to leave class.

Mental health professionals use various assessment methods to answer these questions; these methods are described in this casebook. Common methods include interviews, self-report and cognitive measures, self-monitoring, physiological and medical procedures, role-play, parent or family and teacher measures, sociometric ratings, direct observation, and intelligence, achievement, and personality tests. A multidimensional approach to assessment is often necessary to evaluate different areas of functioning (e.g., social, academic, intellectual, emotional) that may be problematic.

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Michael and his parents were administered versions of the Anxiety Disorders Interview Schedule—a semistructured interview that covers various internalizing and externalizing disorders (Silverman & Albano, 1996; Silverman, Saavedra, & Pina, 2001). The psychologist diagnosed Michael with three disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). One disorder involved an internalizing problem, the second involved an externalizing problem, and the third involved an academic problem. The psychologist rated each disorder as moderate to severe. Michael also endorsed fears of medically related stimuli (e.g., sickness, germs, hospitals, injections), social and evaluative situations (e.g., large crowds, being criticized), and parental arguing.

Michael completed self-report measures such as the Multidimensional Anxiety Scale for Children 2 (MASC 2) and Revised Child Anxiety and Depression Scales (Chorpita, Moffitt, & Gray, 2005; March, 2013). Michael indicated he was often tearful, indecisive, shy, and unhappy in school. He worried about schoolwork, evaluations from others, the future, what his parents would say to him, and bad things happening to him. He had nightmares, trouble concentrating, and various somatic complaints such as feeling sick to his stomach. Michael believed terrible things would happen to him, that he was alone, and that he could never be as good as other kids. Michael seemed anxious and depressed about different areas of his life. Areas of most concern included his current family situation, medical status, social evaluations, and future events.

Michael's parents completed the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001), Family Environment Scale (FES, 4th ed.; Moos & Moos, 2009), Parental Expectancies Scale (PES; Eisen, Spasaro, Brien, Kearney, & Albano, 2004), and Revised Dyadic Adjustment Scale (RDAS; Ward, Lundberg, Zabriskie, & Berrett, 2009), which is a measure of general marital satisfaction. Mr. and Mrs. Rappoport endorsed high levels of attention problems and aggressive behaviors on the CBCL. They emphasized their son's impulsivity, nervousness, poor school performance, arguing, meanness, disobedience, screaming, temper tantrums, and demands for attention. They endorsed few internalizing symptoms. Mr. and Mrs. Rappoport rated their family as conflictive and detached on the FES and confirmed their high expectations that Michael should take much responsibility at home on the PES.

Mr. and Mrs. Rappoport indicated on the RDAS that they frequently disagreed with one another in several areas, especially finances. They rarely had positive conversations with one another or showed affection. These responses contrasted somewhat with their verbal reports during their interview. The Rappoport family was clearly in distress but Mr. and Mrs. Rappoport continued to see Michael's externalizing behaviors as the main problem. They referred especially to his noncompliance and disruptive behavior.

Other assessment instruments in this case included the Teacher's Report Form (TRF; Achenbach & Rescorla, 2001), a continuous performance test, and the Wechsler Intelligence Scale for Children (5th ed.; Wechsler, 2015). Michael's teacher, Mrs. Greco, completed the TRF and emphasized Michael's social and attention problems, especially his regressive behavior, crying, lack of concentration, impulsivity, disorganization, and underachievement. A continuous performance test, which

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measures impulsivity, indicated that Michael's speed of response resembled that of children with attention-deficit/hyperactivity disorder (ADHD). Michael's intelligence test score was in the high average range, suggesting that his academic problems were not because of intellectual deficit. Michael was instead performing far below his ability.

The psychologist believed Michael had various behavior problems that were not well defined. Different functions maintained many of these problems as well. On top of all these, Michael's family situation involved marital tension, conflict, financial stress, and possible maltreatment. Any treatment program would thus likely have to involve the entire family and a complex strategy.

Risk Factors and Maintaining Variables

Several models have been proposed to explain causes of childhood behavior disorders. Psychodynamicists emphasize inborn sexual drives and intrapsychic personality conflicts as precursors to later psychopathology. Attachment theorists speculate that a caregiver's failure to provide for an infant's needs could lead to future psychopathology in that child. These models may have some relevance for youth but the validity of both remains an open question.

A more widely held etiological model, and one mentioned throughout this casebook, is a behavioral one. Behaviorists claim children learn or receive reinforcement for abnormal behaviors. Examples include parents who inadvertently reward noncompliance, family members who provide sympathy for depressive behaviors, and peers who reward delinquent behaviors. Social learning theorists propose that children imitate or model inappropriate behavior of others. Examples include increased child aggression following parental spanking and excessive substance use after watching others drink alcohol or use illegal drugs.

Learning models did seem to apply to Michael's behaviors. Parental attention reinforced his aggression. Social learning triggered Michael's medical anxieties, fear of AIDS, and handwashing. Several of Michael's classmates discussed the student who had hepatitis—describing his hospital stay, isolation from others, injections, and constant need for cleanliness. Like many 9-year-olds, they exaggerated the stories. Michael took them seriously, however, and thus became fearful and compulsive in his handwashing.

Cognitivists believe child psychopathology relates to distorted thought processes that trigger or maintain behavior problems. Examples include anxiety and depression from irrational thoughts of negative evaluations from others and eating disorders maintained by irrational beliefs about beauty and weight loss. Affective theorists claim that some people have difficulty regulating their emotions and subsequently have trouble with motivation, behavior organization, or communication with others. Someone who was maltreated may experience ongoing anxiety or arousal from cues that remind him or her of the maltreatment and this may lead to posttraumatic stress disorder.

Distorted thought processes were not clearly an issue for Michael but he did worry about present and future events. His emotional state was excitable and Michael therefore had problems regulating his behavior. Because of his

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excitability and impulsivity, he had difficulty concentrating on his schoolwork, organizing materials, maintaining conversations with others, and controlling temper tantrums. These problems subsequently led to poor grades, feelings of isolation, and punishment for disruptive classroom behavior.

Child psychopathology clearly relates as well to biological factors. Biological risk factors include genetic predispositions, chromosomal aberrations, central nervous system changes, neurochemical imbalances, and stress and temperament. Evidence supports a genetic predisposition for several disorders such as depression. Chromosomal aberrations such as Down syndrome often lead to moderate intellectual disability. Central nervous system changes can lead to specific developmental problems such as learning disorder or to pervasive disabilities such as autism. Neurochemical imbalances, stress, and difficult temperament influence problems as diverse as social anxiety and ADHD. A medical examination revealed no outstanding problems for Michael. Less obvious problems such as subtle brain changes or ongoing stress, however, might partly explain his misbehaviors.

Family systems models may help explain childhood disorders that result from inconsistent parenting or family dysfunction. The Rappoports' ongoing conflict might have sparked Michael's behavior in several ways. The stress of the conflict could have triggered his sullenness, withdrawal, and isolation. His parents' verbal threats to one another regarding harm or divorce might have fueled Michael's worries about the future. Such depression and worry could then lead to difficulties in concentration, lack of motivation, and poor schoolwork. Mr. and Mrs. Rappoport's fighting also took time away from disciplining Michael for his behavior. Michael's tantrums and other disruptive behaviors were often ignored until they became severe.

Each of these models—psychodynamic, attachment, behavioral, social learning, cognitive, affective, biological, and family systems—holds that specific causal pathways lead to childhood behavior disorders. No one model successfully explains all aspects of a childhood disorder, however. The complexity of childhood disorders instead demands an integrative approach. Combinations of variables from these different perspectives, or multiple causal pathways, are needed to explain fully the etiology of a disorder. Different child, parent, peer, and teacher factors influenced Michael's behavior. The presence of multiple causal pathways suggests as well that successful treatment for children with behavior problems must involve many targets.

Developmental Aspects

Developmental psychopathology refers to study of antecedents and consequences of childhood behavior disorders and how the disorders compare to normal behavior development (Lewis & Rudolph, 2014). An important task of developmental psychopathologists is to identify pathways that lead to normal development, mental disorder, or some fluctuation of the two in children. A developmental psychopathologist may wish to discover what child and family factors lead to depression. He or she might also want to know what factors prevent the development of

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depression, what factors help a person with depression return to mental health, and what factors maintain depression over time.

An important task in developmental psychopathology involves discovering whether childhood behavior problems are stable over time and whether they lead to problems in adulthood. Some childhood behavior problems are *very* stable over time. Consequently, they usually interfere with functioning in adulthood. Examples include autism, profound intellectual disability, and aggressive forms of schizophrenia. Severe forms of late adolescent problems, such as conduct disorder or excessive substance use, may carry into adulthood and create ongoing difficulties.

Other childhood behavior problems remain *fairly* stable over time. They may or may not lead to problems in adulthood depending on severity of the disorder and whether early intervention occurs. Examples include ADHD, learning disorders, aggression, school refusal behavior, eating disorders, pediatric conditions, and effects from maltreatment.

Other childhood behavior problems tend to be *less* stable over time. These problems may dissipate but could still cause problems over time if aggravated by negative environmental events. Examples include fear, anxiety, depression, and elimination disorder.

Childhood behavior disorders may be stable over time but symptoms of the disorders may not remain the same. Children with ADHD tend to become less overactive as they mature, but ongoing restlessness and difficulty concentrating as well as lagging social development create other problems in adolescence. Similarly, a child who wants to coerce items from family members may do so using noncompliance in childhood but aggression in adolescence. A child behaviorally inhibited as a preschooler may avoid new social situations in childhood and become depressed in adolescence.

Symptom change was evident for Michael. His problem behaviors at age 9 differed somewhat from his preschool days but some of his general behavior *patterns* remained the same. His parents described Michael as an "ornery" child who was fussy and who complained about what he had to eat. Mrs. Rappoport also said Michael was a "very sensitive child" who overreacted to criticism and inadvertent contact from others. These general characteristics were somewhat imbedded in Michael's current behavior problems. His temper tantrums were a regressive way of coping with stress and his sudden fear of disease was an overreaction to his classmates' stories. Michael's behaviors were different over time but his behavior patterns were somewhat stable.

Variables that help determine the stability of a childhood behavior problem involve proximal and distal factors (Hayden & Mash, 2014). Proximal factors are those close to a child that have more direct impact on his behavior, such as

1. development of a disorder early in life, especially one that affects language;
2. major changes in a child's brain or other physical status;
3. early and ingrained learning patterns;
4. strong biological predispositions triggered by early environmental events;

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5. ongoing experiences that threaten a child's self-esteem and social and academic competence;
6. obstacles that lead a child to pursue more maladaptive behavior patterns.

Regarding the latter, obstacles such as family conflict or sexual maltreatment could initiate an adolescent's noncompliance or increased alcohol use.

Michael did not have major stressors or biological problems early in life. He did learn that one of the best ways to get parental attention, however, was to act inappropriately. Michael effectively trained his parents over time to give him attention when he was noncompliant, aggressive toward his sister, or problematic in school. In addition, Michael experienced several obstacles when he tried to build long-term friendships, such as loss of recess at school and discomfort bringing potential friends to his house. Lack of friendships then led to maladaptive behaviors such as social withdrawal and depressed mood.

Other factors that affect the stability of childhood behavior problems are distal ones, or those that indirectly affect a child. Distal factors include

1. poverty and/or homelessness;
2. marital conflict and/or inconsistent or neglectful parenting;
3. loss of a parent early in life;
4. severe family dysfunction;
5. general community disorganization.

Marital conflict was most pertinent to Michael. Some of Michael's tantrums were triggered by his parents' fighting or were done deliberately to get his parents to stop fighting.

Treatment

Treatment for the Rappoport family got off to a rough start. Mr. Rappoport became progressively more withdrawn and, after 3 weeks, stopped attending therapy. He did agree, however, to speak with the psychologist by telephone and to help his wife with therapy procedures. Mrs. Rappoport remained adamant about maintaining the focus of treatment on her son. The psychologist, in response, spent the first four sessions describing the family mechanisms behind many of Michael's behaviors and the necessity of including Mrs. Rappoport and Michael's teacher in therapy. Mrs. Rappoport reluctantly but eventually agreed to participate in the therapy. She also agreed to consider the psychologist's recommendation that she and her husband pursue marital therapy.

During this 4-week period when Mrs. Rappoport considered her role in the therapy, the psychologist worked with Michael to address his fear of disease and excessive handwashing. Michael was fully educated about the transmission of disease in general and of AIDS in particular. The psychologist focused on external causes and internal effects of illness much to Michael's fascination. His self-reported anxiety

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