CLINICAL CHILD AND ADOLESCENT PSYCHOLOGY

Third Edition

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CLINICAL CHILD AND ADOLESCENT PSYCHOLOGY

From Theory to Practice

Third Edition

Martin Herbert
University of Exeter

To the memory of a distinguished academic
and clinical psychologist

TONY CARR

CONTENTS

ABOUT THE AUTHOR

Martin Herbert is Professor Emeritus at Exeter University. He was previously a lecturer and clinician at the Institute of Psychiatry in London. This was followed by the post of Director of the School of Social Work and Professor and Head of the School of Psychology and clinical training at Leicester University. He later joined the National Health Service full time and was in charge of the Mental Health Service for children in Plymouth. This post was succeeded by a move to Exeter, where he founded and directed the Doctoral Course in Clinical Psychology as Professor of Clinical and Community Psychology. He was appointed to the Consultant Clinical Psychology post in the Child and Adolescent Department at the Royal Devon and Exeter NHS Health Care Trust. For several years he was a Mental Health Act Commissioner. He now specialises in personal injury psycho-legal work and the evaluation of parent training courses, one of which (the Child Wise Behaviour Management Programme) he co-designed for use in Sure Start and NHS settings. He has published books and journal articles on the psychological problems of children, adolescents and adults. Many of his books have been translated into European and Asian languages. Among his most recent books are *Typical and Atypical Development: from Conception to Adolescence* and *Development of Children and Adolescents: Prevention, Treatment and Training*. He was awarded the Monte Shapiro prize by the British Psychological Society for his distinguished contribution to clinical psychology.

PREFACE

It is my hope that this revised version of *Clinical Child and Adolescent Psychology* will provide a useful introduction to clinical child and adolescent psychology for trainees on postgraduate clinical courses and undergraduate students of abnormal psychology, and also serve as a 'refresher' guide for professionals in health, social and educational settings. The new subtitle 'From Theory to Practice' is intended to re-emphasize my concern in the previous editions, to make clear and explicit the links between the academic and applied aspects of clinical practice.

In my introduction to the second edition of the book, I described the challenge of trying to convey something of the flavour and substance of the clinical child psychology profession of that period. Seven years on, in which there has been a marked increase in the diversity of clinical psychologists' roles, and a wider range of effective interventions to inform their practice, the task is no less daunting. With the dramatic reduction of infectious diseases and other serious physical diseases of childhood, emotional and behavioural disorders have become the new 'morbidity'. This is not a misnomer given the fact that 10–12 per cent of children and adolescents in the general population manifest such disorders. British children with their families, attend a wide variety of services for help with these difficulties. Having a psychiatric disorder predicts a substantially increased contact with social services, special educational resources, the youth justice system and mental health services (Ford, Hamilton, et al., 2005).

Given the uniqueness of each and every child and family, their need for help at times of distress will differ in important ways. The range of psychological interventions required to meet these needs is of necessity wide and varied. They include the following:

- assessing and treating children and adolescents with internalizing problems such as anxiety and depressive disorders, and externalizing ('acting out') disorders such as oppositional–defiant and conduct problems;
- planning and initiating cognitive–behaviour therapy, family therapy and other treatment programmes;

- training parents, teachers, nurses and care staff in the management of disruptive children;
- counselling foster parents on the management of disruptive children;
- conducting psychometric and clinical assessments of infants and children with learning disabilities and developmental delays;
- leading treatment and training interventions for children with learning difficulties and development disorders (e.g. autistic children);
- counselling parents of children and adolescents with emotional, conduct and develomental problems;
- contributing to parents' groups for infants with feeding, sleeping and toileting problems;
- planning and leading parent and teacher behaviour management groups;
- crisis counselling for adolescents who have taken drug overdoses;
- liaising/consulting with health visitors, school nurses and other health professionals;
- counselling/training staff and parents in voluntary groups (e.g. *Sure Start*);
- preparing children (and their parents) for hospitalization;
- counselling bereaved parents with terminally ill children;
- initiating bereavement programmes for children and young people;
- providing stress management for staff working with chronically disabled and terminally ill children;
- providing training and consultations for mental health and child care staff on child protection issues;
- planning and initiating research programmes;
- supervising trainees and colleagues.

THE CLINICAL PSYCHOLOGY KNOWLEDGE BASE

Clearly, with professional roles as diverse as these, the knowledge base required by people entering the profession, or working as qualified psychologists, is extensive, and training takes several years. Kathleen Berger (2000), acknowledging the difficulties of organizing the vast inter-disciplinary scope of a contemporary curriculum on human development, subdivides the subject into three domains:

- *biosocial*, which includes the brain and body, and the influences that direct changes that take place in them;
- *cognitive*, which includes thought processes, perceptual abilities and language acquisition, and
- *psychosocial*, including emotions, personality and interpersonal relationships with family, friends and the wider community.

All three interactive domains are important in different ways for every aspect of human behaviour and personality, and for each age and stage of development. They merge, at all levels, in the main therapeutic approach adopted in this book, cognitive–behavioural therapy.

COGNITIVE–BEHAVIOURAL THERAPY (CBT)

CBT includes a wide range of therapeutic techniques predicated upon the principle that there is a close interrelationship among thoughts, feelings and behaviour. The efficacy of CBT will be reviewed for the treatment (among others) of

- child and adolescent depression,
- the anxiety disorders (e.g. school refusal, panic disorder),
- post-traumatic stress disorder (PTSD),
- obsessive–compulsive disorder (OCD),
- eating disorders (e.g. anorexia nervosa; binge eating disorder),
- the conduct disorders and
- delinquency.

I shall provide background information on the common elements to cognitive–behavioural treatments, some general principles in the administration of CBT, developmental considerations in the use of this method with children and adolescents, and integrated applications of CBT and pharmacotherapy.

CHILD AND ADOLESCENT DEVELOPMENT

A basic assumption of the book is the proposition that much so-called 'abnormal' behaviour in children is not very different from 'normal' behaviour in its development, persistence and susceptibility to change. Behavioural genetics, an important theoretical source, provides evidence that in several problem areas (e.g. autism and reading disability) there is a genetically influenced continuum between what is normal (typical) and abnormal (atypical). It is therefore vital when working with the atypical problems of childhood to have an understanding of what is typical in children's development – what they think, feel, do and say, as they grow up.

It seems more fruitful to ask how children develop behaviour in general, rather than to limit the question to how they acquire abnormal or impaired behaviour as such. Having taught clinical and developmental courses for several years to professional students and practitioners, I am conscious of how limited the cross-fertilization between the developmental and clinical branches of psychology remains. Such mutual exclusiveness is particularly

unfortunate when it comes to understanding the competencies and life-experiences of children with atypical (abnormal) disorders.

In the light of observations such as these, I have had to ask myself yet again the awkward questions that confronted me in the earlier edition: 'Which developmental/clinical subjects should I leave out; which mention in a somewhat cursory fashion and which discuss at greater length and with more depth?'. Readers who are disappointed with some of my choices will find references to the relevant literature, making up (hopefully) for any undue brevity or omissions of topics of particular interest to them.

AN ECOLOGICAL MODEL

My task for the third revised edition is more than an update of the literature. I have attempted to integrate and broaden the scope of the major theoretical foundations of this book: cognitive and social learning and developmental theory. Jay Belsky (1993) proposes an ecological model that integrates interactions between various levels of influence on behaviour:

- The *micro-system* comprises the child's own characteristics and immediate environment.
- The *exo-system* includes social factors that impinge, for example, on the family at risk of domestic violence.
- The *macro-system* is the larger cultural fabric that comprises broad societal attitudes to child-rearing and related matters.

This is a conceptual model that recognizes that emotional and behavioural problems of early life are multifactorial in causation. At each level of this complex interacting system, influences known to be associated with particular styles (for example) of childcare and discipline can be assessed. For example, certain attributes of caregivers may predispose them to indulge in a particular (perhaps physically abusive) activity. Their style of parenting will in turn reflect their own developmental history, knowledge of child-rearing and mental state; also social milieu. These influences, as they affect the child or adolescent at different stages of development, will be a major theme of the book, as are the skills of diagnosing and assessing clinical and developmental disorders. These include the following competencies:

- screening;
- testing;
- making observations;
- constructing formulations;
- planning and negotiating interventions;
- monitoring;
- evaluating.

ACKNOWLEDGEMENTS

ORGANISATION OF THE BOOK

The book divides into five parts, each of which provides background information to the chapters it introduces. In Part I (Chapters 1–4) of the book we examine the ideas and methods by which physical, cognitive, behavioural and emotional disorders and disabilities are assessed and diagnosed. The way a formulation is conceptualized and the consequent selection of data describing the patient's (client's) problems are described step by step, illustrating the rationale of the process in terms of its purpose and underlying theoretical assumptions.

Part II (Chapters 5 to 7) includes an examination of the development and problems (and treatment) of children from the prenatal to the pre-school stages of life. Part III (Chapters 8 and 9) is about the school-going period and considers externalizing and internalizing problems ranging from conduct to emotional disorders. It introduces the disruptive child's classroom behaviour, and strategies for its management. Part IV (Chapters 10 and 11) is about positive mental health and mental illness in early adolescence and young adulthood, and deals with antisocial activities and delinquent disorders. In Chapters 12 and 13 of Part V there are reviews of the plight of children with special needs such as pervasive developmental disorders (e.g. autism; learning disabilities) and of children with serious, sometimes terminal, illnesses (e.g. cancer). Chapter 14 also considers young people whose lives (at any of the ages or stages of development described in the book) are blighted by physical and emotional trauma. The book ends with five appendices:

Appendix I provides details of the Child-Wise Behaviour Management Course.

Appendix II outlines the Child-Wise combined research and clinical child interview.

Appendix III contains the Fear Survey Schedule for Children – Revised, plus a definitive account of the psychometric validation of a psychological test.

Appendix IV includes a guide for parents treating their teenager's panic disorder.

Appendix V lists tests used by clinical psychologists for research and/or clinical purposes.

Part I

INTRODUCTION: THE NATURE OF THE PROBLEM

THE REFERRAL

Parents' concerns about the wellbeing of children often arise from disappointed expectations about *what* and *when* a child should be capable of certain accomplishments, a notion in their minds of a 'developmental timetable'. They (and teachers) may also become worried about the children and teenagers in their care when their behaviour appears (i) to be out of control, (ii) unpredictable or (iii) lacking in sense and meaning. If these tendencies are persistent and extreme they are likely to be labelled as 'problematic' or 'abnormal'. It is misleading to think that families, each of which is unique, will necessarily be troubled by similar-appearing problems to the same extent. The vulnerability of parents to their children's difficulties varies from individual to individual. The differences in 'worry thresholds' mean that parents arrive at referral agencies with children's (and personal) problems that range widely from mild to severe and from typical to atypical (see Herbert, 2003). One mother's concern about her 'emotionally disturbed' daughter, or the 'trauma' her son has experienced at the hands of a bully, may be shrugged off by another more resilient (or uncaring?) parent with 'Oh! It's just one of those things… S/he'll get over it'.

When a child's development seems to be delayed (e.g. in speaking), 'odd' (e.g. autistic) or antisocial (e.g. aggressive), it is quite likely that a sequence of referrals (starting with the family doctor) will lead to a consultation with a clinical or educational psychologist, child psychiatrist or paediatrician. The findings of the team in which they work could lead to a reassuring statement ('there is nothing untoward'), or perhaps some advice. The referral may, however, turn out to involve problems with more serious implications, for example

- a developmental disorder of language and/or learning,
- behavioural difficulties with peers and adults,

- problems with social relationships or
- profound impairments of mental and physical functioning.

Current practice is to assess the developmental needs of individual children relative to their physical and social circumstances. 'Special needs' are specified in terms of what a child requires above and beyond those requirements normally supplied for all children. These needs might include psychological, speech or physiotherapy, special diets, medication, aids to mobility and special educational provision or residential accommodation for children with severe disabilities.

SPECIAL NEEDS

Children are thought to be 'in need' (in today's legislation) if

- they are unlikely to achieve or maintain, or have the opportunity of achieving, or maintaining, a reasonable standard of health or development, without the provision for him/her of specified services by a local authority (Part III of the *UK Children Act*) or
- they are likely to be significantly impaired, or further impaired, without provision of such services or
- they are developmentally disabled. The term 'development' means physical, intellectual, emotional, social or behavioural development; and 'health' refers to physical or mental health.

EMOTIONAL AND BEHAVIOURAL PROBLEMS OF CHILDHOOD

In many respects the emotional and behavioural problems of childhood are exaggerations, deficits or disabling combinations of feelings, attitudes and actions common to all children. Although on a continuum with 'normality', they may result (inter alia) in

- underachievement at school,
- an inability to forge or maintain friendships and
- rebellious relationships with authority figures.

Some of these children are

- awkward in social encounters and experience difficulties in their peer relationships,
- inhibited and fearful,
- insecure when separated from their parents and
- hypersensitive about their peers' opinion of them.

Indirect predisposing
influences

Direct influences
Current (proximal)
circumstances

Hereditary factors
Family upbringing
Temperament, Attitudes
Health/physical impairment
Intellectual ability/disability
etc.

CHILD AND
ADOLESCENT
BEHAVIOUR
PROBLEMS

Opportunity (access to drugs,
desirable goods susceptible to
'lifting')
Provocation
Interference
Stress
Access to reinforcement
etc.

Indirect contextual
influences

Nature of school ethos,
neighbourhood values, peer
group membership
Other affiliations

Historical (distal)
influences e.g. early learning,
separations, trauma etc.

Figure I.1   The source of emotional and behavioural problems

In general, these youngsters tend to cope poorly with the challenges and frustrations of life. The problems often prove to be transitory. However, many go on to suffer from more severe, complex and persistent mental health problems: emotional and behavioural disorders ranging from selective mutism, school refusal, and social phobias to oppositional–defiant and conduct disorders and delinquent activity. Figure I.1 illustrates the many influences, contemporary and historical, direct and indirect, that are potentially involved as precursors to these problems.

Some of the emotional disorders (e.g. obsessive–compulsive problems) are serious enough to affect the youngster's ability to lead and enjoy a normal life. Such cases usually require a specialist assessment and treatment programme following a psychiatric or clinical psychology consultation at a *Child and Adolescent Mental Health Service* (CAMHS). There is a further group of children and adolescents whose mental disorders are so severe that they require intensive (possibly residential) psychiatric treatment, and adjunctive psychosocial support in a CAMHS agency. Psychotic disorders (e.g. schizophrenia), bipolar (clinical) depression and severe feeding disorders (e.g. anorexia nervosa) are examples of what are referred to as 'mental illnesses'. They tend (as is the case with the problems above) to involve a significant biological causal component in what are usually multi-factorial conditions.

Some children are likely to be referred to a *General Hospital* or *Paediatric Development Centre* for physical health and developmental difficulties, for example

- failure to thrive,
- persistent headache,
- abdominal pain,
- bronchial asthma,
- eczema,
- bladder and bowel incontinence,
- chronic fatigue syndrome,
- management problems such as overcoming fear of injections or non-compliance with medical prescriptions,
- assistance in the management of chronic pain, head injuries or terminal illness or
- developmental disorders (e.g. cerebral palsy).

MULTI-AGENCY WORK

The United Kingdom *National Health Service* has undergone repeated changes throughout the 1990s. CAMHS are required to engage in increased consultation and liaison with other agencies working with children. A conceptual model for the child mental health services is made up of tiers or levels of specialization.

- *Tier 1* represents non-mental-health professionals working with children with mental health problems.
- *Tier 2*, with the introduction of primary child mental health workers, is used to describe professionals with specialist child mental health skills working within tier 1.
- *Tier 3* refers to contact with more than one member of the district CAMHS multidisciplinary team.

ACCESS TO SERVICES

The 1999 *British Child and Adolescent Mental Health Survey*, a nationally representative epidemiological study (Meltzer et al., 2000) of childhood psychiatric disorder in Great Britain involved 10 438 children aged 5–15 years. Follow-up surveys of a third of the children seen in the initial survey, and a sample of participating parents, at 20 months (and 3 years), examined the persistence of disorders. The findings paralleled American studies. By the first follow-up, just under half of the children (46.6%) who had a psychiatric disorder at time 1 had not subsequently accessed services. Teachers were the most commonly consulted agency (43.6%),

while children were least likely to be in contact with social services (11.6%). A fifth (22.1%) had been seen by a CAMHS agency.

MULTI-DISCIPLINARY INVOLVEMENT

The conduct and delinquent disorders provide a good example of how childhood psychopathology crosses the traditional disciplinary boundaries of care. Those children who display extremes of aggressive antisocial behaviour at home may require behavioural treatment from a clinical psychologist. At school their 'challenging' behaviour leads often to failure, classroom disruption and suspension, requiring attention from special needs coordinators and educational psychologists. Their deviant behaviour as they enter their pre- or full-teen years may escalate into truancy, neighbourhood delinquency and drug-taking activity, leading to psychiatric, social work and/or probation service interventions.

BACKGROUND TO CHAPTERS 1–4

In the following four chapters we shall view the ways in which disabilities and disorders are assessed, treated and diagnosed. The way in which a formulation is conceptualized, and the consequent selection of data describing the patient's (client's) problem, vary according to the nature, purpose and theoretical assumptions of the agency and the professionals who work in it. There is no single 'correct' way of arriving at a remedial, preventive or treatment programme (see Herbert, 2005). Different disciplines have designed assessment or diagnostic protocols, for example the social work *Core Assessment* leading to a multi-agency plan of action for a 'child in need', or the educational *Statement of Need* for 'special' educational provision.

Chapter 1

CLINICAL DIAGNOSIS AND ASSESSMENT: THEORETICAL CONSIDERATIONS

A clinical assessment generates a set of hypotheses about the nature and causes of children's psychological difficulties, which, in turn, lead directly and logically (ideally) to a formulation and plan of action, designed to help them and their families. This formulation might be a multi-level, broadly based programme involving several members of the team (e.g. psychiatrists, psychologists, speech, occupational and physiotherapists, special education coordinators and social workers), or it might result in an single-handed therapy strategy for which a psychologist or psychiatrist takes responsibility.

APPLIED SCIENCE AND CREATIVITY IN CLINICAL WORK

The knowledge base for (i) formulating explanatory hypotheses, (ii) determining and evaluating a test of the formulation and (iii) translating it into a treatment plan has its roots in psychological science as well as art (creativity and divergent thinking). It is worth noting that the training of clinical psychologists in the UK as 'applied scientists' has long been an article of faith (perhaps I should say 'conviction') originating, in large part, from the examples set by Monte Shapiro and Hans Eysenck at the Maudsley Hospital in the 1950s and 1960s. The emphasis on clinical work based on empirical research has a resonance with the present demand in the health service for evidence-led service delivery and accountability (Long & Hollin, 1997).

There are, however, gloomy prognostications that the applied science model is in retreat. Lilienfeld, Lynn and Lohr, authors of *Science and Pseudoscience in Clinical Psychology*, published in 2003, suggest that 'over the past several decades, clinical psychology and allied disciplines (e.g. psychiatry, social work, counselling) have been witness to a virtual sea-change in the relation between science and practice. A growing minority of clinicians

appear to be basing their therapeutic and assessment practices primarily on clinical experience and intuition rather than research evidence' (p. 1). Certainly there are highly respected critics such as John Marzillier (2004), who has argued in an article entitled 'The myth of evidence-based psychotherapy' in *The Psychologist* (9 July 2004), that the relationship between clinical practice and scientific empiricism is not self-evident.

Perhaps the dream of an absolute and thus uncompromising scientific objectivity in the study and mitigation of young people's mental health problems is a chimera. Psychological disorders, after all, cover a wide spectrum of problems ranging from the existential and amorphous (e.g. an adolescent's sense of alienation, angst about the meaning of life, or morbid preoccupation with his or her identity and lack of self-esteem) to those that are tangible and specific (e.g. fears about attending school, obsessions with germs and irrational jealousies).

The humanistic approaches, so often a feature of counselling and therapeutic work, focus on experience and feeling rather than fact, on subjectivity rather than objectivity and on concerns that are excluded (many would argue) from scientific method. An example of this approach might be the need of an articulate introspective young person for in-depth, goal-free discussions of his or her concerns.

THE IDIOGRAPHIC APPROACH

Gordon Allport, one of the most distinguished personality theorists of the last century, was convinced that the 'nomothetic approach', employing objective procedures and statistical data averaged across individuals, was misleading, in the sense that it describes everyone in general and no one in particular. Allport contrasted the emptiness and aridity of what has been referred to as 'the psychology of the stranger' with the richness of the idiographic approach. *Developmental psychopathology*, a major theoretical theme in the book, with its focus on the origins, course and individual nature of psychopathology, is essentially 'idiographic' in its approach to clinical practice.

It is rooted in developmental psychology, and is thus concerned with variations in the course of typical (normal) and atypical development. It takes into account the 'personal stories' and meanings of life's events, and the idiosyncratic way in which people behave in social and other situations. Holmbeck et al. (2004, p. 35) suggest that the field of developmental psychopathology 'has provided us with a vocabulary with which to explain phenomena that are relevant to therapists and researchers (e.g. risk and protective processes, cumulative risk processes, equifinality, multifinality, heterotypic continuity, resilience, developmental trajectories, distinctions between factors that produce symptom onset versus those that serve to maintain or exacerbate existing symptoms)'.

While it is true that each person is 'an idiom unto himself, an apparent violation of the syntax of the species' as Allport put it, there are also important ways in which individuals resemble one another. Kluckhohn, Murray and Schneider (1953) observed that 'every man is in certain respects like all other men, like some other man, like no other man'. Because we are like all other men and women, some of the determinants of our personality are universal to our species. Allport argued persuasively for the necessity of a marriage between the nomothetic and idiographic approaches in order to achieve a full understanding of the person (Allport, 1937).

The practice of clinical psychology is at its best, in my opinion, when there is a balance between the experimental–quantitative procedures of the nomothetic approach and the individually orientated idiographic procedures exemplified by (i) qualitative analyses, (ii) the serendipitous style of illuminative research, (iii) intra-subject ($N = 1$) treatment programmes and (iv) case studies (see Bromley, 1986; Herbert, 1990; and Chapter 2). Clinical psychology as a discipline contains a creditable amount of science, and vast resources of empirical information. However, the scientist–practitioner's science is not, and because of the exigencies of clinical work cannot be, of the kind represented by what Bernard Notcutt called 'scientism', a pharisaical insistence on the letter rather than the spirit of scientific method (Notcutt, 1953). At the risk of labouring the point, I wish to underline the *craftlike skills* of professional clinical psychologists who engage their patients in therapies that are a blend of applied science and art.

There is, for example, the art of teaching children and adult caregivers; the art of finding and using imaginative materials to capture the interest of children and adults; the art of explaining abstract principles to, and unravelling complex problems with, patients. There is also the all-important art of increasing patients' perceived self-efficacy by means of a collaborative therapeutic endeavour (Webster-Stratton and Herbert, 1994). The 'marriage' of experimental and experiential approaches provides the ingenuity, range and depth of analysis required for the subtle multilevel problems that characterise, so often, childhood psychopathology.

THE STAGES IN A FORMULATION

Stage I. Assessment: The 'what' question

The many complex activities that contribute to a clinical formulation begin with the question 'what'. What is the priority in any clinical investigation of a child's presenting problems: description or categorisation? This debate centres on the concepts of clinical (psychosocial) assessment and clinical (diagnosistic) classification.

Clinical assessment and diagnostic classification

Clinical assessment aims to differentiate, operationalise and measure those behavioural, cognitive and affective patterns considered to indicate psychopathology. As defined by Rune Simeonsson and Susan Rosenthal (2004), it encompasses the use of varied procedures to evaluate and record developmental and psychological characteristics (e.g. behaviour, attitudes and relationships) of the child and, where appropriate, the parents, the family and the school.

Clinical classification, according to Taylor and Rutter (2002, p. 3), is more like a language than a collection of objects. It supports communication and provides an aid to thinking about complex problems. They state that 'the virtues of a good scientific classification are clarity, comprehensiveness, acceptability to users and fidelity to nature; a scheme should change as understanding alters. Each class in the scheme is a concept, not a thing. Its value is in relating individual cases to others, and a scientifically powerful class will do so in ways that are important to the user and include a good deal of meaning. When a case is assigned to a powerful class, many predictions follow'.

Clinical Diagnosis

Formal diagnostic classification involves grouping individuals according to their distinguishing dysfunctional (problematic) patterns of behaviour, cognition and emotion. The best known systems are (i) *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and (ii) *The International Classification of Disease* (ICD-10; WHO, 1992).

(i) *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders*. Underlying the American Psychiatric Association publication of the fourth edition of the DSM-IV is the assumption that specific syndromes (disease patterns) with identifiable and (in somewhat rare cases) specific causes can be diagnosed. Besides diagnostic criteria, the DSM-IV also provides information about mental and emotional disorders, covering areas such as probable causes, average age at onset, possible complications, severity of impairment, prevalence figures, gender ratios, predisposing factors and family patterns.

A system of dimensional (as opposed to categorical) diagnosis based on five axes was introduced for the first time in the third edition of the DSM in 1980 (DSM-III). In the fourth edition (DSM-IV) the axes are as follows.

Axis I: the major clinical syndromes are
   mental disorders
   substance-related disorders
   schizophrenia and other psychotic disorders

mood disorders
anxiety disorders
somatoform disorders
factitious disorders
dissociative disorders
sexual and gender identity disorders
eating disorders
sleeping disorders
impulse control disorders
adjustment disorders
cognitive disorders (e.g. dementia).

Axis II: is designed to specify the personality disorders (e.g. lifelong deeply ingrained patterns of destructive behaviour), and mental retardation (sic), namely

paranoid
schizoid
schizotypal
antisocial
borderline
histrionic
narcissistic
avoidant
dependent
obsessive compulsive.

Axis III: considers any general medical problems that the patient manifests.

Axis IV: includes any environmental or psychosocial factors affecting a person's condition (e.g. problems with the primary support group, educational problems, loss of a loved one, sexual abuse, divorce, career changes, poverty or homelessness).

Axis V: here the diagnostician assesses the person's level of functioning within the previous 12 months on a scale of 1–100:

10 = danger to self and others
50 = serious symptoms and impairment of social functioning
75 = transient impairment of social functioning
100 = superior functioning.

DSM-IVPC.   DSM-IV is encyclopaedic in range and detail, and does not lend itself to day-to-day general practice. A DSM-IV primary care version (DSM-IVPC) describes only the psychiatric disorders that regularly appear in primary care settings, particularly anxiety, depression and psychosomatic disorders.

DSM-IV-TR 2000 4E.   The American Psychiatric Association revised the text of DSM-IV in 2000 to include the latest empirical findings The text revision (no completely new DSM is expected before 2010, or later) ensures that important research that has emerged since the first publication in 1994 is available to practitioners.

(ii) *ICD-10: The International Classification of Disease.*   The 10th edition of the *International Classification of Disease* (ICD-10) came into use in World Health Organisation (WHO) member states in 1994. The ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes. WHO developed a system for use in clinical diagnosis and research (ICD-10) that contained many features designed to improve the reliability and validity of classifications of mental disorders.

   To extend this development to primary care settings, diagnostic and management guidelines were combined in the WHO book *Diagnostic and Management Guidelines for Mental Disorders in Primary Care* (ICD-10 Chapter V, Primary Care Version). The guidelines were developed by an international group of professionals, and were field-tested extensively in over 40 countries by 500 primary care physicians to assess their relevance, ease of use and reliability. In ICD-10 the axes are the following.

Axis I: clinical psychiatric syndromes
   organic mental disorders
   mental and behavioural disorders due to psychoactive substance use
   substance-related disorders
   schizophrenia, schizotypal and delusional disorders
   mood disorders
   neurotic, stress-related and somatoform disorders
   behavioural syndromes associated with physiological disturbances and
      physical factors
   disorders of adult personality and behaviour
   factitious disorders
   dissociative disorders
   sexual and gender identity disorders
   eating disorders
   sleeping disorders
   impulse control disorders
   adjustment disorders
   cognitive disorders (e.g. dementia).

Axis II: deals with specific developmental delays and disorders (concerning speech and language, scholastic skills and motor functions), and pervasive developmental disorders (e.g. childhood autism, Rett's syndrome). They include conditions that are

    paranoid
    schizoid
    schizotypal
    antisocial
    borderline
    histrionic
    narcissistic
    avoidant
    dependent
    obsessive compulsive.

Axis III: considers intellectual level.

Axis IV: enumerates medical conditions.

Axis V: includes abnormal psychosocial situational factors affecting a person's condition (such as abnormal intrafamilial relationships; familial mental disorder, deviance or handicap; abnormal qualities of upbringing; communication problems with the primary support group; chronic stress associated with educational problems; acute life events; societal stressors).

Axis VI: the clinician assesses the person's global level of functioning within the previous 12 months, on a scale of 0–8.
    8 = profound and pervasive social disability
    5 = serious and pervasive social disabilty
    2 = slight social disability
    0 = superior social functioning.

An international version of DSM-IVPC that is compatible with the ICD-10 codes is available.

A cautionary note.   Classifications of whatever kind are open to abuse and have been criticised in various ways (see discussions by Carr, 1999; Taylor and Rutter, 2002). It is not difficult to be critical of the systems described above, despite their undoubted usefulness. To begin with, the defining of particular criteria as 'pathological' depends, among other indicators, upon ethnic values, language, education, religious beliefs or ideology, and is therefore culturally relative, and open to bias of one kind or another.
    Russel A. Barkley (1990) is of the opinion that DSM-IV criteria have (for childhood disorders such as ADHD) the following problems.

- They make no adjustments for age.
- They make insufficient adjustment for gender, despite the fact of differences.
- Behaviour problems are required to show up in several settings (e.g. home and school). In practice this means that parents and teachers must agree that the child has a particular problem before the child