DEVELOPMENTAL PSYCHOPATHOLOGY: THE APPROACH TO THE BORDERLINE CASE

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ABSTRACT

The emergence of developmental psychopathology as a independent discipline has provided various interesting ways of dealing with mental disease, particularly in children. This new approach promises to overcome some of the limitations of previous views of deviance based either on the mental psychiatric model or on different theoretical orientations in clinical psychology.

From a developmental view, psychological and medical sciences have undergone a sort of hierarchical integration in dealing with deviant behaviour. In the present work, the specific contributions of two subdisciplines, Child Psychiatry and Developmental Psychology, will be considered through the analysis of their origins, evolution and theoretical background, in an attempt to provide an integrative view of the issue.

Some of the theoretical principles claiming to support developmental psychopathology as an independent science are discussed with specific reference to their clinical implications. The advantages and limitations of a developmental approach to deviance are considered, and some controversial issues highlighted.

A particularly emphasis is placed on the approach to borderline cases where one cannot establish a well-defined psychopathological entity and therefore neither the medical psychiatric model nor the normal expectations of developmental psychology seem to be appropriate in dealing with such cases. A chapter on the definitional problem related to borderline cases is included, and their importance within the school context discussed

Some traditional systems of diagnosis and classification in child psychiatry are reviewed. In an attempt to overcome some limitations on their use in psychopathology, a modified version of a multi-axial psychiatric scheme of diagnosis and classification is proposed for use within the framework of developmental psychopathology. A case study is included aiming to illustrate a borderline case and to provide a wider discussion about the model of classification and some clinical issues.

CHAPTER I.-INTRODUCTION. -

In the last five years, the explosive growth of interest in the analysis of deviant behaviour in developmental terms has promoted a number of attempts to relate the way, degree and fashion in which traditional fields of research in behaviour (such as developmental, experimental and educational psychology and the clinical sciences of psychology and psychiatry) can contribute to a new and promising perspective of a multidisciplinary science, based on a developmental approach to deviant behaviour. This in the trend of current research has become known as: Developmental Psychopathology.

During the last three decades psychological and medical sciences adopted different theoretical frameworks directing their respective research in areas such as emotions, behaviour and mental processes toward different interpretations for the "same" observed fact. Current research in human behaviour attempts to overcome such a tendency. Thus, psychological and medical sciences have undergone a kind of hierarchical integration and are meeting together in various interesting ways.

The interaction between different sciences in an attempt to explain human behaviour in an integrated way has been fruitful in providing valuable feed-back information, produced from results of research carried out in this perspective, that could be useful in modifying the theoretical

Framework and methodology of the respective parent sciences

In the present work, I will attempt to analyse the role of child psychiatry in the building of some of the foundations of developmental psychopathology, particularly in diagnosis and classification. Similarly, I will try to evaluate the possible effects that this developmental view of deviance could have on the theory and practice in child psychiatry, emphasising the methodological approach of those children, which without invading the criteria of deviance in the field of psychiatry, face turmoil in home and the school. Hence, in appearance, they do not fulfil the expectations of normal Developmental Psychology. The term 'borderline case' has been used for a number of entities in psychiatry and clinical psychology. Hence a chapter discussing the description of what will be understood as borderline will be included.

Borderline case is placed at a middle point between developmental psychology and child psychiatry. Its seems to me that neither normal developmental psychology nor child psychiatry nor clinical psychology has provided a satisfactory framework for dealing with those children. Since a new approach must be attempted and Developmental Psychopathology seems to be a reliable alternative, its value and limitations will receive further consideration in the present work.

On the assumption that borderline cases constitute a cause of school failure in certain children. The implications, approach and management of such cases in the context of the school will be considered, remembering that in the view of developmental psychopathology, improved achievement and the general welfare of the students are

expected to depend on the coordinated work of a multidisciplinary team that includes teachers.

Because it is relatively recent, the theoretical framework of developmental psychopathology is still limited and somewhat amorphous. Further research should yield results which will lead to a refinement of the main theoretical principles invoked.

The term developmental psychopathology has been defined as the study of abnormal behaviour within the context of the effects of genetic ontogenetic, biochemical, cognitive, affective, social or any other on-going developmental influence on that behaviour. (Rolf & Read, 1984 or as defined by Sroufe & Rutter (1984).

> "The study of the origins and course of individual patters of behavioural maladaptation (p.18).

These developmental view of deviance has a basic working principle: when one can learn more about normal functioning of an organism by studying its pathology and; likewise, more about its pathology by studying its normal conditions (Ciccheti 1984).

However, some traditional conceptions of deviance must be critically analysed. That is the case with the traditional dichotic judgement of health/disease or normal/pathological.

The term 'health' is still ambiguous. The World Health Organization defined heath as "the bio-psycho-social equilibrium" and the controversy about what defines disease remains unsolved.

The term "normal" refers only to the proximity to the standards of a selected population and thus it limits and individualistic and circumstantial approach to the individual's behaviour. The term "pathological" itself indicates damage, distortion or deficit. Despite the fact that, strictly speaking, pathology is a process extended through time and must be understood in a temporal way. Instead, others terms have appeared in the literature of developmental psychopathology attempting to avoid the connotations if the term "illness". Terms such as specific developmental disorder, competence or incompetence for certain expected tasks and adaptative or maladaptive conditions are now common, carrying on implicit a view of deviance in terms of developmental achievements (Greenspan and Pogerss 1984).

Deviant behaviour has been associated with a number of social, biological and environmental factors. However, the medical model long used to conceptualise deviance as a disease or pathological state, focusing on the therapy to "normalize" and return people to a functioning capacity in the society has been widely criticised by authors working form social perspectives. Firstly, the system established of labelling children according to a traditional medical classification of diseases has often inflicted damage on children, mainly because of the difficulty of detaching such labels even after improvement (Scheff 1976) and secondly, because of the influence of labels in the diagnosis and evolution of some cases. For example, Temerlin (1968) conducted an experiment in which several American psychologists and psychiatrists diagnosed as psychotic a "patient" (actually, an actor

portraying a normal, healthy man) in a video proceeded by commentaries by a distinguished psychiatrist considering the patient a psychotic.

In the field of developmental psychology, the complexity of understanding a child's behaviour is matched by issues arising from social rules and demands, genetic influences and biological growth. A criterion of normality has been based on expected standards of achievement that define a child as normal.

Whereas, in the medical model, "deviance" has been treated as inherent to the individual, some authors have argued that its application results from a process in which rule breaking actions have been observed. Thus, in this latter view, "deviance" is a property conferred upon behaviour by people who have come in direct or indirect contact with it (Conrad 1976). Indeed, some authors have even denied the existence of mental illness (Szazs 1967).

Then controversy between those who think that deviant behaviour is labelled "deviant" aa a result of the way it is perceived by other people, (thus, rejecting certain characteristics inherent to the subject), and those defending the medical model, (who thus consider the sing and symptoms observed as guidelines for a diagnosis, classification and prognosis), could be alleviated through a wider developmental perspective in which other sciences involved in the study of the complex phenomenon of human behaviour participate in the analysis of an specific case with a multi-dimensional perspective of the individual and his / her circumstances, a different levels and different times. Therefore, a new definition of normality and deviance must be derived with respect to gender, age, context, developmental tasks and progression of development over time.

This demands that the theoretical orientation that need to be adopted in the approach to deviant behaviour must contain certain categories of variables derived from the original sciences and exclude some others. For this, comparative studies between the approaches of different sciences must be carried out in order to understand the different levels of interpretation and to establish their limitations and capacities.

The analysis of the interaction between the perspectives of developmental psychologic and child psychiatry raises some questions that ought to be solved if developmental psychopathology is to be consider a discipline standing on its own as an independent science. For example: is it appropriate to consider ALL psychological disorders of children as developmental disorders? How can insights from psychiatric practice influence research in developmental psychopathology? What is the link between psychopathology in children and adult life?

In the broad context in which developmental psychopathology seems to emerge, it is particularly interesting to compare the origins of child psychiatry and the historical evolution of its understanding of deviance with the origins and changes in the conception of deviance in developmental psychology.

The renewal of interest in the relation between children´s and adults´ psychopathology has stimulated the efforts of a numbers of researchers towards a solution of the apparent gap

between the psychiatric disorders of childhood and adulthood. Some questions might be answered through this process: is mental development in children related to future mental disorders? Is adolescence the starting point of adults´ psychiatric disorder? Are children´s behaviour predictive of future mental health?

Similarly, the diagnosis and classification of the children studied must be broadened to include salient normal developmental issues. The multi-axial diagnostic approach in psychiatry seems to offer some advantage for developmental psychopathology. However, some question must be answered: how can the multi-axial scheme of diagnosis and classification be use in developmental psychopathology? What are its advantages and limitations?

In order to understand the origins of the perception of deviance in developmental psychopathology, a historical review and that analysis of some of the most popular classificatory systems in child psychiatry can provide some information about the uses, risks and limitations of their use. They may also guide us as to the design of a diagnostic and classificatory system appropriate in dealing with borderline cases.

The dialectic interaction between the theoretical principles of developmental psychology and child psychiatry has established a new perception of the child with ill defined difficulties in the school, home or group. This developmental view is capable of producing better results in the approach of dealing with such cases.

The perspective of developmental psychopathology will allow us to improve, eventually, our knowledge of mental disease and normal behaviour. Most important the research performed in this developmental view may overcome the limitations of the different theoretical orientation that had dominated the mental health fields and that must stand up to the empirical enquiry. This sort of research must challenge the trend of producing methods of inquiry according to a given theory for a system of producing methods to test theories. In this scope, some questions have priority: can a developmental view of behaviour influence etiological explanations in child psychiatry? In this view able to promote therapeutical guidelines? Is its prognosis of mental disease reliable?

Finally, if deviant behaviour must be considered in the context of the school, developmental psychopathology should influence the way of handling the student with behavioural or emotional disturbance. Must the teacher be trained to deal with borderline cases? Is psychopathology an important variable in the students' performance? What could constitute the best experiences for researchers involved in this field?

Some suggestions derived from the present work may be worth considering in the enormous task of devising and testing the ways by which developmental psychopathology must grow. Not all the questions raised in this introductory chapter will be analysed in the same depth: some of them will remain as questions. Thera are still more questions than answers. Developmental psychopathology is emerging: It has a long way to go.

CHAPTER II HISYORICAL PERSPECTIVE

A comparative review of the origins and evolution of child psychiatry and developmental psychology may provide the rider with a better perspective on the origins and value of developmental psychopathology in the approach to deviance, particularly in children.

Psychiatry and psychology are both major contributors to psychopathology. Because they overlap so much, it is difficult to separate their respective contributions (Zubin et. al. 1985).

Historically, some areas such as phenomenology, clinical diagnosis and therapeutical regimes, germinated in psychiatry domains, while others such as behaviour modification and psychometrics emerged from de psychological laboratories. However even these historical events have not commanded general acceptance. For instance, psychologists point out that the diagnosis of mental retardation originated with the development of mental tests, while psychiatrists indicated that behaviour modification has its beginning in psychiatry (Marks 1981).

Although both fields are closely related, the study of their differential contribution to psychopathology can be made regarding their applied approach to deviance rather than through the analysis of their respective theoretical background (Zubin et. al. ibid.).

The identification and systematic classification of mental disease is not remote. For years mystical conceptions about the human mind and the dichotic separation between body and soul kept explanations of behaviour far from the result of methodical observation and mental aberration and insanity were conceived as a unitary affection that “came upon a person” no matter where or how (Schopler and Reichner 1976). “The appearance of a formal historiography of psychiatry in the 19th century, coinciding with the raise of the modern psychiatric profession, has played a strategic role in the medical, philanthropic, humanitarian and political aspects in mental health” (Farrel 1985 p.9).

A relevant issue for the present work is the so-called phenomenon of “Adultomorphism” – a tendency to see in the disorders of children, replicas and predecessors of analogous conditions in adults a distinctive character in psychiatric practice for many years (Phillips, Draguns and Bartlett 1975).

Historically, the field of child psychiatry has been adult orientated. Consequently, the study of psychopathology in children has principally been a downward extension of an extrapolation of the study of psychopathology in adults. (Garber 1984). For instance, Kraepelin in 1894, published systematic study, describing, itemizing and classifying different patterns of mental illness. In the four volumes of his monumental opus, no reference to children is found; children were not then an object of psychiatric curiosity. Henry Maudsley can be regarded as the first psychiatrist who addressed himself to childhood psychosis at a time when most of his colleagues denied its existence. In his book “pathology of mind” (1987), Maudsley dedicated 34-page chapter to insanity in early life. (see.-Bynum 1985).

In the origins of psychiatry, interpretations of deviance were made in a rather speculative way. For instance, Spitzka in 1889 declared that insanity in children was caused by heredity, fright, sudden temperature changes and masturbation. In my view, it is still sad to see mother speculative interpretation of deviance by professionals of the mental health field as illustrated by Farrel's statement considering the moral implications of psychiatry intervention: "psychiatry is not and cannot be part of the scientific enterprise".(1985). A practice based on the empirical evidence is imperative.

In May 1933, at meeting of the Swiss psychiatry society want of the trailblazers, Maurice Trammer, advocated the name "Kinderpshychiatrie" to serve as a designation for as a scientific discipline that had reached a point where it cut stand by itself.(Cranner 1976) with the stablishement of child psychiatry, a gap arose between the pathology of childhood and that of adults. Adolescents were then in middle point for which no explanations were available.

During the history of the study disease, a number of conditions that clinicians have claimed to identify as "mental illness" have been described in text books. However a definitional problem persists, and a need for a more adecuate approach to such condition in children is necessary. A number of apparent different conditions or equally labelled. For instance, the wide use of the label "hypper-active imperative child syndrome"for divers neurological and emotional disturbance and the ambiguity of the practically unlimited tipes of "neurosis"

On the other hand, developmental psycology emerged early in this century with the interest og psycologists in how and why the human organism grows and changes from its initial forms in uterus to an adult being. Inthis sense, development could be defined as the transformation in the person`s physical and neurological structures and behavioural traits wich changes in orderly measurable ways, lasting mainly for the first twenty years of life. (Mussen et. al,1981) A pionner in this field is G. Stanley Hall, who is considered by some to be the founder and catalyst of developmental psychology (Crains 1983). He investigated the "Contents in Childre`s mind" in 1981, almost at the same time as psychiatrists became interested in mental afflictions in children.

Originally, psychologists assumed that developmental changes were largely the result of biological maturations and they assumed that the age differences which they observed represented innate universal patterns of development and physical and intellectual changes. This period, between the 1920`s and 30`s was marked by a relative naïve empiricism in which researchers investigated many differents areas, collecting large scores of data with little theoretical orientation. (Vasta R. 1982). For instance, reports at the time emphasised the average height and weight at different ages, the number of words that a child must read at five etc. (Mussen et. al. ibid)

After the Second World War, experimental psychology attempted, not only to describe the behavioural and developmental changes observed but to predict and explain them. this was the time when grand theories of child behaviour and macroanalysis emerged within a dominant environmentalist view: Such researchers were reluctant to assume that children´s behaviour was biologically determined (Mussen op. cit. p.17)

The stage from the 70's is less easy to characterize in developmental psychology. However, there has been and abandonment of the strong exclusively theoretical camps. The study of the interaction of innate and acquired personal traits and the increasing interest in studying the specific proceses and mechanisms involved in behaviour are distinctive events. (Vasta p. 17 ibid) More recently, developmental psychologists have been interested in the social application of the knowledge gained about children from many years of scientific research, attempting changes in schools and other institutions for children. (Mussen et. al. op. cit.)

Child psychiatry and developmental psychology were botg influenced by the different theoretical orientations dominating the mental healthelds. For instance, the psychoanalytical school led by Freud and the behaviourist approach of Watson both agreed that the events of early years were paramount importance for later develpmenta and that entities such a neurosis in adults have predecessors in childhood disorders. (see Clarke an Clarke 1976). Psychiatrists then gave paramount mportance ti those events. Thus psychoanalyst and developmental psychologist directed their efforts to identify, measure and interpret such early events.

Jean Piaget had definitive influence on developmental psychology when he proposed tha development resulted from the interaction between maturational changes and experience and emphasized cognitive development. This is a relevant point in the building of developmental psychopatology . Piaget's influence on psychiatry although less transcendent that in developmental psychology, produce some changes in the interpretation of mental illness (see Anthony's "The significance of Jean Piaget for child psychiatry" 1956)

The overlap between psychiatry and psychology in the approach to deviance has been logically extended to their branches. Therefore, child psychiatry and developmental psychology tend to cover the same entities with different theoretical approaches: developmental psychology is mainly concerned with universal patterns of development and child psychiatry is concerned with mentally ill children. However, it seems to me, that it is in the study of individual differences, in the study of a particular child, where child psychiatry and developmental psychology share a common interest in their approach to deviance.

Numerous investigators have already related developmental psychology to child psychiatry in the study of mental disease, some of the most relevant works being: The Hartmann's monograph (1950) "Psychoanalysis and developmental psychology, Wolff's "The developmental psychology of Jean Piaget and the Psychoanalysis" (1960). Einsenberg's (1977) "Development as an Unifying Concept in Psychiatry"and Rutter's (1980) " The foundations of developmental psychopatology". However, the challenge for developmental psychopatology persists of how to combine, creatively, the two scientific disciplines – child psychiatry and developmental psychology – into a comprehensive strategy for studying children's normal and abnormal functioning at different stages of development. The interaction between the two disciplines might be fruitful in improving the approach to deviance; developmental psychology could be enriched by the vast instrumental and

methodological advantages of the current cassifications in mental disease, and child psychiatrists could find reliable explanations for the origins and evolution of certain conditions. Which in the sole framework of current pychiatryc practice remain controversial and sometimes rather speculative. As Einsberg (1977) (20) has argued: "… A developmental perspective constitutes one essential underlying and unifying concept in psychopatology of both adults and children". In a broader view, the process of development may constitute the crucial link between genetic determinants and environmental variables, between social and individual psychology, between psychogenetic and physiogenic factors. (Rutter 1980 (21))

If Developmental Psychopatology constitutes a reliable alternative to the approach of the study of normal and abnormal behaviour, it seems to be clear, that this developmental perspective will dictate a new approach to the problems of categorizations, diagnosis and classification in psychopatology, and that the research performed should provide meaningful evidence for the construction of a new and more comprehensive theory in explaining deviance.

Developmental psychopatology emerged as ana independent discipline within the field of developmental psychology making non-matked difference (sic) between normal and abnormal functiotining and its emphases are made clear by Srofe and Rutter (1984) (22) when claiming:

> The developmental psychopatologist is concerned with the origins and time course of a given disorder, its varying manifestations with development, its precursors and sequelae, and its relation to nondisordered patterns of behaviour. (p.18)

Thus , the comparative analysi between the approaches of modern child psychiatry and developmental psychology is valuable because only by understanding the nature of developmental process - with progressive transformation and reorganization of behaviour, as the developing organism continually transacts with environment – is it possible to understand the complex links between early adaptation and later disorder. This perspective may overcome some of the limitations of the medical model in dealing with deviance.

CHAPTER III.- DEVELOPMENTAL PSYCHOPATOLOGY: A THEORETICAL FRAMEWORK

A vast background of results, product of century of research in developmental psychology, has provided the foundations for the emergence of developmental psycholpathology as a separate discipline in its own right. The domains of developmental psycholpathology are defined and differentiated from other analogous sciences such as clinical psychology and psychiatry for their emphasis in the approach to the study of deviance, studying the origins and time course of a given disorder, in relation to non disordered patterns of behaviour.(Cichetti 1984 (1))

In general, deviance is a complex phenomenon which can be approached in different ways and the different levels. For instance, at a behavioural level, disorders can be coinceived as a complicated pattern of responses to environmental stress; phenomenologically, they could be seen as eexpressions of personal discomfort aor anguish; at a neurophysiological level, they could be interpretated as sequelae of complex neural and chemical activity; intrapsychically, they could be organized into unconscious processes that protect against anxiety. In a developmental view, diaviance, as I shal argue, can be regarded in terms of maturation and the quality of the adapatation in diffrente stages of development.

This new approach to deviance, in developmental term is know as developmental psychopathology and it has fundamental principle: deviant behaviour can only be evaluated within the context of a broad developmental framework that establishes the expected maturational changes in a “normal individual”, providing a criterion for the judgement adapatation or maladaptation to new stages of developmente.

Srofe and Rutter (1984) (2) have defined developmental psychopathology as:

> The estudy of the origins and of course of individual patterns of bejavioural maladaptation, whatever the age og onset, whatever the cause, whatever the transformations in behavioural manifestation, and however complex the course of developmental pattern may be (p.18)

The name of the discipline is descriptive in the sense that it is concerned with development, using the perspective of developmental psychology as ana important tool of enquiry in focusing on pathology. That is: pathological patterns of behaviour are conceived as developmental alteration ns. Indeed, the emphasis on the need to understand processes of development carries with it the idea that there has to be a central interested in both the connectiosn and lack of connections between normality and disorder. (Rutter and Garmezy 1983 (3))

In seeking to understand the development and manifestations of patterns of maladaptation, developmental psychopathology must also understand developmental aspects of successful adaptations. Competence and incompetence, “vunerability” are two sides of the same coins (Gramezy 1974 (4))

There is a proposition in developmental psychopathology which calims that individual functionin is coherent across periods of discontinuos growth and despiste fundamental transformation in manifest nehaviour. (Srofre 1979 (5)). Therefore, it is presumed that a particular form of maladaptation will be related to the adapatattional history. As stated by Srofre and Rutter (1984) (6): “Changes as well as continuity is lawful an therefore reflective og coherent development”. (p.22)

Consequently, the view of developmental psychopathology regarding adaptative and maladaptative behaviour along a continuum provides a new theoretical framework in solving some of the questions that, within the context of the different theoretical orientations in child psychiatry and normal developmental psychology, have given rise to an enormous amount of research, sicussion and sometimes speculations. For instance, in the early days of psychoanalysis, there was belief that an understating of childhood would reveal the originis and meaning of adult emportance for psychoanalysts. (Clarke y Clarke 1976 (7)). Disturbnces in adults were explained by relating their current affect and behaviour to possibly traumatic experiences in childhood or to a failure to achieve the marutational changes required for development, such as the illefects of deficiencies in early parenting or some traumatic experiences in childhood, which were regarded as permanent and irreversible. (Bowlby 1951 (8))

It is now generally agreed that isolated traumatic event rarely mould individual lives irreversibly, that healing processes continue to be operative throughout life, and that the life cycle does not follow an invariating sequence. (Vaillant) 1977 (9)) Therefore the number of factors moulding behaviour should be analysed in a broad persepective, comparing normal an abnormal behaviour, considering “protective” and “triggering” factor in mental disease and the ways and degrees in which the interaction with the environment influences individual variables such as genetic factors, self- assessment or physical growth.

In a developmental view number of factors act simultaneously to mould or modify behaviour. The occasion, length, kind of experience and circunstances are all important in determining certain forms of deviant behaviour.

The establishment of the theoretical framework in which developmental psychopathology bases its methods of enquiry, requires a comparative analysis of the approach of both child psychiatry and developmental psychology in order to establish preventive and protective factors in mental health. Remembering that deviant behaviour is at the end the result of the interaction of the complex factors intervening in development, with progressive transformation and re-organization of behaviour.

The basic principle of traditional psychopathology in which behaviour or mental activity is regarded as a reaction by the organism to an event in its environment is broadened to comprise non manifested behaviour and to evaluate the effect og well-achieved developmental milestones in preventing future mental disorder. (Davies 1962 (10))

Despite the clarity of the purposes of such a conception of normality/abnormality as a unit, so far the body of research in developmental psychopathology is mainly bases in studies

focusing on deviance rather than normality, apparently for clear methodological advantages. First of all, registers, follow-up and retrospective studies have been made in children attending psychiatric clinics or institutions under the influence of medical model. Therefore, an emphasis to study the "patient" (implicit in the context of illness) and not the children, was unavoidable. On the other hand, studies with normal population such as the British cohort studies, have registered suchan enormous amount of data that their analysis will take many more years. (Butler 1983 (11))

The emphasis on deviance within the framework of illness is clearly illustrated by some of the studies of the major psychiatric syndromes sucha schizophrenic mother (Mednick 1978 (12)), or the follow-back estudies between schizophrenics and other partients with psychiatric disorders (Watt et. al. 1984 (13)) or the study of Robins (1966) (14) who undertook a 30 year follow-up of 436 children attending a psychiatric clinic. Such research esblished some trait in pre-schizophrenic children such as anti.-social behaviour restricted to family and acquaintances, lower level of intererpersonal social competence and depressive, worrying overdependent behaviour, neuro- developmental immaturities and attention deficits, (Rutter 1985 (15). However, these studies fail to establish the main features preventing the development of schizophrenia in the children of schizophrenic mothers (only 10% of Madnick`s sample develop schizophrenicia and only 10% o schizophrenics have a parent with the same condicion) and most critically, until recently most of the studies filed to compare children at risk of other mental disorder (i.e. schizophrenia) or to a mental disease in general. (Rutter ibid)

Some other major psychiatric syndormes are even more challenging to developmental psychopathology, since they occur almost entirely after puberty. These include the case of the major affective disorders such as major depression (uni-polar) or manic-depressive disorder (bi-polar). Of coruse, conditions such as depression do exist in childhood but the rate and sex ratio change considerably after the time of puberty. Before puberty depression is more common in boys. After puberty it is more common in girls. The rate of suicidal attempts and manic episodes also show a massive rise en prevalence with age. (Rutter 1985 (16), Saffer 1985 (17)). The explanations for this fenomenon are still hypothetical. It is possible that such disorders do occur in childhood but that they have diffrente manifestation because young children lack the cognitive structures required to experiences feelings of guilt, self-blame and dislike, or it may be that the biological substratum of the disorder is not present before adolescence . Yet again, it may be that life eventes that tende to precipitate these condicions are less common in childhood or the protective effects of the family support are more available before adolescence. (see.- Cicchetti and Schneider-Rosen 1985 (18)).

Whatever the reason (s), developmental psychopathology ahould consider the fildings mentined above in a integrative perspective that allows us to mesasure the effect of each one of the factores involved as well as the resul mets of their interaction. Furthermore, attention to protective factors or events to prevent such disorder must be considered in future empirical research.

Despite the limitation in the scope of the medical model, one must not fail to recognize its merits in dealing with extreme cases. The use of powerful anti-pdychotic drugs and ethe improvement of institucional attention to mental health has decrease the number of inmates in psychiatric institutions and has provided what is arguably a better life for many of those affected. (Shepherd 1966 (19), Howelly 1977 (20)).

Nevertheless, these are number of condition, less incapacitating but extremely common, that cause axiety for parents, teachers and certainly for the child. They are usally related either to adaptational problems during differentes stages of development itself, or both. The medical model has not been the best framework to deal with these conditions.

This is the case quite common emotional disorders in childhood with no particular increase in adolescence. Most of the children with emotional disturbances as “morbid” seems to be less userful than the developmental perspective, focusing such entities in terms of psychological and biological maturation and social adapatation.

In an effort to establish a developmental view of the way in wich abnormal conditions come about the links between childhood and adult life have been studied in a search for aantecedents of mental disordesr with no prior expectation than normality and abnormality necessarily blend into oneanother or reflect the same sausal mechanisms. (Rutter 1985 (22)) Recently, authors such as Kohlber et.al. (1972)(23) concluded that most adult disorders were, in fact, predictable from broad indicators of early maladaptation such as school failure, poor peer relationship and from: “varius forms of competence and ego maturarty rather than problems and symptoms as such”. (p.1274). in oppsotion to such predictive findings, authors like Hay (1964) (24) claimed:“…no special predisposition to adult life psychiatric disorders seem consistently to follow psychological disorders en childhood”(p.2).

However some arguments opposed to this view of dicnotinuity have been proposed by authors claiming to identify protective and preventative traits of future mental disease in children. For instance, Zahn-Walker et. al. (1979) (25) have put forward the view that characteristics such as sensitivity and responsibility in mothers of childrenswho han suffered deviant behaviour promote attitudes of altruism and reparation later on, and Garmezy (1974) (26) has established that factors such as high I.Q. psychopathological manisfestations in children at risk of mental illness such as the offspring of schizophrenics.

The developmental view in focusing psychopathology, continues the long-lasting disagreement in developmental psychology between the studies supporting continuity in development and authors claiming discontinuity. By contuinity one must assume that the transformation during development is a mainly quantitative process although qualitative changes are not deniend. Theres is evidence supporting both positions. For instance in relation to the notion that previus experiences is a valuable determinant of behaviour, Aronfreed (1968) (27) has concluded that children had were more likely to be emphatic in situations that they had previously experienced, and Robins (1978) (28) has studied a group of children with conduct disorders such as destructiveness, theft, aggressivity and violence. Robins concluded that only a minority og children showing persistent conduct disorder

would be problem-free as adults. Therefore, while emotional disorders will not be related to adult life psychopathology conduct disorders tend to show continuity and have predictive value.

On the other hand, Kagan (1980)(29) has probably given more extensive support to the argument of discontinuity, claiming that development is mainly a qualitative change rather than a quantitative one. He claims that this change depends mainly on the maturation of the Central Nervous System, and supports the idea that the reorganization of behaviour "may wipe all thanhas gone before…" (p.3)

Futher research in the problem of contuinity vs. discontinuity in developmente will solve some controversial points. However more questions than answers are still available.

Of course, there are certain major reorganizations of behaviour during the course of development that no-one can dispute. That is the case of puberty and the example adduced by Kagan (1983) (30) of the emrgence of self awareness between 18 months and two years of age. However, one cannot undervalue the influence of the environment, mainly in disadvantaged conditions. For intances, malnutrition will decrease mental capacities, delay the onset of puberty and affect height. (Valenzuela 1976 (31)). On the other hand, it seems to be reasonable to assume that past experiences and personal history became transcendent factors at certain astages of developmenta. For instance, events such as parental death and separation, illness, handicap and danger of death could have paramount importances for future development, not only because of the fact itself, but because of the circunstances and consequuences og their occurrence.

The empirical evidence surrounding the estastistical relation between childhood experience an adult problems is not strong enough to construct a developmental explanation of the meaning of such experience. (Rutter 1980 (32)) Some phenomena such as the so-called "sleeper effect" (thenmdelayed effect of early experience) and the related issues of "vulnerability" and protective factors need further empirical evidence. The difficulties in attempting to establish conclusive judgements about contuinity and discontuinity are widely aanalysed by Rutter (1979) (33), Brown and Harris (1978) (34) an Rutter (1979) (35).

The current trend towarts the issue of contuinuity in developmental investigators can be illustrated by Rutter's conclusions 1985 (36) leading to an integrative analysis of the events occurring during development:

> "it may be concluded that there are discontuinuites in development of both maturational and experiential origin. However, these do not involve a total re-organization of behaviour, they may well have links with the past, and the process of negotiation of the major life changes may be shaped by past experiences and prior competences"(p.731)

Regarding the principles explaining normal and abnormal development, another point must be made clear trhough the research in developmental psychopathology. This is concerned

with the time in wich diverse environmental or biological stresssors affect the individual and influence the appeareance of deviant behaviour. This is a controversial point sinces biological and psychological theories persist in opposed perceptions of the issue.

At a biological level, it is experimentally demonstrated that perturbation-induced changes appear to be more lasting and transcendent in developing organisms than in adult ones. The work of Knap and Mandell (1973) (37) is illustrative. They induced biochemical changes in the brain of young and adult rats with lithium, demostrating that while in adult rats these changes were transitory, in developing rats these changes were definitive and persisting in adult life. The experimental manipulation of neurochemical functions in animals has established that the effect of these changes is different depending on the degree of development, being more important in early stages. The evidence is ample, enzyme production, receptor activity and axoplasmic flow af enzymes. (see.- Mandell A. (1976) (38)

In the framework of developmental psychology isolated events are though to have little effect on children's development. Psychologists usually give more importance to the quality and consistency of the eventes rather than to the age of onset. Apparently, the onset time of certain stressful events becomes important only when the kind og stressor is evaluated according to the stage of development achieved. That is: a given stressor has a differential effect on children, depending on their stage of development. Futhermore, it seems logical to assume than the children from a same group (age group) would have subtle differences in their development due to the complexity of this phenomenon and the number of factors determining maturaty (physical conditions, previous experience, social condictions etc.). for instance, Garmenzy and Rutter (1985) (39) have reviewed the effect of severe traumatic experiences in children, such as rape, war, kindnapping and burning. They reported a wide variation in the consequuences of such experiences in the shorth and long term. They concluded, tentatively, that suc a variation is due to a number of factors like the kind of stressor, the "vulnerability" of the child, and some environmental condition such as family characteristics and social class. The assumption that stressfuk eventes will have differential effects on the child depending on his/her developmental history has clinical implications sice the effects, prognosis an therapeutical guidelines can only be evaluated through the study of the particular childs ddevelopmental history.

To illustrate the above, let use take parental divorce, a common situation affecting children. Divorce affects children differently, depending on factors such as age-group. For example, pre-school children tend to regress behaviourally, become worriend about being abandoned by both parents and feel responsible for the divorce. (Wallerstein and Kelly 1980 (39)); school children of 7-8 years old are likely to perceive one of the parents as responsible for the divorce. (Hess and Camera 1979 (40)). Therefore, the psychotherapeutical strategies are more likely to be successful when they consider the way in which divorce affects children having regard to their age, gender and other influential factors. A prognosis could then be made depending on the protective and "vulnerability" condictions present in the child.

Finally, in the clinical approach to the study of children, developmental psychopathology must search for better methods of collecting and interpreting the informations necessary in order to establish the developmental history of a particular child. For this purpose, the methods of diagnosis and classification regarden normality and deviation as a wholen must be tested (see next chapter), and a new vocabulary able todeal with the children in developmental terms must be introduced. Actually, some new terms are used by developmental authors attempting to overcome the limitations of the medical model. For instance, competence an adaptation are fashionable. Competence, refers to capacities or manifesations in the normal chld at certain atages of developenta like, sitting, walking, abstract thinking. (Kendall and Learner 1984 (42)). Adaptative behaviour is used tob label the adequate reaction in response to certain environmental psycho_social stimuli at different ages and at different levels of functioning. (Greenspan and Porges 1984 (42). Thus, compentence is used to compare the child with his/her cohort group and adapatation is used to evaluate the child`s reaction to his/her particular context.

The emergence of developmental psychology is showing interesting ways in interpreting mental disease and it has established a number of questions that ought to be solved through research in this perspective. New explanations of old recognised facts are now being proposed. For example, the fear of extragers described in the one-year old an regarded as a fixed milestone in developmental growth is now conceived as a "developmental organizer (Stephen and Rutter 1985 (43)) and is described by Sroufe 1977 in terms of "…discontinuity in development that reflects the acquisitions of cognitive ability to make complex comparisons, judgements and decisions" (p.733) (44)

Cichetti's (1984) (45) comments on the emergence of developmental psychopathology provid roughly an idea of the current stage of this apparently new discipline:

> "This is te time of consolidation, time when impressive but scattered interdisciplinary results could be collected, combined and transformed into a united discipline having its own history, integrity and program to the future." (p.1)

CHAPTER IV.- DIAGNOSIS AND CLASSIFICATION IN DEVELOPMENTAL PSYCHOPATHOLOGY.

"The basic aspect of a good diagnosis es that it belongs to the realm of discovery rather than the realm of verification." Reinchembach 1938

On of the areas in wich child psychiatry and developmental psychology as an independient discipline is in the diagnosis and classification of the cases of study. Classification as a means of ordering information and groupin phenomena is basic to all forms of scientific enquiry; mental disease is no exception. The World Health Organization within the context of the International classification of diseases (I.C.D.) (1) has been concerned with the primary standardisation of psychiatry diagnosis. Classification and statics of mental disease based of empirical findings. Similary, results from research in developmental psychology have established well-defined expectations in certain fields of development such as physical growth measured in weight and height; psychomotor activity in the first year life (age to fix sight, to establish a social smile etc.) and speech development. They constituted some of the most mportant milestones in normal development.

On a development view, children are expected to behave differently at different ages and in differents contexts; diffrente phases of development are associated with diverse stressors, thus differents susceptibilities must be taken in account. (Rutter 1981 (2))

It is a common observation that as the individual mature, more difficult and complex tasks are required in the environment and equally difficult and complex responses are expected. This general observation is valid for mental health, where symptoms of neurological or cognitive impairment in early stages of development seem to be less complex than those observed in latter stages. For instance, a severe delay in speech appearance or a marked lack of socil responsiveness in a there yeard old would be powerful indicators of a developmental disorder such a infantile autism (Tustin 1975 (3)). While in adolescence, a wider evaluation of the different dimension in wich the individual develops (peers, home, school) is necessary in the search for conduct disorder. The mental evaluation willa have to asses not only the quantity and quality of the speech but the coherence and contents of the ideas if in search of psychosis.

The progressive complex nature of development requires a multi-dimensional assements of the individual that provides the information necessary to evaluate the degree and quality of the "development achieved" and compare in with the "development expected". Therefore, developmental psychopathology requires a system of classification that both meets the general criteria of a good classification (e.g.reliability, validity, coverage, utility) and addressed the salient developmental issues and parametres of development (Garber 1984 (4)).

In child psychiatry the efforts to achieve a universal and reliable classification in mental health were sponsored by the World Health Organization, in the early 50´s, as a part of the general efforts towards the International Classification of Diseases (5). However,

Stangel's(1959)(6) analysis of this classification (I.D.C-8) led to the conclusion that this initial effort had failed to find a general acceptance in the psychiatry practices.

In 1964, the WHO Scientific Group of Mental Health Research, stronglyadvocated the development of a classification in mental disorder, on the basics of a ten-year research programme they recommended a multi-factorial diagnostic scheme that was published in the 9th. Revision of the I.C.D. (7)

In the first proposal for a multi-axial system of classification the first axis was intended to cover the clinical and psychiatry syndromes. The second axis was concerned with the level of intellectual function and the third comprised the associated etiological factors whether physical on environmental. (Rutter et. al. 1975(8) a multi-diemnsional approach to psychopathology conditions was for the first ime attempted, broadening the scope of the study of deviance. (see.case in chapter IV). Equally import is the fact that foe each axis a non-abnormaal code was included and it was recommended that every patiente must have some coding in each axis.

Historically, a major obstacle to progress in research in general psychopathology has been the lack of well articulated and reliable systems for classifyin behaviour and emotional problems in children. (Graber 1984(9). Some other classificatory systems have been suggested, probably eachof them with its own methodlogical advantages. However, their acceptance has been limited. For example, the system devised bye the GROUP OF ADVANCEMENT OF PSYCHIATRY IN 1966 (10),the clinically based system of the American Association the DSM-III, to which I will be referring widely; the models proposed by Quay and Quay (1965) (11), the system of Conners (1970) (12), the model of Achenbach (1978) (13) and thata proposed bye Neuroterlein et. al. (1981) (14).

Most of discussion in the present work will be based on the DSM-III, (Manual of Diagnosis and Statiscs in Mental Disease of the American Psychiatry Association (15)) for the following reasons:

- In the DSM-III, each one the mental disorders in conceptualised as a clinically significat behaviour or psychological syndrome or pattern that occurs ina aindividual and is a tipically associated with either a painful syndrome (distress) or impairment in one or more areas of functioning (disability) (p.6).
- There is an nference that there is a behavioural, psychological or biological disfunction, and that the disturbance is not only the relathionship between the individual and the society, but in the child himself. (p.6).
- The approach by DSM-III, is atheoretical with regard to the etiology or pathophydological processes, except for those disorder for wich they are well-established and therefore included in the definition of the disorder. (p.7).
- The DSM-III, provides a framework of reference for entities which are not considered as mental disease but which constitute major factors of psychiatry refrence.

In the DSM-III, , the multi-axial classification system is a hierchically organised as follows:

AXIS I.- Is used for all the mental disorders (excluding those considered in Axis II) and the major psychiatry syndroms. It is also used for quoting conditions not attributable to mental disorder that are the focus of attention of treatment. For example, in AXIS I, one can place: psychosexual disorders or major affective bi-polar disorder or child-parent conflict. Multi-quotation in the axis is possible when appropriate.

AXIS II.- personality disorders and specific developmental disorders ae recorded in this axis. For instance, developmental reading disorder, schizotypal personality etc.

AXIS III.- This axis is used to recor the associated physical (medical) condictions such as diabetes mellitus epilepsy, etc.

AXIS IV.- This axis provides supplementary information about the severity of the psycho-social stressor (e.g.death of a relative, change of school etc.).This relevant to the assessment because of the fact thaht when a specific psychosocial stressor is identified the prognosis is better. (p. 26)

AXIIS V. This axis is devoted to the highest level of adaatative functioning in the past year and as conceptualized in the- DSM-III, focuses in adaptative functioning in three major areas: social relations, occupational functioning and used of leisure time. The use of adjetives such s good, superior, fair and poor is suggested.

An example of the use of this multi-axial system could be illustrative:

AXIS I.- V62.89 BORDERLINE FUNCTIONITING

AXIS II.- 301.83 Rule out: borderline personality disorder.

AXIS III.- Malnutrition grad I.

AXIS IV.- Pyschosocial stressors: no information.

Patient of very low socio-economic status.

AXIS V.- Fair.- Although school failure reported. The patient maintains good social relations at home and with peers.

As the reader can notice, the advantage of the use of a multiaxial classification system such as the DSM-III is obvius: one can collect, interpret and analyse more information about individual in a systematic and hierarchical fashion.

However, this model has a major methodological limitation in the scope of developmental psychopathology: it only considers the evaluation and recording of pathological or abnormal events (consistent with the medical model). Therefore, the view of the general conditions and the context in wich the case is being studied is poor nd does not provide information suitable for detecting protective or preventive factors in the evolution of the disorder. For the same reasons, the DSM-III system iis not applicable to the study of “normal” children.

In any model of classification there are series of criteria wich must be applied in orden to asses its value such as reliability, information demands and practical use.

For reability one ssumes that people will use the system to produce the same coding for the same patients. The identification of the sources on unreability is an essential poit to improve any classificatory system. No classificatory system achieves 100% agreement in the Dx. Of all cases.it is also important to identifity the amount and sort of information necessary to identify and calssify the disorderns according to the scheme. This will be a crucial point in the interaction with developmental psychology since informationconcerned with a normal expectattions should indeed be considered. Practical use depends on its availability, wich means that people, involved in the use of the system should find it clear, simple and anambiguous.

A system of calsification with the above characteristics is necessary for the construction of Developmental psychopathology. For te categories ised in any classification to have menaing, they muste show that they differ in terms of etiology, symptomatology, course, response and treatment or some other variables of normality, associated with the developmental process, in the approach to a case, will provide more ground to support and evaluate the system of calssificataion used. The interaction between developmetanl psychology and child psychiatry could |lead in the future, to a wide classification of mental disease that can provide more information to both developmental psychology and child psychiatry.

Developmental psychology has the challenge of incorporating into a system of classification the fluid concept of developmental progression with respect to each of the various domains of functioning. This requires the establishment of certain milestones of normal developmental achievement at two differente levels: at a general level of average competencies and capabilities are stated for a particular level where goals or desired compentencies are stated for a particular case, providing the opportunity for the evaluations of adaptative and maladaptative behaviour. (Rutter & Cox 1985) (17))

The contribution of developmental psychology in establishing a criterion of normality, requires a delineation of the various developmental tasks, milestones and eventes that children undergo during the process of maturation. As may (1979) (18) has expressed:

> “it is necessary to catalogue the typical time course of behaviour and their expected base rate at variouspoints in development.”

Classification in developmental psychopathology must consider what is age-appropiate, and age specifici at a particular point of development, but, more important,it should consider the normal progression of development in terms of developmental milestones (behaviours and functions that are to be accomplished by a certain age) and developmental tasks, viewed as issues around which development is organized. (Ciccetti and Pogge-Hess 1979 (19)) or a Phillips et. al. (1975) (20) claim:

> " the designation of certain behaviours or clusters of behaviour as deviant involves both normative an ipsative judgment about the child in relation to his or her own baseline and assessment of the central tendency of his or her peers…"

In other words: to asses psychopathology and associated maladaptative functioning in the context or specific developmental tasks, a classification system should include a description of the salient developmental issues and a categorization of both competent and incompetent adaptation to them. regarding this point, developmental psychopathology could adopt a multi-axial classification system such as that proposed in the DSM-III, ina a modiefied fashion that overcomes the major limitation of the scheme which is the lack of a criterion for normality. Therefore, a suitable system of data collection and interpretation in developmental psychology must include de description of the salient developmental issues and the information necessary to understand the particular case within its circunstances, as Garber (21) warns:

> "future attempts to classify developmental psychopathology should be sensitive to the potencial for sex and age related diffreneces in childhood disorders and should include a catalogue of normative information about the behaviour or custer of behaviours comprising the disorder". (p.36)

In fact, the system proposed in the present work, has taken the five axes of the psychiatric model, focusing the case on developmental terms as a whole (pathological and non-pathological issues), attempting to take the advantages of the medical approach to mental illness and tehe information provided for normal physical and psychological development.

In our model, the first axis is the indentification axis and will be concerned with the personal data of the individual, the puropose of the evaluation (case study, research, pruposes, etc,) providing space for a diagnostic category when necessary.

The second axis is reserved for the evaluation of the psychological development of the child in terms of vognitive development, intellectual performance and personality traits. The results of psychological tests must be recorded in this area. (I.Q., locus of control, projective tchniques etc.)

The third axil will be used to evaluate the physical development in terms of growing, physical characteristics and medical conditions. The importance of this axis lies in the evaluation of the influence of biological factors in development.

The fourth axis is assingned to evaluate the social development and the major environmental sets which development occurs, in this axism it is particulary important to describe the family history, the socioemocional condictions, peer relations and school performance as well as the use of leisure time and interests.

Te fifth axis is reserved for describing the degree of adaptation to some particularly important eventes during developmenta. This axis is based on the assumption that some eventes during development areof paramount importance for the subject, such as paternal

death, accidents and diseases, starting school, menarche etc. this axis is capable of providing wider infromaation about the child.

And additional axis (VI) is proposed due to the integrative evaluation of developmenta and the analysis of the interaction between the axes and in order to registrer the evolution of the case in a temporal, quantitative nd qualitative way. The following scheme is allustratives of the system proposed. It is described in general terms due to limitations this work. In the case-study (CHAPTER- VII) an applicable example is provided and further commentaries included.

The system proposed previously has the advantage that it can be used not only as a method of diagnosis in the approach of clinical cases, but also may constitute an important tool of enquiry in research whithin the framework of developmental psychology in the normal population. Nevertheless, some warnings about its ue ought to be considered.

In every case the model deal with children not with patients. The axes-apriori- are equally important in the evaluation. However, depending on the case, a certain axis could have a major relevance in the approach. For instances, in the precence of a severe abnormal physical condition Axis V would be a crucial etc.

The evaluation must include two different essential aspects : one is the interaction between the axes: Whether physical factors influence social and psychological condictions whether social factors promote psychologicas changes on whether a particular event influences ather xes. Another importants aspect is the evolution of the case; that is, a prospective and retrospective evaluation must be performed to see whether the same conditions are present or if the therapy has promoted changes, etc. finally, the system must be tailored to evaluate a particular child, that is general parameters of development are devised to compare the child with his/her cohort group and provide valuable information ins establishing competence or incompontence for certain tasks. However, the conditions and factors determining the child´s situation are different for every case.

Therefore, adaptation and maladapatation can only be evaluated in an individualistic approach.

Some limitation in the modl must be considered as well: for example, the risk of labellinf children according to their behaviour is still present, due tp the need to use diagnostic categories. This point must be rememberd.

Because this approach is individualistic for each case, it may icreasse the risk that a given evaluator might record and interpret the situation according to his/her own viewa. This subjevity can be alleviated through the use of descriptive term instead of interpretative ones, and of course by submitting the case to a process of validation. (validation for consensus?) Considering that the criteria in orden the perform further comparative studies between the cases. For example, it would be difficult to compare a case in which personality development was described in terms of Erickson’s (22) model of development with a case based in Piaget’s (23) developmental structuralist approach.

In conclusion, much further work is required to develop a really satisfactory system of classification for child psychopathology. Howeer, ther are some indication that a mult-axial framework is likely to prove to be the most satisfactory system of classification. However, any system of diagnosis and classification can only be truly evaluated through the measrument of its effects in transforming the clinical practice in mentalsciences and through the benefits to the child and the investigato

CHAPTER V.- BORDERLINE CASE: A DEFINITIONAL PROBLEM.-

A number of entieties in clinical psychology and chil psychiatry are labelled is borderline. This is perhaps analogous to other uses of this word within the medical model, eith refrence to entieties in which are not early clarified as an "illness" but wich at the same time are not "normal". a highly illustrative case is that of "borderline hypertensionn" in medicine. the estatistically normal blood preassure in the U.S. adult population is 120/80 mmgh; when the low figure (diastoli preassure) is heigher than 90 mmHg, the diagnosis of hypertension is established. If a patient has a blood preassure 120/90 mmGh. This is indeed in the limited between normal figure and the criterion of pathology, therefore is consireded as borderline. (See. Harrison 1980 (1))

In mental health fields, the term borderline is used for a number of entieties such as: borderline intelligence, borderline personality disorder and a borderline schizophrenia (DSM-III (2)).Futhermore, the term "borderline" itself is used among clinicians to connote case where a clear psychopathological entity connot be defined. "this cas is borderline…" is a common expression in clinical psychiatry practice. However, the term borderline is ambiguous. It is generraly used to labele a number of poorly defined entieties in clinical psychiatry and psychological practice. Hence, explaining what will be usderstood as – bordeline case- in this work is by no means a proposal for a new label or classification in mental disease, neither is it attempt to establish a morbid entity. it is mainly an attempt to describe the sor of chil who could benefit potentially bye the approach of developmental psychopathology and that coul be found in the school and not in a mental health service. Sroufe and Rutter (1984) (3) highlighted the importance of such cases:

> "…While degree and variety in childhood problems are important predictors, some children with only mild (or non appareant) behavioural and emotional problems become severely disordered adults. (p.18)"

If some cases indeed do become severely disordered adults, others will develop normal behavioural patterns. Hence, approachin such cases within the framework of illness is not ponly unconvenient bust sometimes harmful. Many antieties in mental health are difficult to define within the context of illness. Murphy (1985) (4) claims:

> "…There are certain psycho-social disturbances, not primarly psychiatric in character, and that are not to be routinely, taken into a psychiatric charge, but benefiting from judicious psychiatric instruction such as delinquency psychosomatic illness, psychopathy and some fromms of religious possession and "latah-type disorder like echolalia and echopraxia." (p.158)

Children eho might constitute borderline case are not always taken to a mental health institution because the symptoms presented are milder or less consistent than well defined psychiatric syndromes, or because such as " the child´s temper…" or a simply because there is reluctance by the relatives to make contact with the medical establishment Gruthrie (1985) (5) in referiring to the medico-legal problems of cases considered as "borderline" in mental health states.

> “Patientes with the borderline syndrome,, although not alwys the sickest patients, aften cause the most difficulty becase of their intense and often contagious affections.” (p.9)

However, ther is no clear definition of whats constitutes a borderline case, particulary in children, in the medical model, the category of classification is based on a cluster of symptoms (or syndrome) derived form the clinical experience. However, the medical model fails to incude the breoad spectrum of maladapatative responses to the demands of school, parents or peers, that not being well defined, do no meet the criteria of illness.

On the other hand, In developmental psychology, the criteria for normatily varies according to the place, time cultural values and the theoretical orientations of the psychological practice. For example, a newborn baby of a 3 kg would be considered of low weight in England while it would be classified as “normal weigh” in Mexico. (valenxuela 1976 (6)). Similary, the standars of normal height are different in the generation of Mexican children orn in the 60´s and those born in the lates 70´s. (Valenzuela ibid). alsso, certain sexual activities would be considered as normal or abnormal depending on the social values. The clinical value of such sexual activities would be different between apsychoanalytic orientated psychologist and a behaviourist arientated one. Furthermore, the standard deviation for certain normal developmental expectations is so wide that it is not possible establish real criteriafor normality. That is the case of the appearance of the secondary sexual characteristics, equally “normal” at 12 or 16 years old. (Mussen et. al.. 1980(7))

Considering the above, a number of cases in clinical psychology and child psychiatry will present non-well defined symptoms or patterns of deviant behaviour or they will not manifest the achievement of clear developmental milestones. These rather confusing cases between the fields of normal developmental psychology and child psychiatry are considered as “borderline cases”

Borderline cases are concerned with common psychological and psychometric conflicts in children. Thus, there eill be little discussion about the less frequent and more disabling major conditions in mental health such as dementia, schizophrenia and psychotic depression.

I am particulary interested in borderline cases, because the medical model seems to be less appropriate when they are concerned that the framework developmental psychopathology although it has demostred its efficacy in dealing with extreme cases. The advances in psychiatric hospitalization and the use of powerful anti-psychotic drugs has decreased the morbidity and mortality due to mental disease in the last ten years.(Schaffer 1980 (8)) Also borderline cases can be found in the schools as an important cause of school failure. The early detection and the intervention of the school in remedial actions, might constitute an important action in preventing adult mental disorder and combating school failure. (see.- CHAPTER VI)

However, there is a difficulty defining the threshold for case in mental health. In extreme cases, symptoms such as autism and hallucinations are anough to support the diagnosis of

schizophrenia, but in most cases, symptoms such as “worring” have no discriminatory value. Therefore, the limits of a borderline case are much more difficult to establish since symptoms themselves rarely have any meaning without the circunstances.

Furthermore, some authors have questioned the existence of –cases- in mental health. Copeland (1978) (9) claims:

> The concept of case is a chimera existing only in the mind of the investigagtor, id only the common ground between the mistaken attempts of a unitary concepts, such as the psychiatric’s unrelated clinical judgement and the many definitions required by the epidemologists that have led the investigators to act as if a case were a sigle entity for so long. In spite of what they claim to do, they have acted as if the searched for a platonic ideal – there is no such ideal for a case.- (p.11)

According to Copeland, in face of children with difficulties in the school or home due to behavioural or emotional disturbance, rather than attempting to identify the characteristics necessary to stablish a –case- an important queston must be made: a case for what?

In the other words, not all “deviant” behaviour are necessary part of a psychiatric case. Symptoms should be interpreted within the context in which they occur and certainly the medical model is not the only alternative in dealing whith children´s behavioural disorders. The description of a case might depend on the purposes of the survey. Therefore I will be referring a a borderline case to a child with characteristics such as behavioural or emotional disturbance without a wel defined psychiatry diagnosis. Assuming that in children, susch condition, in a developmental view, is transitory, capable of developing towards normal or abnormal states.

In psychiatry diagnosis, the dsm-iii (10) has established criteria for the diagnosisi of “borderline personality disorders” and has define them as: “…identity disturbance manifested by uncertainy abut several issues relating to identify such as self-image, gender identitu, long-term goals o career choice, friendship patterns, values and loyalties.” (p.7). The DSM-III demands at least five of the following characteristics to establish the doisgnosis; impulsivity and unpredictability in at least two areas of functioning (overeating, substance-abuse etc), a pattern of intense and unstable personal relationships; inappropriate anger; marked shifts of mood; intolerance of being alone; feelings of emptiness.(p.323)

The borderline intellectual disorder DSM-III is included as well, and its is described in terms of I.Q. reangng form 71-84. (p.332)

The DSM-III as a conditions not attributable to mental disorder but which are not clearly defined such ass occasional parental conflict, mild academical problems etc.

The DSM-III warns also that the schizoid and schiazotypal personality disorders considered as borderline cannot be made before 18 years old.

To sum up, there is a defitional problem concerning to borderline cases. Despite the efforts of the DSM-III toestablish criteria for their diagnosis, still the easiest way to explain borderline case would be as all those cases poorly described in psychiatric terms or those cases where either “normality” or “deviance” are difficult to define.

CHAPTER VI.- BORDERLINE CASE IN THE SCHOOL.-

On the assumption that intellectual, emotional and behavioural conditions with the scope of developmental psychopathology constitute an importante cause of school failure and demand special attention from teachers and parents, in this chapter I will attempt to analyse the major ways in which such cases may be approached from a developmental.view with special refrence to the important of the school in dealing with such cases.

The relations between psychopathology and the school are diverse. First and foremost, because there are a number of pathologist affecting school performance, such as reading developmental disorders (dyslexia), mental deficiency, infantile autism and others. And secondly, as I shall argue, because psychopathological entities themselves might be influenced by the school context.

I do not pretend to over value the importance of the school in dealing with psychopathological cases, no to provide teachers with the theoretical background to perform complete clinical and therapeutical tasks. Rather, a particular emphasis is made in the intervention of a multidisciplinary team (including teachers) in dealing with borderline cases, in the role of the teacher in identifying children with emotional and behavioural problems and in general, on the analysis of the role of the school in influencing psychopathological cases.

In general more emphasis has been given to the influence of family background and intellectual ability on school performance but little consideration has been given to the school. (Ouston J. 1980 (1)). the limitations of the school have been highlighted by a number of works demostrating the effects of the school on the individual’s behaviour when compared with familial influence: For example. (Jenks et. a. 1977 (2)) In general , the weight of the empirical evidence seem to indicate that home environment is more important that school enviromente in determining or influencing educationatl achievement. (Coleman 1966 (3)), Wiseman 1967 (4) and Craft 1967 (5))

Similarly, some programmes, specially designed to improve the achievement of pupils in disadvantaged condictions, have themselves had little effect on children as pointed out by the first reports of the American “Head start” program. (see. Rutter and Madge 1976 p.231 (6)) This means that the cycle character and the intergenerational contuinuities of such extremely disadvantaged conditions are indeed difficult to modify. (Rutter and Madge ibid) Therefore, defining those aspectsof the studentes wich are susceptible to influence by the school and the degree to wich they can be transformed, constitute a wise action in order to make the most of the time and resorurces of the schools in helping children with behavioural or emotional disorders.

Its is essential to know what one cannot change in order to make the greatest efforts in transforming whats is changeable. Cases with regular social disadvantages or minor physical or psychological problems could be helped. The identificationof these cases, defining them in developmental termn, might help to reduce the numer of cases of school failure due to borderline psychopathological entities. Most important, the intervention of a multidisciplinary team in dealing with thses cases within the school context, coul be the most importatnt factor in preventing future adult mental disorder.

The approach to the study of learning from a developmental view must follow certain general principles. First of all, it seems logical to assume that older children learn more and faster that younger children because of their greater maturation and experienced. Hence, learning expectations in general should consider different developmental capacities in children. (Stevenson H. 1980 (7))

In addition to this natural progressive development of the child's physical and cognitive capacities, the school has been shown to be useful in fostering certain social and intellectual abilities. It is now well supported by empirical evidence that children attending school develop better intellectual and social abilities than children out of the school. Stevenson (ibid) stated:

> " the aspects of attending school that contribute most strongly to developmental changes are not clear, but demands of verbalization, solving complex problems and abstract thinking, must be important. (p.114)

There are a number of factors affecting learning in the second. For example, the effects of social class, ethnic toward the school, the expectations of both teachers and pupils and health conditions have been widely reported. (Harris I. 1961(8))

This chapter is concerned with som psychopathological conditions influencing school atttaiment. There different general areas of psychopathology affecting the school will be considered: cognitive development, emotional disturbance and behavioural problems.

Obviously severaly, affected children are beyond the limits of the present analysis. They are handled in special onstitutions, subject to the domains of special education, I am particularity interested in children showing discrete difficulties in school, in the reservead and less socialized pupils, in teenager suffering anguish and insecurity, in shorth: in borderline cases.

Cognitive development includes the cognitive skills necessary to cope with the demands of the school such as language, abstract thinking, mental processing and, in general, the intellectual abilities included under the concept of ntelligence.

Intelligence, although still difficult to define, constitutes a valuable predictor of school performance limited only bye factors such as cultural values. (Vernon 1970 (9)

In th school, there are a number of children whose I.Q ranges between 71-84. These figures are not low enough to establish the diagnosis of mental deficiency but certainly theay are

not considered within the limits of "normality". These children, according to the DSM-III, are considered as 2brderline mental deficiency" (DSM-III p.40 (10))

Aomw of the children with borderline I.Q. figures cope successfully with the school burden. (Rutter, Tizard and Whitmore 1970 (11)) However many mora fail in the school. Rutter and Madge (1976) (12) claim:

> On the whole, person with mild intellectual retardation is most handicapped during his school days, when his intellectuall capacity is likely to lead to school failure in the face of demand for new learning. P.83

Of interest for both education and developmental psychopathology is the fact thata a child having borderline intelligence will not automaticallyt fail at the school. Hence we must ask: wich factors acting in children with borderline intelligence may prevent school failures? Can children with borderline intelligence be helped in the school? Do borderlin case in the school demand curricular changes?

It is important also to recognise thata intellectual borderline defiency has other implications apart from those related to the school. For example, in the follow-up estudy of Baler et. al. (1966) (13) 206 children with mild mental retardation were studied. They showed a higher incidence of marital, civic and educational failure in early adult lige than the control group, but surprisingly, this difference tended to diminish with time, being minimal at the age og 40. Similarly, Tizard (1974)(14) reported a rise in the I. Q. values in late adolescence and early adult lifemong mildly retarded children. This rise has bee associated with improvemet in social adjustamente and occurs in any reasonable environment which impedes intellectual developmet (Rutter an Madge 1976 (15)).

The above information may lead one to think from a developmental view, that mild recoradton can be interpretated as a delayed development of most intellectual capacities. Therefore, the early detection of such case and adequate intervention my lead to achievement f the expected intellectual capacities.

Both detection and intervention can be carried out in schools with the appropaite resources. However, the identification of pupils with borderline intelligence has certain limitations. For example, the application of intelligence tests to whole population of students would identifity both succesfull and unsuccesfull pupils, making the searchfor protectivefactors and vulnerability feasible. However, the label of borderline intelligence, might have negative effects on the self-concept of succesfull students and also on the behaviour and expectations of teachers.

In the face of borderline intelligence or students with low academic attainment, the school must be able to provide the adequate stimulus to develop those intellectual capacities demanded in "normal" development. Teachers must be aware that these children can improve. Vocational implication shall be considered since midly retarded people cope better with a non-manual commercial job (Baller et. al.ibid)

In preveting mental disease, the school seems to have an important role. Although there is a well established association between mental retardation and psychiatric disorder, (see.- Rutter's review 1971 (16)) there is still controversy about the attributions of this association to organic causes such as brain disfunction. However, adverse social consequences and school failure seem to be equally important in triggering psychiatric disorder. The intervention of a multidisciplinary team in dealing with a borderline case is more likely not only to improve the efficiency of the school but eventually also to reduce the incidence of psychiatric disorder in adults.

Finally, one must look ate the differential diagnosis in borderline mental retardation. Entities such as specific developmental disorder affect usually only one cognitive area (reading, language) while in mental retardation there is a deficit in all intellectual ares (DSM-III p.41 (17)). Pervasive developmental disorders are generally speaking a quantitative delay in development and must therefore be considered as a possible diagnosis.

Emotional factors are also blamed for causing school failure in a number of children. However, it seem ore difficult to establish when and hoe emotional disturbances affect children. For instance, under the label of "psychological problems" there is an overlapping in the teacher reports of cases attributed to emotional problems and behaviour disorders. This is propably because emotional life nfluences overt behaviour to a very important degree. (Hersov 1980 (18)) Most important, perhaps, is the fact that the school system is mainly concerned with the intellectual development of the pupils. Thus, less importance is given to their emotional and psychological maturartion. Theachers usually notice and report those cases in which emotional disturbance affects overt ehaviour. They give greater importance to the consequences of the behaviour itself than to the origins and causes of such behaviour.

Similarly, some investigators report number of conditions believed to produce emotional disturbance such as parental death, parental divorce or hispotalization, relating them to school performance. For instance Davies (1979) (19) reported that children from "atypical" family situations (one parent family, separated or divorced couples etc.) tend to achieve less at school than the control group. However, this statistical relation between such "high risk" condition of emotional disorder and low school attainment is not clear. A cause-effect relationship cannot be established and, most important, a direct link between "emotional disturbance" a "school failure" is not explicit.

The term emotional disorder is used without etiological connotation often for mild and less well differentatiated conditions. (Rutter et. al. 1975(19). Therefore, it is important to draw the distinction between behavioural and emotional disorders. Emotional disorders are shown by abnormal anxiety, fear, depression and the like, while conduct disorders are characterized by bullying, destructiveness, theft and violence with impaired social and personal functioning. (Robins 1972 (20))

Some well defined emotional disorders have been identified and related to the school. For instance, Achembach a nd Elderbrock (1989) (21) using teacher reports, established two groups of emotional disorder, all related to low academic attainment. One "internalizing" of

over controlled behaviour and another comprising inattentiveness, often nervous-overactive and aggressive behaviour. Naylor (1972) (22) reported tahta anxious children learn less that non.anxius children.

Nevretheless, it is a difficult to establish the diagnosis of emotional disorder. First of all, emotional disorders tend to be reactive to adjustment situation and persistence over a period of time is usually difficult to establish. At the moment, no reliable criteria are available to distinguish in child hood, between disorders which prove transient and those which persist into adult life. (Rutter and Madge 1976 (23)). Secondly, extreme cases are usually related to clinical psychiatric syndromes. Hence emotional disorder is handled as a consequence of the primary psychiatric disorder. Finally, the so-called-neurotic traits- such as thumb sucking, nail eating and food fads, are not valid indicators of emotional disorders. (see. Hersov 1980) (24))

The term – emotional disorder- in childhood is used in reference to poorly defined psychopathological entities. Rutter and Schaffer (19080) have criticised the failure of the DSM-III to make adequate provision for the common anxiety disorders in childhood ins adolescence. Therefore, a developmental approach to such cases coul be helpful in the search for the meaning of such emotional disturbances in development and their implications in mental health. It seem to be clear that emotional disorders rarely procede psychiatric disorders in future adult life. (Robins 1972 (26) However, mild emotional cases need futher consideration since they are still ansource of anxiety for parents and teacher. Most of the so-called emotional disorders can be considered as “borderline cases”.

Of special special interest for the present chapter is the “emotional disorder” khnow as School Refusal- or- School Phobia.-

Authors claiming its existence as an independient psychopathological entity have described its clinical manifestations and speculated about its possible origins since the early 40´s. Patridge (1939) (27) defined school phobia as the absence from the school due to extreme anxiety, geerally diminished by the mother´s presence. Blanco (1972) (28) defined school phobia as the “…unwillingness to leave the mother and attend the school”. It is common younger dependent children, and it is identified by crying and anxiety in the child and by ansenteeism.

The clinical picture usually attributed to such cases starts with vague complaints of school and reluctances to attend. Boys and girls are equally affected, and their history usually shows previous fair attainment.

Characteristically children remain at home and an increased incidence of disturbed family settings is reported. (Johnson et. al. 1941 (29))

A changes in this behaviour requires a prior modification of the factors involved in the mother/child relationship and the recordition of the reinforcement potentials in home and the school. (Blanco, ibid)

However, authors like Warren (1948) have claimed that the syndrome was not clear cut clinical entity but rather consisted in phobic tendencies overlapping with hysterical and neurotic patterns and Hersov´s (1980) review of the problems states:

> The evidence shows that school refusal is not a true clinical entity with a uniform etiology, psychopathology,course, pregnosisi and treatment, but but rather a collection of symptoms or syndrome occurring of against the background of a variety of psyachitric disorders. (p.383)

There is controversy in reported prevalence (see. Hersov´s review op.cit.) and the lack of a clear cut clinical presentation does not support the existence of such an entity as an independent clinical syndrome. It is more likely that the school problems re reported in these cases are the consequence of primary underlying developmental changes, rather than problems originating primarly in the school. Those developmental changes must be better understood in dealing with these children.

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