Childhood Psychopathology Overview

Brief Overview

This walks you through developmental context, externalizing vs. internalizing disorders, diagnostic challenges and prevalence figures, and outlines major treatment approaches.

Key Points

- Understand why age-norms, remission, and limited self-knowledge complicate assessment.
- Learn the main externalizing (e.g., ADHD, Conduct Disorder) and internalizing (e.g., anxiety, depression) conditions.
- Review UK prevalence statistics and the link between childhood and adult psychopathology.
- Get a snapshot of etiological factors and therapeutic options for each disorder.

Difficulties in Studying Childhood Psychopathology

- **Developmental context**: problems must be evaluated against age-appropriate norms.
- **Spontaneous remission**: many issues resolve as quickly as they appear.
- **Limited self-knowledge**: children's immature insight hampers self-reporting.

Domains of Childhood Psychopathology

Externalizing Disorders

> **Externalizing disorders**: outward-directed behavior problems such as aggressiveness, hyperactivity, non-compliance, or impulsiveness.

- Conduct Disorder
- Attention Deficit Hyperactivity Disorder (ADHD)

Internalizing Disorders

- **Disorganized thinking** – derailment, tangentiality, clanging, neologisms, word salads (example of incoherent speech).

Diagnostic Categories (DSM-5)

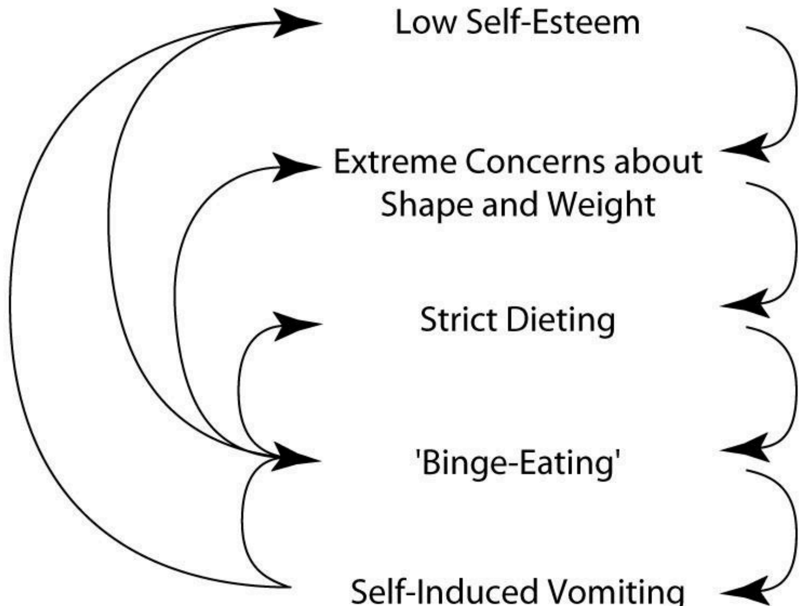
Disorder	Core Features	Typical Duration
Delusional Disorder	One or more non-bizarre delusions ≥ 1 mo; no schizophrenia criteria	≥ 1 mo
Brief Psychotic Disorder	≥ 1 day but < 1 mo of psychotic symptoms; full return to baseline	1 day–1 mo
Schizophrenia	≥ 2 of: delusions, hallucinations, disorganized speech, grossly disorganized/catatonic behaviour, negative symptoms (≥ 1 mo)	≥ 6 mo (including prodrome)
Schizoaffective Disorder	Schizophrenia criteria + concurrent mood episode (depression/mania)	Variable

Prevalence & Course

- Lifetime prevalence 0.3 (≈ 24 million worldwide).
- Typical onset **15–35 yr**; mortality ~**50 %** higher than general population.
- Course: prodromal (slow decline ~5 yr), active (clear psychosis), residual (positive symptoms lessen, negatives persist); relapse common, often triggered by stress or medication non-adherence.

Aetiology – Diathesis-Stress Model

Factor	Evidence
Genetic	First-degree relative ↑ risk × 10; MZ concordance ~44 % vs DZ ~12 %; sibling risk 7–9 %.



The diagram visualises the self-perpetuating cycle: low self-esteem → extreme shape concerns → strict dieting → binge-eating → self-induced vomiting, highlighting points where CBT intervenes.

Substance-Use Disorders 🚬

> **Substance-use disorder (SUD)** is a chronic, relapsing condition characterized by impaired control over substance use, despite adverse physical, psychological, and social consequences.

Core Concepts

> **Substance abuse** – maladaptive pattern of use leading to significant adverse consequences.
> **Substance

Nicotine Use Disorder 🚬

> **Nicotine**: an addictive drug that produces both physical and psychological dependency.

- Rapidly shifting, shallow emotions.
- Uses physical appearance to draw attention.
- Speech is impressionistic, lacking detail.
- Self-dramatisation and theatricality.
- Suggestibility.
- Considers relationships more intimate than they are.

Cluster C: Anxious/Fearful Disorders

Avoidant Personality Disorder (AvPD) 🚪

> *A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.*

Core Criteria (≥4 of 7)

- Avoids occupational activities requiring significant interpersonal contact.
- Unwilling to get involved unless certain of being liked.
- Restricts intimacy due to fear of shame or ridicule.
- Preoccupied with criticism or rejection.
- Inhibited in new situations because of perceived inadequacy.
- Views self as socially inept or inferior.
- Reluctant to take personal risks or try new activities.

Dependent Personality Disorder (DPD) 🤝

> *A pervasive and excessive need to be taken care of, leading to submissive, clinging behaviour and fears of separation.*

Core Criteria (≥5 of 9)

- Difficulty making everyday decisions without excessive advice.
- Needs others to assume responsibility for major areas of life.
- Trouble expressing disagreement for fear of losing support.
- Difficulty initiating projects alone (low self-confidence).
- Goes to extreme lengths to obtain nurturance, even unpleasant tasks.
- Uncomfortable or helpless when alone.
- Urgently seeks new relationships when one ends.
- Unrealistically preoccupied with fears of being left to care for self.

Definition (DSM-5)

> Persistent fear of social or performance situations where the individual fears negative evaluation, leading to avoidance or marked distress.

Core DSM-5 criteria (selected)

- Marked fear of scrutiny in social situations.
- Fear of acting in a way that will be judged negatively.
- Situations provoke fear (or in children, crying, freezing).
- Active avoidance or endured exposure with intense anxiety.
- Fear is *out of proportion* to actual threat.
- Persistence ≥ 6 months; significant functional impairment.

Prevalence & demographics

- **4–13 %** in Western societies.
- Higher rates in females; typical onset in mid-teens.
- Lowest remission rate among anxiety disorders.

Aetiology

Domain	Highlights
Genetic	Twin studies: ~13 % variance in social fear; broader anxiety heritability 30–50 %.
Familial & Developmental	Maternal anxiety, behavioural inhibition in childhood, parental over-control, low warmth, use of shame.
Cognitive	Information-processing bias; heightened self-focused attention; excessive post-event rumination; negative self-evaluation.

> **Image: Social anxiety rating bar graph** – shows how observers (negative, neutral, positive) rate speeches of low vs. high socially anxious speakers.

	prefrontal cortex, hyper-reactive amygdala, heightened start