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Problems for the Book of Problems? Diagnosing Mental Health Disorders Among Youth

Philip C. Kendall and **Deborah A. G. Drabick**
Temple University

Abstract

As an introduction to the Special Issue that includes a series of articles on comorbid mental health conditions among youth, some issues pertinent to the diagnostic system are considered. The discussion of illustrative issues that affect the diagnoses of mental health problems among youth includes reminders to consider the source, the time frame, what's normal, the situation, the data, and the effect of changing diagnostic criteria. We support the *DSM* and *ICD* efforts to continue to develop as instruments by relying on the data.

Keywords

childhood disorders; child mental health diagnosis; DSM; ICD

The present introduction to the Special Issue on “Comorbidity in Children’s Mental Health” does not provide an exhaustive discussion of all of the issues that impact the diagnoses of mental health problems among youth. Rather, these issues are highlighted in the articles included in this Special Issue. Similarly, the present introduction is not the place for a comprehensive and detailed data-based review that could directly inform additional advances in the *DSM* or the *ICD* systems. With comorbidity as the theme of the Special Issue, the authors of the accompanying articles provide ample discussion of co-occurring symptoms, limited symptom specificity, and related matters that should be taken into account when diagnosing youth with mental health problems.

In this illustrative introduction, we describe and consider a few topics. For example, when striving for an accurate diagnosis of children’s mental health problems, how should divergent reports of symptoms from various sources (e.g., parent, child, clinician, teacher) be weighted? What duration of symptoms (time frame) best reflects disordered functioning, and does the time frame vary across age and developmental periods? Although any discussion of “normal” varies based on the definitions or conceptualizations of developmentally appropriate behaviors, typical development and the many vicissitudes within it, as well as cross-situational consistency of behavior, necessarily bear directly on diagnostics. These topics are among the issues that we consider in the following sections. In another discussion (Drabick & Kendall, 2010), we consider several additional topics relevant to diagnosis among youth from a developmental psychopathology perspective.

DSM and *ICD* are diagnostic systems in the process of review and completion. We, like others, hold that the data should drive the diagnostic system, and that caution should guide

changes in diagnostic criteria. We hope that the next needed studies will be informed by the discussions raised in this Special Issue, and further, that the results of these proposed studies will inform the next iteration of diagnostic systems. Before launching into a consideration of sources of concern within the existing diagnostic systems (e.g., *DSM-IV-TR*; American Psychiatric Association [APA], 2000), it would be remiss not to first mention several worthwhile and meritorious advances that have been made from previous editions. To illustrate, we will use the *DSM* as an example. For anyone whose first endeavor into psychodiagnostics was with the “mustard manual,” a name reflecting the color of the notably thin, out-line-style Diagnostic and Statistical Manual of Mental Disorders (APA, 1952), the now bulky and descriptive *DSM* (APA, 2000) has much to be applauded. Once a bulleted list of disorders lacking specifiable criteria, the manual has been transformed to include detailed and specific sets of symptoms required for diagnoses. The poorly named and often single-theory-driven categories of the initial manual have been replaced by aptly labeled disorders that are no longer burdened by theoretical persistence to the neglect of data. In short, the advances in the *DSM* over the past 40 years are noteworthy, laudable, and move the field in the right direction. However, given our quest for excellence, several important issues are still in need of attention.¹

CONSIDER THE SOURCE

It is quite simple to generate examples in which considering the source is critical for understanding the information provided. For instance, when a 16-year-old girl tells her mother that she attended “the best concert ever” and that “everyone was there,” the parent considers the source and recognizes that the statement meant that the teen had an enjoyable time and saw many people she knew. Considering the source is crucial for obtaining an accurate understanding of a situation, and several important sources are often available when we attempt to identify and diagnose child/adolescent mental health problems. For starters, there is limited agreement between parents’ reports of their children’s behaviors and children’s own self-reports (e.g., Achenbach, McConaughy, & Howell, 1987; Choudury, Pimentel, & Kendall, 2003; De Los Reyes & Kazdin, 2005; Grills & Ollendick, 2002). Although a more detailed review of the research would point to subtle features that might account for these differences, such as contextually dependent behaviors and discrepant informant perspectives (Achenbach et al., 1987; De Los Reyes & Kazdin, 2008; Grills & Ollendick, 2003; Kraemer et al., 2003), the big picture is nevertheless informative; specifically, parents and their offspring typically do not agree in terms of their perspectives about child symptoms or the mental health needs of the youth (e.g., Yeh & Weisz, 2001).

Consider a mother who brought her daughter for treatment for social phobia. The teenage girl was quiet, but entirely capable of conversations with peers and adults. She was active in extracurricular activities at school but engaged in these activities in a somewhat reserved style. Her behavior and emotional functioning were well within normal limits, except when viewed from the perspective of the mother, who, by the judgment of professionals, was an exceedingly outgoing social butterfly, and whose interactions were ebullient, effusive, and, to some, including her daughter, excessive and annoying. Clearly, the daughter was not in need of therapy for social phobia, but rather the mother and daughter had different views of the daughter’s mental health and social adjustment. Suffice it to say that parents/teachers, teachers/youth, youth/professionals, etc., are among the several dyads for which agreement can be less than preferred (Kolko & Kazdin, 1993).

¹ The present considerations will not address treatment implications (see, e.g., Kendall & Clarkin, 1992; Kendall, Kortlander, Chansky, & Brady, 1992).

The lack of a “gold standard” in identifying youth psychological difficulties highlights the need for added research and consideration given to the divergent perspectives that are brought to the diagnostic evaluation of youth. Although informant disagreement may be expected, the reasons behind such disagreement are not necessarily evident. In addition to differences related to contextual demands and informant perspectives, parents may be driven by other motivational factors to seek a diagnostic label for their child (Kendall & Flannery-Schroeder, 1998). For example, disorder diagnoses are often required to make a child eligible to receive services. Thus, if a parent wants services and/or a professional thinks services are warranted or potentially useful for a child, the diagnosis (accurate or not) can be *used* as the means to secure the services. Such a case might occur when a parent, anticipating the benefits associated with more test-taking time, pursues a diagnosis for his or her child to obtain the desired accommodations. Other disagreements may be linked to children underreporting (minimizing) externalizing problems. Although disagreement can happen for multiple reasons and can be linked to various disorders, the end results are the same—potentially incorrect individual diagnoses and inaccurate data on the incidence/prevalence of disorder. How many false positives exist in a data set driven by needs for services?

CONSIDER THE TIME FRAME

Youth is a period of life known for its dramatic cognitive, emotional, social, and physiological changes. The absence of change would be more noteworthy than change itself. Accordingly, professionals should be cautious not to hastily accept brief snapshots of behavior as indicators of permanent patterns of functioning or the presence of pathology or impairment. To their credit, the *DSM* and the *ICD* often require a symptom to exist for a specified duration of time before it is taken to be meaningfully indicative of the presence of the disorder. Temporal specifications are a step in the right direction; however, the validity of these durations is not uniformly supported. Going one step further, would longer or shorter durations be more appropriate depending on the age or developmental level of the child? Should the time frame depend on the severity of the symptom or the type of syndrome or disorder? Some behaviors, such as oppositional behaviors, are developmentally expected during certain developmental periods (Dix, Stewart, Gershoff, & Day, 2007) but problematic at others. Other behaviors, such as running away and suicidal ideation, are considered problematic regardless of developmental period. These examples beg the question of whether we should apply the same symptom duration criteria across developmental periods, or whether flexibility is needed to determine whether symptom durations correspond to impairment and levels of distress that meet diagnostic criteria.

Time frames related to symptoms and diagnostic criteria become especially important in the context of efforts to evaluate treatment outcome (e.g., psychological therapies, medications, or their combination). When evaluating outcomes that are based on the presence or absence of a diagnosis or both, participants must meet diagnostic criteria at entry and then, following the intervention, not meet diagnostic criteria. When the time frame for a disorder requires (for example) four months, and the treatment is completed in six months, there is not a conflict: the criteria can be evaluated fairly and the evaluation of outcome is unaffected. However, what happens when the time frames are different (e.g., the criteria for a diagnosis require the symptoms to be present for four months, but the treatment lasts only two months)? If the posttreatment evaluation is two months after treatment begins, it is possible that the youth who began treatment meeting the temporal criteria would, for those symptoms with the six-month duration, still meet criteria after the two-month intervention. And this could be true regardless of whether the intervention was in fact effective. Thus, the evaluation of outcome would be unwittingly influenced by the time frame criteria. It may be unclear how to proceed in such instances. For example, does one change the diagnostic

“time” criteria at the posttreatment evaluation? Does an evaluator change the diagnostic criteria at pretreatment and posttreatment to ensure consistency at both measurement points? If so, how does this alteration affect the generalizability of the findings, given the inclusion of participants who meet and do not meet the *unaltered* diagnostic criteria? Should different definitions of disorder, for onset and remission, guide decisions about outcomes (see, e.g., Frank et al., 1991)? Diagnostic systems would be advanced by added clarity with regard to symptom duration. In addition, the duration criteria would inform and be informed by issues related to typical development, a point to which we now turn.

CONSIDER WHAT’S “NORMAL”

There are multiple ways to define normal behavior. Examples include considering what is typical of most people in the same developmental period or under similar circumstances, what is statistically within the average range, or what is not associated with interference or distress (i.e., not maladaptive; Wakefield, 1997a, 1997b). As we weigh several issues facing *DSM*, *ICD*, or other diagnostic systems, we remind ourselves that the desired goal of the diagnostic system is the accurate identification of youth who are suffering, whose behavior/emotion is maladaptive and interfering, and for whom services can be remedial and beneficial. But we cannot ignore that this optimal identification can go awry. When parents or professionals set too narrow a definition for acceptable child behavior, they simultaneously set too wide a definition for unacceptable behavior. Do we really want children to “sit still and be quiet”? Do we strive for automatons? Does healthy adjustment through development not include facing conflicts, solving problems, tolerating differences of opinion, and participating in working collaborations? Conflict is a normative part of development (Emery, 1992), serving the role of testing boundaries and providing information about the degree of power and intimacy in key relationships, and should not be mistaken for “temper dysregulation disorder.”

What happened to the important role of nonadult-directed “play” in normal, well-adjusted development (Hartup, 1996)? Children acquire life skills when they arrange their own games, even if not consistent with the official rules of soccer, basketball, or computer games. Children learn valuable lessons among themselves in preschool and kindergarten, often associated with social play and interactions. Creativity emerges from creative activity, and happiness from fun activity. The boy is father to the man. The rule-governed child is father to restricted adulthood.

Parents, unwittingly, may be overly concerned with child behavior. Parental monitoring can be and often is a good thing. One can argue, and the data support, that delinquent youth benefit from increased parental monitoring of youth activities (Dishion, Patterson, Stoolmiller, & Skinner, 1991). But monitoring can be taken too far. The “helicopter” parent who hovers over the child and monitors every undertaking is not benefiting the development of the child. For example, parents of children with an anxiety disorder are less likely to grant autonomy to their child and more likely to monitor activities beyond what is necessary (Ginsburg & Schlossberg, 2002; Hudson & Rapee, 2001; Luis, Varela, & Moore, 2008; Moore, Whaley, & Sigman, 2004; Ollendick & Horsch, 2007).

Statistical definitions of what is considered normal offer advantages, but not all who are statistically abnormal require change. The fourth grader who is 6 ft. 2 in. tall is statistically aberrant, but we do not need to shrink him. The child who scores 148 on an IQ test, despite being on a statistically small tail of the distribution, does not need to be dumbed down. High levels of prosocial behavior are rare, but we certainly would not want children to be less sympathetic and supportive of peers. Indeed, statistical extremes can be favorable. Highly prevalent conditions that are not statistically unusual nevertheless may be associated with

serious impairment. For example, obesity, pandemic in the United States, is associated with deleterious health effects and long-term outcomes. A purely statistical definition of “abnormal” would be misleading. Thus, the use of normal (typical) development is a most valuable backdrop against which to view potentially aberrant development.

How active is this seven-year-old relative to large samples of other seven-year-olds? How long can this nine-year-old pay attention, relative to others of the same age, grade, or developmental level? And what is a reasonable expectation for both child activity and attention between ages 6 and 12, relative to the data on activity and attention for youth? Clearly, knowledge of developmental norms is critical for making decisions about whether a child’s behavior falls within normal limits or requires further attention (Drabick & Kendall, 2010). Moreover, parents and/or professionals whose definition of normal is too narrow can have the tendency to fall prey to diagnostic false positives—seeing more pathology than is merited by the behavior. A diagnostic system that does not permit or encourage adequate consideration of developmentally appropriate behavior thereby identifies increasingly higher percentages of youth and may no longer accurately capture that which is abnormal.

CONSIDER THE SITUATION

Attention-deficit/hyperactivity disorder (ADHD) can serve to illustrate the value of considering the situation. That is, we see merit in having the criteria for ADHD include evidence of cross-situational consistency: the child’s behavior at home, at school, and observed. Although there may be shortcuts (one person simply asking about the different situations), it would be preferred to have independent data from separate sources with the professional integrating the information. The sources should be consistent in terms of displayed symptoms (e.g., inattention, overactivity), and symptoms in only one situation are not sufficient to meet diagnostic criteria (APA, 2000).

Cross-situational consistency makes sense because if the problem is indeed one within the child, then it should go with the child from one situation (environment, context) to another. If the behavior is not attributable to the child, but instead is a function of the situation (environment, context), then the behavior would vary across situations and it would be inaccurate to ascribe a trait label (diagnosis) to the child. Although ADHD illustrates the merits of cross-situational consistency, there are other diagnoses where reliance on a single source can lead to diagnoses. Would it be an advantage, and advancement, for the diagnostic system to be more uniform in its recognition of the need for cross-situational consistency? Might a lack of attention to cross-situational consistency lead to overdiagnosis and increased comorbidity?

Some data suggest that requiring cross-situational consistency increases the specificity of diagnoses (Youngstrom, Findling, & Calabrese, 2003) but can lead to underdiagnosis if the different sources of data do not have diagnostic specificity. In addition, there are some instances where cross-situational consistency may not be needed, such as when determining suicidal intent.

As one considers the situation, one also recognizes the influence of interactions between individual differences and situational demands. The same child characteristic (or trait, behavior style, or temperament) may be more or less problematic, and more or less desirable, in different contexts. That is, the same child characteristic could be a strength or weakness, as seen by parents or teachers, depending on the situation (Carey, 1998).

CONSIDER THE DATA

The field of child mental health is, almost by definition, focused on the unusual. And the unusual, also by definition, is not customary. Having said that, it is worth reminding ourselves not to be overly influenced by an *N* of 1. It is no doubt true that there is a former high school dropout who successfully graduated with honors from Yale, and that there are likely teenage delinquents who served penitentiary terms yet matured into respected and elected members of the community governance. But would we not agree that these examples are the exception, rather than the rule? The data, like them or not, inform us of the factors that are predictive of certain outcomes, and the general and powerful predictors are typically not the odd or the unusual cases.

When a diagnostic system seeks to determine the symptoms to include as markers of a disorder, it continues to be essential that the data drive the decisions. If cruelty to small animals is a reliable and significant predictor of later antisocial behavior, then the validated evidence of such behavior merits inclusion in a diagnostic decision. If one professional had a client who dreamt about violence toward his father, yet violent paternal dreams do not significantly predict later mental health status, then such a symptom, separate from the proselytizing skill of its proponent, should not be included in the diagnostic system. Let the data tell us, and let the statistical combinations of data inform us. Clinical predictions typically do less well than those that capture data and are statistically informed (Dawes, Faust, & Meehl, 1989).

CONSIDER THE EFFECT OF CHANGING CRITERIA

Students of child mental health first learned that autism occurred in one in 7,000, then one in 3,000, then one in 500, and most recently the autism spectrum disorder is said to be evident in one in 110 children (Centers for Disease Control and Prevention [CDC], 2006). What has happened to account for such a trend?

Clearly, and with proper change in the name of the disorder, there have been adjustments in the criteria used to diagnose the presence of the condition labeled variously as autism and autism spectrum disorder. As members of the profession, we are aware of these adjustments in the diagnostic system, and we act with the guidance provided by the knowledge that the organizing system has changed. However, nonprofessional laypeople are not as informed, and misguided interpretations of the change in prevalence can have profound influence. As this example illustrates, changing diagnostic criteria can have wanted and unwanted effects within society.

What would be the long-term result on the field of child mental health if we increasingly label/diagnose children, report increases in the incidence of specific disorders, and provide increased mental health services? On the one hand, if the diagnoses are accurate and the services prove helpful, all would be good. On the other hand, if the services prove to be less than preferred—and this would be increasingly likely when the diagnoses are inaccurate and those receiving services do not really need them—then we run the risk of society judging our efforts and concluding that we are “ineffective” or that we “overdid it” or both. To the extent that diagnostics are *in*accurate, the long-term view includes myriad serious and unwanted consequences.

What if, in contrast to increasing the number of youth diagnosed with mental health problems, we were to expand the skills given to parents; foster the acceptance of a broader and more flexible view of normal development; and underscore an understanding of the merits of play, variation in behavior and emotion, and the power associated with learning to cope with the inevitable adversities of life? Diagnostics label the child, attributing the

problem to the child. Maybe the increased prevalence of “psychopathology” among youth is not the kids’ fault!

Does the book of problems have problems? Yes, to a degree. Does the book of problems, itself, meet diagnostic criteria? That is, if we consider the source, examine what may be seen as normal, and weigh the other influences, is the *DSM* (or *ICD*) disturbed? We think not. We see it more as a developing instrument that is striving for improvement by efforts to rely on data. Nevertheless, it is not without issue and true advancement will require reaffirmation of the role of data-driven decisions, along with separation from financial forces that are not mental health oriented. Many of the central and critical concerns regarding comorbidity in children’s mental health will be considered in the articles that constitute this Special Issue. These informed considerations help shape not only the questions but also the potential resolutions to the problems facing accurate diagnosis of children’s mental health.

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REFERENCES

- Achenbach TM, McConaughy SH, Howell CT. Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*. 1987; 101:213–232. [PubMed: 3562706]
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 1st ed. Author; Washington, DC: 1952.
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed., text revision. Author; Washington, DC: 2000.
- Carey WB. Temperament and behavior problems in the classroom. *School Psychology Review*. 1998; 27:522–533.
- Centers for Disease Control and Prevention. Mental health in the United States: Parental report of diagnosed autism in children aged 4–17 years—United States, 2003–2004. *Morbidity and Mortality Weekly Reports*. 2006; 55:481–486.
- Choudury MS, Pimentel SS, Kendall PC. Childhood anxiety disorders: Parent-child (dis)agreement using a structured interview for DSM-IV. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2003; 42:957–964. [PubMed: 12874498]
- Dawes RM, Faust D, Meehl PE. Clinical versus actuarial judgment. *Science*. 1989; 243:1668–1674. [PubMed: 2648573]
- De Los Reyes A, Kazdin AE. Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework, and recommendations for further study. *Psychological Bulletin*. 2005; 131:483–509. [PubMed: 16060799]
- De Los Reyes A, Kazdin AE. When the evidence says, “Yes, no, and maybe so”: Attending to and interpreting inconsistent findings among evidence-based interventions. *Current Directions in Psychological Science*. 2008; 17:47–51. [PubMed: 21243087]
- Dishion TJ, Patterson GR, Stoolmiller M, Skinner M. Family, school, and behavioral antecedents to early adolescent involvement with antisocial peers. *Developmental Psychology*. 1991; 27:172–180.
- Dix T, Stewart AD, Gershoff ET, Day WH. Autonomy and children’s reactions to being controlled: Evidence that both compliance and defiance may be positive markers in early development. *Child Development*. 2007; 78:1204–1221. [PubMed: 17650134]
- Drabick DAG, Kendall PC. Developmental psychopathology and the diagnosis of mental health problems among youth. *Clinical Psychology: Science and Practice*. 2010; 17:272–280. [PubMed: 21243110]

- Emery, R. Family conflicts and their developmental implications: A conceptual analysis of meanings for the structure of relationships. In: Hartup, W.; Shantz, C., editors. *Family conflicts*. Cambridge University Press; New York: 1992. p. 270-298.
- Frank E, Prien R, Jarrett R, Keller M, Kupfer D, Lavori P, et al. Conceptualization and rationale for consensus definitions of terms in major depressive disorder: Remission, recovery, relapse, and recurrence. *Archives of General Psychiatry*. 1991; 48:851–855. [PubMed: 1929776]
- Ginsburg GS, Schlossberg MC. Family-based treatment of childhood anxiety disorders. *International Review of Psychiatry*. 2002; 14:143–154.
- Grills AE, Ollendick TH. Issues in parent-child agreement: The case of structured diagnostic interviews. *Clinical Child and Family Psychology Review*. 2002; 5:57–83. [PubMed: 11993545]
- Grills AE, Ollendick TH. Multiple informant agreement and the anxiety disorders interview schedule for parents and children. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2003; 42:30–40. [PubMed: 12500074]
- Hartup WW. The company they keep: Friendships and their developmental significance. *Child Development*. 1996; 67:1–13. [PubMed: 8605821]
- Hudson JL, Rapee RM. Parent-child interactions and anxiety disorders: An observational study. *Behaviour Research and Therapy*. 2001; 39(12):1411–1427. [PubMed: 11758699]
- Kendall PC, Clarkin JF. Introduction to special section: Comorbidity and treatment implications. *Journal of Consulting and Clinical Psychology*. 1992; 60:833–835. [PubMed: 1460146]
- Kendall PC, Flannery-Schroeder EC. Methodological issues in treatment research for anxiety disorders in youth. *Journal of Abnormal Child Psychology*. 1998; 26:27–38. [PubMed: 9566544]
- Kendall PC, Kortlander E, Chansky TE, Brady EU. Comorbidity of anxiety and depression in youth: Treatment implications. *Journal of Consulting and Clinical Psychology*. 1992; 60:869–880. [PubMed: 1360989]
- Kolko DJ, Kazdin AE. Emotional/behavioral problems in clinic and nonclinic children: Correspondence among child, parent, and teacher reports. *Journal of Child Psychology and Psychiatry*. 1993; 34:991–1006. [PubMed: 8408380]
- Kraemer HC, Measelle JR, Ablow JC, Essex MJ, Boyce WT, Kupfer DJ. A new approach to multiple informants: Mixing and matching contexts and perspectives. *American Journal of Psychiatry*. 2003; 160:1566–1577. [PubMed: 12944328]
- Luis TM, Varela RE, Moore KW. Parenting practices and childhood anxiety reporting in Mexican, Mexican American, and European American families. *Journal of Anxiety Disorders*. 2008; 22:1011–1020. [PubMed: 18083326]
- Moore PS, Whaley SE, Sigman M. Interactions between mothers and children: Impacts of maternal and child anxiety. *Journal of Abnormal Psychology*. 2004; 113:471–476. [PubMed: 15311992]
- Ollendick TH, Horsch LM. Fears in clinic-referred children: Relations with child anxiety sensitivity, maternal overcontrol, and maternal phobic anxiety. *Behavior Therapy*. 2007; 38:402–411. [PubMed: 18021954]
- Wakefield JC. Diagnosing DSM-IV-Part I: DSM-IV and the concept of disorder. *Behaviour Research and Therapy*. 1997a; 35:633–649. [PubMed: 9193127]
- Wakefield JC. When is development disordered? Developmental psychopathology and the harmful dysfunction analysis of mental disorder. *Development and Psychopathology*. 1997b; 9:269–290. [PubMed: 9201445]
- Yeh M, Weisz JR. Why are we here at the clinic? Parent-child (dis)agreement on referral problems at outpatient treatment entry. *Journal of Consulting and Clinical Psychology*. 2001; 69:1018–1025. [PubMed: 11777105]
- Youngstrom EA, Findling R, Calabrese J. Who are the comorbid adolescents? Agreement between psychiatric diagnosis, parent, teacher, and youth report. *Journal of Abnormal Child Psychology*. 2003; 31:231–245. [PubMed: 12774858]