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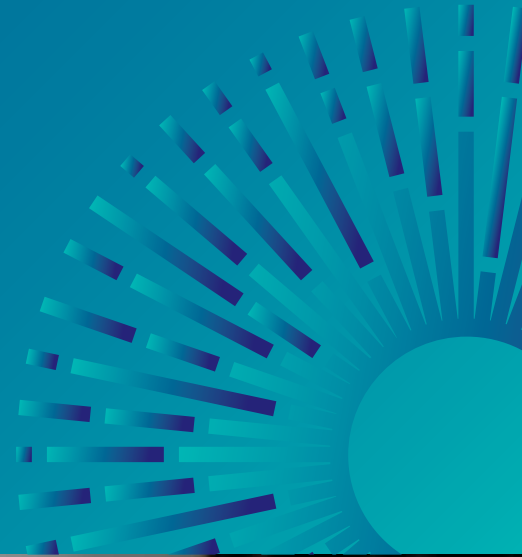
Diagnosis in child mental health

Exploring the benefits, risks and alternatives

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Summary

Service providers seldom have time to explore the debates, complexities and nuances surrounding the diagnosis of child mental health conditions. This paper is designed to encourage practitioners in the child and family welfare sector to examine their own understanding of diagnostic systems, and to critically reflect on the role that diagnosis plays in their work with children and families.

KEY MESSAGES

- Like adults, children experience mental health difficulties. For some, a diagnostic label plays an important role in their treatment and recovery.
- In the late 20th century, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) revolutionised the nature of mental health classification by providing a common language to define mental health difficulties.
- In Australia, the DSM-5 is now the primary system for identifying mental health conditions. The tenth edition of the *International Classification of Diseases* (ICD-10) is also sometimes used. Both systems focus on overt symptoms, rather than underlying causes or surrounding social context.
- The diagnostic systems used in Australia are still being debated. Critics argue that they pathologise normal human experiences, decontextualise mental health difficulties, lack scientific validity, and are culturally insensitive.
- Emerging evidence suggests that certain mental health conditions may be overdiagnosed in children. Numerous converging factors are thought to contribute to potential overdiagnosis, including the influence of the pharmaceutical industry.
- This paper takes the view that current diagnostic systems are best seen not as scientific certainties, but rather as cultural tools used to understand different varieties of psychological distress and impairment.

Introduction

The identification and diagnosis of child mental health conditions attracts controversy. Uproars about the over-diagnosis of attention deficit/hyperactivity disorder (ADHD) have been a media staple in recent years, with claims that Australia has become a “medication nation” (Schwarz, 2016) nurturing “a generation of Ritalin kids” (Fife-Yeomans, 2009, paragraph 1). The federally funded “Healthy Kids Check”, aimed at screening 3–5 year olds for signs of psychosocial and development problems, was defunded after three years, but not before generating considerable debate within both popular and academic forums (e.g. Newman, 2012; Prior, 2012). And the early intervention strategies of the nationwide Early Psychosis Prevention and Intervention Centres (EPPIC) have attracted ongoing criticism, with, for example, prominent United States (US) psychiatrist Allen Frances (2011, paragraph 4) declaring them “a vast and untried public health experiment that will almost surely cause more harm to children than it prevents”.

No recent document in the field of mental health has generated more debate than the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013; hereafter “DSM” is used to refer to the diagnostic manual in general, as opposed to any particular edition). In Australia, as in the US, the DSM is the primary system for identifying mental health conditions in both children and adults.¹

The DSM provides labels for clusters of behavioural health symptoms (i.e., it is descriptive), and in the large majority of cases does not attempt to describe the aetiology of the symptom-based disorders it identifies (i.e., it is not explanatory). It is a highly influential document, not only shaping research, policy and treatment, but drawing the official boundaries between “normal” and “abnormal”, healthy and sick. As Mayes and Horwitz (2005, p. 265) observed, “few professional documents compare to the DSM in terms of affecting the welfare of so many people”.

Perhaps because of its pervasive influence, the DSM has been subject to intense scrutiny. For example, it has been criticised for medicalising the normal rhythms of life, decontextualising mental health difficulties, and being influenced by the profit-motives of pharmaceutical companies. These and other criticisms are outlined in the sections below. It should be noted here, however, that many of the criticisms of the DSM are as much about its misuse as they are about the framework itself. For example, while the DSM presents itself as a descriptive document, it is often inappropriately used as an explanatory framework, in which case the social and developmental contexts of mental health conditions can easily be obscured.

When those being diagnosed are children, new layers of complexity are introduced.

Children are profoundly dependent and sensitive to their contexts. Despite the widespread propagation of biological explanations of mental health, the strongest predictors of child mental health difficulties are family and environmental factors (J. Bayer et al., 2011; Patalay & Fitzsimons, 2016). For example, adverse childhood experiences, including exposure to family violence and maltreatment, are strongly associated with mental health difficulties in both childhood and later life (Kerker et al., 2015).

Normal child developmental trajectories also vary widely, meaning that it can be difficult to make accurate diagnoses for younger children (Prior, 2012; Szaniecki & Barnes, 2016). Where children are concerned, the lines separating normal development and mental health difficulty can be particularly troublesome to draw. And even if these lines are drawn accurately, appropriate supports are often unavailable (Prior, 2012).

Despite these complexities, Australia has witnessed a steady rise in the number of children diagnosed with mental health conditions, which is concordant with worldwide prevalence trends (Merten, Cwik, Margraf, & Schneider, 2017). Research has also documented a recent increase in the use of

¹ The United Kingdom and many other European countries favour the tenth edition of the *International Classification of Diseases* (ICD-10; World Health Organization, 1992), which for the purposes of this paper is similar to the DSM.

psychotropic medications to treat child mental health difficulties (Zito et al., 2003). Such trends have concerned many mental health professionals, who have argued that the field of child mental health is marred by “epidemics” of overdiagnosis and over-treatment (e.g. Basu & Parry, 2013; Batstra & Frances, 2012). However, overdiagnosis and over-treatment are a problem of developed countries, with chronic under-recognition of child mental health difficulties a more likely scenario in the developing world (Barbour et al., 2013).

While many service providers have well-established views on diagnosis, they may not have the capacity to explore the debates, complexities and nuances of diagnosis in child mental health. They may not be aware, for example, that the disorders in the DSM and similar frameworks are arrived at through the consensus of committees of mental health experts, are sometimes based on scant empirical evidence, and tend to be more influenced by historical and practical considerations than any clear rationale (Frances & Widiger, 2012).

That diagnostic categories are decided by committees and influenced by practical considerations does not automatically make them invalid. Indeed, the boundaries of diagnostic categories are rarely drawn by scientific evidence alone; many physical medical conditions also have their diagnostic parameters decided and revised by committees of experts. Nonetheless, it does suggest that the diagnostic categories used in the Australian mental health care system are not set in stone. Rather, they are ways of understanding human challenges that convey both benefits and risks, and for which there can be legitimate alternative understandings. The more insight that service providers have into the nature of the diagnostic frameworks that shape their practice, the more likely it is that they will make appropriate decisions when children in their care are experiencing mental health difficulties.

Language is important

The language used in the context of mental health experiences and systems is important. Some terms are obviously stigmatising or outdated (e.g. “schizo”, “nuts”). Others can seem benign, but actually reflect unproven or misleading views. There are many different opinions about the respectful use of language in the context of mental health, and it is incumbent upon each service provider to identify language that reflects their own views, is consonant with the principles of their workplace, and respects the dignity of the service users with whom they work. The following notes on language use in this paper reflect the informed preferences of the author:

- The terms “mental health condition”, “mental health difficulties” and “distress and impairment” are used throughout this paper. These terms acknowledge the difficult experiences of those diagnosed with mental health conditions, while avoiding some of the limitations identified throughout this paper, such as over-medicalisation.
- Because this paper advocates for the use of the biopsychosocial model in paediatric mental health, the term “mental illness” is not used. This term can be seen to suggest that conditions such as major depressive disorder, ADHD and oppositional defiant disorder are biologically based brain diseases.
- The word “disorder” is used in places throughout this paper, but only in the context of referring to the DSM (which classifies “mental disorders”) or specific diagnostic categories (e.g. “conduct disorder”). A limitation of this word is that it can negate the understanding that some mental health symptoms are reasonable reactions to, or even adaptive solutions for, trauma or difficult circumstances (Watt, 2017). For example, in the disordered context of a family home where there is violence and abuse, it may be adaptive for a child to develop the symptoms of anxiety. To label the child’s anxious response as “disordered” subtly locates the issue in them, rather than in their family environment.

About this paper

This paper is designed to encourage practitioners to critically reflect on the role diagnostic systems play in their work with children and families.

Sections 1 and 2 explore the most widely cited strengths and criticisms of current diagnostic systems. Section 3 explores the evidence behind claims of widespread overdiagnosis of certain child mental health conditions. In section 4, children's and parents' views of diagnosis are explored. Finally, in section 5, a number of alternatives or adjuncts to current diagnostic systems are outlined and then illustrated in an extended case study.

At the end of each section is a series of “critical reflections”, designed to encourage practitioners to connect what they have read back to their own professional experiences. While this paper is intended primarily for service providers in the child and family welfare sectors who work with children from birth to 12 years of age, it is also likely to be relevant to a wide range of health and welfare practitioners. Many of the readers of this paper will work in non-clinical environments and will not themselves be responsible for diagnosing children. Nonetheless, diagnostic labels will still influence their work in myriad ways, affecting how they interpret children's distress and impairment, the expectations they have of families, and the interventions they provide.

Diagnostic systems: DSM, ICD and DC:0-5

The DSM features heavily in this paper, at times acting as a proxy for similar diagnostic systems. The reasons for this are twofold. First, as the DSM has been subject to much more critical analysis than any other diagnostic system, most of the literature relevant to this paper was focused on the DSM. Second, as already mentioned, the DSM is the most widely used diagnostic system in Australia.

The *International Classification of Diseases* (ICD) is the main alternative, though it is similar to the DSM in many respects, tending “to follow palely in the footsteps of its big American brother” (Tyrrer, 2014, p. 283). The major difference between the DSM and ICD is that while the former provides operational diagnostic criteria for its disorders, the latter relies on narrative descriptions of disorders. Efforts are currently being made to “harmonise” the two diagnostic systems, so they share the same “metastructure”, as well as the same terms to denote their major diagnostic categories (Maj, 2011).

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, ZERO TO THREE*, (DC:0-5 2016) is an alternative for diagnosing infants and young children that places more focus on incorporating contextual factors into the diagnostic process, though it is small and lesser known than the DSM or ICD.

This paper is firmly rooted in the view that child mental health difficulties are best understood within the biopsychosocial model, which focuses on the ways in which biological propensities interact with psychological and social factors to lead to specific behavioural and emotional outcomes (Engel, 1977).

While the biopsychosocial model is widely invoked in Australian health services, it is common for the “bio” aspects of the model (e.g. genetic predispositions, psychotropic medications) to receive more attention than the “psycho” (e.g. coping skills, personality) and the “social” (e.g. socioeconomic status, social support) (Gambrell, 2014). Conditions such as major depressive disorder, ADHD and oppositional defiant disorder are often presented as biologically based brain diseases—a position that has little empirical support despite vast amounts of funding being allocated to uncovering the biological bases of mental health conditions (Deacon, 2013). For example, none of the psychiatric disorders identified in the DSM-5 have been shown to have a simple biological cause, and few have reliable biomarkers (i.e., they cannot be diagnosed using medical procedures, such as blood tests or fMRI scans) (Deacon, 2013; Frances & Widiger, 2012). Similarly, there exists no credible evidence that mental health conditions are caused by “chemical imbalances” in the brain, nor that psychotropic medications work by correcting such imbalances (Deacon, 2013). As the editor of the most widely read trade publication in the field of psychiatry, the

Psychiatric Times, observed, “in truth, the ‘chemical imbalance’ notion was always a kind of urban legend—never a theory seriously propounded by well-informed psychiatrists” (Pies, 2011, paragraph 1).

Critical reflections

- What are your views about diagnosing children with mental health conditions? How do these views influence the way you work with children and families?
- How have your views about diagnosis been changed or reinforced by professional training and experience, personal experience, and/or the media?
- How has your understanding of diagnostic systems influenced your practice? Are there understandings that you would like to develop in order to enhance your practice?

1. Strengths of current diagnostic systems

For much of the 20th century, mental health practice did not place much focus on particular diagnostic categories (Mayes & Horwitz, 2005). Early psychiatric frameworks (e.g. DSM-I and DSM-II) conceived of mental health symptoms as reflections of intrapsychic conflicts or difficult life circumstances that existed on a continuum with normality. However, with the publication of the DSM-III in 1980 the nature of mental health classification was revolutionised, as Mayes and Horwitz (2005) explain:

In a remarkably short time, psychiatry shed one intellectual paradigm and adopted an entirely new system of classification. The DSM-III imported a diagnostic model from medicine where diagnosis is “the keystone of medical practice and clinical research” (Goodwin & Guze, 1996). Psychiatry reorganized itself from a discipline where diagnosis played a marginal role to one where it became the basis of the specialty. The DSM-III emphasized categories of illness rather than blurry boundaries between normal and abnormal behavior, dichotomies rather than dimensions, and overt symptoms rather than underlying etiological mechanisms.

The DSM’s symptom-based model of categorisation allowed the mental health professions to develop highly standardised ways of measuring mental health difficulties (Kawa & Giordano, 2012). This standardisation, which was and continues to be enormously productive, is the root of most of the strengths of the DSM and similar frameworks. Some of the commonly cited strengths of these frameworks are:

A common language for service providers

Diagnostic frameworks give psychiatrists, psychologists, social workers and other health and welfare practitioners a common language to define and understand mental health difficulties (Frances & Widiger, 2012). When professionals use the same terms in the same ways, diagnosis and treatment can become more predictable and standardised.

Before DSM-III, it was more likely that two mental health professionals would provide different diagnoses for the same patient (Mayes & Horwitz, 2005). One of the keys to the success of the new classification system was its increased inter-rater reliability, which is a measure of how often two or more people arrive at the same diagnosis given the same presenting patient (Batstra & Frances, 2012).

A reliable framework for researchers

Standardised diagnostic frameworks have been powerful enablers of mental health research (Mayes & Horwitz, 2005). Large-scale clinical research relies on reliable diagnostic categories, which allow the research to be replicated by multiple researchers. The lack of reliable diagnostic categories in early psychiatric frameworks made such research virtually impossible. The publication of DSM-III

and its successors precipitated a massive proliferation of clinical research (Mayes & Horwitz, 2005). Indeed, “evidence-based practice” in mental health is underpinned by the diagnostic categories provided by standardised diagnostic frameworks.

A coding system for statistics and administration

Government regulators and insurance companies around the world have enthusiastically embraced DSM and ICD frameworks because of the increased clarity they provide (Mayes & Horwitz, 2005). For example, DSM-5 criteria are used to determine diagnoses for some conditions, including conditions commonly diagnosed in children, that are likely to meet the disability requirements for eligibility to the National Disability Insurance Scheme (NDIS) (National Disability Insurance Agency, n.d.).

Increased clarity in legal proceedings

Although the American Psychiatric Association (2013, p. 25) cautions that “the use of the DSM-5 should be informed by an awareness of the risks and limitations in its use in forensic settings”, the DSM is relied upon in many areas of the Australian legal system, both civil and criminal. Legal proceedings often require that experts conduct evaluations and provide judgement on the mental health of the parties involved, and the DSM, as imperfect as it is for legal purposes, provides “the best tool for experts to achieve a reliable and accurate judgment on the presence or absence of specific mental disorders” (Frances & Halon, 2013, p. 343).

Critical reflections

- What would your practice with children and families be like without the common language provided by frameworks such as the DSM?
- Does the standardised nature of mental health diagnosis benefit your work with children and families? Does it hinder your work in any way?
- Can you think of any other benefits to using standardised diagnostic frameworks?

2. Criticisms of current diagnostic systems

As mentioned above, the DSM has been subject to much criticism. These criticisms run the gamut from concerns about particular controversial mental health conditions (e.g. gender dysphoria, autism spectrum disorder) (e.g. Lev, 2013; Volkmar & Reichow, 2013) to wholesale rejection of the philosophical and/or scientific basis of such frameworks (e.g. Gambrell, 2014; Timimi, 2014). Two caveats should be noted before exploring these criticisms. First, while critiques of the DSM and ICD are important, especially given their worldwide influence, it is also important to acknowledge that many of the accusations levelled at these diagnostic systems are not necessarily all about the systems themselves. They are also about the ways in which these systems are used in society, particularly in societies such as Australia and the US, which privilege biomedical understandings of mental health. Diagnostic systems cannot always be held responsible for all the ways in which they are used or misused.

Second, there is a tendency for critics of current diagnostic systems to overgeneralise (Bell, 2017). Documents such as the DSM-5 and ICD-10 are very diverse, meaning that there are generally many exceptions to any blanket statements about the entire works. For example, the argument that the DSM pathologises normal human experiences may be credible when considering generalised anxiety disorder, but it is difficult to see how it applies to Tourette’s disorder. As Bell (2017, paragraph 42) suggested, “diagnosis can really only be coherently criticised on a case-by-case basis or where you

have demonstrated that a particular group of diagnoses share particular characteristics". With these provisos in mind, the following criticisms of the DSM and similar diagnostic systems are some of the most commonly cited.

Pathologising normal human experience

Perhaps the most widespread criticism of the DSM is that it has led to the "medicalization of normal life" (Frances, 2013, p. iii), expanding the concept of mental disorder to include difficult but expectable human experiences such as sadness, grief, shyness, anxiety, disappointment, inattentiveness, irritability, anger and stress (e.g. Frances, 2013; Greenberg, 2013; Paris, 2015).

Criticisms of this sort usually come in one of two variants (Maj, 2015). First, some argue that specific diagnoses such as ADHD and disruptive mood dysregulation disorder do not qualify as legitimate mental health conditions. Second, some suggest that the thresholds for diagnosis of legitimate conditions, such as major depressive disorder and generalised anxiety disorder, are too low.

Unfortunately, the question of over-pathologisation is very difficult to settle because there is no clear definition as to exactly what a mental disorder is. The current boundaries between normal human problem and mental health condition are decided not by clear-cut laboratory tests, but rather by a mixture of professional opinion, empirical evidence and risk-benefit analysis (Frances & Widiger, 2012; Maj, 2015). It is undoubtedly difficult to create diagnostic criteria that adequately recognise human distress and impairment without encroaching on experiences that are generally considered a part of "normal life". Nonetheless, labelling healthy people as mentally disordered has many negative results, including stigma, unnecessary treatment, overuse of potentially harmful psychotropic medications, the misallocation of medical resources, and personal and familial distress (Batstra & Frances, 2012).

Decontextualising mental health difficulties

Another common criticism of the DSM is that it obscures the contexts in which mental health conditions occur. Some authors focus this criticism on social determinants—including poverty, marginalisation and discrimination—which have been consistently identified as among the strongest predictors of many mental health conditions (Allen, Balfour, Bell, & Marmot, 2014). Others suggest that the DSM inadequately accounts for individuals' historical and current relational context, which may include trauma, attachment difficulties, and child abuse and neglect (Dignam, Parry, & Berk, 2010; Parry & Levin, 2012; Watt, 2017).

As proponents of the biopsychosocial model have stressed for over three decades, children's health and development occurs within multiple contexts, including the family, school, local neighbourhood and community environments, and each of these environments is in turn influenced by broader social, economic, political and cultural factors. Children's development can also be profoundly influenced by adverse experiences such as abuse and neglect, with some suggesting that many mental health symptoms should be seen as adaptations to trauma rather than as pathologies (Watt, 2017). The disorders in the DSM, however, are generally identified by focusing on individuals' recent symptoms.

Although the DSM has long claimed to be "atheoretical", numerous authors (e.g. Castiglioni & Laudisa, 2015; Timimi, 2014) have argued that its symptoms-based "checklist" approach actually relies on a strongly individualistic worldview, one which precludes understandings that account for historical and environmental influences. Such individualism neatly dovetails with the biomedical model of mental health, which sees mental health conditions as biologically based brain diseases, and which consequently emphasises pharmaceutical treatments over more holistic interventions (Castiglioni & Laudisa, 2015; Deacon, 2013).

Lack of scientific validity

It is common for critics to argue that while the DSM demonstrates adequate *reliability* (i.e., it helps ensure that professionals use the same terms in the same ways), it lacks *validity*, which, in the broadest sense, means that the disorders described do not accurately capture the nature of people's mental distress and impairment.

Some critics have focused on the processes by which the DSM framework is constructed, arguing that the diagnostic categories should be decided by scientific evidence rather than committees of experts, or that committee members' links to the pharmaceutical industry create egregious conflicts of interest (e.g. Greenberg, 2013). Others have criticised the lack of conceptual clarity and scientific objectivity in the DSM, suggesting, for example, that the absence of biological corroboration for the vast majority of disorders undermines the validity of the entire framework (e.g. Deacon, 2013).

A number of alternatives to symptoms-based diagnostic frameworks have been proposed, the most popular being the Research Domain Criteria (RDoc) project (Insel, Cuthbert, Garvey, & Heinssen, 2010), which aims at grounding diagnostic criteria in neuroscience and behavioural science. However, none of these alternatives have gained widespread acceptance from the mental health field. Even though some of the architects of recent iterations of the DSM have agreed that the current system is far from perfect, they have suggested that it is still necessary until a widely accepted alternative can take its place (Frances & Widiger, 2012).

Cultural insensitivity

Although the DSM goes some way in accounting for cultural variation in how mental health difficulties are experienced, labelled and explained, some authors have argued that it is complicit in the process of cultural colonisation. That is, it imposes one understanding of distress and impairment on cultures and groups of people who have their own legitimate alternative understandings (Barker, 2003; Timimi, 2014).

The authors of the DSM-5 recognise that the document is a cultural artefact of the US, stating that, "The current formulation acknowledges that all forms of distress are locally shaped, including the DSM-5 disorders" (American Psychiatric Association, 2013, p. 758). Yet because of the DSM's vast influence on healthcare systems, government departments and universities worldwide, its categories of health and sickness are often presented as the only valid perspective (Barker, 2003; Timimi, 2014).

Alternative viewpoints, such as traditional Aboriginal and Torres Strait Islander understandings of wellbeing—where health is seen as an outcome of the harmonious interrelation of mental, physical, cultural, spiritual and environmental factors (Poroch et al., 2009)—are sidelined. As Watters (2010, p. 2) explained, this "globalization of the American psyche" does not simply affect how pre-existing symptoms are interpreted, but can influence the very ways in which people experience mental health difficulties:

Over the past thirty years, we Americans have been industriously exporting our ideas about mental illness. Our definitions and treatments have become the international standards. Although this has often been done with the best of intentions, we've failed to foresee the full impact of these efforts. It turns out how people in a culture think about mental illnesses—how they categorize and prioritize the symptoms, attempt to heal them, and set expectations for their course and outcome—influences the diseases themselves. In teaching the rest of the world to think like us, we have been, for better or worse, homogenizing the way the world goes mad.

While the criticism that the DSM is colonising is important to consider, it is, at least in part, an outcome of the framework's vast influence, as opposed to inherent features of the framework itself.

Critical reflections

- What are your reactions to reading the above criticisms of diagnostic frameworks? Do these criticisms challenge your views? Do they support views you already hold?
- Are any of these criticisms especially relevant to the children and families you work with?
- Have there been times when your work with children has been negatively affected as a consequence of their diagnosis? How did you attempt to overcome this?

3. Overdiagnosis of child mental health conditions

What should we make of the oft-repeated claims that too many children are diagnosed with mental health conditions, that the field of paediatric mental health is plagued by “false epidemics” and “psychiatric fads” (e.g. Frances & Batstra, 2013; Greenberg, 2013)?

Three mental health conditions in particular have inspired such claims.

The first is ADHD, which is widely believed to be overdiagnosed. Indeed, a study exploring attitudes of the general public in Queensland found that “the overwhelming majority of participants [78.3%] agreed that that too many children are diagnosed with ADHD when they don’t really have it” (Partridge, Lucke, & Hall, 2014, p. 4).

Such attitudes are fuelled by media reports of research findings that can be interpreted as providing evidence of ADHD overdiagnosis, such as the recent and widely reported finding that the youngest children in Western Australian primary school classrooms were roughly twice as likely as their oldest classmates to be prescribed psychotropic medication for ADHD (Whitely et al., 2017).

The second is Autism Spectrum Disorder (ASD), the diagnostic criteria for which have undergone significant changes in the DSM-5, partly as an attempt to reduce the ballooning number of children being diagnosed (Basu & Parry, 2013).

The third is the highly contentious Paediatric Bipolar Disorder (PBD), the prevalence rates of which increased by over 4,000% between 1994–95 and 2002–03 (Moreno et al., 2007). Most of this massive rise in diagnosis was contained within the US however, and may, at least in part, be attributed to US policies allowing direct-to-consumer advertising of psychotropic medications (Parry & Levin, 2012). A survey of Australian and New Zealand child psychiatrists found that 90% thought that PBD was overdiagnosed in the US (Parry, Furber, & Allison, 2009).

While public attitudes and dramatic rises in prevalence rates suggest that overdiagnosis may be occurring, they do not in themselves provide conclusive evidence. Perhaps rates have risen because child mental health difficulties were previously under-recognised. Maybe negative community attitudes simply reflect a lack of awareness that children can develop mental health difficulties.

The different meanings of overdiagnosis

In order to properly investigate claims of overdiagnosis, it is necessary to distinguish between two different uses of the term “overdiagnosis”.

1. As a pathologising of normal human experience

First, the term “overdiagnosis” serves to make the point, discussed earlier in this paper, that the diagnostic criteria or thresholds in the DSM lead to normal human experiences being labelled as pathological.

As already mentioned, it is difficult to provide conclusive evidence in support or refutation of this argument because it is not possible to know the “true” prevalence of DSM disorders. Unlike many physical conditions, which can be identified using objective measures, such as X-rays for broken bones, DSM disorders lack external criteria for examining their validity (Frances & Widiger, 2012).

Arguments for or against particular diagnoses cannot be settled using scientific evidence alone, but must also draw on professional judgement, public opinion, philosophical investigation, risk-benefit analyses, and various practical lines of reasoning (Frances & Widiger, 2012; Maj, 2015).

A historical example is the removal of homosexuality as a disorder from the seventh edition of DSM-II in 1974, which arguably had much more to do with pressure from gay rights activists—who drew on philosophical concepts such as “human rights”, “equality” and “justice”—than it did with appeals to empirical evidence (R. Bayer, 1987).

More recently, a number of prominent mental health professionals have drawn on different forms of evidence and argument to assert that current diagnostic systems lead to far too many people in developed countries being diagnosed with mental health conditions (e.g. Brinkmann, 2016; Frances, 2013; Greenberg, 2013; Paris, 2015).

2. As misadministration of diagnostic criteria

Second, the term can be used to indicate that too many people are given psychiatric labels because diagnosticians do not properly adhere to diagnostic criteria. In other words, this use of the term is intended not as a criticism of any particular diagnostic system, but rather points to problems with their administration in clinical settings.

This form of overdiagnosis is easier to prove or disprove, because once the diagnostic criteria in the DSM or ICD are taken as a given, they can provide a relatively reliable baseline against which to measure the number of diagnosed cases in a given cohort.

In a recent meta-analysis of research investigating overdiagnosis of mental health conditions in children and young people, Merten and colleagues (2017) identified 17 studies that focused on particular conditions, including ADHD, PBD, ASD and anxiety disorders. Although the majority of these studies found evidence of overdiagnosis, all but one failed to meet the strict criteria of the meta-analysis. The single study that met the inclusion criteria, by Bruchmüller and colleagues (2012) in Germany, involved sending 473 registered child and adolescent psychotherapists (who included psychologists, psychiatrists and social workers) case vignettes describing a child fulfilling or not fulfilling the diagnostic criteria for ADHD. The authors found evidence of overdiagnosis: while 16.7% of participants diagnosed ADHD although diagnostic criteria were not fulfilled, only 7% gave no diagnosis for vignettes that fulfilled the criteria for ADHD. In sum, while the available research suggests that in developed countries certain child mental health conditions are overdiagnosed (in the second sense of the term), more research is needed before definitive statements on this matter can be made.

The causes of overdiagnosis

There is no single cause of overdiagnosis. If and when it does occur, it is most likely due to numerous converging pressures (Coon, Quinonez, Moyer, & Schroeder, 2014). The most commonly cited of these pressures are discussed below.

Influence of the pharmaceutical industry

Drug companies, who have a clear interest in increasing the number of children who use psychotropic medications, have in recent years marketed to younger and younger customers (Frances & Widiger, 2012). The scope of this marketing exercise is difficult to underestimate, as Batstra and Frances (2012, p. 7) describe:

Drug companies are ubiquitous players in psychiatry, influencing thought leaders and consumer advocacy groups, monopolizing professional “education”, lavishing trips and meals, clogging physicians waiting rooms with attractive salespeople, stocking doctors with free samples, and (in the USA) conducting direct-to-consumer promotion campaigns in the print media, on TV, and on the Internet.

Numerous authors have argued that pharmaceutical industry influence has been a key driver in the dramatic rises in the prevalence rates of childhood conditions such as ADHD, PBD and ASD (e.g. Batstra & Frances, 2012; Greenberg, 2013). While these authors have clearly demonstrated the pharmaceutical industry’s influence on psychiatric practice in the US, laws prohibiting direct-to-consumer marketing of medications in Australia suggest that this influence may be tempered somewhat in the Australian context. Further, it is unclear to what extent drug companies influence the diagnostic practices of non-psychiatric professionals, such as paediatricians.

Diagnostic inflation

“Diagnostic inflation” is another way of referring to the criticism that has recurred throughout this paper: that by introducing new disorders, and reducing the thresholds for existing disorders, diagnostic systems such as the DSM pathologise human experiences that were previously considered normal. Even small changes in the diagnostic criteria for mental health conditions can lead to huge increases in the number of children being diagnosed (Frances & Widiger, 2012).

Diagnostic upcoding

“[Diagnostic upcoding] occurs wherever medical practitioners are under pressure to give a diagnostic label in order to provide treatment and be reimbursed” (Parry & Levin, 2012, p. 59). Diagnostic upcoding is less of an issue in Australia as the health system does not normally require diagnosis for reimbursement for therapy, unlike in the US. However, it is still relevant in the case of ASD, because a positive diagnosis confers education and family financial welfare (Parry & Levin, 2012). Indeed, a study involving specialist medical clinicians in Queensland found that, in the face of uncertainty, many would provide an ASD diagnosis even though the criteria had not been met (Skellern et al., 2005).

Service provider factors

Some authors have explored the qualities of service providers (e.g. general practitioners, psychiatrists and psychologists) that may lead them to provide unwarranted diagnoses. For example, some have suggested that intolerance of uncertainty can be a powerful motivator for diagnostic testing (Coon et al., 2014). As Coon and colleagues (2014, p. 1017) observed, “the culture of medical education is an early impetus for training providers to find comfort in commission and fear in uncertainty”. Research also suggests that clinical judgements tend to be influenced by various heuristics and biases (Bruchmüller et al., 2012). Take ADHD, which is more likely to affect boys than girls, as an example. A boy with certain ADHD symptoms is more likely to be seen as a prototypical ADHD case than a girl with the same symptoms, and thus is more likely to be diagnosed with the condition, even if he meets exclusion criteria (Bruchmüller et al., 2012).

Critical reflections

- How would you respond to parents who were concerned that their child had been misdiagnosed?
- Can you think of a time when you adjusted your practice to work with a child who you believe had been misdiagnosed?
- Do you have first-hand experience of the factors that may lead to overdiagnosis, such as diagnostic upcoding?

4. Children's and parents' views of diagnosis

Diagnosis is both a category and a process (Callard, 2014; Kokanovic, Bendelow, & Philip, 2013). Thus far this paper has discussed it as a category, exploring the benefits and risks of conceptualising human challenges as discrete, symptoms-based disorders. Yet it is also important to remember that diagnostic categories are applied not to inert objects, but rather to people who have their own opinions and feelings about being diagnosed, and whose identities and lives can be profoundly influenced by receiving a diagnosis. Most of the qualitative research on people's experiences of being diagnosed with a mental health condition has been conducted with adults (e.g. Kokanovic et al., 2013; Rønberg, 2017; Rose & Thornicroft, 2010). Such research suggests that diagnostic labels are “engaged and lived with in multiple, ambivalent and often contradictory ways” (Callard, 2014, p. 528). For example, in a study of Australian adults diagnosed with depression, Kokanovic and colleagues (2013, p. 387) observed that participants,

... found themselves caught between the allure of medicalised discourse with its promise of cure and relief from “symptoms”, and resistance to it, based on the recognition that their problems originated in the social domain, which was thought to be too complex to be treated with medication.

Interventions tend to be more effective when service providers acknowledge and respect service users' understanding of their own difficulties, including their ambivalence, uncertainty and inconsistencies (Bringewatt, 2013).

There is only a very limited body of research exploring how children understand and live with a mental health diagnosis, most of which focuses on those diagnosed with ADHD (Bringewatt, 2011, 2013, 2017; Cooper & Shea, 1998, 1999). In a study involving 11-16 year olds, Cooper and Shea (1998) observed that while children and young people tended to welcome the diagnosis of ADHD because it provided a rational explanation for their problematic behaviour, many expressed feelings of isolation, helplessness and low self-esteem as a result of being diagnosed with what they saw as a permanent affliction. “Of particular concern,” to Cooper and Shea, were “recurring inaccuracies in pupils' perceptions of the nature of ADHD as a solely biological determined phenomenon” (p. 36).

Similarly, Bringewatt (2011) interviewed young adults about their experiences of being diagnosed with ADHD as children and found that most participants perceived their diagnosis as simultaneously empowering and stigmatising. Being diagnosed helped them to better understand their thoughts and behaviours, to access treatment and academic support, and to make positive changes in their lives. Yet their diagnostic status was also a potent source of embarrassment and shame, with almost all participants hiding it not only from their classmates, but also from their siblings.

Bringewatt (2013) also found that children actively negotiated different mental health narratives, with some embracing medicalised accounts of their ADHD, and others resisting them. Many appreciated medical narratives because they reassured them that their behavioural difficulties were legitimate, common and “not their fault”. Yet others were concerned about the stigma and labelling associated with medicalised accounts, and emphasised ways they had been supported that did not involve pathologising their differences to other children.

There is a similar paucity of research investigating parents' experiences of their children being diagnosed with a mental health condition. Again, much of the limited research has focused on ADHD (Harborne, Wolpert, & Clare, 2004; Singh, 2003, 2004). In a study of the mothers of boys diagnosed with ADHD, Harborne and colleagues (2004) found that while many mothers believed ADHD to be a biologically based condition, professionals and members of their extended families were more likely to believe the condition was related to psychological or social factors.

The implications of these differing perspectives were that mothers felt blamed for their son's difficulties. The mothers engaged in battles with professionals and family members over the nature of their son's difficulties, and experienced significant emotional distress.

The issue of blame—both self-blame and blame from others—was also prominent in the findings of Singh (2004), who interviewed mothers of boys diagnosed with ADHD. Singh found that an ADHD diagnosis offered mothers some relief from the burdens of guilt and blame, in that it shifted the locus of responsibility away from them and towards their son's brains—from “mother-blame” to “brain-blame”. Those who started their children on psychotropic medications, however, were often subject to another cycle of mother-blaming, this time “accused of using Ritalin as a quick-fix to make their own lives easier” (p. 1203).

When compared to mothers, Singh (2003) identified very different views and experiences among fathers of boys diagnosed with ADHD. Fathers' perspectives on ADHD symptoms, diagnosis and treatment tended to fall into one of two categories: “reluctant believers” or “tolerant non-believers”. That is, many fathers were resistant to medicalised accounts of their son's behaviours, identified with their son's symptomatic behaviours, and were opposed to treatment with psychotropic drugs.

Critical reflections

- In your experience, how do children and families respond to receiving a mental health diagnosis? Have you noticed gendered patterns in these responses?
- How do you “check in” with children and families about how they relate to the diagnostic labels that are applied to them?
- Have there been occasions where you held different opinions about diagnostic labels to the families you were working with? How did you attempt to resolve this?

5. Beyond the diagnostic frame

It is not uncommon for mental health professionals to complete their clinical training—to be in the powerful position of applying diagnostic labels to those in their care—without much exposure to the critical perspectives outlined in this paper (Gambrill, 2014).

The diagnostic categories in documents such as the DSM-5 and ICD-10 can be presented as the only legitimate way of thinking about people's struggles. Many service providers and users alike are unaware of alternatives to diagnostic practice and the treatments that tend to follow from it. Most of these alternatives are not antithetical to diagnosis, but rather seek to ensure that the process of diagnosis unfolds within a broader frame, one in which people's contexts and histories are acknowledged alongside their symptoms.

The following is by no means an exhaustive list, but simply gives a sense of some of the models and practices that can provide alternatives or adjuncts to service providers in the child and family welfare sector who are concerned about the limitations of current diagnostic systems.

Psychosocial assessment

As opposed to diagnostic systems that focus on individuals' symptoms, psychosocial assessment tools account for a broad range of risk and protective factors that affect mental health, including physical health, behaviour and habits, home and school environments and family and social relationships.

A number of psychosocial tools have been developed for use with teenagers and young adults, such as the widely used HEADSS assessment instrument (Cohen, Mackenzie, & Yates, 1991). However, “despite their great potential to inform intervention planning, screening instruments that

assess children’s exposure to multiple, non-behavioural risk factors are rare” (Dwyer, Nicholson, & Battistutta, 2003, p. 699). Nonetheless, those psychosocial tools that have been developed for use with children—such as the Pediatric Symptom Checklist (PSC: Jellinek et al., 1988) and the Child and Adolescent Survey of Experiences (CASE: Sandberg et al., 1993)—offer service providers a structured way of understanding the different stressors in the lives of children and their families and may be used as standalone assessments or adjuncts to clinical diagnosis.

Stepped care

In the stepped care approach, a continuum of mental health services is offered, ranging from less intensive initiatives available to all, to increasingly intensive interventions for people who do not benefit from first-line interventions, or can be predicted not to benefit from them (Bower & Gilbody, 2005).

Stepped care both promotes the most efficient use of resources and helps to ensure that interventions are better matched to individual and population needs. Batstra and Frances (2012) suggested that a stepped care approach can be used to avoid premature diagnosis and over-treatment, especially in less severe cases where diagnosis is inherently uncertain. Such an approach encourages service providers to sit with uncertainty, as uncomfortable as this can be. For example, these authors suggest “watchful waiting—a period of continued assessment, monitoring, and scheduled follow-up with no pretence of a definitive diagnosis or active treatment” (p. 8). Diagnosis will normally be a part of a stepped care approach, but “stepping up” to a diagnosis occurs only after previous steps have proven insufficient.

Trauma-informed care

Trauma-informed care can be described as a framework for human service delivery that is based on knowledge and understanding of how trauma affects people’s lives and service needs (Harris & Fallot, 2001). It involves a range of practices that are directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and adversity on an individual, and an appreciation for the high prevalence of experiences of trauma and adversity among children in the community.

Trauma-informed care requires consideration of a child’s whole environment and experiences, and of how his or her symptoms and presentations may be adaptations to trauma rather than “disorders” (Herman, 1992). Watt (2017) argued that the DSM is ultimately incompatible with trauma-informed approaches because in most cases it encourages service providers to focus on symptoms without consideration of the stressors that may have caused them. Others have suggested that trauma-informed approaches are an important adjunct to formal diagnosis, providing an explanatory power that is missing from purely descriptive documents such as the DSM.

Attachment-based intervention

Attachment theory posits that human beings are an inherently social species; that human neurobiology is geared towards the formation and maintenance of relationships (Bowlby, 1988). Attuned and consistent caregiving is associated with an optimal attachment experience, while dismissive or enmeshed caregiving is associated with insecure attachment. In any case, early attachment experiences are internalised by growing children, and, through the formation of internal “working models” of self and others, form the basis of their emotional, social and cognitive development.

Attachment-based interventions acknowledge that relational processes are central to the development, course and treatment of mental health difficulties in children and adults alike. This focus on relationality puts such interventions at odds with current diagnostic systems, which tend to be individualistic. As Denton (2007, p. 1146) argued, “Although DSM strives to apply the bio-psychosocial model, there is a notable and strikingly absent consideration of the role of relational processes and disorders in the development, maintenance, and manifestations of mental disorders.”

Case study: Tom, age 4, and his mother Ruby, age 26

The following case study was provided by a clinician in the Restoring Childhood Program at Berry Street, which is a child-focused, trauma-informed program that provides therapeutic services for children and young people who have experienced family violence. This case study provides an example of a successful intervention that was sensitive to trauma, attachment and the broader relational context in which the child's mental health symptoms were manifesting. The practitioner used a psychosocial assessment, but delayed seeking a formal mental health diagnosis, instead engaging in a period of "watchful waiting".

Ruby and Tom experienced months of family violence perpetrated by Ruby's former partner. They were referred to the Restoring Childhood Program for therapeutic intervention, and the first step was a comprehensive psychosocial and risk assessment. These assessments revealed that they had moved house and ceased all contact with the perpetrator of violence.

In the first parent session, Ruby expressed her concern for Tom and "what he's been through", and voiced her fear that the violence had "scarred him". Ruby spoke about Tom's refusal to use a potty or toilet: "He just flat out won't go now, won't even try it." Ruby said Tom had been "almost fully toilet trained" when the family violence began, but feared that "he's gone backwards". Ruby made the connection that on a number of occasions she had taken Tom into the toilet to try to protect him from the perpetrator of violence "because it was the only door with a lock". Ruby wondered if, even in their new house, Tom was afraid of being in the toilet.

Tom's refusal to use the toilet was causing Ruby severe stress: she was tired of dealing with poo-filled nappies, her extended family were concerned about his reluctance to "be a big boy", and child care was unwilling to allow Tom to progress if he wasn't toilet trained. Ruby expressed her fear that "he's damaged forever and we'll never get past this—I can't handle it anymore". At this point, I was concerned that Tom's refusal to use the toilet was disrupting Ruby and Tom's attachment relationship.

As part of the Restoring Childhood model, we completed four Brief Relational Intervention and Screening after Trauma and Stress (BRISC) sessions consisting of a parent session, two dyadic play-based sessions, and a parent review session. Tom appeared to enjoy routine and consistency, and a focus on animals. I provided a bag of animal figurines and each session Tom carefully removed them one-by-one, identifying them, and telling us about their habitat and eating habits. With obvious pride, Ruby told me Tom was "obsessed with animals and knows more about them than anyone I know". Both dyadic sessions were taken up with this process, and during them I noted Tom made sustained eye contact, was talkative and friendly with me, but that his speech was limited beyond the animal-talk, and his pronunciation difficult to understand at times, with Ruby often providing interpretation.

In the parent review session, Ruby reported that Tom's acquisition of vocabulary had also "gone backwards" since the violence. While Ruby was impressed by his zoological knowledge, she also worried "he's really obsessed—that little professor thing". Ruby said she had done a Google search of "symptoms" as she wondered if Tom's "quirks" could indicate autism spectrum disorder (ASD), and asked my opinion. We discussed how children's trauma symptoms can be confused with the symptoms of mental health conditions, especially when diagnosticians are not fully aware of a child's trauma history. Ruby said, "it would be hard to tell which is his personality, and which is what's happened to him, and how they cross over," and I agreed.

Following the BRISC, Ruby and Tom were assessed as needing medium-term intervention to address Tom's elimination issues and the effect they were having on his primary attachment relationship. Ruby and Tom continued with weekly relationship-based, trauma-informed Child-Parent Psychotherapy (Lieberman, Ghosh Ippen, & Van Horn, 2015). At this point, I thought it was important not to rush into seeking a formal diagnosis of encopresis, ASD, or any other condition, but rather to follow a child-led process of watchful waiting to allow Tom to express more about the underlying meaning of his symptoms. I wondered if a diagnosis may locate the "issue" in Tom, whereas using a trauma-informed, psychotherapeutic approach could

help Ruby understand Tom's reactions to the situation they had been in, and that we could continue to rely on their relationship to attend to Tom's needs.

At the start of every session, Tom brought each animal out of the bag, told us about its eating and living habits, and set them out on the floor; he was able to give me a concise description of the differences between African and Indian elephants which delighted Ruby. However, his refusal to use the toilet continued to cause grief for her. Once, when the therapy room filled with the smell of poo, Ruby burst into tears and said, "He's not even trying!" Tom looked up at her distressed face with concern, and Ruby quickly said, "Sorry mate, let's get that nappy changed".

In a parent session, Ruby reported having her own problems with enuresis as a child and described the embarrassment and distress this caused her. She worried Tom would be "picked on and teased forever if he doesn't get over this". Again, she raised the possibility of ASD, and I sympathised with Ruby's hope that such a diagnosis would provide a biological way to explain Tom's difficulties, and offer a clear treatment plan. Ruby had spoken to a general practitioner and was unsure how she would afford the specialist assessment fees, so we planned for her to talk to her case manager about potential funding. In the meantime, we decided to give Tom some more time; Ruby said, "I'm just not going to pressure him about it at all—I'll just stay calm." In Ruby's words, our aim was to "just try and help him with the trauma".

Our sessions saw Tom leading the way with the animals each week, with my reflecting to him and Ruby how much he was learning, and how much he had to teach us. Tom presented as excited to come to sessions, and calm during them. He would regularly do a poo in his nappy during the hour, and Ruby came prepared "just in case". She remained calm too, and as she changed his nappy we would continue the talk about the animals, asking "And where do they poo?" This made Tom laugh and he said, "In the jungle!", or "On the grass!", or "In the jungle toilet!" Ruby reported that Tom had been experimenting with weeing on the potty at home, with her making a special time mornings and evenings for them to sit together while he tried it. Ruby had bought some "big boy jocks" which Tom was wearing at home. Ruby said, "We're having some accidents but it's okay".

After eight sessions of a similar format, one day Tom surprised us—after setting out all the animals he said, "I don't want to play with the animals, I want to do something else". Ruby and I both jumped to follow this lead, joining in with a cooking game. At the end of the session I asked Tom, "Should we start with something different next week?" and he nodded. The following week, we started the session in the toilets of our office building "just to have a look".

Soon Tom began each session by doing a wee on the toilet before going into the therapy room. Ruby told me with a smile that they were having regular "poo parties" in the toilet at home before bath time, and proudly reported Tom had done "one poo in the toilet and we named it and then flushed it to go on its holiday". Tom laughed and talked about this with delight.

Weekly sessions continue, and Tom has moved up with his peers at kindergarten, and is using new words and phrases. He still wears nappies outside the home and Ruby says, "It's fine, I'm just staying chill about it". She is currently looking into ways to fund an ASD assessment and says, "I want to do everything I can for him so we will still do it—but I know he's doing okay at the moment". Tom is enjoying playdough, bubbles and other games in sessions, and always checks in with the animals.

Note: The names used in this case study are pseudonyms.

Critical reflections

- Critical reflection on diagnostic systems is not a standard component of mental health training in Australia. Why do you think this is the case?
- In what ways do your professional experiences reflect the tensions or inconsistencies between current diagnostic frameworks and the alternative approaches outlined above?
- Do you apply alternative models or practices in your work with children and families? How successful have these applications been?

Conclusion

This paper has reviewed some of the debates, complexities and nuances of diagnosis in child mental health. Such a review suggests that current mental health diagnoses are best seen not as scientific facts, but rather as cultural tools used to understand different varieties of psychological distress and impairment, and to distinguish between “normal” and “pathological” thoughts, feelings and behaviours. This is not said in an effort to discredit the DSM or any other diagnostic system. Where would we be without tools? And it is certainly not intended to deny or diminish individuals’ suffering. Seeing diagnostic categories as cultural tools simply opens a door to different questions and ways of understanding, e.g.:

- “Is this the appropriate tool for the task at hand?”
- “Would other tools produce different outcomes?”
- “Just because I could use this tool, does it mean I am obliged to?”

It is hoped that this paper will encourage practitioners to bring such questions to their work with children and families.

It is important to critically question diagnostic systems and processes. Such questioning can help ensure that mental health interventions are grounded in an accurate understanding of the difficulties that service users face. And it can encourage service providers to make appropriate decisions when working with children and families.

While this paper has offered readers a high-level understanding of diagnosis in child mental health, many of the specific practice implications and dilemmas that follow from this understanding are beyond its scope. For instance, this paper touched on the issue of mother-blaming, noting that biological explanations of mental health difficulties can shift the locus of blame away from mothers and towards their children’s brains. Any attempt at promoting biopsychosocial or relationally oriented approaches to mental health assessment and treatment must reckon with the prospect of mother-blaming, because it challenges one of the only social narratives assuring mothers that they are not to blame for their children’s difficulties. There are ways to address such risks, but they require a more detailed treatment than can be provided in this paper.

This paper began with some examples of controversies in the area of child mental health. While such controversies can illuminate particular problems, they also tend to be polarising, such that discussion becomes dominated by the voices of those who espouse certainty. Mental health practice, too, is often led by those who feel sure of their understanding. The obvious problem with this is that the field of paediatric mental health is full of uncertainties. The best responses to such uncertainties are humility, curiosity, caution and openness to all options and alternatives.

This paper has not delved into the intricacies of diagnosis simply for academic purposes, but rather because children who are experiencing mental health difficulties deserve to be met by practitioners who are awake to the complexity of the difficulties before them.

Critical reflections

- Have your views about diagnosis in child mental health changed after reading this paper? Have they been confirmed?
- Has this paper challenged you to think differently about your work with children and families? In what ways?

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