This is a chapter excerpt from Guilford Publications.
DSM-5® Diagnosis in the Schools, by Renée M. Tobin and Alvin E. House.
Copyright © 2016. Purchase this book now: www.guilford.com/p/tobin2

2

Psychiatric Diagnosis

Issues for School Psychologists

Copyright © 2016 The Guilford Press

PSYCHIATRIC DIAGNOSIS AS A TASK IN SCHOOL SETTINGS

Traditional educational and psychological assessment within school settings began with psychometric measurement of cognitive abilities and academic achievement, and evolved to include evaluations of behavioral adjustment and personality. The results of these evaluations were usually communicated in descriptive narratives, with or without accompanying standard scores. Diagnostic classification was typically limited to a statement of eligibility for services (e.g., "eligible for special education") and perhaps a broad designation of the area of eligibility (e.g., "emotional disturbance"). Although most school psychologists were probably aware, on a professional level, of the publication of the landmark third edition of the DSM (DSM-III; American Psychiatric Association, 1980), it had little direct influence on their practice or daily work activities. By the time DSM-III-R was published (American Psychiatric Association, 1987), the situation had begun to change, and publications and workshops addressing the use of the DSM in school settings began to appear. The publication of DSM-IV (American Psychiatric Association, 1994) occurred in the context of broad economic, political, and social changes in the delivery of mental health services in the United States. These changes have, among many other effects, brought psychiatric diagnosis within the assigned tasks of an increasing number of school psychologists and other child-focused practitioners.

The current forces driving the increased interest in formal medical

diagnosis of children's behavior and learning problems reflect the changing economic realities affecting many school districts. Despite occasional denouncements of school districts' "extravagance," the continued enactment of mandated services without accompanying mandated funding has increased the financial burden on many schools. Coincident with this situation has been the increased difficulty in obtaining school funding from traditional tax sources. The search for alternative funding sources to help relieve the expense of mandated programs has led to an interest in providing additional funding beyond special education.

One example of such an attempt is the introduction (and referral to committee) of the Mental Health in Schools Act of 2013 (H.R. 628/S. 195) as a potential amendment to the Public Health Service Act sponsored by Representative Grace Napolitano (D-California). This bill proposes to provide $200 million in competitive grants (maximum of $1 million each) to add mental health providers and services in the schools. Despite the support of 85 representatives and 65 professional organizations, including the American Counseling Association, the American Psychological Association, and the National Association of School Psychologists, this bill appears unlikely to be passed in the near future, leaving a continued, immediate need for funding. One method of such funding beyond the establishment of these types of grant-funded programs can be found by tapping into third-party reimbursement (i.e., commercial and governmental health insurance) for psychological services provided within schools.

It is at this point that the DSM enters the picture because, among the other roles played by psychiatric diagnosis, it clearly serves the primary "gatekeeping" function for insurance companies and government agencies in determining reimbursement decisions. If the school district is to gain access to potential sources of mental health service reimbursement, it is necessary for a qualified professional to determine appropriate DSM-5 classifications and corresponding ICD-9-CM (and shortly ICD-10) numerical codes for insurance review consideration. Thus, psychiatric diagnosis has increasingly become part of the task of school psychologists. The expanded attention given to diagnostic classification can be seen in a miniseries devoted to the topic in *School Psychology Review* (Power & DuPaul, 1996a). It is also reflected in the "DSM-5 and School Psychology" series of articles featured in *Communiqué*, a National Association of School Psychologists publication, that began in 2013.

PSYCHIATRIC CLASSIFICATION AND ITS ROLE IN SCHOOL SETTINGS

Psychological assessment is a broad process that encompasses many different approaches to understanding and measuring human actions and

Copyright © 2016 The Guilford Press

adjustment. The activities usually involved in mental health assessment differ in some important ways from the evaluation procedures traditionally used by school psychologists. First, DSM represents a categorical classification system; that is, the goal in using it is to arrive at a category or categories that most accurately reflect a youth's adjustment and functioning at this time. The purposes served by classification can include the assignment of treatment or other appropriate disposition; efficient communication with other professionals; and statistical record keeping for use in program planning, outcome research, or other application.

In addition, this classification process depends crucially upon the clinical judgment and decision making of the individual mental health professional. Psychologists need to keep in mind that DSM-5 is a document written primarily by physicians and intended primarily for the use of physicians. The working perspective in medicine is that of an individual practitioner who actively assembles relevant data, evaluates the data, arrives at working diagnoses, and acts upon the diagnoses to provide appropriate interventions. The considerable degree of authority and responsibility that the practitioner thus assumes is somewhat foreign to the practice traditions of many allied health professions. Psychology has evolved out of an academic tradition that values careful development of positions, cautious formulations of hypotheses, and consensual decisions. When one of us was a clinical psychology intern in a medical center, a supervisory psychiatrist on staff pointed out a difference he had observed in the typical oral presentations of psychology interns and psychiatry residents. The interns tended to communicate by carefully stating all the data and the rationales leading up to their final diagnostic conclusions, whereas the residents had learned to begin by stating their diagnostic impressions and, if there were questions, following these assertions up with their observations and rationales. This observation captures a valuable lesson in terms of beginning to understand the consequences of differences in professional training and traditions and in dealing with physicians. In using DSM-5, it is helpful to recognize that the judgment and decision of the professional practitioner usually serve as the basis for classification.

Although there are significant issues to be considered regarding the use of categorical diagnostic classifications with clients, especially with children, most of these are not addressed in detail here. Even to sketch the outlines of this topic would exceed the desired length of this text. Frick, Barry, and Kamphaus (2009) and Mash and Barkley (2009) present good discussions of many of the issues involved in the diagnosis and classification of psychiatric syndromes in youth. Critiques of the DSM approach in general (Kirk & Kutchins, 1992; Kutchins & Kirk, 1995) and of DSM-5 in particular (Frances, 2013; Greenberg, 2013; Wakefield, 2013) have appeared, and others will follow. This critical attention is desirable for the positive

Copyright © 2016 The Guilford Press

evolution of our efforts to understand and classify childhood behavior problems.

For the purposes of this book, however, it is assumed that a decision to use psychiatric diagnoses for classification purposes has already been made. Given this decision, the question becomes this: How can the DSM classification system be used to yield the most reliable, accurate, and useful results? This book is intended to help the reader become familiar with the main features of this approach to understanding and classifying emotional, behavioral, and cognitive disturbances in adjustment. In particular, we have tried to help bridge the differences in orientation and training between the school psychologists who are increasingly being called upon to use this classification system in their work settings and the practicing physicians for whom the DSM was primarily intended.

WHO CAN DIAGNOSE WITH DSM-5?

We have been asked the question in our classes for graduate students in school, clinical, and counseling psychology and in workshops for educational professionals and school administrators: Who can diagnose children using the DSM? Our first, glib and facetious, answer is "anyone who wants to," an answer intended to provoke our audience into thinking more about the question. What they are really interested in is "Who can use DSM legitimately, appropriately, legally, and ethically?" This question requires more consideration but, in our opinion, has a fairly straightforward answer as well: any professional who is competently prepared to make mental health diagnoses and is legally permitted to do so by the statues of the state in which he or she resides. In the words of DSM-5: "Clinical training and experience are needed to use DSM for determining a diagnosis" (p. 5).

There are really two issues at play in this question. First, mental health diagnosis is a professional activity with potentially serious and enduring consequences for our clients. Anyone seeking to engage in such activity has a responsibility to make sure that adequate preparation and training has been acquired to carry out this activity in the best and most responsible manner possible. Typically, graduate training in a professional human service program that includes relevant course work in human development, psychopathology, and assessment is part of the necessary training. It is likely that specific course work in using diagnostic systems such as the DSM, as well as supervised experience in practicum sites, is included in this training. Within this preparation, trainees complete readings and discussions and have opportunities to question and receive feedback on diagnostic perceptions under the supervision of an experienced professional. Second, mental health diagnosis is an activity that is regulated by state

Copyright © 2016 The Guilford Press

statutes in most of the United States. Part of being a professional is working to stay informed of the relevant state and federal laws that govern the performance of your services. In most states of which we are aware, mental health diagnosis is a recognized professional activity of licensed mental health professionals. Each professional in all licensed and regulated careers should ensure that he or she is practicing within his or her area of professional competence and within the proscribed boundaries of his or her profession in his or her state.

This general answer also applies to school psychologists in particular. McBride, Willis, and Dumont (2014) wrote, "We believe that a diagnosis from DSM should be within the competence of most school psychologists and that the level of training required to become proficient need not be as extensive as the level of training needed to prescribe appropriate treatments for those disabilities" (p. 427). School psychologists are well versed in developmental psychopathology and its assessment, diagnosis, and treatment. What often constrains school psychologists in diagnosing is not a lack of training but a legal prohibition of the practice by a school psychologist in a particular state. A common example is diagnosis of Attention-Deficit/Hyperactivity Disorder. Several states require diagnosis by a medical professional (e.g., a physician) for consideration of special education services for related symptoms, often in the Other Health Impairment category. It is puzzling that the trained school psychologist who is well versed in DSM-5 diagnosis and has conducted a comprehensive evaluation of the child's functioning is not permitted to provide the diagnostic label in some contexts. This example highlights the importance of understanding both the necessary qualifications for using DSM and the related legal issues. There is a difference between what a professional is competently trained to do and what the laws in a given state will allow him or her to do. It is important to be aware that these are two separate but related issues. It is easy to fuse our understanding of the law and local customs with our understanding of our professional capabilities. In the case of providing DSM diagnoses, these two issues are not in agreement as practiced in some states. It is unfortunate that many state laws have prevented the cost-effective use of school psychologists' expertise to streamline these processes.

Copyright © 2016 The Guilford Press

DEVELOPMENTAL CONSIDERATIONS IN DIAGNOSING CHILDREN AND ADOLESCENTS

Although, as we have stated previously, space considerations preclude a detailed debate of the merits and demerits of a categorical diagnostic system such as DSM-5, most commentators agree that the application of such a system to children and adolescents is especially challenging. In this

section, we discuss some of the developmental features that must be taken into consideration in the psychiatric diagnosis of children and adolescents.

A typical adult client presents himself or herself to a mental health professional and reports the concerns that have led him or her to seek services—for instance, sadness and crying spells, discouraging marital conflicts, or questions about career direction. The most commonly used assessment tool/approach is the clinical interview. Based on the verbal information reported by the adult client, the professional arrives at an assessment (which may include a DSM diagnosis), proposes a treatment plan, and makes a disposition of the case. Often implicit in this exchange are the assumptions that the client's report of his or her circumstances is largely accurate; that the client's personality and cognitive functioning are relatively stable over time; and that (within certain ethical boundaries) the agenda of therapy is largely shaped by the client's wishes and goals. These modal features of work with adults influence many aspects of service provision, including the practices leading to diagnosis.

Professionals working primarily with children and adolescents deal routinely with quite different initial characteristics. Young persons almost never refer themselves for treatment or other psychological services; adult caretakers (parents, teachers, other concerned adults) refer them because they become concerned about their adjustment, functioning, progress, or happiness. A basic truism is that what children and adolescents may worry about most may not be what concerns their caretakers most. For instance, fears of animals constitute the most common extreme anxiety reactions of children, yet fears of animals are not the most commonly seen fears in professional practice with children. Fears of school are not frequent among children's anxiety problems; however, historically "school phobia" has been one of the most commonly seen and investigated childhood fears in clinical circumstances (Miller, Barrett, & Hampe, 1974). This disparity illustrates one of the most important factors in assessing child and adolescent psychopathology: Adults refer young children because of behavior that causes the adults concern. This prerequisite has profound implications for what problems are noticed, are studied, become better understood, and evolve into recognized diagnostic entries.

Children and adolescents also appear to be more influenced by environmental variables than adults; their behavior is more situationally specific. Many aspects of young persons' adjustment and functioning, including their problems, are more fluid and evolving than is the case for most adults. This plasticity creates problems for categorical classification systems, in which it is assumed that the classified things or individuals remain relatively constant unless they are deliberately changed. This greater responsiveness to environmental contingencies also means that a greater degree of attention must be devoted to evaluating situational characteristics and variables

Copyright © 2016 The Guilford Press

in arriving at an understanding or diagnosis of young people's problems. For instance, the requirement in DSM-5 of basing a diagnosis of Attention-Deficit/Hyperactivity Disorder upon manifestation of symptoms in at least two settings greatly affects the identified population and its modal characteristics. Requiring cross-situational manifestation (pervasive Attention-Deficit/Hyperactivity Disorder) reduces the number of children identified as having Attention-Deficit/Hyperactivity Disorder, may reduce false-positive diagnoses, may increase false-negative diagnoses, and probably leads to a focus on more severely disturbed children—thereby altering the modal features of a child diagnosed with Attention-Deficit/Hyperactivity Disorder.

In addition to the need to attend to environmental features, the language and cognitive differences between youth and adults must be taken into consideration. A primary reliance on verbal reports in the context of a clinical interview is often seen as a much less acceptable source of data for evaluating children and adolescents than for evaluating adults. For example, clinically depressed children, especially preschool and early primary school children, may not report themselves to be sad. They may report physical concerns or vague complaints of "not feeling well." Their nonverbal behavior may prompt others to express concerns about their well-being. They may show, but not necessarily report, a decrease in activities they previously enjoyed. In the words of one of our students, children tend to "walk the walk" of depression rather than "talk the talk." Interviews with parents and other collateral informants, behavior rating scales, naturalistic observations, and formal psychological testing all play a relatively more important role in the assessment of children and adolescents than in that of adults. These differences have implications for the use of DSM-5 with children and adolescents and bring into focus some of the recurrent dissatisfactions with the DSM system. In this book, we try to point out occasions in which additional sources of information can be especially useful in applying DSM-5 classifications to the evaluation of young people.

Copyright © 2016 The Guilford Press

Copyright © 2016 The Guilford Press. All rights reserved under International Copyright Convention. No part of this text may be reproduced, transmitted, downloaded, or stored in or introduced into any information storage or retrieval system, in any form or by any means, whether electronic or mechanical, now known or hereinafter invented, without the written permission of The Guilford Press.
Purchase this book now: www.guilford.com/p/tobin2

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com