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Conceptualizing mental disorders in children: Where have we been and where are we going?

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Abstract
Conceptions of mental illness in children are bound by cultural and social conventions of what constitutes healthy and unhealthy development. To understand current conceptualizations of disorders in children, we review the history of these conceptualizations from three intertwined perspectives: a sociopolitical history of American children and families, the history of the mental health fields and scientific disciplines involved in diagnosing children, and the evolution of children's role in the *Diagnostic and Statistical Manual of Mental Disorders*. We review where the field has been in its conception of childhood mental illness throughout the past century, where we believe it is now, and raise questions about the direction in which child diagnosis may be headed as we enter the new millennium. We conclude with social policy recommendations based on theory and research regarding mental disorders in children.

Developmental psychopathology recognizes the necessity of studying social context in understanding the development of the child (e.g., Boyce, Frank, Jensen, Kessler, Nelson, Steinberg, & the MacArthur Research Network on Psychopathology and Development, 1998; Cicchetti & Aber, 1998). Likewise, we believe it is important to explore sociocultural context as a pathway to understanding the development of the scientific fields involving children. In this article, we review the sociocultural trends that have molded the common conceptualizations of mental illness in children over the past century and a half. We examine broad historical trends, both within the mental health field and without, that have influenced our understanding of child psychopathology, and we discuss in detail the evolution of these trends in the official text of modern American psychiatry: the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA]). The new millennium provides us with the opportunity to take stock of how our conceptualizations about mental disorders in children have evolved throughout history. It is our hope that this look at the past will provoke serious thought about where research, practice, and policy regarding childhood disorders is headed as we approach the second century of progress in the psychological study of children.

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Conceptualizations of Children and Mental Illness Prior to the 20th Century

References to emotional and behavioral disorders in children were rare prior to the 18th century (Kanner, 1962). "Psychological" explanations were nonexistent; beginning in the 5th century, unusual, bizarre, or problematic behaviors in children were often viewed as signs that the child was possessed by evil spirits (Zilboorg & Henry, 1941). Although 18th century asylum administrators began to speak

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of emotionally or behaviorally disturbed children, case histories suggest that they viewed such children as inherently evil, if no longer literally possessed by evil spirits (see Kanner, 1962, for case examples). Only children with severe disturbances (psychotic, autistic, etc.) came to the attention of such early practitioners.

Psychiatric authorities through the 18th century tended to view the child as "merely a miniature mirror image of the adult" (Rubinstein, 1948, p. 314). This failure to conceptualize childhood mental disturbance as distinct from adult mental disturbance reflected the sociocultural belief that children were merely smaller versions of adults. Aries (1962) argued that "childhood" as a unique phase of life was not recognized until the 17th century. Children were distinguished from adults on the basis of size, but the idea of qualitative differences in social, emotional, cognitive, or moral development between children and adults was not yet considered. Prior to the 17th century, children were dressed as adults, and were afforded no unique developmentally appropriate literature, games, or special activities. This view of children as miniature adults must be considered within the broader context of preindustrial society. High child mortality rates, for example, may have deterred adults from investing special attention in individual children. Economic needs were often used to justify the practice of child labor. Limited occupational and educational choices in preindustrial America constrained the perception of the child as a unique individual with a wide range of future self-identities (Demos & Demos, 1969).

As the idea of "childhood" as a qualitatively distinct stage of life began to take hold, 19th-century psychiatrists began to express limited interest in the possibility of childhood insanity. Benjamin Rush, commonly considered the first American psychiatrist, turned attention to childhood disturbances; however, he viewed childhood behavior problems as highly transient. In 1812, he made the following influential statement suggesting an inability of children to retain mental illness due to the immature and unstable nature of their brains:

> The reason why children and persons under puberty are so rarely affected with madness must be ascribed to mental impressions which are its most frequent cause being too transient in their affects, from the instability of their minds, to excite their brains into permanently diseased actions. (cited in Jones, 1999, p. 18)

Although this belief in the impossibility of mental illness in children persisted largely until the end of the 19th century, by the 1880s several psychiatrists were expressing interest in two unique forms of childhood mental illness—masturbatory insanity and excessive intellectual exertion. Spitzka, for example, wrote in detail about a disorder he termed "typical masturbatory psychosis" (Rie, 1971; Rubinstein, 1948), in which insanity was the result of childhood masturbation. Another disturbance, primarily afflicting young women, was "excessive intellectual exertion," which led to neurosis and hysteria (Jones, 1999). These initial formulations of childhood mental disorders reflected the prevalent Victorian mores of the times.

Child Welfare and Progressive Era Reforms

The turn of this past century marked a change in the zeitgeist of conceptualizations of childhood problems and mental disorders. In 1909, Ellen Key proclaimed the 20th century as the "century of the child" (Kanner, 1962; Rie, 1971). In retrospect, her prophetic claim appears quite accurate. Changes in views toward childhood mental illness were intertwined with progressive era reforms surrounding women, children, and the weak and ill members of society. Levine and Levine (1970) paint a picture of the American city created by the converging forces of rapid industrial expansion, urbanization, and increased immigration following the Civil War. Urban America was fraught with overcrowded slums, widespread poverty, poor working conditions in factories outside of the home, and increasing rates of juvenile delinquency (Spargo, 1906; Levine & Levine, 1970). With the commencement of the progressive era at the turn of the century, human-

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itarian-minded individuals sought to reform these degrading conditions.

This humanitarian reform philosophy was to have lasting effects on the treatment of children. A first step in the child welfare movement was the recognition that more attention had been devoted to animal welfare than to the welfare of children. In fact, the first documented child abuse trial was brought to court in 1870 by the American Society for the Prevention of Cruelty to Animals (ASPCA). In the final decades of the 1800s, systematic child protection laws began to appear. Federal support was given to this cause in 1912 with the founding of the Children's Bureau to protect the rights and welfare of children. A parallel goal of the child welfare movement was the struggle to pass child labor laws during the early 1900s, culminating in the Child Labor Act of 1916.

Another influential change in the lives of children was the introduction of free and compulsory education. Public school systems emerged in the latter part of the 19th century, gradually becoming compulsory. This system of compulsory schooling was a solution to the emerging urban crisis of masses of "idle youth" hanging about city street corners (Katz, 1976). Compulsory school systems did much to facilitate attention to children's developmental stages through the process of age grading.

The Psychological Birth of the Child

Clinical beginnings: Psychological testing and the child guidance movement

The psychological study of the child had its origins in the progressive era and its humanitarian spirit. Between 1896 and 1909, three landmark movements in the diagnosis of mental illness in children were ushered in by three men of lasting influence—Alfred Binet, Lightner Witmer, and William Healy.

The French psychologist Alfred Binet, together with his colleagues Victor Henri and Theodore Simon, inaugurated the intelligence testing movement in 1905 by developing the first standardized test of children's "higher mental processes." The original purpose of the test was diagnostic—it was conceived of as a tool for identifying which children would encounter academic difficulties in regular school settings. Out of a similar concern for children's academic development, the first psychological clinic for children was founded in 1896 by Lightner Witmer, an American psychologist at the University of Pennsylvania. Witmer's clinic was dedicated to the assessment, treatment, and study of childhood disorders; however, these disorders were conceived of largely as school related in nature. Witmer called for the qualitative study of the individual patient for diagnostic, therapeutic, and educational purposes, with a particular focus on children exhibiting learning difficulties (Shakow, 1968).

While Binet and Witmer focused attention on common childhood problems in education, William Healy brought attention to a wider range of socioemotional problems, stemming from a progressive era concern for the prevention of juvenile delinquency. The pioneering work of Healy and the child guidance movement is grounded in the larger mental hygiene movement that came onto the reform agenda in the late 1900s. The child guidance movement has been characterized as a progressive child-saving effort (Horn, 1989). Throughout the movement "child-guiders" or "child-savers," as they were called, shifted their attention from juvenile delinquency to the emotional and behavioral problems of everyday children. In this transformation, mental hygiene practitioners evolved into the first generation of child diagnosticians (Horn, 1989).

The history of the child guidance movement began in Chicago in 1909 when a private philanthropist financed the Juvenile Psychopathic Institute (JPI) as an adjunct to the juvenile court in Chicago. Psychiatrist William Healy was chosen to head the institute, which was to become the first child guidance clinic. Under Healy's leadership, a multidisciplinary team, including psychiatrist, psychologist, and social worker, conducted extensive interviewing with delinquent children and their families, and made recommendations for treatment. Healy and his team were interested in the role of the environment in the etiology of delinquency, and often located "causes" of

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delinquency in poor parenting, poor nutrition, or degrading social conditions (Shakow, 1968). While Healy's approach constituted in-depth diagnosis of the child and his or her surroundings, there was no use of a systematic nosology that could be employed across locales.

In 1915, Healy summarized his view that there was no single etiology for delinquency, but rather a complicated "web of causative factors" unique to each child (Jones, 1999). He also stated that juvenile delinquents were typically *not* psychopaths, but rather normal children of normal intelligence with significant problems in multiple areas of their lives. In 1917, Healy moved to Boston to develop the Judge Baker Guidance Center, a prototype for new child guidance clinics opening nationwide. In 1921, The Commonwealth Fund Report provided government funding for the development of child guidance clinics across the country. The clinics spread quickly, continuing their growth after the war, and by 1942 child guidance clinics were present in nearly all major U.S. cities (Stevenson, Plant, & Shaw, 1943).

The problems of the everyday child

Beginning in the 1920s, the social class and the nature of the problems seen in child clinics across the country began to widen. Mental hygiene professionals found that "normal" schoolchildren had many behavior problems that merited clinical attention. A national survey of school-aged youth revealed evidence for many mild and moderate forms of disorder in children. In the 1920s and 1930s, mental hygiene professionals and the public alike began to speak of the "problem child." The problem child was defined as "normal"—not a delinquent or psychopath—but displayed behavioral attributes that went against some system of authority, such as the school or parent (Jones, 1999). Typical examples of such "maladjustment" included nail biting, enuresis, masturbation, night terrors, or disobedient behavior, such as lying, bullying, and precocious sexual activities (Horn, 1989). The focus on the problems of the "everyday child" eliminated much of the stigma associated with seeking child mental health services, since it was no longer simply extreme cases ("delinquents" and "psychopaths") who merited the attention of mental hygiene professionals (Jones, 1999). This trend of viewing the problems of the "normal" child as worthy of clinical attention has been referred to as "medicalizing maladjustment" (Richardson, 1989).

Can this trend be understood in the context of changes in the social climate and family structure engendered by urbanization and industrialization? In preindustrial times, the family operated as a unified entity to produce the materials necessary for the family's sustenance. With the production of food and clothing taken out of the household sphere, and employment now typically outside of the home, the public and private spheres of life became increasingly separated. The family's sole job—typically taken on by the mother—was now to provide a nurturing and comfortable home for the husband and children. Nurturance of the child as the primary and often sole job of the mother prompted what Horn (1989) has called an "obsessional concern" over the child. Decreased mortality rates accompanying medical advances also meant that mothers could now emotionally afford to invest more care and attention into each individual child. This shift was accompanied by social changes in growing urban communities. By the1920s, middle-class families' anxieties skyrocketed as they worried about the corrupting influences of movies, dance halls, and automobiles (Horn, 1989). Under these anxiety-provoking conditions, mothers increasingly turned to child guidance professionals for help in raising children.

A final trend in the assessment of children in child guidance clinics has been referred to as "mother blaming." Recent analyses of archival data from the Judge Baker Guidance Center show a trend toward blaming the mother for the child's presenting problems (Jones, 1999). The idea that childhood problems were the manifestations of poor child rearing spread rapidly and was capitalized upon in the 1940s and 1950s by authors of popular child-rearing texts (Jones, 1999).

In addition to the expansion of problems treated by the child guidance movement, in

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the 1930s and 1940s psychiatrists and psychologists were again recognizing more severe problems of childhood, such as psychoses (Kanner, 1962). Discussions and texts on the diagnosis and treatment of childhood schizophrenia and autism emerged. This focus on severe emotional disturbances in childhood shed light on the increasing need for a common diagnostic nosology.

Child psychology as an academic field of inquiry

In discussing the roots of the field of developmental psychopathology, Cicchetti (1990) explained that normative and clinical approaches to child development grew in parallel before they could be integrated into the unified approach offered by developmental psychopathology. This parallel growth can be seen in the simultaneous growth of child psychology as an academic discipline during the same period in which clinical attention toward children burgeoned. The scientific study of child development commenced in the late 1880s to the early 1900s. The psychologist G. Stanley Hall is typically credited with inaugurating the academic study of the child, known as the child study movement. Hall conducted extensive surveys of parents, teachers, and mental health professionals in an impressive effort to compile encyclopedic information about normal development in children.

As Sears (1975) discussed, the origins of the child study movement date to the 1906 observation by an Iowa housewife that there was more scientific research on livestock and agriculture than on children. In 1916, the Iowa Child Welfare Research Station was opened as the first child study institute (Sears, 1975). Although the idea for such research existed before World War I, results of widespread physical and cognitive testing in conjunction with the draft revealed deficiencies in the literacy and dental hygiene of America's young men. These discoveries fueled national interest in child research and child care. The federal government subsequently funded child development institutes across the nation. These research centers gathered information about normative development in terms of social, physical, and cognitive development. As part of the child study movement, the Society for Research in Child Development (SRCD) formed in 1934 and began publication of the journal *Child Development* in 1935.

The Development of Child Treatment: Psychoanalysis and Behaviorism

Conceptualizations about mental illness in children were influenced by major streams of intellectual thought in psychiatry and psychology, including psychoanalysis and behaviorism. By and large, these therapeutic paradigms focused primarily on adults rather than children, although they expanded the possibilities for therapy with children.

At the turn of the 20th century, Freud introduced his theory of childhood sexuality, in which early experiences and child development set the stage for subsequent psychopathology. Freud's work brought attention to the psychological importance of childhood. As psychoanalysis as a discipline grew, theory and technique regarding work with children also grew, since Freud's ideas emphasized the importance of developmental stages and experiences in childhood as critical for the subsequent development of neuroses. Freud commented that child psychoanalysis confirmed "on the living subject what we had inferred (from historical documents, as it were) in the case of adults . . . but the gain for children was also very satisfactory" (Freud, 1933, p. 148). Freud supported the work of his daughter, Anna Freud, in expanding psychoanalytic technique and principles in direct work with children.

During this same time period, the advent of behaviorism supported the study of mental disturbance in children, but did not see it as a distinct process. Learning theorists, for instance, claimed that both normal and disturbed behavior in children and adults could be explained by the same principles of operant or classical conditioning. John B. Watson worked with children and reported case studies that were used to demonstrate that principles of conditioning and extinction worked with youth (Frame & Matson, 1987).

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Although psychoanalysis and behaviorism were innovative in providing psychological models that influenced the treatment of children, neither of these schools of thought advanced a separate diagnostic nosology for children. This matched an antilabeling trend that delayed the development of a systematic nosology of childhood disorders within psychiatry in the first half of the 20th century. Psychiatrists such as Adolph Meyer and Harry Stack Sullivan downplayed diagnostic "labeling" based on concerns that psychiatric labels would produce undue stigma as well as self-fulfilling prophecies (Frame & Matson, 1987).

World War II was a critical point in legitimizing and advancing the development of mental health services and diagnostic labels for children and adults (Shore & Mannino, 1976). With the prevalence of war-related psychological disturbances, the need for a psychiatric nomenclature became increasingly apparent. The classification of mental "diseases" was an important aspect of the effort to substantiate the medical validity of psychiatry (Richardson, 1989). After the war, child guidance clinics became gradually subsumed into child psychiatry departments (although some independent child guidance clinics still exist).

The Official Nosology: DSM-I and DSM-II and Childhood Diagnosis

It was in this professional climate that the APA introduced a committee to formally establish a uniform nomenclature by which statistics from hospitals and clinics could be compiled and compared. Although the International Classification of Diseases was in its sixth edition (ICD-6; World Health Organization, 1948), it interspersed a variety of mental illnesses throughout its catalog of medical disorders. The development of a particularly American field of psychiatry also spurred the movement to introduce a distinctly American compilation of mental disorders. In 1952 the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I; APA, 1952) was published. This manual, and its subsequent editions, were to have a profound impact on the conceptualization of childhood mental illness and related social policies in the latter half of the 20th century. The DSM can be seen as a lens that distills social policy and political conceptualizations of mental illness into a handbook for practitioners. The authors of this paper are neither blind advocates nor hypercritics of the DSM. Its current predominance and widespread usage among mental health practitioners makes it an important focus of inquiry in a discussion of diagnostic practice and theory (for a critical perspective, see Kutchins & Kirk, 1997).

Under the nosology of the DSM-I (APA, 1952), no distinction was made between childhood and adult disorders. Little attention was paid to potential differences between adults and children in terms of diagnostic classification, and a child could be given an adult diagnosis. There were a few exceptions to this general rule. The childhood type of schizophrenia was established as a special category since it was a notable exception to early adult onset schizophrenia. However, childhood was characterized by "transient situational disturbances" currently described as adjustment disorders. These adjustment reactions could also be diagnosed in adults; the qualifiers simply represented a notation of what period of life such an adjustment reaction occurred in, such as "adjustment reaction of adolescence," "adjustment reaction of early childhood," or "adjustment reaction of late life."

Examples of these adjustment reactions suggest that most childhood difficulties would be subsumed under these categories. For example, the adjustment reaction of infancy included "undue apathy, undue excitability, feeding and sleep difficulties" that "in most cases . . . will be outgrowths of the infant's interaction with significant persons in the environment or a response to the lack of such persons" (APA, 1952, p. 41). Similarly, the adjustment reaction of childhood included habit disturbances (nail biting, sucking, enuresis, masturbation, tantrums), conduct disturbances (truancy, stealing, destructiveness, sexual offenses, use of alcohol), and neurotic traits (tics, habit spasms, stammering, overactivity, phobias). The DSM-I suggested that "care must be taken to differentiate these tran-

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sient situational responses from the psychoneurotic reactions" and that "the more prolonged and definitive disturbances will be classified elsewhere." A similar differential is suggested (APA, 1952) for adjustment reaction of adolescence, where,

> the superficial pattern of the behavior may resemble any of the personality or psychoneurotic disorders. Differentiation between transient adolescent reactions and deep-seated personality trait disorders or psychoneurotic reactions must be made. (p. 42)

In the nosology of DSM-I (APA, 1952), all adult disorders were applicable to children, although a differential diagnosis between a transient adjustment difficulty and a more ingrained neurotic or personality disorder was necessary. This reflected the prevailing psychoanalytic theory about the etiology of difficulties for adults lying in childhood experiences. Therefore, it was possible to identify and diagnose any adult psychoneurotic disorder in a child. This was a distinct break from the ICD-6, which included a special section on disorders of childhood. The DSM did not provide any special provisions or mention of childhood disorders beyond spelling out some of the common adjustment reactions of infancy, childhood, and adolescence.

The second edition of the DSM (DSM-II; APA, 1968) included for the first time a section called "Behavior Disorders of Childhood and Adolescence." The new edition followed the conventions that the ICD used with children, and was based on the ICD's eighth edition (World Health Organization, 1968). This new section introduced the concept of less stable childhood disorders that were halfway between a full disorder and an adjustment reaction. DSM-II specified transient situational disturbances as responses that "occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress . . . if the patient has good adaptive capacity his symptoms usually recede as the stress diminishes" (APA, 1968, p. 48). Examples of such reactions were "separation from mother, jealousy over birth of younger brother, irritability and depression with school failure." On the other hand, "Behavior Disorders of Childhood" included categories such as the hyperkinetic reaction of childhood, the runaway reaction of childhood, the overanxious reaction of childhood, and the withdrawing reaction of childhood. Each of these disorders was described, and cursory provisions were suggested for making a differential diagnosis between a childhood and adult disorder, since a child could still qualify for either. For example, the withdrawing reaction of childhood "should be reserved for those who cannot be classified as having Schizophrenia and whose tendencies toward withdrawal have not yet stabilized enough to justify the diagnosis of Schizoid Personality" (APA, 1968, p. 49).

DSM-II (APA, 1968) began the trend of acknowledging the intermediate nature of childhood illness that is less fixed than an adult disturbance but also deserves recognition beyond that of an adjustment reaction or brief transitional change. However, DSM-II continued to argue that adult disorders were "lifelong patterns, often recognizable by the time of adolescence or earlier" (APA, 1968, p. 41). The tension between the continuity of childhood development and adult difficulties was outlined in elementary terms in DSM-II. In this way, DSM-II can be seen as a transition between the first half of the 20th century, in which children were viewed primarily as miniature adults, and the second half of the century, in which children were studied, treated, and classified in a distinct fashion.

A Growing National Concern: The Child of the 1960s and 1970s

Federal initiatives and policies

If the first half of the 20th century brought children's mental health needs to the attention of families, clinicians, and scientists, the 1960s and 1970s can be seen as a time of national and political concern over the mental health of the American child. The increased national attention to the child may have been a function of the postwar "baby boom," with the number of children in America increasing sharply from 1946 to 1964 (Federal Inter-

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agency Forum on Child and Family Statistics, 1997). The mental health needs of this growing group of children and adolescents were brought to the forefront in a groundbreaking report from the Joint Commission on the Mental Health of Children in 1969. Among its sweeping list of recommendations, the report called for a more adequate classification system for emotionally disturbed children (Joint Commission on Mental Health of Children, 1970). Although this report spawned White House conferences in 1970 and 1971 to reinforce its extensive recommendations, most went ignored by politicians. In 1982, Jane Knitzer highlighted federal and state inaction in her own influential report, *Unclaimed Children* (Knitzer, 1982). The Carnegie Council also noted the unavailability of services for children despite what was viewed as a crisis in mental health needs among children and adolescents (Keniston & the Carnegie Council on Children, 1977).

Although reports typically highlighted federal inaction, this period saw the birth of several federal initiatives that are still in place as we enter the 21st century. For example, Project Head Start was initiated in 1965 as a preschool intervention for economically disadvantaged children (Zigler & Styfco, 1996). As another example, early and periodic screening, diagnosis, and treatment (EPSDT) was mandated by Congress under Title XIX of the Medicaid Act. Efforts to reach children in their communities and in their schools were also abreast. The community mental health movement, inaugurated by President Kennedy's address to Congress in 1963, represented an effort to offer comprehensive diagnostic, treatment, and preventative services on a community-wide basis. The 1970s also witnessed an effort to bring mental health services to the schools, such as through school health centers (Weist, 1998). In 1975, Public Law 194 (PL-194) was passed, proclaiming a right to a free and appropriate education for disabled children.

The coalescing of a child-focused field of study

Paralleling the federal policy initiatives and political changes described above, professional and scientific growth in child-related mental health fields was reflected in the proliferation of new journals devoted to child issues in the 1970s (e.g., *Journal of Abnormal Child Psychology* and *Journal of Clinical Child Psychology*). In 1963, the American Psychological Association formed a section on clinical child psychology, and the 1970s witnessed an increase in the number of programs offering training in child clinical psychology (Donohue, Hersen, & Ammerman, 1995). It was also during this period that infancy, toddlerhood, and adolescence were investigated as phases of "childhood" requiring special study (Shore & Mannino, 1976). As Rie summarized in a 1971 review, "attention seems finally to be directed to those issues which are of specific relevance to childhood and to the evolution of concepts of child psychopathology" (Rie, 1971, p. 46).

The time was ripe for a more useful and descriptive psychiatric nosology of childhood mental disturbance. As the antilabeling movement waned, clinicians and researchers alike agreed that a more specific diagnostic system would facilitate communication among professionals about different symptom patterns and would aid in predicting response to treatment. The third edition of the DSM (DSM-III; APA, 1980) represented "a culmination of an increased awareness of the utility of psychiatric diagnosis and an attempt to make such a classification reliable and valid" (Frame & Matson, 1987, p. 11).

The Elaboration of Child Disorders: The Emergence of DSM-III

The shift in the DSM's definition of psychiatric disorders in general, and disorders of childhood and adolescence in particular, was greatest between the second and third editions of the DSM. DSM-III (APA, 1980) contained detailed descriptions of mental disorders and specific criteria to help determine diagnoses. Whereas DSM-II (APA, 1968) defined disorders within a psychoanalytic framework, the authors of DSM-III (APA, 1980) eschewed this and all theory, instead focusing on research-based criteria that characterized specific types of mental disorder.

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In addition, DSM-III (APA, 1980) described concomitants of disorders that served to give a clearer clinical picture of the individual. DSM-III criteria incorporated the new concepts of subjective distress and impairment in one or more important areas of functioning. DSM-III also introduced a multiaxial system of diagnosis in which clinical syndromes, personality disorders, specific developmental disorders, medical conditions, psychosocial factors, and global functioning were all considered. Finally, DSM-III provided a list of characteristics that were associated with each disorder, such as age of onset, sex ratio, and relevance of family history.

The childhood disorders section of the DSM-III (APA, 1980) was "formulated largely on the basis of negotiations among the committees responsible for the DSM" (Achenbach & McConaughy, 1996). A number of new subsections were added to the section entitled "Disorders First Evident in Infancy, Childhood, or Adolescence." For example, DSM-III introduced a new categorization, "Specific Developmental Disorders," that is divided into five subcategories based on the subject of the learning difficulty (e.g., reading or arithmetic). This section is based on the premise that children are expected to attain adequate levels of competence in multiple areas by a certain age, and that the lack of competence suggests a specific type of impairment. The authors contended that these types of disorders grew out of problems in biological maturity (APA, 1980, p. 92), and thus their inclusion in DSM-III was controversial.

DSM-III (APA, 1980) contained 4 times as many diagnostic classifications for children and adolescents as had DSM-II (APA, 1968; Bemporad & Schwab, 1980; see Figure 1). DSM-III structured the section entitled "Disorders First Evident in Infancy, Childhood, or Adolescence" into five subcategories based on the most salient dysfunction associated with particular disorders: intellectual, behavioral, emotional, physical, and developmental. The decision to place disorders in these sections (rather than in other sections of the manual not devoted to youth) was based on the assertion that these disorders usually first appear before age 18 years. The authors acknowledged that children and adolescents may experience disorders described in other sections and should receive those diagnoses when appropriate. In addition, adults could receive diagnoses from the "child" section if they first manifested the relevant symptoms in their youth and the symptoms subsequently persisted into adulthood; the authors of DSM-III also stated that adults may receive diagnoses from the "child" section even if the onset of the disorder was in adulthood as long as the necessary symptoms were present. These decisions reflect the continued theoretical difficulty in articulating the relationship between a childhood disorder as a separate entity, as an entity that is a precursor to an adult difficulty, or as a less well defined adult disorder.

Aside from the disorders that were placed in the "child" section, several Axis I diagnostic categories in DSM-III (APA, 1980) included caveats concerning their applicability to specific age groups. These modifications were added to suggest that youth may exhibit different presentations of certain disorders. For example, children under 6 years of age could receive a diagnosis of major depression if they were experiencing depressed mood and *three* associated symptoms, whereas individuals over 6 years (including children, adolescents, and adults) had to experience depressed mood plus at least *four* additional symptoms. Modified criteria were also used for dysthymia, which could be diagnosed in a child or adolescent if the symptoms endured for at least 1 year, compared to 2 years for adults. These modifications implied that children exhibiting less severe symptoms than adults warranted diagnosis and clinical attention.

Perhaps the greatest change in the conceptual distinction between children and adults can be seen in the guidelines for diagnosing personality disorders. Beginning with DSM-III (APA, 1980) and its multiaxial system, clinicians could diagnose a personality disorder in addition to an Axis I clinical syndrome. However, certain instructions were included to guide those working with children and adolescents. For example, the diagnosis of borderline personality disorder in youth was only to be given if the syndrome was not better

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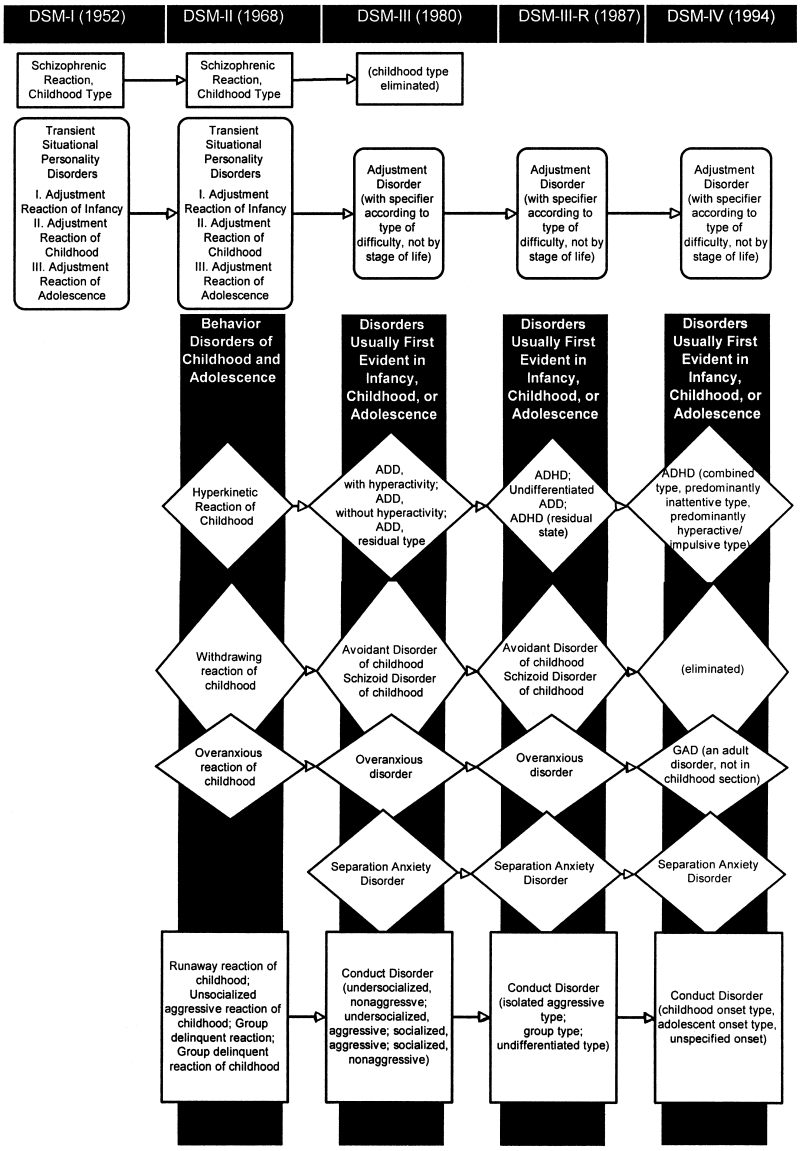


Figure 1. Childhood diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders.*

accounted for by identity disorder, an Axis I disorder that does not connote a pervasive and problematic style of interacting with the world. In addition, it was not possible for a person under 18 years of age to receive a diagnosis of antisocial personality disorder because research had shown that the behaviors that characterized this disorder may occur exclusively in youth and then sharply decline in adulthood.

Many Axis I disorders that were diagnosed before age 18 years could be reclassified as Axis II disorders once the individual was of age. This occurred when a persistent maladaptive pattern of behavior had been evident for many years. For example, avoidant disorder of childhood could become avoidant personality disorder if the individual had shown a chronic pattern of avoiding social relationships. Identity disorder could be diagnosed in individuals under 18 years of age if they reported distress due to uncertainty concerning identity; at age 18 years, this diagnosis would change to borderline personality disorder. The

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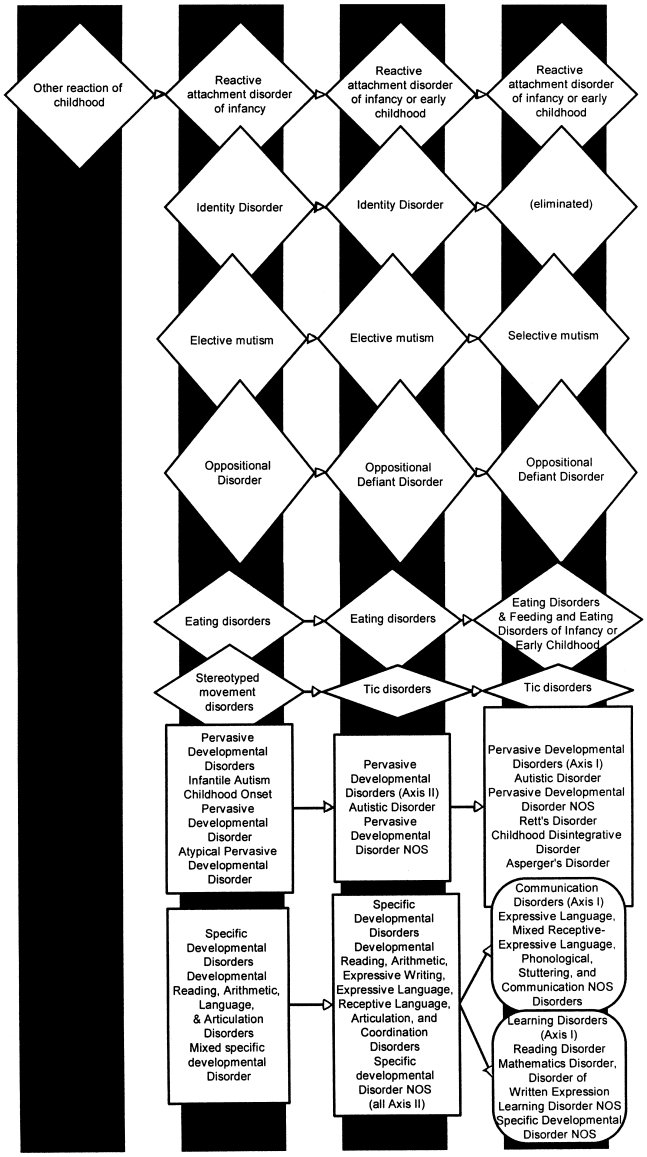


Figure 1. Continued.

authors of DSM-III (APA, 1980) recognized the problems inherent in labeling children and adolescents under 18 years of age as personality disordered. This classification implied that the personality disturbances of children and adolescents were not as chronic or immutable as those of adults.

DSM-III (APA, 1980) began to expand and elaborate childhood diagnostic categories by increasing the number of childhood disorders, introducing caveats stipulating age-related criteria, and introducing developmental delays and learning difficulties as disorders. These changes, while limited, were an initial attempt at focusing attention on childhood mental illness as distinct from adult psychopathology.

New Directions in Child Psychopathology and Diagnosis: Expanding Possibilities

Directly linked to the publication of DSM-III (APA, 1980) were advances and refinements in the practice of diagnosing specific child-

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hood disorders. The behavioral descriptors of syndromes introduced in DSM-III facilitated the development of systematic diagnostic instruments (Pumariega & Glover, 1998). Beginning in the mid-1980s, structured diagnostic interviews were developed to increase interrater reliability in diagnoses, with both child- and parent-report versions increasingly available (e.g., Albano & Silverman, 1996; Silverman, 1994). The utility of symptom checklists has also been recognized; a number of popular checklists for child disorders such as the Children's Depression Inventory (CDI; Kovacs, 1985) and the Conners Scales (Conners, 1990) have been widely used by researchers and practitioners (Pumariega & Glover, 1998). Empirically derived multi-informant checklists for internalizing and externalizing syndromes, such as the Child Behavior Checklist (CBCL), Youth Self-Report (YSR), and Teacher Report Form (TRF), have also achieved widespread usage (Achenbach, 1991; Achenbach & Edelbrock, 1983; McConaughy & Achenbach, 1990).

The trend of according children a central role in society continued after the publication of DSM-III in 1980 (APA). As the baby boomers themselves began to have children in the 1980s, America became an increasingly child-centered society. The role of children and adolescents in the national economy increased dramatically in the 1980s and 1990s as they became targeted as significant consumers of music, clothing, video games, and toys (West, 1996). Concern over childhood mental illness has been thrust into public attention by a media frenzy covering several tragic shootings committed by school children in the 1990s. These public acts of violence by a few disturbed children have raised the question of "what is wrong with today's children" for millions of parents and educators.

Paralleling the public attention given children, developmental psychopathology emerged in the mid-1980s as a unique approach to the development of psychopathology across the life span, with considerable energy devoted to understanding the development of psychopathology in childhood (e.g., Cicchetti, 1993; Cicchetti & Toth, 1995; Sroufe & Rutter, 1984). This field has provided rich theoretical ground for integrating knowledge gained from the diverse disciplines that study both normative and deviant development in children. Developmental psychopathology has also encouraged inquiry into the meaning and nature of "disorder" (Achenbach & McConaughy, 1996; Wakefield, 1997). Alternative schemes to DSM disorders based on empirically derived syndromes of internalizing and externalizing behavior in children have also been proposed by developmental psychopathologists (e.g., Achenbach & Edelbrock, 1983).

Changes in the practice and implications of childhood diagnosis were, in part, the result of the increase in description and attention given to childhood disorders in DSM-III (APA, 1980). DSM-III marked a turning point in the field for both research and clinical knowledge. The introduction of learning disabilities and specific descriptions of emotional and behavioral problems facilitated the formulation of future research projects exploring the development and treatment of uniformly defined disorders. DSM-III's incorporation of symptom lists and exclusion criteria was the first step in allowing researchers to study explicitly and consistently defined problems (e.g., Barkley, Anastopoulos, Guevremont, & Fletcher, 1991; Kendall, 1994).

Refinement: DSM-III-R and DSM-IV

Building on its predecessor, the revised third edition of the DSM (DSM-III-R; APA, 1987) continued to refine diagnostic categories based on research findings and clinical impressions. Most changes that were relevant to children and adolescents focused on additional age-related qualifiers to existing adult diagnoses. For example, major depression and dysthymia could be diagnosed in children and adolescents if they exhibited irritable instead of depressed mood (depressed mood was necessary for the diagnosis in adults). One criterion of posttraumatic stress disorder (PTSD) described reexperiencing the traumatic event; DSM-III-R noted that children sometimes exhibited this symptom by reenacting themes of the trauma in their play. In this small number

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of cases, DSM-III-R attempted to more accurately describe the symptoms of mental disorder in children as distinctive from adult presentations.

Although too few, some changes in diagnostic criteria further reflected the need to take developmental level into account. A DSM-III-R (APA, 1987) diagnosis of anorexia nervosa could be given to children as a result of failure to make developmentally expected weight gains, instead of exclusively weight losses. Developmental level was also taken into account in the revision of the section concerning pervasive developmental disorders. Added to the criteria for autistic disorder were clinical descriptions of how the disorder may present at different ages. Implied in these revised diagnostic criteria is the idea that developmental level may be an important moderator in the manifestation of psychopathology. A final change in DSM-III-R was the use of clinical research field trials to validate diagnostic categories. Results of these field trials were used to expand and clarify the subtypes of child disorders including attention deficit disorder (ADD) and conduct disorder (CD).

The fourth edition of the DSM (DSM-IV; APA, 1994) continued the trend of DSM-III-R (APA, 1987) in attempting to refine diagnostic criteria. In an effort to incorporate the idea that disorders may be manifested differently as a result of characteristics of the individual, each diagnostic category included a new introductory section entitled "Specific Culture, Age and Gender Features." Although this section did not modify the diagnostic criteria, it drew attention to age and, implicitly, level of development. For example, DSM-IV states that symptoms of major depression may change with age. When depressed, children are more likely to exhibit somatic complaints and irritability, whereas psychomotor retardation and hypersomnia are more common in postpubertal individuals. Similarly, children with the diagnosis of social phobia may cry or throw temper tantrums when they become anxious, although adults typically display other symptoms.

Like its predecessor, DSM-IV (APA, 1994) continued to apply age-related criterion and to refine subtypes of child disorders. An age of onset criterion (by age 3 years) was brought back (after having been dropped in DSM-III-R) to the diagnosis of autistic disorder to make this threshold more consistent with clinical impressions. DSM-IV identified more examples of behaviors symptomatic of conduct disorder and, in addition, added behaviors that females were more likely to exhibit. The diagnosis of conduct disorder in DSM-IV also required the specification of age of onset, based on findings that early onset was associated with a lifelong pattern of aggressive and antisocial behavior (Loeber & Dishion, 1983). Age of onset proved helpful in identifying children at risk of receiving a diagnosis of antisocial personality disorder in adulthood.

In DSM-III-R (APA, 1987) pervasive developmental disorders, learning disorders, motor skills disorders, and communication disorders were all coded on Axis II due to their early age of onset, persistence, and stability into adulthood. In DSM-IV (APA, 1994), these syndromes were moved to Axis I, which reflects their reconceptualization as malleable, mutable clinical disorders rather than pervasive and enduring styles of relating to the world.

Child Diagnosis, Special Services, and Social Policy

As a result of many of these changes in DSM III-R and DSM-IV (APA, 1987, 1994), DSM-defined diagnostic categories began to play a greater role in social and educational policies relevant to the lives of children. In the final decades of the 20th century, diagnoses of childhood mental disorder were linked to special education services in the public school system. The passage of the Education for All Handicapped Children Act of 1975 (PL-194) opened access to a free and appropriate public education for children with disabilities. In the subsequent decades, the parameters of "disabilities" have been debated and revised following frequently heated controversy. PL-194, as well as Part B of the Individuals with Disabilities Education Act (IDEA), specified three categories under which children with mental illnesses can qualify for special ser-

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vices and resources in the school. Under the category "Specific Learning Disability" children with a documented learning disability are considered eligible for special services. States vary in the criteria used to define "specific learning disability," even when standardized intelligence and achievement tests are employed. More controversial have been the categories "Seriously Emotionally Disturbed" (SED) and "Other Health Impaired" (OHI). States have disagreed considerably over what childhood disorders constitute these conditions, often leaving parents to argue with schools to obtain services from fiscally strained systems. By the 1990s, DSM became a tool in implementing the social policy initiatives articulated in IDEA and PL-194.

Childhood diagnoses remain linked with educational services, and there is the reported feeling among clinicians that some parents may visit their pediatrician or psychologist in hopes of leaving the office with a diagnostic label for their child. An example that has received much media and professional attention is the case of attention-deficit hyperactivity disorder (ADHD). Although the increase in prevalence of ADHD coincides with advances in scientific knowledge about the nature of the disorder (see Barkley, 1998), it is notable that ADHD has also become increasingly linked to eligibility for school services. Child advocates have argued that children with ADHD are eligible for special services under the OHI category; however, states have widely disputed this claim. In 1991, the Department of Education issued a memorandum clarifying that ADHD does fit under the OHI category and that children with ADHD could qualify for services if they evidenced significant functional impairment. In March 1999, ADHD was added explicitly into the list of relevant disorders in the text of the OHI category. As these trends in educational policy continue, it is likely that the granting of school services will increasingly hinge on diagnoses provided by child mental health practitioners and defined by the DSM.

The 1991 and 1999 revisions of IDEA stemmed from another trend in child mental illness which also has its roots in the 1980s—the parent advocacy movement (Rog, 1995). Parental advocacy groups for children with various mental disorders have grown rapidly and have been influential in public policy and in general views toward childhood mental illness. The role of the parent as an advocate for a child who "has" a mental illness is very different from earlier conceptualizations of the parent as the primary cause of the child's mental illness. The mother-as-cause perspective has been replaced with a biology-as-cause perspective, which is embedded in the biological psychiatry of the 1990s (Kiesler, 1999). The utility of psychopharmacology in treating childhood disorders such as ADHD and depression has clearly contributed to this perspective. Both parental advocacy and biological theories of etiology have had the effect of decreasing the social stigma associated with mental illness, but also of placing responsibility for the disorder out of the child's or even the family's control.

The Meaning of Childhood Mental Disorder: Needed Clarifications

Throughout this article, we have examined conceptualizations of mental disorder in children by narrating three intertwined historical stories: the political and social history of American families and children, the story of the development of mental health fields devoted to child psychopathology, and the story of the evolution of a psychiatric nosology. A prominent theme played out in each of these stories has been a shift in focus on the child. Scientists now agree that children are not immune to psychopathology and that mental disorders can be diagnosed in children with relatively adequate reliability. The prevalence of childhood disorders of all types has been shown to be widespread. The most conservative estimates indicate that at least 12% of children under 18 years of age suffer from a mental disorder, with estimates as high as 22% reported (National Institute of Mental Health, 1990; Tuma, 1989).[1]

1. Estimates from the Surgeon General's Report on Mental Health indicate that approximately 70% of children and adolescents with a diagnosable mental disorder do not receive mental health services (Substance Abuse and Mental Health Services Administration, 2000).

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Yet, after 150 years of theory and research, we are still ill prepared to answer many fundamental questions about the nature of child psychopathology. The book is far from closed on the classification and validity of childhood disorders. At its most basic level, the question remains: what do we mean when we say that a child has a mental disorder?

Is child psychopathology "in" the child?

The meaning of childhood mental disorder raises larger issues about the meaning of disorder in general, a topic of much recent debate (see Clark, 1999; Richters & Cicchetti, 1993; Wakefield, 1997). The authors of DSM grappled with the question of the meaning of mental disorder for many years, offering no written definition until 1980. This definition, largely reflective of the atheoretical and noncontextual format of the DSM system since 1980, locates disorder within the individual and describes disorder as (APA, 1994)

> . . . a manifestation of behavioral, psychological, or biological dysfunction in the individual. . . . [N]either deviant behavior (e.g., political, religious, or sexual) nor conflicts between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual. (p. xxi)

Locating disorder within the individual is partially a byproduct of biological psychiatry's disease model of mental illness (Kiesler, 1999; Sroufe, 1997), in which mental disorders are presumed to be the result of a "broken brain" (Andreason, 1984). According to the medical model, children's behavioral and emotional problems are equated with organic disease states (Sroufe, 1997).

Some, however, are hesitant to apply a disease model of mental illness to children. Psychologists believe that children are more malleable than adults and are therefore more easily influenced by contextual factors. Does a child diagnosed with oppositional defiant disorder, conduct disorder, or major depression *have* an internal dysfunction manifesting itself in the behavioral syndrome described in DSM? In many cases children's difficulties may indeed be manifestations of dysfunction in internal mechanisms or processes, such as emotion regulation, behavioral inhibition, or neuropsychological deficits. Yet clinicians would likely want to know about this child's life before answering such a question (Richters & Cicchetti, 1993). For example, consider Katie, a young girl with a psychologically intrusive and controlling father who was referred to a clinic because she was exhibiting anxiety in school. Does Katie possess an internal anxiety dysfunction, or is her anxiety the product of interactions with her father? Does Dennis, who lives in an impoverished neighborhood and carries a gun in fear of a neighborhood gang, *have* an internal conduct disorder dysfunction? Similarly, Richters and Cicchetti (1993) present the cases of Tom Sawyer and Huckleberry Finn, beloved figures of American fiction whose life contexts support involvement in a variety of mischievous behaviors that would qualify them for diagnoses of conduct disorder if they were alive today.

As Jensen and Hoagwood (1997) have suggested, presumed psychopathology may often reflect a mismatch between persons and their environments rather than an internal dysfunction. Others (e.g., Cicchetti, 1987; Sameroff & Emde, 1992) have outlined "relational disorders" that might be considered in diagnostic systems. The "Zero to Three" group has proposed an alternative relational diagnostic system for infants based on context, norms, and parent–child interactions (Zero to Three/National Center for Clinical Infant Programs, 1994). Despite the relevance of contextual features in defining "pathology" (e.g., Cicchetti & Aber, 1998, Jensen & Hoagwood, 1997; Richters & Cicchetti, 1993), DSM's diagnostic system continues to formulate childhood disorders in noncontextual terms.

In contrast to a simple causal model, developmental psychopathologists present evidence that disorder develops via complex interactions between multiple etiologic factors (e.g., Belsky, Hsieh, & Crnic, 1998; Cicchetti & Toth, 1995; Rubin & Mills, 1991). As presaged in Healy's discussion of "the complex web of causative factors," theorists increasingly endorse a biopsychosocial approach fo-

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cusing on risk and protective factors at the biological, psychological, and sociocultural levels (Kiesler, 1999; Sroufe, 1997). Disorder, then, cannot be located exclusively within the child but within the coactions of the child's biological predisposition and his or her life contexts—including family, neighborhood, peers, and culture (Jensen & Hoagwood, 1997).

How is child psychopathology different from adult psychopathology?

Benjamin Rush admonished psychiatrists against diagnosing mental disorders in children due to the immature and unstable nature of children's brains. Although his description of the inability of transient mental impressions to permanently excite children's brains into disorder is outdated, we must ask ourselves whether there is a kernel of truth in his warnings about the transience of disorder in children. Is there any empirical truth to the folk adage that children will "grow out of it"? There is evidence to the contrary that anxiety disorders, depression, and behavior disorders do persist into adulthood for a significant number of children and adolescents (Christie, Burke, Reiger, Rae, Boyd, & Locke, 1988; Kandel & Davies, 1982; Mash & Dozois, 1996). In the realm of conduct disorder, for example, it is known that a large number of boys exhibiting early-onset conduct disorder will exhibit antisocial behaviors across the life span, with many receiving a diagnosis of antisocial personality disorder (Moffitt, 1993). Yet there is also discontinuity in disorders from childhood to adulthood; for example, even within the category of conduct disorder the majority of children receiving this diagnosis *are not* diagnosed with antisocial personality disorder as adults (Hinshaw, 1994). The field is only beginning to elucidate the factors that can help us predict whether a problem in childhood will be transient or will continue into adulthood. What, then, does it imply when a child is given a diagnosis? Is this merely a stage or is it an early form of disorder that will persist into adulthood? Further, how do we conceptualize childhood disorders as distinct from adult disorders? Is a disorder diagnosed in childhood a downward extrapolation of an adult disorder, a precursor to a continuous problem, or a qualitatively distinct disorder? While it is less common to observe homotypic continuity from childhood to adulthood (identical symptoms persisting over time), the presence of heterotypic continuity (different symptomatic expressions over time of the same underlying disorder) complicates decisions about whether a child's presentation should be considered an early manifestation of an "adult" disorder (Sroufe & Rutter, 1984).

The title "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" belies the ambivalence of the authors of DSM about the relationship between these "childhood" disorders and the disorders outlined in the rest of the manual. Such disorders constitute a separate category in that they are "usually" diagnosed in childhood, yet children can receive diagnoses in most other categories and adults can receive diagnoses usually reserved for children. Research is beginning to clarify factors that are helpful in predicting the continuity and persistence of disorders into adulthood, and to examine how a disorder may be expressed differently at different developmental periods (heterotypic continuity). The notion of multiple pathways leading to the same disorder (termed equifinality), as well as the notion of similar pathways leading to different disorders (multifinality), has emerged from developmental psychopathology's emphasis on developmental trajectories of adaptation and maladaptation (Cicchetti, 1990; Cicchetti & Rogosch, 1996; Sroufe, 1989, 1997).

Empirical evidence exists to support the utility of conceptualizing psychopathology in terms of a pathway model that acknowledges both equifinality and multifinality. For example, recent longitudinal studies have shown that children who exhibit diverse symptoms such as depression or conduct problems in youth are both at greater risk to attempt suicide in adulthood, although presumably through different pathways (Harrington, Rutter, & Fombonne, 1996). Research also shows that children who exhibit problems such as depression do not necessarily become de-

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pressed as adults (Harrington et al., 1996); other outcomes may include antisocial personality disorder (Harrington et al., 1996) or schizophrenia (Walker, Neuman, Baum, Davis, DiForio, & Bergman, 1996). It is time to incorporate research and theory on the qualitative differences in disorder among children and adults into a consensual understanding of the meaning and implication of disorder in childhood.

Has the diagnostic pendulum swung too far?

The field has shifted, in 150 years, from decrying the existence of childhood mental disorder to declaring that as many as one in seven of our children suffer from a mental disorder. Perhaps the most important question raised in this review is whether, in our diagnostic advances and refinements, we have become overzealous in diagnosing and labeling children. In many ways, the current sociocultural and scientific context supports the diagnosis of children. Third-party reimbursements for visits to mental health professionals and publicly funded services in schools and mental health clinics often depend upon diagnostic labels (Kiesler, 1999). Social stigma has decreased due to several factors, including the popularization of the biomedical model and the increased involvement of parents and schools in seeking mental health services for children.

Is there reason to be more hesitant in labeling children? The answer to this question is largely unknown. Studies have yet to elucidate the long-term effects of having been labeled with a disorder as a child. We do not know if there are negative long-term effects of diagnostic stigma, or whether the interventions and services that accompany the diagnostic label outweigh the potential negative consequences. Central to the question of whether we are overdiagnosing children is a more fundamental question about whether we have overdefined pathological behavior. Beginning with the child guidance movement, the problems of the everyday child became the focus of clinical attention. Have we cast too wide a net for what we consider deviant? If large proportions of children exhibit behavior we have defined as "abnormal," perhaps it is better to consider this behavior normal.

Cross-cultural research suggests that the prevalence of childhood disorders is linked to adult expectations about appropriate behavior and varies across different cultures (Weisz, 1989). We must, therefore, examine our own culturally bound assumptions about appropriate and normal childhood behaviors. An often discussed but important example is the diagnosis of ADHD (e.g., Jensen, Mrazek, Knapp, Steinberg, Schowalter, & Shapiro, 1997). To what degree should we expect young children to have difficulty sitting still quietly and attentively at a classroom desk for 6 hours a day? Some have raised the question of whether our societal expectations for children in this regard are developmentally appropriate. For example, Elkind has argued that we are hurrying our children into adulthood, failing to give them "the luxuries of childhood" (Elkind, 1981; Garbarino, 1986).

Questions about the "abnormality" of children's behavior must be addressed empirically by integrating research on normative development with diagnostic practices and formulations. Assessment tools that allow researchers and clinicians to compare children's behaviors to those of a normative sample of same-aged children for assessment (e.g., CBCL; Achenbach & Edelbrock, 1983) and for treatment (e.g., normative comparisons; Kendall & Grove, 1988; Kendall, Marrs–Garcia, Nath, & Sheldrick, 1999) are invaluable in this regard. While developmental psychopathologists have made important strides in recognizing the need for such an integration, little headway has been made in incorporating knowledge about normative development into DSM's diagnostic nosology. Although caveats are provided stipulating differences in clinical presentation between children and adults, normative differences between children of different ages are still largely ignored. Using DSM-IV (APA, 1994), an 8-year-old and a 16-year-old require the same level of symptomatology to qualify for ADHD. However, because 8-year-olds are generally less attentive and more active, it is more likely that an 8-year-old will be diagnosed with ADHD, regardless of the fact that the adoles-

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cent may be much more "abnormal" in comparison to his age-mates. An ideal diagnostic system, even within the confines of DSM's descriptive approach, would incorporate developmentally graded changes in criteria for disorder, based on studies of normal development at different ages. DSM has taken some steps in this direction but has explicitly included developmental considerations in diagnostic criteria in only a few instances.

Social Policy Implications

As this historical review indicates, a bidirectional influence has existed between conceptualizations of mental illness in children and social policy. Interest in the psychological development of the child has been closely tied with social policies addressing children's well-being. For example, the child labor and child welfare laws of the early 20th century turned attention to the well-being of the child, which was paralleled in the subsequent founding of child guidance and child study centers. Progressive era social reforms spurred a new conceptualization of the child, which came to encompass child development as a distinct and important area of clinical and scientific inquiry. As documented, these lines of inquiry have led to the accumulation of knowledge about the development of psychopathology in children.

We have documented instances in which social policy and social climate have informed research initiatives. For example, the social problem of juvenile delinquency at the turn of the past century spurred interest in understanding the etiology of problem behavior, an interest that led to the founding of the Juvenile Psychopathic Institute and the subsequent child guidance movement. Similarly, deficiencies in the hygiene and literacy of young men revealed in the World War II draft provided initiative for child study institutes. Unfortunately, we see less evidence for instances in which research findings are taken as the basis for social policies concerning childhood disorders. How can we incorporate advances in knowledge of child psychopathology into policies for the diagnosis and treatment of mental disturbances in childhood? The recognition throughout the past century and a half that many children are in need of mental health services is certainly laudable, but we must ask if current policies are appropriate for the delivery of such services.

Current practices in the diagnosis of mental disorders in children are inextricably linked with service availability and service reimbursement by managed care systems. In line with the disease model of mental illness (see Sroufe, 1997), the current zeitgeist leans toward providing compensation for diagnosed "brain disorders," providing greater and more consistent compensation for disorders presumed to have a strong organic basis (e.g., depression, ADHD). Compensation decisions are often determined in a formulaic fashion based on the specific disorder diagnosed; for example, reimbursement may be given for a child diagnosed with conduct disorder but not for a child exhibiting serious anger and parent–child conflict.

Yet research from several perspectives, including developmental psychopathology and clinical psychology, has highlighted the importance of contextual and interpersonal features in the development of social and emotional disturbances in children. It is not difficult to raise the question of whether children experiencing difficulties that fall outside the rubric of DSM's "endogenous" conceptualization of disorder are not also entitled to mental health services. Contextual and relational disturbances in the parent–child system (e.g., parental coercion, psychological control), the peer system (e.g., peer rejection), and environmental factors (e.g., poverty) have all been linked to the development of psychopathological disturbance in many children. If we are serious about at-risk youth and prevention, then we must consider a child who is experiencing serious impairment in school, social, or family functioning as a result of a problem in one of the above systems as worthy of services even if the child does not meet the diagnostic criteria set forth by DSM for an Axis I disorder. In many cases such a child would benefit significantly from psychosocial services, yet these services will likely be denied by the managed care system because the child does not fall into one of DSM's diag-

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nostic categories (either because the child's difficulties are part of a relational disturbance, are subsyndromal, or are a mix of symptoms that do not fit clearly into a DSM diagnosis). Is it in the best interests of children that a DSM (or other categorical) diagnosis be set forth as a necessary criterion for financial reimbursement for health services, or even for eligibility for school services such as special education? If one responds yes, then it is likely that many practitioners will continue to grapple with the decision of forcing a child into a diagnostic category that does not adequately capture the nature of the child's problems simply because it will secure services for the child (vs. sticking to a more appropriate diagnosis, or to a lack of diagnosis, that may fall outside of what managed care systems have defined as "reimbursable").

A cogent argument that can be made is that the primary criterion on which service delivery decisions should be based is the degree of functional impairment in a child's life (e.g., impairment in functioning within the school, family, and peer settings). Because functional impairment is a subjective clinical judgment (Jensen & Hoagwood, 1997), impairment decisions will need to be informed by normative data cataloging reasonable expectations for academic, interpersonal, and behavioral functioning for children at particular developmental stages. To maximally meet children's needs, each child's situation would be looked at uniquely and decisions would be made based on consideration of multiple factors, including but not limited to a child's diagnostic status.

Managed care systems and, to a lesser extent, schools often feel the pragmatic push to rely on categories and formulas for the disbursement of services to children because of needs for efficiency in cost and time. Take, for example, the practice of school systems determining whether a child qualifies as learning disabled by considering the discrepancy between IQ and achievement test scores. This procedure, as well as HMO procedures of providing reimbursement for children with one of a predetermined list of diagnoses, may seem appealing because they imply equal treatment of all children and offer efficient rules for determining eligibility for services. Nevertheless, such practices of "diagnostic gatekeeping," in which specific diagnoses open or close the gate to service delivery, likely result in the denial of services to children in need of assistance, as well as the provision of inappropriate services to children who have been incorrectly or inappropriately diagnosed, often for the tautological purpose of receiving such services.

In between these extremes of individual evaluation for each child and adherence to strict cutoffs and formulas lies a middle ground that may prove promising for policies regarding the provision of services to children. Cost efficiency and time efficiency may support the continued use of diagnostic categories or test score formulas as *guidelines* for service provision. However, these guidelines must be applied *flexibly,* with input from individual evaluations by child mental health practitioners given due weight in decision making. A flexible system would require psychologists, physicians, and other clinicians working with children to (a) increase participation in the ranks of service delivery systems at clinical, administrative, and advocacy posts; (b) ensure high-quality and continuous training for child clinicians as well as physicians, including ongoing consumption of research on child psychopathology; (c) employ well-validated state-of-the-art testing instruments and assessment procedures to allow more accurate and comprehensive information to be gathered about each child; and (d) secure from service delivery systems a greater role for child clinicians in decision-making procedures.

Some school systems across the country have gone in this direction with the implementation of a prereferral intervention program for children considered at risk for problems in the school setting. In this model, a pupil assistance committee, referred to as the PAC team, reviews cases and designs services for children at the "prereferral" level, meaning before a diagnosis is given. Children are not required to meet criteria as OHI or SED in order to merit services, thus increasing the potential for early intervention and the avoidance of labeling. For example, a child who is

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experiencing difficulty with the transition from elementary school to middle school may be identified by the PAC team for the designation of special services to ease this transition, without implying or requiring that the child be conceptualized as experiencing a mental disorder. This model offers a promising alternative to traditional school system policies.

In addition to decisions regarding whether services will be provided to children, psychological research can be informative about the types of interventions and policies that are offered. Research conducted by developmental psychopathologists has illustrated the central role of context—both interpersonal and situational—in children's behavioral and emotional difficulties (e.g., Cicchetti & Aber, 1998). The classical disease model focuses therapeutic attention on the utility of pharmacotherapy and individual treatment and minimizes attention toward environmental factors (Sroufe, 1997). Children are increasingly treated with medication; a recent study showed that the numbers of even very young children (2–4 years of age) receiving stimulant and antidepressant medication increased dramatically from 1991 to 1995 (Zito, Safer, dos Reis, Gardner, Boles, & Lynch, 2000). From a contextual perspective on child psychopathology, however, interventions would be targeted not only at the child but also at families, schools, and communities. Research illuminates the contextual factors that are relevant to the development of child psychopathology, and social policies aimed at improving these environmental conditions can flow from such research. For example, research by Patterson and colleagues has demonstrated the relevance of coercive parenting in the development of antisocial behavior problems in boys (Patterson, DeBaryshe, & Ramsey, 1989), as well as the effectiveness of parent training interventions in preventing and ameliorating such problems (Patterson, Reid, & Dishion, 1992; Southam–Gerow & Kendall, 1997). Research may support the provision of other services to parents and communities, such as financial assistance, prenatal care, public housing improvements, and targeted improvements in public school systems. Just as such policies are best when informed by research findings, research on their effectiveness must inform the policymakers of the future.

Conclusion

Progress invites scrutiny, and as we move into the next century of progress in research, practice, and policy concerning mental disorders in children, we must begin to scrutinize our underlying assumptions about what it means for a child to be "mentally ill." This review has raised many questions that should be given serious consideration by those interested in preventing, treating, and understanding the development of psychopathology in children. For example, when should a child's behavior be considered disordered or pathological? What are the boundaries of normal development? How best can we conceptualize and study the complex factors that interact to produce mental disorders in children? What is unique about disorder in childhood? Are childhood disorders marked by transience or continuity? What are the effects of being labeled as "mentally ill" in childhood? How can we best allocate service resources to optimally benefit all children in need? What interventions and policies will be most beneficial for such children? The answers to these questions will prove essential in developing informed and effective policies for diagnosticians, clinicians, schools, communities, and families of the 21st century.

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