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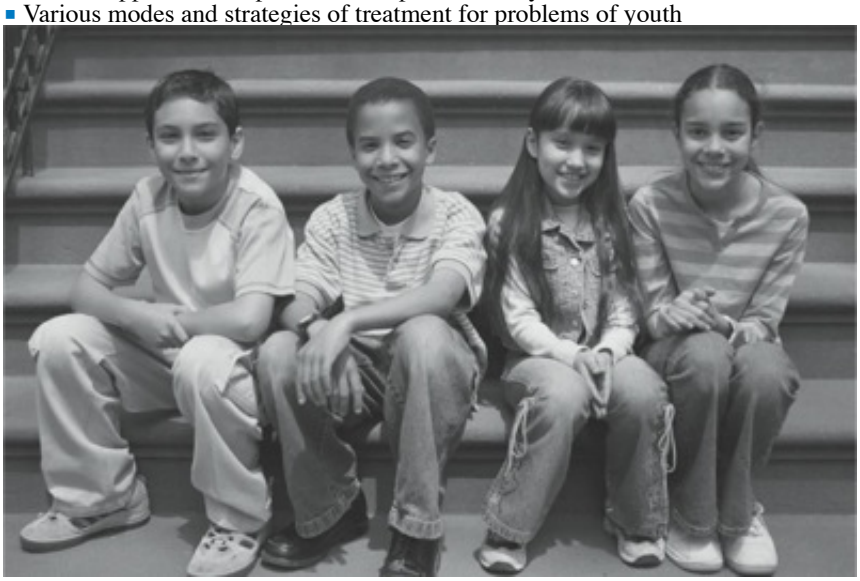
CHAPTER 5 Classification, Assessment, and Intervention

LOOKING FORWARD

After reading this chapter, you should be able to discuss:

- Processes of classification and diagnosis
- DSM and empirical approaches to classifying psychological problems of youth
- How assessment is conducted and various approaches to assessment
- Various approaches to prevention of problems of youth
- Various modes and strategies of treatment for problems of youth



How are behavioral disorders of childhood and adolescence defined, grouped, evaluated, and treated? In this chapter we will introduce the processes of classification, assessment, and intervention.

The terms *classification, taxonomy,* and *diagnosis* are used to refer to the process of description and grouping. **Classification** and **taxonomy** are the delineation of major categories or dimensions of behavioral disorders, done for either clinical or scientific purposes. **Diagnosis** usually refers to assigning a category of a classification system to an individual. **Assessment** refers to evaluating youngsters, in part to assist the processes of classification and diagnosis and in part to direct intervention. All of these entwined processes are intricately related to the clinical and scientific aspects of child and adolescent disorders.

CLASSIFICATION AND DIAGNOSIS

Classification systems are employed to systematically describe a phenomenon. Biologists have classification systems for living organisms, and physicians classify physical dysfunction. Similarly, systems exist to classify psychological dysfunction. These systems describe categories or dimensions of problem 8384behaviors, emotions, and/or cognitions. A **category** is a discrete grouping, for example, anxiety disorder, into which an individual's symptoms are judged to fit or not fit. In contrast, the term **dimension** implies that an attribute is continuous and can occur to various degrees. Thus, for example, a child may exhibit high, moderate, or low levels of anxiety.

Any classification system must have clearly defined categories or dimensions. In other words, the criteria for defining a category or dimension must be explicitly stated. Clear and explicit definitions allow for good communication among professionals. Also, one must be able to clearly discriminate diagnostic groupings from one another. It must be demonstrated, too, that a category or dimension actually exists. That is, the features used to describe a category or dimension must occur together regularly, in one or more situations or as measured by one or more methods.

Classification systems must be reliable and valid. These terms were applied to research methods in chapter 4. When applied to classification or diagnosis, the terms retain the general meanings of consistency and correctness but are used in somewhat different ways.

Interrater reliability refers to whether different diagnosticians use the same category to describe a person's behavior. For example, it addresses the question, Is Maria's behavior called separation anxiety by two or more professionals who observe it? **Test–retest reliability** asks whether the use of a category is stable over some reasonable period of time. For example, is Sean's difficulty, originally diagnosed as oppositional–defiant disorder, diagnosed as the same disorder when he returns for a second evaluation?

There are also questions about the **validity** of diagnostic systems. To be valid, a diagnosis should provide us with more information than we had when we originally defined the category. Thus diagnoses should give us information about the etiology of a disorder, the course of development that the disorder is expected to take, response to treatment, or some additional clinical features of the problem. Does the diagnosis of conduct disorder, for example, tell us something about this disorder that is different from other disorders? Does the diagnosis tell us something about what causes this problem? Does it tell us what is likely to happen to youngsters who have this disorder and what treatments are likely to help? Does it tell us

additional things about these young people or their backgrounds? The question of validity is thus largely one of whether we know anything we did not already know when we defined the category. Another important aspect of validity is whether our description of a disorder is accurate. Is the way we have described and classified this disorder the way it actually exists? Answering this question is often not an easy matter.

Finally, the **clinical utility** of a classification system is judged by how complete and useful it is. A diagnostic system that describes all the disorders that come to the attention of clinicians in a manner that is useful to them is more likely to be employed.

The Dsm Approach

The most widely used classification system in the United States is the American Psychiatric Association's ***Diagnostic and Statistical Manual of Mental Disorders (DSM)***. The Tenth Revision of the ***International Classification of Diseases (ICD)*** developed by the World Health Organization (1992) is an alternative system that is widely employed. There has been some concern that the DSM coverage of disorders has not given sufficient attention to younger children (Egger & Emde, 2011). The **Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC: 0–3)**, one response to this concern, is a system developed to classify mental disorders of very young children (Zero to Three, 2005). We will focus our discussion on the DSM because it is the dominant system in the United States.

The DSM is often referred to as a **clinically derived classification** system. Clinically derived classification systems are based on the consensus of clinicians that certain characteristics occur together. These have been described as "top down" approaches (Achenbach, 2000). Committees of experts propose concepts of disorders and then choose diagnostic criteria for defining disorders. It is from these criteria that the development of assessments and evaluations proceed.

The DSM is also a **categorical approach** to classification; a person either does or does not meet the criteria for a diagnosis. In a categorical approach the difference between normal and pathological is one of *kind* rather than one of *degree*. This approach also suggests that distinctions can be made between *qualitatively* different types of disorders.

The DSM is an outgrowth of the original psychiatric taxonomy developed by Kraepelin in 1883. There have been a number of revisions of the DSM system. The most recent revision is the DSM-5. The DSM-5 provides information regarding a large number of disorders. These disorders are organized into groups of related disorders (chapters). A description and diagnostic criteria are provided for each disorder. In addition, there is accompanying text material that provides information about features that may be associated with a disorder (e.g., low self-esteem) and information regarding cultural, age, and gender features; probable course of the disorder; prevalence; familial patterns; and so on (American Psychiatric Association [APA], 2013).

Historically, the classification of abnormal behavior focused primarily on adult disorders and there was no