Ethical Issues in the Diagnosis of Mental Illness in Children

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Abstract

In its current state, the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) (2013) provides relatively little distinction in how to go about the diagnosis of mental disorders in children. The majority of disorders outlined in the DSM-5 concern the diagnosis of older and much more developed individuals (adults and late-teens). A child's mind works differently than theirs in many ways due to the fact that a child's mind is still developing and changing; some criteria for a specific diagnosis can actually be present in a completely healthy and developing child. There are however, a small collection mental disorders that are focused primarily on children which have their own set of criteria that is better defined in relation to standard childhood behavior. This is where the ethical issue comes in: If we currently have exceptions for a few specific disorders when diagnosing children, are we not ethically bound to do so across the board? Current practice sees therapists adjusting requirements and compensating for the child's development with how they see fit; there is no uniform process or research outlined in modern diagnostic literature. This is one of the main causes for the over-diagnosis and misdiagnosis of many disorders in children. If it is understood that early detection and treatment can help a child later in life and that the gap in direction impedes this process which can possibly bring harm to these children, doesn't it work contrary to the general goal of therapy? It does, and because of this, it is absolutely critical that solutions to this problem are researched and developed. Whether these solutions consist of amendments to the current state of the DSM-5 or an entirely separate manual for child diagnoses, we should be ethically bound to resolving this critical issue.

Ethical Issues in the Diagnosis of Mental Illness in Children

In the diagnosis of mental disorders in all individuals, mental health professionals in the United States look towards the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a guide. Currently in its fifth edition, the DSM has been through a great many years of research and refinement to become the manual it is today. (American Psychiatric Association, 2013) This does not mean it is without its issues. Since its inception, the DSM has been scrutinized by both psychologists and psychiatrists for a lack of strict definitions and criteria for diagnosing people, particularly children, with mental disorders. This is a particularly alarming issue due to the dangers posed by misdiagnosis and over-diagnosis in children at a young age. While each edition of the DSM improves upon and attempts to fix this serious issue, there has yet to be any form of a viable fix-all solution.

With the release of the DSM-5, the American Psychiatric Association (APA) presented a grand total of eight different mental disorders both specifically targeted at and containing different diagnostic criteria for children. (American Psychiatric Association, 2013) These eight disorders equate out to a rather small percentage out of the over three-hundred that are currently listed within the DSM. Ethically, this is entirely unsound. Not all children suffering from some form of a mental illness will fit within the criteria or have issues related to the few child-specific disorders or updated criteria, so when a therapist is attempting to diagnose a child, they apply the adult criteria. (Wedge, 2011) This in turn leads to even more issues such as possible damage from the misdiagnosis of a child at a young age. Again, ethically, this practice is unsound and potentially harmful in the long run. These two over-arching ethical issues lead the way into many more, smaller ethical issues and questions that have no official answer or very much research into as of yet. Educationally, personally, socially, and even physically, children are being subjected to a dangerous, yet unspoken practice that seems to go against many of the basic tenants of therapeutic practice.

A solution is a necessity when dealing with this disastrous and growing issue. There are a multitude of possible fixes to be had however none of them seem to be being looked into. With the urgency of this issue in general, it is a disturbing idea to think that those who are in charge of this are

completely passive to the issue. With each passing day, more and more children are touched by misdiagnosis and wrongful treatment with no solution in sight.

Old Practices for the Developing Mind

Within the DSM-5, there are over three-hundred different mental disorders. Most of these disorders revolve around adult diagnoses and criteria with relatively little in the way of age differentiation. Everyone's age is, of course, constantly changing and with it, their psyche is as well. This is most prominent in children. While an adult's mind changes, it is over a much longer period of time than a child or adolescent's which is what allows for the DSM-5 to have criteria that remains stagnant in design. When taking children into consideration however, it does not take their constant state of change and mental plasticity into account; which can explain for much of their fluctuating and sometimes even chaotic behavior that is considered normal for their age. Because of this, the many of the behaviors commonly found in normal, developing children can be seen or interpreted as a symptom of a mental disorder. Take the example given by Professor Christopher Lane of Northwestern University: "Children exhibiting prolonged temper tantrums can now be diagnosed with disruptive mood dysregulation disorder. That's along with ADHD, oppositional defiant disorder, and bipolar disorder, which are already in the manual and share a great deal of overlap." (Guldberg, 2013) It is quite common knowledge that children of a specific age set will exhibit temper tantrums that could last a good while. The interpretation of the severity or, as stated in the APA's statement on this specific disorder, if the situation is overblown, is highly subjective to the person observing the behavior. (American Psychiatric Association, 2013) Subjectivity in medical terminology is like being vague in that the therapist has to do their own interpretation of the behavior based on their own preconceptions. This shows how vague the terminology used in the DSM-5 is and how easy it is to misinterpret behaviors as symptoms. Also stated in the quote by Christopher Lane is that there is a lot of overlap in the criterion for mental disorders. This again is a prime example of how the vague terminology used by the DSM-5 can lead to the misinterpretation of (possible) symptoms as something more severe than they really are. This is one of the reasons that the diagnosis rates of, for example, Bipolar Disorder have risen 40-fold in children and adolescents. (Moreno, Laje, Blanco, Jiang, Schmidt, Olfson, 2007) This just all goes to show that adult level

criteria for diagnoses do not aptly apply to children well and that there is urgency for the APA to create more diagnostic criteria or constraints to better fit the developing mind of a child.

There are however, a small selection of mental disorders in the DSM-5 that either have criteria pertaining to, or are targeted specifically at, children and adolescents. A few of these are Childhood Schizophrenia, Internet Gaming Disorder, Specific Learning Disorder, and Attention Deficit Disorder. (American Psychiatric Association, 2013) There are relatively few of these, a couple dozen at most, within the DSM-5. The specific mental disorders directly targeted at children are, in essence, a set of specific criteria that is given its own name for a diagnosis instead of being noted within the original criteria listed. If there currently are exceptions for a few specific mental disorders when diagnosing children, shouldn't this ethically be done across the board? The answer to that is yes. Yes, the DSM should properly identify specific criteria for children that are inappropriate or appropriate to apply and yes the DSM should do this with all mental disorders listed, it is entirely unethical to apply adult criteria to children and expect it to properly fit within the constraints and developing mind of a child. This issue alone encompasses the entire collection of ethical issues when diagnosing children with mental disorders as it covers all aspects of definition and treatment for children when dealing with any possible diagnoses. This ethical quandary leads directly into another that is centered on the possible mistreatment and damages that can be caused to children who are misdiagnosed with a mental disorder.

Social Labeling and the Medicinal Monster

One of the key dangers in misdiagnosing a child with a mental disorder is the amount of damage that can be caused by it to most, if not every aspect of their life. Their perception of themselves, how others treat them, the damaged caused by medication to their mind and body, and even their ability to properly go through school are tested and damaged by this negligence. On the topic of educational and social damages, Betsy Gunzelmann's book *Hidden Dangers: Subtle Signs of Failing Schools* gives some prime examples of how the language in the DSM and the lack of literature for diagnosing children leads to issues concerning children. The language and improper diagnostic criteria of the DSM-5 makes way for people to become amateur psychologists, regardless of the fact that they could be nowhere near qualified to make such judgments. Teachers and parents who find

that a child is a little more active than others or just doesn't want to deal with a child who has a lot of energy could claim that the child is hyperactive and suggest ADD/ADHD diagnosis and medicinal treatment. (Gunzelmann, 2012, p. 40) Now of course these accusations would then be brought up to a physician or therapist who would then refute or accept them based upon their observations and opinion. However, the report or the parents, teachers, and whomever else is involved has a part in the decision made by the therapist. These reports can easily have exaggerated numbers or the person reporting could have different definitions for the severity of the situation. This not only demonstrates the susceptibility of therapists to being lied to by exaggerated peer reports, but also the ease of which unqualified and mostly uninvolved people can insert themselves into a situation that could be nothing and damage it.

How does this have to do with educational or social damage? This type of amateur diagnosis "labels" the kid at their school. This labeling causes the school to recognize the child (or by the teacher at least) as someone who might need special attention or different treatment to properly go through school. (Gunzelmann, 2012, p. 63) This in turn will cause the child to be looked at differently by the other students (unfortunately), at least in the younger ages, and teachers as being different from them and even by some, socially unacceptable. Their behavior is watched over much more diligently and any outburst can be called another symptom of whatever diagnosis they were initially accused of. (Gunzelmann, 2012, pp. 61-64) On top of this, their special attention or treatment in the school can often lead them to being held back from advancing where they should because of a simple label that possibly does not even apply to them. It suppresses their ability to achieve in areas they can due to the generalization of mental disorders in school. (Gunzelmann, 2012, pp. 61-64) In all basic senses, children who are improperly diagnosed in their younger years are held back and are unfortunately looked down upon by others which keeps them from actively achieving or excelling at what they could if they were not labeled as they are.

Children are easily manipulated by labels and their adult peers who give assign them. There really is not too much that needs explaining in this as the initial description provides all of the necessary details. Children who are given labels are basically being told that there is something wrong with them and that they are different. This can potentially take a toll on their self-esteem and sense

of personal ability, leading to depression and other issues, even if the label is improperly applied. (Wedge, 2011) This and everything before can be even further damaged by medication.

Medication is one of the most dangerous effects that improper diagnosis can bring about. This will potentially cause physical and psychological harm to children who should not be being treated medically. Medication is a very difficult type of treatment to get right in the first place as the therapist who is prescribing it has to infer the correct dosage of medication from the child's behavior. The therapist then alters medication or dosage depending upon the outcome of the medication on the child's ability to function. Take for example, a study on the effects that Ritalin has on hyperactive children and their ability to learn. One of the outcomes showed that when 30% of children who were considered to be hyperactive were given this medication, adverse affects such as cognitive impairment were found. Similar effects were measured when a child is given too much medication; there is a good chance that the child will experience adverse affects as a result of the side effects from medication. (Swanson, Kinsbourne, Roberts, & Zucker, 1978) So even with children who have been screened and properly labeled as hyperactive, cognitive impairment and other effects from the medication given to them were still found, especially in those who have a dosage that is considered to be too high for them.

While that was a study on the impairment caused by this medication to children who are known to have a hyperactive disorder, it can still be applied to children without this. Research such as this allows for inferences to be made about the possible outcomes of medication on children who are improperly diagnosed with a mental disorder. When children are given too much medication, side effects are more likely to happen as demonstrated in the study above; so what happens when a child who requires no medication or a different type of medication is given it? The side effects are even worse. Again, take the example of Ritalin from the study on hyperactive children, when a child is given too much (or in the case of this argument, given it at all), the possibility of cognitive impairment is quite high. So the medication ends up harming the child mentally instead of the intended effect of helping them. The same can be said about what the medication can do to the child physically as well. This medication has the ability to interfere with a child's everyday physical activities with side effects such as nausea, sleepiness, and numbing. (American Society of Health-

System Pharmacists, 2014) While side effects are generally rare, children can be more susceptible to them due to their age and developing bodily systems. These effects are however, much rarer than mental impairment as with most medications.

One of the many reasons psychotherapists work in this field is to help people get better and live with their mental issues if they have them. One of the many tenants of being a doctor is to help people rather than harm them with treatment. As anyone could infer based off of the actions of doctors in general, the early detection of any illness and the treatment of said illness helps people both immediately and later in life. (Casey & Berman, 1985) Why else would this be a modern practice? However, as stated many times before, the misdiagnosis and unnecessary treatment due to the misinterpretation of vague and poor criteria surrounding children in the DSM-5 causes a lot of harm as well. If this is all understood, then why is there little to no movement in the stricter definition and criteria of diagnosis of mental illness in children? The harm brought to these children runs entirely opposite to the tenants of psychotherapy and treatment; it is an entirely unethical practice in the field of medicine and psychology. Children are being hurt and something needs to be done about it.

Possible Solutions & Conclusion

The research and development of possible solutions to this issue have been a topic for a good while now; however, it has made very little headway in the redefinition of mental disorders as listed in the DSM's many revisions. The current state of the identification and treatment of childhood mental disorders is lacking in literature and refinement. In order to fix this, the first step would be research into and identification of the symptoms or definition of symptoms to apply to children who are facing a possible diagnosis of a mental illness. Many of the criterions simply do not apply well to children and adolescents who are still developing and have an explanation for their fluctuating behavior status. An example of this can be seen with children who have a lot of energy at a young age. It is quite common for children in their younger years to have a lot of energy and a need to expend it; however it is entirely possible for a therapist or peer to mistake this type of behavior as hyperactivity and a symptom for a mental disorder. The second step would be to clean up the language in the DSM to be much more precise and less vague as to allow for a more accurate

diagnosis. The current language used in the DSM is completely subject to how the therapist or person identifying the mental disorder interprets it. This causes a great deal of confusion because what is severe to someone may be mild or moderate to another, thus failing to meet requirements of a specific disorder or meeting another that is much more severe. Language subjectivity is one of the DSM-5's largest problems.

The third step would be the identification, definition, and testing of the different treatment options available to children. According to Kazdin and Weisz's article *Identifying and Developing Empirically Supported Child and Adolescent Treatments*, a vast majority of treatments for children and adolescents have not been investigated thoroughly or at all. (Kazdin & Weisz, 1988) This cannot go on. If a treatment is not proven to work, how is it possible to know that it is actually treating the issue in the first place instead of just covering it up? This problem is what leads to the harm that poor treatment for misdiagnosed children deal with. This issue of harm from treatment is, as said before, caused by the poor language and literature concerning children in all versions of the DSM. The last step would be the implementation of this research into the DSM and its future versions. This can be done in a large variety of ways, the best of which are either amendments to the DSM-5 that, in the next revision, are implemented into the book, or as an entirely separate manual release that pertains entirely to children and adolescents. Of those two, the entirely separate manual is the most attractive the DSM would become less convoluted and thick than it would be with the potentially large amount of child based definitions and treatment.

The current state of the DSM is horrible when diagnosing and treating children with mental illness. Its vague language and general application of adult diagnostic criteria to children makes way for a variety of ethical quandaries that cause harm to children every day. Is it ethical to have a few specific disorders for children and then apply adult diagnoses to them as if they were not still developing? No, it is entirely unethical. It ignores everything that is known about their developmental patterns today. Is it ethical to continue diagnosing and labeling children while having full knowledge that these psychiatric illnesses are easily misdiagnosed due to poor interpretation of language and diagnostic criteria? No. Finally, is it ethical to continue treating children with unproven psychiatric treatment and medication when it can potentially cause harm if the child is

misdiagnosed with a disorder or the treatment doesn't actually treat what it is thought to be treating? Absolutely not, it goes against everything that psychotherapists strive to do in their field. Although this is not true for all medications and treatments, as stated before: a majority of treatments and medicinal interventions have yet to be fully investigated or tested specifically with children. This clearly presents a potentially dangerous and particularly troublesome issue, Solutions need to be made to mend these disturbingly dangerous issues in order to better protect, treat, and help children. These solutions could come in the form of amendments to the DSM or an entirely separate manual but whatever the solution ends up being, it has to happen.

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