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A CRITICAL HISTORICAL ANALYSIS OF ADOLESCENT DIAGNOSTIC
BEHAVIORALLY BASED DISORDERS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree
Doctor of Philosophy
in the Graduate School of the Ohio State University

By

Christopher A. Mallett, MSW

*****

The Ohio State University
1999

Dissertation Committee

Professor Keith Kilty, Adviser
Professor Virginia Richardson
Professor Tom Gregoire

Approved by

Social Work Department
ABSTRACT

Social Construction and Critical Theory have both in the past been utilized as basis of analysis on systems and mental health diagnosis within the field. This research incorporates these theoretical perspectives in reviewing the historical development of adolescent behaviorally based disorders. The most prevalent diagnostic categories were identified through epidemiological research and included both Conduct and Oppositional Defiant Disorders. A critical historical analysis (historiography) researched the past one-hundred years focused on the following areas: originations and changes in the diagnostic system's classifications of these two disorders, associations involved in impacting these changes, clinical studies identified as supporting these diagnostic categories, key individuals who emerged from this historical search and funding sources that impacted the changes over time.

The first half of the research time period finds a number of categorizations and associations affiliated with differing nosologies as important in the development of these behaviorally based
diagnosis. However, the predominance of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) began to emerge after 1968. A handful of individuals played a key role in the development of these diagnostic categories and their influence can be seen in the associations as well as the clinical studies that were analyzed and cited as supportive of the categorizations. It is concluded that a small number of individuals, groups and locations have had an inordinate amount of influence on the knowledge purported to be supporting the utilization and categorization of these two mental health diagnostic categories for adolescents. Yet it is also seen that these diagnostic categories changed little over the past fifty years and that this impact has been confirmatory and professionally political in nature.
ACKNOWLEDGMENTS

I owe my motivation, drive and dedication toward this degree to both my Mom and Dad who have instilled in me what it takes to replicate their phenomenal academic and professional achievements – Thanks for being who you are.

I would like to thank Dr. Keith Kilty for his time, intellect, attention and, unbeknownst to him, the motivation that his perspectives and views have given me over the past three years.

I also thank and give reciprocities (if this is possible) to those other individuals who have been involved in this process (both professionally and personally) - you know who you are.
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FIELDS OF STUDY

Major Field: Social Work
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Chapter 1

General Purpose/Goals

The purpose of this writing is to investigate and establish what we know about the most prevalent psychiatric diagnostic labels for adolescents and how this “knowledge” has emerged over time. Psychiatry, as a field of medicine, emerged as a distinct area of practice during the middle to end of the eighteenth century. This historical focus will begin the inquiry during the later decades of the 1800’s to coincide with the emergence of mental health as a conceptual entity, the emergence of Social Work as a profession and the recognition of adolescence as a growing distinctive developmental time period. This inquiry adheres to the perspective that there exist differing roles for diagnosis and differing perspectives in the mental health field as to the utilization and application of diagnosis. This investigation begins with an overview of the diagnostic system currently utilized in the United States as a benchmark for mental health diagnosis (the Diagnostic and Statistical Manual of Mental Disorders) and sets into context this system that has emerged over time.

After establishing this contextual and historical benchmark of the prevalent diagnostic system for mental health, the focus will be on the field of adolescence and diagnosis that are most prevalent. From the identification of most prevalent diagnostic categories, an investigation into the history of these adolescent diagnostic categories is to be asked through appropriate research questions searching historically over the past
century. The purpose is to establish what is known and how this knowledge was acquired regarding the history of these adolescent psychiatric categories/disorders.

Thematic and specific goals of this project include a search to understand the historical development of these adolescent psychiatric categories and nosologies that have emerged over this time period and have become as integral as these categories are within the current mental health system. The subtheme of this goal is to understand what background/knowledge/research and support that exists, for this current adolescent mental health diagnostic system.

A second goal for this research is to identify key times, themes, individuals, and organizations that have had significant influence on the history of adolescent diagnosis and diagnostic nosologies. Through analysis of the past century of diagnostic and mental health psychiatric development, this goal is to determine what influences on this area within these organizations or individuals that exist(ed), in the accumulation of this knowledge.

A third goal is to bring to the literature a clearer knowledge of the history and development of the most highly prevalent adolescent disorders (categories) as defined today through the Diagnostic and Statistical Manual of Mental Disorders (1952, 1968, 1980, 1987, 1994). There currently exists no comparable study or research asking these questions of the mental health field or toward the acquisition of this knowledge.

Problem Statement/Area

This writing is an investigation into the historical development of adolescent psychiatric diagnostic categories. Psychiatric diagnosis is a powerful tool utilized within
the mental health treatment of adolescents and has become an unavoidable component for social workers and mental health professionals in the field. Psychiatric diagnosis has become omnipresent for adolescents within the mental health system and is imperative in many situations for funding sources to be accessed, and for treatment professionals to work with this population within both public and private settings (see Frank and Manning, 1992, “Economics and Mental Health”). The range of impact that these psychiatric diagnoses has on the individual is debatably broad, ranging from clinically necessary (DSM, APA; 1980) to inconsequential (Cantwell, 1973) to harmful (Szasz, 1963 - 1994).

The social work field has worked with youth since the inception of our profession. Beginning from the settlement house days through numerous changing foci of our work, one constant has been the prevalence of “at risk” youth (see Platt, 1976). Although the adolescent population represents a small percentage of professional time within social work, this group is arguably one of the most vulnerable. With societal pressures, changes and challenges affecting this group, many adolescents experience a difficult developmental time (see Grotevant and Cooper, 1983; Allison and Sabatelli, 1988; Anderson and Fleming, 1986; and Shapiro, 1988).

In those situations where adolescent developmental difficulties become more extreme and merge with the mental health field for assistance, another level of challenge exists for the youth. Within the mental health field, assumptions toward these difficulties arise from differing fields and perspectives. Different professions and trainings in the field bring distinctly differing frameworks to the analysis of mental illness and correspondingly different prescriptions of cause, effect and outcome. In addition, an
inordinate percentage of mental health dollars originates from public sources and is designated toward child welfare dollars. These child welfare dollars have merged extensively with the mental health field for qualification and access (Chaiklin, 1993).

It is important as social work/mental health professionals that we understand fully the tools that are utilized as interventions within the field. To incorporate in treatment planning the use of psychiatric diagnosis and the impact this has on the direction of treatment, it is imperative that as individual workers we understand and know as much as possible concerning these dimensions of our work. If we are to work with adolescents (or it can be argued any other population group) with mental health/emotional difficulties, then we must be cognizant of the tools that we are incorporating in the treatment. This writing is asking the question of what do we know of this area and how did we come to gather this knowledge. This is not a question of whether diagnosis for adolescents is accurate, nor whether certain diagnoses are more or less helpful to the professional and/or adolescent. It is a question of if psychiatric diagnosis are utilized in the mental health workers care for adolescents, how have we come to understand this area of therapeutic knowledge.

There is debate as to the appropriate role diagnosis should have in mental health treatment (see for example Turner’s “Social Work Treatment”, 1996, and the wide array of differing therapeutic options). A problem arises when this area of treatment planning (psychiatric diagnosis) becomes inordinately important in guiding interventions as is argued by Szasz (1994) and Restivo (1988). The problem for the social work field is that historically we use tools/interventions without knowing what supports this “fad” like usage (see Dumont, 1984; Restivo, 1988).
There is much literature addressing the area of mental illness and/or mental disorders. Supporters of the system site vast documentation of individual diagnostic categories supporting the proliferation of disorders over the past thirty years (DSM, 1980, 1987, 1994); while other authors view mental illness as a social construction warped through cultural, economic and power/territorial influences. It is this latter critical perspective that has evidenced a need and supports a continued exploration into understanding more clearly the area of mental illness/disorders via a specific population. Working on the basis that some of our knowledge and information about psychiatric diagnosis is explained and understood through these forces of culture and society, then our field has a duty and professional obligation to more fully understand this area.

Knowledge Acquisition

Knowledge is acquired through numerous methodologies, frameworks and strategies across many fields of research, academics and professions. Knowledge is defined through empirical measures differentiated by the methodologies employed.

This knowledge can be defined through quantitative, qualitative, post-modern and other frameworks reliant on the perspective of the researcher and goals of the research. This research project will be utilizing a qualitative historiographical methodology supported by critical and social construction theory in the search for new understanding of this topic.

The Diagnostic and Statistical Manual of Mental Disorders

From the 1800’s through the middle of the 1960’s, there did not exist a
predominant psychiatric diagnostic system utilized in the United States. However, there
was, beginning at the turn of the 19th century, numerous differing nosological systems
incorporated in different areas of the country. In some areas diagnostic systems were
endorsed through state and governmental agencies for utilization in institutional care,
while others were primarily designed and implemented only in certain hospital
organizations, educational institutions or localities. Organizations (or structures) of
diagnostic systems remained within this state of decentralization through the second
World War in the 1940’s, when federal governmental agencies needed to became
involved in responding to the needs of veterans and survivors of this war (Malinowski,
1954).

There was a shift in psychiatry from an institutionalized system of care toward a
community-based approach in the field when it was realized that the diagnostic systems
and treatments incorporated were relatively inadequate during and after World War II,
and that psychiatric ailments were not always permanent (see Henderson and Gillespie,
1959). There was also increasing discontent with the dehumanization of long-term
psychiatric institutionalization of patients. The focus after World War II on community
psychiatry allowed the field an ability to expand its work and focus for the next two
decades.

Psychiatry had before this time (prior to World War II) been relegated to a less
rigorous, and by some, as a subcategory within the field and practice of medicine. This
“step-sibling” perception by many in the field of medicine now had an opportunity to
reshape its work by moving from the focus on institutional care to the larger community-
based audience and field.
These changes are also mirrored by the merging of numerous membership organizations representing the field of psychiatry into a more predominant organization titled the American Psychiatric Association. This organization significantly grew in membership numbers and synthesized numerous nosological categorizations (from the 1920's and 1950's), changing titles numerous times in the publishing process, until the title "Diagnostic and Statistical Manual of Mental Disorders" was printed by the American Psychiatric Association in 1952.

This first edition of the Diagnostic and Statistical Manual was not a significant event and continued along with numerous other diagnostic systems to have been utilized throughout the country (Wakefield, 1992). The same can be stated for the introduction of the Diagnostic and Statistical Manual of Mental Disorders-II in 1968. This Manual represented a doubling of the number of diagnostic categories that could be utilized and a more significant contribution by the American Psychiatric Association in production of this Manual. There was reportedly increased utilization of this Manual (DSM-III, 1980), although this is difficult to quantify during this time period.

During the 1970's, the American Psychiatric Association made a concerted effort to change this diagnostic system of diagnosis from its then current (1968) dynamic definition to a descriptive categorization of disorders. This was accomplished through the introduction of the Diagnostic and Statistical Manual of Mental Disorders-III in 1980. This change in nosology typology also significantly increased the number of diagnoses available for utilization, and circulation of this Manual was ten-fold the earlier version published (APA, 1987). Our current knowledge of the mental illness field has been defined through the Diagnostic and Statistical Manual of Mental Disorders-III, the next
revision DSM-III-R, (APA, 1987) and DSM-IV (APA, 1994), which were by this time now published through a separate entity of the APA, the American Psychiatric Press.

The DSM-III-R and DSM-IV versions continue to categorize disorders through the descriptive typology, setting out categorical criteria for diagnostic threshold through the meeting of certain levels of characteristic and behavioral benchmarks. These latest two DSM versions increased the number of available diagnostic disorders upwards to 350 separate categories, as well as a significant growth in the number of disorders specifically for children and adolescents (under age 18). What separates these latter three Diagnostic and Statistical Manuals (APA, 1980, 1987 and 1994) was the tremendous reception that they received from the mental health and medical field, as well as the corresponding need for treatment services to be offered only in correspondence with an appropriate DSM diagnostic category (Wakefield, 1992).

Within the field of mental health, there are distinct differences among factions as to the conceptualization of the DSM versions. Within psychiatry, the concept of diagnosis has a long and supported history of usage in treatment for the individual. The field of psychiatry's originations in psychoanalytic (and later broadened to psychodynamic) theories and concepts fits well with this focus on individual psychopathology. The DSM diagnosis of the individual and subsequent "deviant" or "abnormal" outcome of these diagnostic categories conforms to these psychiatric frameworks, in addition to the influence of operating within the field of medicine and search for causal explanation. Of course with any field of inquiry, unanimity is unattainable, and there are differing factions along the spectrum within psychiatry supporting these nosologies (examples include the dissension of the Group for the

Psychology can also be categorized within a psychodynamic perspective within mental health, yet also has a significantly wider spectrum of inclusions in perspectives. In addition to diagnosis, there are many additional tools utilized within this field. These tools incorporate developmental levels, cognitive and emotive testing and place this information within a larger context. This field also works with youth in a myriad of settings and under numerous titles.

The social work field brings a significantly different perspective to the field of mental health diagnosis. Social work’s history incorporated two different tracks including settlement houses (community-based work of Jane Adams) and Mary Richmond’s influence incorporating diagnostic perspectives in working with individuals. Over time, the field has utilized a variety of changed perspectives; however, over the past few decades has theoretically incorporated the individual as one component in the analysis of the family, society, culture and system within which the individual presently lives. A connecting theme also includes a focus of work with the disadvantaged within society.

Among adolescents, these fields perspectives differ with psychiatry’s focus on treating individuals as singular entities struggling with mental constraints deemed to be distinct mental health disorders. Social work tends to perceive the adolescent as an individual within a system including family, culture, development and any other domain that is claimed to be affecting the adolescent.
Adolescence and Mental Illness

The concept and theoretical support of adolescence as a distinct developmental time period utilized for this historical analysis (which is to date back over one hundred years) is supported in the literature by four authors.

Anthony Platt (1975) published discussions and descriptions of the formation of the juvenile justice system and the differentiation of this age category as distinct. Platt comments that the juvenile court system was part of a general movement removing adolescents from punishment-oriented plans toward being dependent on others and victims of neglected care. Massachusetts and New York passed laws (1874 and 1899) calling for separate trials for minors and Illinois set up the first official juvenile court in 1899. By 1917, all but three states in the country had passed juvenile court laws (Platt, 1975). There were also other laws passed in the early 1800’s treating criminal acts by children differently than by adults. Important in the development of these movements were what Platt terms “child savers”, individuals and organizations focused on securing rights and placing dependency children and adolescents upon others. Platt comments also on the development of the reformatory in the mid-1800’s as discipline and differentiating treatment for this age category.

The second author, Robert Church (1976) writes of the historical development of the high school. This author’s writing reinforces this developmental time frame as continuing the differentiation of this age category of adolescence. For with the explosive growth and utilization of high schools, more adolescents were moving from a work world to continued years in school. Church points to the explosive growth (nine-fold increase over three decades) beginning in 1890 for this secondary education, and its rise as the
preeminent domain of being the most important and progressive niche of education.

Coinciding with Church was Joel Spring (1964) who reinforced the importance of this era in education and differentiation and focus on this age group.

G. Stanley Hall (1904) wrote of this age and development time for adolescents within sociology and published extensively contending that this age category was different from childhood and young adulthood on numerous tenets. These included the notions of self-consciousness, vanity, showing off, desire of independence, planning for life, social organizations impact, and other areas different and unique to adolescence.

These authors' writings show support from an educational, sociological, developmental, and punitive system perspective in supporting research that is planning on an historical analysis beginning at the end of the eighteenth century, through the next one hundred years, setting this age category of adolescence as a unique and appropriate age differentiation. This research will be applying the concept of "mental illness" to this age group and finds support in the literature from these authors in differentiating adolescence as a unique entity.

Research on Adolescent Psychiatric Diagnostic Prevalence Rates

Worldwide, ICD-9, Behavior Rating Checklists (parents and teachers) and DSM designs comprise the tools utilized in reporting emotional and behavioral difficulties for adolescents. Outside the United States, studies have been conducted in New Zealand (Feehan, 1992; McGee and Williams, 1990 and 1991), Canada (Offord, 1989), London (Quitton and Rutter, 1985), Puerto Rico (Bird, 1990-1991) and Germany (Esser and Schmidt, 1990). Stated prevalence rates from these studies range widely from 16%
(Quitton, 1985) to 37% (Feehan, 1993) to 49.5% (Bird, 1988) within each of their respective cultures. Bird comments on the difficulty in accumulating accurate cross-cultural data. "The fact remains . . . that the findings from these epidemiological studies are widely divergent and it is impossible to tell whether the large differences that exist reflect the fact that there are more disturbed children in one setting than another or are purely the reflections of methodological differences" (Bird, 1995).

Within the United States,

a minimum of 7.5 million, or at least 12% of the 63 million children . . . are in need of mental health services for emotional or other problems. The 3 million of those children (40%) are of such degree and persistence that they are identified as “serious” or “severe”. Some estimates are even higher, suggesting that possibly as many as 9.5 million children, or 15% of America’s children, in need of mental health treatment may not be receiving appropriate services (Regional Research Institute, Portland, 1990).

The Statistical Records of Children finds an adolescent emotional disorder prevalence rate to equal 18.5% of all children aged 12 - 17 (DSM Axis I disorder), while 22% of these reported problems emerge during this age period (Schmittroth, 1994, p. 436 - 441).

The Journal of the American Academy of Child and Adolescent Psychiatry found a prevalence rate to be not less than 11.8% (Schwartz-Gould, 1981). These numbers originated from the U.S. Department of Health and Human Services "Vital and Health Statistics of the National Consortium for Health Statistics" and a limited accumulation of information compiled through various interest group organizations (Children’s Defense Fund), and quasi-governmental clearinghouses citing a small number of regional and local studies conducted by independent researchers.

DSM mental health diagnosis of adolescents vary widely. Epidemiological studies have been blocked through “the absence of a common language in matters of case
definition, diagnostic criteria and classification of data; the lack of agreed, standardized, widely acceptable, and reliable assessment tools; and the lack of common analytic techniques and uniform ways of data presentation” (Costello, p. 836). A handful of researchers in this country have categorized adolescent DSM diagnosis with diverse results.

Over the past 15 years, eight study results have been published in the United States (Cohen, 1992; Kashani, 1986; Anderson, 1993; Costello, 1988 and 1989; Whitaker, 1990; Velez, 1988; and Reinherz, 1992) searching exclusively for DSM III, III-R and IV diagnostic mental health prevalence rates for adolescents aged 13 to 18. These studies vary as to their design, techniques for data gathering, location and populations examined, reported reliability, validity and replicability, yet published the following results:
1 - Separation Anxiety/ADHD (10.32% mild; 9.7% moderate; 58.0% severe)
2 - Overanxious Disorder (3.3%; 8.6%; 17.25%)
3 - Conduct Disorder (3.1%; 7.8%; 13.9%) N = 734
4 - Oppositional Disorder (3.2%; 5.9%; 8.9%) Ages 10 - 14
5 - Alcohol Abuse (none; 22.7%; 17.7%) 2.5 year study


<table>
<thead>
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<th>Age 10 - 13</th>
<th>Age 14 - 16</th>
<th>Age 17 - 20</th>
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<td>B - 12.8%</td>
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<td>5.4%</td>
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<td></td>
<td>G - 15.4%</td>
<td>14.1%</td>
<td>13.8%</td>
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<tr>
<td>Separation</td>
<td>B - 11.4%</td>
<td>1.2%</td>
<td>2.7%</td>
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<tr>
<td></td>
<td>G - 13.1%</td>
<td>4.6%</td>
<td>1.8%</td>
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<tr>
<td>Major Depression</td>
<td>B - 1.8%</td>
<td>1.6%</td>
<td>2.7%</td>
</tr>
<tr>
<td></td>
<td>G - 2.3%</td>
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<td>ADD/ADHD</td>
<td>B - 17.1%</td>
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<td>5.8%</td>
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<td></td>
<td>G - 8.5%</td>
<td>6.5%</td>
<td>6.2%</td>
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<td>Conduct Disorder</td>
<td>B - 16.0%</td>
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<td>9.5%</td>
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<td>G - 3.8%</td>
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<td>B - 14.2%</td>
<td>15.4%</td>
<td>12.2%</td>
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<td></td>
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<td></td>
<td>G - 0</td>
<td>3.1%</td>
<td>8.9%</td>
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1 - Anxiety Disorders (8.7%) Columbia, Missouri
2 - Conduct Disorders (8.7%) N = 150
3 - Depression (8.0) Ages 14 - 16 with 18.7% diagnosis
4 - Oppositional Disorder (6.0%) 15% sample
5 - Alcohol/Drug Abuse (6.0%) 72.4% response rate
6 - ADD/ADHD (6.0%)

1 - Anxiety Disorders Pittsburgh
2 - Oppositional and Conduct Disorders 22.0% ± 3.4%
3 - ADD/ADHD N = 300
4 - Compulsive Disorder
5 - Depression

1 - Dysthymic Disorders (4.9%) N = 356
2 - Major Depression (4.0%) Ages 15 - 18
3 - Generalized Anxiety Disorder (3.7%) Categories chosen by raters.
4 - Bulimia (2.5%) All more common in girls.
5 - OCD (1.9%) No externalizing disorders included.
6 - Panic Disorder (.6%)
7 - Anorexia Nervosa (.2%)


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<th>Time 1</th>
<th>Time 2</th>
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<tr>
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<td>Age</td>
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<td>9 - 12</td>
<td>13 - 18</td>
<td>11 - 14</td>
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<tr>
<td>1 - Oppositional Dis.</td>
<td>15.6%</td>
<td>18.6%</td>
<td>22.5%</td>
</tr>
<tr>
<td>2 - Conduct Dis.</td>
<td>11.9%</td>
<td>11.6%</td>
<td>10.9%</td>
</tr>
<tr>
<td>3 - Overanxious Dis.</td>
<td>19.1%</td>
<td>12.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>4 - ADD/ADHD</td>
<td>16.6%</td>
<td>9.9%</td>
<td>12.8%</td>
</tr>
<tr>
<td>5 - Separation Anx.</td>
<td>25.6%</td>
<td>6.8%</td>
<td>15.3%</td>
</tr>
<tr>
<td>6 - Major Depression</td>
<td>2.5%</td>
<td>3.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>One or More</td>
<td>19.4%</td>
<td>16.4%</td>
<td>15.6%</td>
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a - significantly more males than females
b - significantly more females than males

New York State
Ages 9 - 18
Prevalence = 17.7% N = 776


<table>
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<th>Disorder</th>
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<td>1 - ADD/ADHD</td>
<td>6.7%</td>
</tr>
<tr>
<td>2 - Oppositional Dis.</td>
<td>5.7%</td>
</tr>
<tr>
<td>3 - Conduct Dis.</td>
<td>3.4%</td>
</tr>
<tr>
<td>4 - Separation Dis.</td>
<td>3.5%</td>
</tr>
<tr>
<td>5 - Overanxious Dis.</td>
<td>2.9%</td>
</tr>
<tr>
<td>6 - Simple Phobia</td>
<td>2.4%</td>
</tr>
<tr>
<td>7 - Depression</td>
<td>1.8%</td>
</tr>
<tr>
<td>One or More</td>
<td>17.6%</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Alcohol Abuse (32.4%)</td>
<td>(Gender bias)</td>
</tr>
<tr>
<td>2 - Phobias (22.8%)</td>
<td>(Socioeconomic bias)</td>
</tr>
<tr>
<td>3 - Drug Abuse (9.8%)</td>
<td>(Socioeconomic bias)</td>
</tr>
<tr>
<td>4 - Major Depression (9.4%)</td>
<td>(Gender and Socioeconomic bias)</td>
</tr>
<tr>
<td>5 - Post Traumatic Stress Disorder (6.3%)</td>
<td>(Gender bias)</td>
</tr>
<tr>
<td>6 - OCD (2.1%)</td>
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</table>

Table 1.1 Epidimiological Studies of Adolescent Disorders within the United States (post 1980)
A rank order analysis of these results finds the most common Diagnostic and Statistical Manual of Mental Disorders-IV diagnosis and definitions for adolescents to be:

1. **Oppositional Defiant Disorder (ODD):** a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months and is characterized by the frequent occurrence of at least four of the following behaviors: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, being angry and resentful or being spiteful or vindictive (DSM-IV, p. 91).

2. **Conduct Disorder (CD):** a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months: aggression to people or animals, destruction of property, deceitfulness or theft, or serious violations of rules (DSM-IV, p. 85).

Research Questions

This writing proposes an investigation into these specific diagnostic categories/disorders identified through the analysis of this epidemiological data focusing on the limited population group (adolescents), and to research how these most prevalent diagnostic categories have evolved over the past one-hundred years.

The mental health field has experienced an exponential growth of documentation into specific diagnostic categories as well as an increase from 50 to over 350 individual diagnostic categories listed as disorders within the most recent revision of the DSM. One of the largest increases of diagnostic research has occurred within the childhood and adolescent diagnostic categories, and it is within this field of published discourse with which this research is focused.
The research question asks what are the originations of the most prevalent psychiatric diagnostic labels for children and adolescents (Conduct Disorder/Oppositional Defiant Disorder) and how was this knowledge acquired? A follow up question asks what influences and factors have impacted these diagnostic categories over time? A time frame of approximately one-hundred years is chosen to mirror the growth and development of the modern psychiatric field, conception of mental health, emergence of adolescence as a distinct developmental time period and later the introduction and impact of the utilization of the Diagnostic and Statistical Manual of Mental Disorders - the current guidepost for diagnostic categorization.
Chapter 2
Conceptual Framework

Critical Theory

Originations of this theoretical perspective come from what is referred to by some as the metatheory of critical social science. This theory is an attempt to understand rationally and responsibly the manner of oppressive societal features, with the goal of transforming society and finding liberation for the individual. A trio of theorists were responsible for the formation of contemporary sociology (Karl Marx, Max Weber and Emile Durkheim), with the first two individuals to have had a most influential role and impact on critical theory formation (Agger, 1979). Both of these theorists were concerned with the conflictual features of capitalist society and contradictions this placed on the individual. The role of this theory in Marxism was to be a catalyst in overthrowing capitalist society and ushering in communist society, not through understanding society philosophically, but through changing societal structure.

The term critical theory originated from the Frankfurt School in Germany during the 1920’s and 1930’s (Jay, 1973). The social theorists most connected to this school of thought have included a number of often referenced sources and individuals including Max Horkheimer (“The Eclipse of Reason”, 1974), Herbert Marcuse (“Eros and Civilization”, 1969), Theodor Adorno (“Dialectic of Enlightenment”, 1972) Jurgen
Habermas ("Legitimation Crisis", 1975) and Clas Offe ("Contradictions of the Welfare State", 1984). From these authors (as well as other less prominent writers) emerges the theory supporting the gaining of individual self-knowledge. This self-knowledge is inextricably intertwined with the workings of society, and through the education of the individual the oppressed find ways of understanding their capacity to change this situation. This theory is an action-based theory predicated on a Marxian ideal of not simply philosophizing life situations but about making substantial changes. Marxian ideals prescribe this as building toward a revolutionary change.

Critical theory proposed that an alternative conception of social science be required, incorporating both the historical totality of society and the belief that this analysis could not be indifferent, value-free and should engage within the process of change (Morrow, 1994). This theory presents an "attitude of antagonism and critique in the face of deeply problematic contemporary social formation" (Poster, p. 3, 1989). Conceptually there is a focus on viewing society as transitory and fallible in any given moment and this potential disassembly may lead to improvement for the individual. This theory disagrees with the legitimizing process of power formations for institutions, in continuing with the goal of alleviating the suffering of individuals.

Habermas (in McCarthy, 1978) expanded this theoretical sphere to include a more specific focus on questioning. He introduced a definition of "public sphere" separate from the private interests as a medium of reform; argued that in capitalism the state enters the economy and puts in crisis the legitimacy of the state by politicizing economic issues; claims that science is integrated into the economy and becomes part of the ideology; and pursues a revision for increased public discussion and consciousness.
Utilizing theoretical perspectives of this larger context in searching for societal and cultural impacts within a capitalist framework, a number of authors, discussed in the next section, have written of this perspective in relation to psychiatric concepts.

**Critical/Social Construction Theory Applied to Psychiatric Concepts**

Incorporating social and cultural impact upon mental health and psychiatric concepts, these authors comment on how critical theory perspectives assist in understanding the knowledge created.

Critical theory brings to question how the larger institutions within medicine/psychiatry are impacting the individual with which psychiatric diagnosis is prescribed. This critical perspective is supported by Blumer (1962) who as a proponent of symbolic interaction, incorporated the philosophies and writings of Mead. The term "symbolic interaction" refers to interaction between individuals. The uniqueness of this view is that "fact that human beings interpret or define each other’s actions instead of merely reacting . . . based on the meaning which they attach . . . human interaction is mediated by the use of symbols, by interpretations" (Rose, p. 180). Critical theory questions how the larger societal framework impacts these interpretations.

Thomas Hobbes believed that the ultimate power is the power to make definitions. Others have questioned the process of defining mental illness/disorders as a system (Szasz; Dumont, 1984 and 1987; Kirk and Kutchins, 1991 and 1994) and this area of questioning has over the past three decades had intermittent influence on this debate. This is an important perspective and usage of this theoretical base for this research, not only because there exists little in the literature focused on adolescent diagnosis within
this theoretical concept, but for the more obvious and apparent practice implications. As discussed earlier, the social work profession has over the past century of "service" defined itself through differing eclectic frameworks, much influenced through the cultural forces of the times (Szasz, 1994, p. 34).

There exists an underlying principle and absorbed value within a capitalist culture that strongly dictates toward self-determinism, independence and self-reliance; alongside a focus on the individual as not only the designer of their actions but also responsible for their difficulties (Weber). When individual actions and reactions to living lead to actions deemed unacceptable, there is a cultural construction within society aiding in this definition process (Descartes, Szasz, 1994). It is this focus on the individual as being responsible for their living situations supported by the foundation of "modern science" and "psychiatric knowledge" utilizing "known facts" that is argued to exist as a powerful cultural influence on the acceptance of the DSM diagnostic system. A system itself which identifies the individual as the person with a "disorder". The question more poignantly asked through this critical perspective is how are we certain that mental illness/disorders exist as we believe or perceive of them to be. Some authors have both directly and indirectly asked this question.

Adam Smith first forwarded the concept that scientific concepts are inventions of the imagination in his "History of Astronomy", published in 1790. "To the discoverer... the constructions of his imagination appear so necessary and so natural that he is apt to treat them not as the creations of his own thought but as given realities" (Eisenberg, 1988, p. 2). Writing in the 1930's, Fleck (1935) claimed that many very solidly established scientific facts are undeniably linked, in their development, to prescientific,
somewhat hazy, related pre-ideas and that even the modern concept of disease entity is an outcome of such a development and by no means the only logical possibility. Fleck claims that history shows it is feasible to introduce completely different classifications of diseases,

... facts are like cows. If you look them in the face hard enough, they generally run away... The etymology of the word fact reveals it as that which has been made, in accord with its root in the Latin facere, to make. Yet we tend to think of facts as given entities, not fabrications (Stehr and Meja, 1984, p. 223-225).

Dumont took this further in that we have been trained to believe that knowledge arises from a process of drawing lines, making distinctions, of seeing meaning as a definition (Dumont, 1984). Szasz wonders if these categories are created, and not discovered, how is the field certain that the field of mental illness has gotten these things in the correct classes (Szasz, 1963). Malinowski (1954) predates these authors and points to the interconnections of magic (as a precursor) to science, and finds that magic is akin to science in that it always has a definite aim intimately associated with human instincts, needs, pursuits, and is governed by theory.

Dumont (in Phillips, 1974) continues this questioning of knowledge of this field and believes that facts are dependent on interpretation within a certain space and milieu. This is concurred with by Gould (1981) who points out that culture influences what we see and how we see it and the difficulty of facts being distinct entities. Specific to the field of psychiatry, Conrad (1980) points out that the belief in medicine is the society's way of assisting in warding off collective fears and public anxieties. Horwitz (1982) concurs that labeling, rather than denial of mental illness, is the typical response of professionals to unusual behavior.
C. Wright Mills postulated that capitalism's economics has a powerful influence on the debate of the usefulness and appropriateness of science in society and believed the "conception of modern science (to be) a subordinate part of the wasteful absurdities of capitalism" (Restivo, 1987, p. 7). It was continued that the power elite had managed to institutionalize deviant behavior through this empirical cloak. "Science has become the major establishment in the American political system . . . the only set of institutions for which tax funds are appropriated almost in faith, under concordats which protect the autonomy, if not the cloistered calm of the laboratory" (Lessel, 1988, p. 18). More recently, Dixon (1984) theorizes these economic motivators within science impact social construction, for the increasingly central economic importance of science gives it a political significance that is lost in debates that focus on how it is applied to socially desirable or undesirable ends. Latour (1984) agrees that this scientific exploration and explanation race is so expensive that only a few institutions or professions are able to sustain it. This then restricts who can be involved in the production of facts and severely limits the time frame of this involvement.

Criticism within the laboratory finds that the scientist "rarely attributes a deviation of results from expectations to sampling variability, because he finds a causal explanation for any discrepancy. Thus, he has little opportunity to recognize sampling variability in action. His belief in the law of small numbers, therefore, will forever remain intact" (Kahneman, 1982, p. 29). This practice of social organization is then extremely difficult to change with career risk for individuals tied to certain lines of inquiry and the direction or pathway of research (Dumont, 1990).

Chaiklin (1993) sees the individual as potentially much more significant in impact
on this system. Human history changed when people found that with a few simple rules of evidence they could establish a truth that would hold until it was overturned by a new truth. This procedure came to be called the scientific method. Chaiklin claims that anyone who uses this method can produce knowledge. This capability is at the heart of democracy. Prior to this, one had to ask a priest or some other intermediary to the divine for explanations of the world and other truths (a similar rationale as Malinowski, 1954).

In our society we want to believe in medicine, as we want to believe in religion and our country; it wards off collective fears and reduces public anxieties. In significant ways medicine, especially psychiatry, has replaced religion as the most powerful extralegal institution of social control... Medical social control of deviant behavior is usually a variant of medical intervention that seeks to eliminate, modify, isolate, or regulate behavior socially defined as deviant, with medical means and in the name of health (Conrad, 1980, p. 241 - 242).

The use of medical and scientific rigors, and consequential proselytisms of objective coherence, have become powerful determinants of structure within society. So effective that debate as to the appropriateness of this structure is often dismissed as irrelevant. Conrad continues that defining an illness within medical terms is a social construct producing ideological benefits. This is the issue at hand, a questioning of the background of knowledge and available support for the current utilization of mental illness diagnosis.

Horwitz (1982) concurs that there is an inverted relationship between formal psychiatric control and informal social control and that when the latter is available the former is less likely to be utilized. This is social control that is manipulated and shaped through rhetoric, for Latour (1987) believes that rhetoric plays a more influential role in the scientific and technical fields because of the lack of knowledge for whom those the
rhetoric is intended.

Boxer (1987), in agreement with Hobbes (in Szasz, 1961), believes that the essence of power is the ability to create categories and get the world to see things this way. Edelman (1977) admits to the need for categorization in science, but also advocates the necessity of recognizing that it is also a political tool, establishing status and power hierarchies (see Landrine, 1992). Meenaghan and Kilty (1994) support this critical perspective in believing that the creation of scientific knowledge is not value-free and is greatly influenced by the social context of the discoverers. Starr (1982) agrees and applies the concept of dependence of the profession and individuals that they have on each other in producing this knowledge.

A more recent focus of this area has been written of within a postmodern qualitative perspective. This arena of theorizing does not accept the perception of knowledge as a map with an objective reality, but views this conception through the process of a linguistic and social construction of reality. Rorty (1979) argues that knowledge is not a matter of interaction with a nonhuman reality, but of communication between persons. Kvale (1995) expands this concept to the community, "truth is constituted through a dialogue . . . interpretations are discussed and negotiating among the members of a community" (Kvale, 1995, p. 24). This view also referenced as "relativism" and is impacted through the discourse medium of language, claimed to be subjective. Additionally, Kvale points to who the researcher is and this person's credibility as an important criterion of whether a research report is accepted. Also questioned is the impact of who is in a position of power to decide on a focus of study, the direction of funding to support research and what values are attached to these
McWilliam (1996) follows this line of writing, yet advocates to further the use of qualitative inquiry through affecting change within the field of inquiry. Reason (1996) is not as forceful in this author’s utilization of these ideas, but finds three areas important within this theoretical focus. These include the ability of research to be utilized as personal action, political action, education, liberation; for this research to be concerned for the needs of oppressed and disadvantaged people; and to correct what is seen as the harmful consequences of the positivist worldview.

Schwandt (1996) reiterates the perspective that social science inquiry is a linguistic and social construction but extends this with a belief that within a postfoundational epistemology there needs to be learned an ability to exist with uncertainty, without knowing the final answer and without having the loose-ends of research able to be resolved and solved when a project is completed. It is purported that this historical reliance on positivism is a result of the power of moral-political ideas of disengagement. Taylor (1985) reminds us that the adoption of a framework for explanation in sociopolitical inquiry carries with it the adoption of the values implicit within this framework. Meenaghan and Kilty (1994), as referenced earlier, agreed that the research cannot escape being value-free and is greatly influenced by the social context.

There is concern voiced by Harman (1996) within this perspective who finds that there is a dominant theme referred to as a central myth with which the modern world is organized. This myth provides the fabric, meanings and values that bind it together and shapes the central institutions which are strongly influenced by Western science. This is
supported by a second myth that it is rational to have social decisions directed by economic values.

The social construction of mental illness was a topic of writing by Lerman (1996) and focused on the development and influences of the psychodiagnosis of women. This author cites that within the mental health field the failure to explore content of the individual's situation is very harmful and that the diagnostic process is inevitably linked to the personality, theoretical orientation, and cultural circumstances of the therapist. This author reiterates the concerns expressed by Caplan (1995) that the system of diagnosis was designed by Caucasian males and ignores the concerns of women, minorities and other disenfranchised groups. Although the focus on pathology is on the inner condition of the individual, what is not explored thoroughly is how changes in social views cause change in pathology - for example, the debate over homosexuality, masturbation and premenstrual syndrome as diagnosable disorders.

Lerman (1996) seconds the idea put forth by Kirk and Kutchins (1992, 1994) that as "political power and social influence of this group (psychiatry) increases, its terminology experiences wider and more general acceptance" (Lerman, 1996, p. 104) It is continued that the purpose of the current diagnostic system serves the needs of the medical and legal systems primarily and of individuals secondarily. Landrine (1992) takes the perspective that one's social status in a stratified society may be the single best predictor of the specific psychiatric disorder. The author focused on those roles within society and the impact that this has on the assigning of psychiatric diagnosis.
Critical/Social Construction Theory Applied to the DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), uses a partialization process to categorize certain aspects of human behavior and is a product of this scientific enterprise. The APA over the past thirty years has come to dominate the diagnostic definitions within mental disorders and critics voice numerous concerns. Dumont (1984) finds the line drawing of categorical differences an exercise by elite practitioners and endorsed by associations of these same practitioners with the concepts of reliability and validity supported quite poorly. Hubbard and Walk (1993) place this categorical procedure as an outcome of utilizing the medical model and treating mental health diagnostic categories as discrete entities. These authors believe this may not be the accurate procedure.

Spector (1977) comments on the more expansive issue of defining a social problem. This author claims that there is a competitive process associated with receiving attention for social problems from different groups and that when one group wins out over another, then this groups vocabulary may be adopted or institutionalized. Spector agrees with Boxer in the competitive nature of defining a social problem. Szasz, widely commented on in the field, applies this concept to psychiatry and claims that "psychiatrists and their powerful allies have thus succeeded in persuading the scientific community, the courts, the media, and the general public that conditions they call mental disorders are diseases" (Szasz, 1994, p. 36). Neitzsche (in Baynes, 1987) supports this conceptually and writes of the ability of language to impose order onto a world and shift power from one focus to a differing focus through this common medium, thus giving the ability for a social problem to emerge and to change over time.
Progress is often affirmed by denigrating the past and reinterpreting it to be much less satisfactory than it actually seemed at the time (see Chailklin, 1993). The DSM-I and DSM-II were challenged because the psychiatric political and territorial climate forced a reanalysis of the professions’ foundations and direction. Lipton (1985) points out that through the introduction of the DSM-III that the concern over diagnostic reliability was resolved through the support of the National Institute of Mental Health, American Psychiatric Association and supported by leaders in the field. This author claims that the influence of these organizations assisted in there being less criticism in the adoption of this new diagnostic vocabulary. Spencer (1982) challenges the assumption that the introduction of the DSM-III gave any additional scientific support for utilization and challenges the ability for mental health professionals to use the Manual at all.

Restivo (1987) continues in claiming that this vocabulary adoption did occur within the psychiatric field and production of the Diagnostic and Statistical Manual of Mental Disorders for “critical sociology of science cannot for any reason ignore the fact that epistemic communities develop self-validating knowledge-use systems, and that the claims, predictions, recommendations, and theories of a prestigious epistemic community can be taken as warnings, become self-fulfilling prophecies” (Restivo, 1987, p. 490). Over the past ten years, Caplan (1995) has also given voice in the literature to the feminist perspective and bias claimed with the Diagnostic and Statistical Manual in application to this topic of psychiatric diagnosis.

Perelman (1982) takes this question of defining social problems and brings an additional twist to this argument. “The relationships between linguistic terms and the concepts or images they symbolize are never entirely stable . . . every definition
implicitly admits that some other definition is possible; otherwise, there would be no need to define in the first place" (Perelman, 1982, p. xiii). Spector (1977) supports this lack of stability between symbols and language and also applies them to the definition of a social problem. This author believes that the social problem can only be defined once it is consensual and decided by large numbers of people as being unacceptable (see Conrad, 1980, for additional concurrence).

Foucault (in Nelkin, 1985) observed and agrees that tests are instruments of control and that the power to define the normal can impose the standards of conformity, while the ability to measure individual deviations can justify classification and hierarchy. Tests have been used to measure competence, to define deviance, and to exclude those who appear less desirable to a group's social or economic goals. Foucault believed illness and deviance can also be social constructs with the boundaries between normal and healthy difficult to differentiate. Even incorporating the terminology of categorization implies or explicates the values involved in the differentiating process and subsequent stigma, as written of by other authors. This era of labeling theory can be referenced for more information through Cullen (1978), Gove (1980) and Gibbs (1981).

Nelkin (1987) claims that the need to have social institutions to assist in organizing society also ironically surfaces the need, through economics and administration of knowledge generated through scientific endeavors, and opens the way up for stigmatization and discrimination. van Pragg (1993) concurs that what is not mentioned in the DSM then becomes somewhat irrelevant. It is the ease with which mental disorders and diagnostic categories have assimilated within societal perceptions that is questioned. The omnipresent and deeply engrained cultural ideology of self-
reliance and independent responsibility assists in the absorption of this mental disorder model.

From this societal framework of operation there is a very real pressure that is pushed downward to individual workers. The need for success, recognition, and funding within the scientific enterprise is a constant source of motivation for the individual. Publication of research and the process itself is questioned by Kirk and Kutchins and reinforced by the earlier discussions of rhetoric. "Scientific journal articles are more than dry, disembodied reports, full of facts without soul. To the contrary, the scientific article is itself an intricate method of persuasion, a form of rhetoric" (Kirk and Kutchins, 1992, p. 164). Fleck (1935) believes the impact of publication is nearly irreversible, for once a statement is published it becomes part of the social forces that then are difficult to think of in any other way.

Disseminating this academic and professional "knowledge" to individuals in society does not pose difficulties within a culture that puts both faith in the reported result and ambivalence towards the endeavors of "science". Nelkin (1987) believes that the explanation of complex and unfamiliar science and technical matters is most often accomplished through the use of analogy, imagery and metaphor. An imagery that is not delegated to use outside of professional ranks, for science has become in Western society a claimed superior form of knowledge, and those who have reached the positions of authority within the field are deemed to have the insight ability into other social problems in society. This proliferation of claimed knowledge continues through publication and Lipton (1985) believes that papers are published not to disseminate information but for prestige, giving rewards to those who work and exceed the norms of the profession.
These rewards are most often economic.

This system of support is continued through the very use of language as communication for the "scientific enterprise". The acceptance of the DSM ideology within mental health is accomplished very simply by speaking its purported language, as claimed by Spencer (1982). The literature and linguistic usage within the system assist in becoming a belief condition for those in the community applying this language. This ready acceptance of the language of diagnosis leads to the curious self-inflicted predicament of labeling and subsequent stigma (see Cullen; 1978, Gove, 1980; and Gibbs, 1981). Kirk and Einbender (1993) believe that this ease of diagnostic labeling is of utmost confusion given the "facts" of their existence. These authors claim that diagnosis are unreliable and dehumanizing and are a better reflection of the person diagnosing then the individual receiving the diagnosis.

Brown (1987), through studying the many functions that diagnosis has within mental health settings finds that there are many conflicting applications of this act and that psychiatry is not well enough equipped to successfully implement this system. Correspondingly within philosophy, Bernstein (1983) supports this perspective within inquiry and points to relativism as theoretically more supportable. Bernstein states that we are forced to recognize that in the end analysis these concepts should be understood in relation to the conceptual and theoretical framework, culture, society and paradigm.

Of particular focus on practice within the social work field, one of the guideposts of therapeutic/theoretical practice is summarized through Turner's "Social Work Treatment, Interlocking Theoretical Approaches" (1996). This compilation of practice options discussed a varying range of twenty-five differing approaches, of which only four
(ego psychology, existential, functional, psychoanalytic) theoretical foci have a psychodynamic base to the categorization. Psychiatry's diagnostic system has its historical roots within the psychodynamic theoretical ideas and it is important to note that many in social work practice work within very differing and wide-ranging theoretical basis. However, there is some irony in the cross categorical utilization of a diagnostic system that many practitioners do not theoretically or in practice find acceptable.

Eisenberg (1988) takes this paradox a step further in saying,

To recognize that scientific theories are inventions of the imagination is to enhance rather than to diminish their grandeur. It is; however, their very success in introducing order into the chaos of appearance that makes it easy to mistake them for reality itself. . . if professional ideology influences society, it also profoundly reflects the values of the society in which it is embedded (Eisenberg, 1988, p. 8).

Kvale (1992) looked specifically at the practice of psychoanalysis and through the postmodern writings of Geha and Schafer finds the gulf between the interpretive categorization of the mental illness field for the professional potentially vastly different from the desire for the individual to hold onto the belief in this as truth. This is pointed to as a disturbing and neglected area of writing and one which needs additional review.

In investigating the interworkings of a psychiatric hospital, Barrett (1996) ethnographically viewed the differing perspectives of these professions working with the residents and found that the end result of viewing the mentally ill was open to interpretation via differing groups, yet very bound by the structure and intentions of the institution with which these differing perspectives worked.
Conclusion

The critical/social construction theoretical framework is reviewed as a compilation of previous authors who have questioned the diagnostic system’s foundation of disorders. It is from this line of inquiry of mental health disorders that have brought about changes to the system over time that may have benefited those individuals within the system of services. To not readily accept the norm of what is believed to be true and what is accepted as a system of diagnosis is a common theme of these authors. This issue and perspectives are continued through this research in focusing on how we have come to understand adolescent disorders. Underlying this effort is the theoretical perspective of social constructionism/criticalism and its focus on the myriad of influences upon what is reported to be “fact” or “knowledge”.

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Chapter 3
Methodology

Introduction

The past review of critical/social construction theory as applied to the mental health field shows a continuous line of questioning as to the many impacts and influences culture and society have on understanding the dynamics of mental disorders. The research questions are asking what are the originations of Conduct Disorder/Oppositional Defiant Disorder and how was this knowledge acquired, with a follow up question asking what influences and factors have impacted these diagnostic categories over time. In answering these research questions, two methodologies - one more philosophical and one more practical in application - are to be utilized. The more philosophical methodology of critical inquiry mirrors the questions supported by the theoretical focus of social constructionism and allows for an investigation into the myriad of factors that may be historically impacting this area. More practically, it is a historical analysis method (historiography) that is designed for an investigation as to the possible changes over time that are to be reviewed, and gives structure to this inquiry in answering the research question(s). Next is a review of critical methodology, followed by the use of historical analysis (historiography) methodological design support within social work literature, and concluding with the parameters of this research project.
Critical Methodology

The area of critical inquiry, or of perceiving of inquiry, has origins in thinking and writing of over seventy years. This theoretical/methodological/philosophical approach to research has numerous niches and applications through differing perspectives. Goldstein sees this theoretical history as a medium for change stemming from Marxist dialectics. This author points to more contemporary writers applications of this theme to include the "writings of Freire (1973) and the conscientization movement, in Schon’s conception of reflective practice (1983), or in the feminist movement and the many other efforts aimed at ‘consciousness raising’ by many minority and marginal groups in our society” (Sherman and Reid, 1994, p. 47). It is continued that this method of inquiry includes the assumption of multiple realities, constructed both personally and socially.

Another perspective that is applicable to this research is the viewpoint of critical theory and the dialectical focus on the social construction of experience of the researcher (Denzin and Lincoln, 1994, p. 138). In a very thorough review of this historical literature, Kincheloe and McLaren (in Denzin and Lincoln, 1994) highlight some significant and relevant aspects of the criticalist as researcher utilizing the work as a social criticism embracing certain assumptions. These assumptions include “that all thought is fundamentally mediated by power relations that are social and historically constituted; that facts can never be isolated from . . . values or . . . ideological inscription; that the relationship between concept and object is . . . mediated by the social relations of capitalist(ism); (and) that certain groups . . . are privileged over others . . . and that oppression is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable” (Denzin, 1994, p. 140-141). Power, or ability to
therefore define as Hobbes perceives,

... is in one sense a highly abstract and theoretical question, made all the more difficult by disagreements over what is meant by the concept of power, but the issues immediately become very clear when we think of power as manifesting itself in terms of who benefits, who shapes the political agenda, who holds key positions, and who has a say-so on the big decisions. Nor is the question abstract when it comes to hopes for greater freedom and equality, for such hopes soon bump up against the power of social classes, economic institutions, political groups and state agencies (Domhoff, 1990, p. viii).

Schwandt (1996) categorizes this perspective under numerous names (critical theory, critical social science, new paradigm research, praxis-oriented research, critical inquiry, emancipatory social theory, emancipatory research, feminist research) and continues with this reasoning that critical theory "can be characterized by its critical consciousness - systematically investigating the manner in which that lived experience may be distorted by false consciousness and ideology... critical science methodologies are preoccupied with reduction of illusions in human experience" (Guba, 1996, p. 268).

Comstack (1982) utilizes this ideology through looking more specifically at a methodology of critical inquiry with the driving principle being that "all men and women are potentially active agents in the construction of their social world... and that they can be the subjects, rather than the objects, of socio-historical processes" (Bredo and Feinberg, 1982, p. 371). The aim and method are directed to be self-consciously de-alienating to reappropriate the societal perspective and is written of by Comstack to be a historical explanation process. Comstack's steps methodologically include the identification of movements of social groups whose interests are progressive; developing an interpretive understanding of meanings and values held by the group; studying the historical development and current social conditions that constrain the groups'
understanding; constructing models of these relations of social conditions, meanings and group actions; elucidating the fundamental contradictions; participating in the education of new perspectives for the group; and participating in a theoretically grounded program of action to lead to less alienation and clearer understandings (Bredo and Feinberg, 1982).

Continuing in this methodology of inquiry, Morrow (1994) reviews thoroughly the application and finds the implications of a “critical theory of society as an interpretive structuralist research program” (Morrow, 1994, p. 25). Specifically speaking, critical theory is eclectic with respect to methodological techniques and includes “interviewing; mass media analysis; archive searching; examination of official statistics and reviews of published literature. Furthermore, critical social research also uses . . . historical reconstruction, action research” (Morrow, 1994, p. 227).

There is an additional perspective by Nagel that questions how an individual can attempt to incorporate a perspective or view of a “particular person inside the world with an objective view of that same world, the person and his viewpoint included . . . (within this dynamic) we get the interplay of these two uneasily related types of conception and the essentially incompletable effort to reconcile them” (Nagel, 1986, p. 3). It is the difficulty of this reconciliation and demarcation of views of the individual that is posited to be of influence on the activities within this theoretical perspective. This is furthered by Zavala in focusing on discourse and language and believing that “immediate access to reality remains a romantic myth surviving only in ideologies and people’s minds” (Zavala, 1987, p. 198). It is this symbolization and “re-presentations” that lead to the seeing of realities.
Fay (1987) supports this theoretically through viewing critical inquiry as a modality through which the "oppressed are educated about their situation and about their potential capacity to alter it . . . critical social science seeks to be a practical force by galvanizing its audience into socially transformative action" (Fay, 1987, p. 205). Thomas continues with this idea and believes that the "term critical describes both an activity and an ideology . . . a rethinking of comfortable thoughts" (Thomas, 1979, p. 17).

Methodologically, "... what we chose to study is simply a window into a broader scene. When done correctly, we gain new insights that we would not otherwise notice. It is fully appropriate to start with a general topic and simply ask, I wonder what's there?" (Thomas, 1979, p 36-37).

"Our understanding of mental illness has been obstructed by the assumption that reality comes packaged in well-bounded categories waiting to be discovered. A growing body of epidemiological and clinical studies as well as elementary principles of philosophical inquiry do not support the assumption" (Dumont, 1984, p. 332). As for the future of the DSM, "it happens that coming to an agreement on a methodology, people can obtain in certain periods and in certain disciplines a unanimity which they may not find again elsewhere; but nothing guarantees its indefinite continuation" (Perelman, p. 160).

Historical Analysis Methodology Literature Related to Social Work

Webb and Campbell (1972) support the utilization of differing methodologies when investigating a research area. They cite the using of differing research designs to assist in balancing the weaknesses/limitations that each design bring to the project, to
bring more clarity to what is being “measured” and explore the variety of ways to come
to “understand” or “know”. They write of the importance of using unobtrusive measures
in research, including the written record and archival literature.

Within the field of education, Rury (1993) writes of historical inquiry that
because of its “interpretive frames of reference (that) always change, this makes history
both an exciting field in which to conduct research and a difficult one to assess at any
given time” (Lancy, 1993, p. 247). This mirrors some earlier descriptions within history
and is continued with “historians rely upon interpretation to generate coherent
explanations of the past” (Lancy, 1993, p. 244). Also emphasized is the need for a
researcher to have an internally consistent interpretive outlook and aim to have a clear
point of view.

Krathwohl (1992) references this method for education and social science
research in general and points to a number of key themes as important within this
discipline. This author claims that historical researchers “adduce a rationale from the
evidence or may have developed it in advance and seek to demonstrate its validity; that
the focus of a historian’s design is often emergent . . . the necessity for understanding the
meaning of construct in the culture and at the time studied (and) the possibility that
constructs change in meaning over time” (Krathwohl, 1992, p. 574-581).

Rubin and Babbie (1990) point to citations within social work literature around
three themes of historical analysis. These include a large portion of biographies of social
work pioneers, case studies of social welfare policies and what they call
“historical/comparative” analysis. This latter traces themes of social forms over time and
searches for patterns with which to predict. Stuart (1981) writes directly of the use of
historical research in social work and believes that this area of research focused on a specialized topic may suggest new areas for investigation. This author highlights four steps in this process including choosing a research question, gathering evidence, determining what this evidence means and report writing.

Within the earlier discussed theoretical perspectives supporting this inquiry, there are a number of published similarities including "Corruption of Freedom in America" (Schroyer) and "Modern and Postmodern Architecture" (Habermas) - both critical historical studies that looked at societal and cultural influences upon these researched topics. Other research that is related includes "Historical Analysis of Americas Reading Instruction: Its Development and Significance" (Smith, 1934) and "Historical Analysis in Psychological Research" (Breakwell). These two writings also incorporate how changes occurred for the topics of reading and psychological research over time, and how professional and cultural influences impacted these changes. For methodological similarities within dissertations printed in the United States, see "Historical Analysis of an Urban School" (Randolph, Dissertation at OSU, 1991), "An Historical Analysis of Administrative and Educational Methods with Emotionally Disabled Students" (Patrick, 1996), "An Historical Analysis of the Community Approach to Delinquency Prevention" (Nelson), and "An Historical Analysis of Punishment Policy" (Jane). These dissertations identified historical methodologies in researching these areas of study, utilized specific time periods of study and sought to incorporate the influences and perspectives of society in the analysis.

The design of historical analysis, though not heavily utilized within the social work field, allows the research question to be asked and for the inquiry to support itself
through the tracing of these events, themes, patterns, literature, individuals, organizations etc., that are integral in coming to understand, to the best of a researcher’s ability, a level of knowing not previously attained. Examples within the field include the following: “The History of Mental Symptoms” (Berrios) who looked at the verbiage of fourteen categorical symptomalogies and traced their originations from the mid-nineteenth century through to the 1970’s; “Social Order/Mental Disorder; Anglo American Psychiatry in Historical Perspective” (Skull, Andrew), who traced themes from the past century as they related to the psychiatric community; “Historic Themes and Landmarks in Social Welfare Research” (Zimbalists, 1979), which looked back historically from the 1860’s through the 1960’s and identified thematic research areas within the field; “Cycles of Reform in the Care of the Chronically Mentally Ill” (Morrissey and Goldman, 1984), who traced eighty years of changes within this field; “In the Matter of Color: Race and the American Legal Process” (Higginbotham, 1978), who analyzed two hundred years of legal documents; and “Mental Illness and American Society: 1875-1940” (Grob, 1983), a review of seventy-five years of how psychiatry was limited to the institutionalizing of those considered deviant or insane.

Methodology for This Research

Philosophical Bridge

Gottschalk references the two distinct entities of methodology within the field of history, one more traditional and one more recently utilized. This former method is
referred to as analytical historical method and entails “within limits, scientific - i.e., its results are subject to verification and to intelligent agreement or disagreement among the experts” (Gottschalk, 1950, p. 8). This is differentiated from “historiography”, a more philosophical and polemic methodology potentially influenced through the values, biases and perspectives of the historian. The method of historiography, and its increased use within the field of history, is supported through a number of areas of literature in its utilization for this research.

The first area of literature that supports this methodology and assists in bridging the philosophical (social construction/critical) inquiry with this historical method (historiography) was published during the 1970’s. A group of history academics published inquiry within this “critical” perspective in reviewing certain social cultural topics within history. What was published is referred to as “Selections from the Annales” (Volumes 1-6). It is these volumes of historical literature that utilized (and were influenced by) the posits of critical theory, relativism and social construction of inquiry in relation to the research within the field of history. These writings were some of the earliest within the field of history that focused on the factors that may be influencing what historians typically had studied up to this point. This research brought a wider lens of inquiry looking toward cultural, economic, societal and interpersonal influences upon the interpretation of historical events and focused on marginal groups within society. The Annales brought research of this nature and broadened to look at topics including the biology of humans, family and society, rural society, medicine, deviants and the abandoned and other topics neglected throughout historical studies.

The marginal groups of society rarely contribute directly to political and social history as it is conventionally written and
taught. An uneasiness develops among political historians when it is suggested that (these groups) be included in the syllabus or textbook of a history course... Social historians, too, are often reluctant to embrace the study of marginal groups... they find it difficult to fit deviants into social theory as it has been classically defined (Forster, 1978, p. vii-viii).

A second area of literature within history continues this theoretical bridging of cultural/societal impacts on historiography and involves a body of literature focused on the solving of social problems. The earlier proponents for the focus on social problems within history were by Charles Beard, James Harvey Robinson and Carl Becker who writing in the 1930's allowed for later writers to address specifically identified cultural ills. These writers addressed the proportion of historical literature up to the point that was identified as inspection toward the past and concluded that only a "tiny amount (of writings) were deliberately directed to the solution of vital problems: racism, poverty, war, repression, loneliness, etc." (Zinn, 1970, p. 142). Up to this point, if social problems were addressed it was more by chance than design. "Great history is written when the historian's vision of the past is illuminated by insights into the problems of the present" (Carr, 1961, p. 31).

Carr (1961) continues to advocate for the removal of "shame" (from criticisms) toward the complaints that subjectivity is widespread in the writing of history and proposes for additional advocacy issues focused historical writing to improve the quality of the historical literature. The lack of this occurrence is pointed to be propelled through the historical commitment to instrumental values - "to specific nations, organizations, leaders, social systems, religions, or techniques... (which) creates powerful pressures for hiding or distorting historical events" (Zinn, 1971, p. 145). The lack of need to separate the objective from the subjective within historical writing is supported by Carr
(1961) who believes all history is subjective and that it is a myth that there are historical
facts waiting to be discovered by the historian.

Morton White (in Zinn, 1971) supports this philosophy of writing outside of these
instrumental values with a fundamental aim to tell as much of the story of the past as
possible. Examples include Beard’s study of the making of the American Constitution
with an eye on the force of economic interest in public affairs, and Vann’s writing of the
Jim Crow era focused on equal treatment for living. These authors advocate for the
utilization of a present problem centered approach to the writing of the American past
and believe there is much merit to the historiography approach.

Cook (1973) continues with this focus of inquiry in believing that much of
historical inquiry is relatively useless in application and supports the niche of those
writers labeled radical historians. These writings focus outside of the mainstream of
literature (influenced by critical inquiry and Marxian frameworks of analysis) and see the
“origins of events not only in the social, economic, and political situation, but also in the
motives of that class which owns the nation’s corporations and governs the state . . .
camouflaged behind the rhetoric of equal opportunity (within “democracy”) (Cook, 1973,
p. 6). These writers, progressive in nature, explore the discrepancy between the rhetoric
and reality within this historical inquiry and include William Appleman Williams,
Eugene Genovese, Staughton Lynd and Howard Zinn.

Benson theorizes a broader incorporation of reaction to radical historians and
believes the primary goal should “be to develop credible, empirical theories about human
behavior highly useful to human beings struggling to create a better world . . . and that no
intrinsic, necessary contradiction exists between the quest for scientific . . . knowledge
about human behavior and the desire to change the world for the better” (Benson, 1978, p, 430-431).

**Methodology**

Both the publishing of the Annals and the writings of history that focused on social problems support the research question and stated problem area of this project. Within the history methodology literature, there are a number of writings considered “classics” in historiography that set forth the basics of solid writing of history (including Carr, Clubb, Fisher, Fritze, Norton, Graff and D’Aniello). Carr sets forth a philosophy of historiography (a philosophical methodology influenced through the values, biases and perspectives of the historian) and covers a wide range of requirements. Carr reinforces Nagel’s position and the interaction of the researcher’s position within society in believing that this position in time and in society greatly impacts what the historian sees. It is not that facts speak for themselves, rather that the historian calls upon these facts and gives meaning and context to them within the presentation. This interpretive realm gives a duty to the writer of evaluation. It is posited that the historiographer does not simply record but works with the gathered information and attempts to give meaning to this events through this evaluative process. Carr recommends to “study the historian before you study the facts” (Carr, 1961, p. 17). Carr believes that the historian is obliged to choose a perspective of history, for the use of language does not allow neutrality. It is not stated that there does not exist objectivity in history, but that there are checks and
balances as to achieving a semblance of order.

One route of achieving this objectivity is to bring “into the picture all known or knowable facts relevant . . . to the theme on which he (she) is engaged and to the interpretation proposed” (Carr, 1961, p. 22). This leads to a continual interaction of the researcher and “facts”. Through so doing, the goal of history is to understand the past and increase mastery of the present. This is accomplished through generalization - a differentiating trait from the collector to the historian. To generalize is to use this interpretive historian perspective and to apply the learning from the study of past events and patterns, and to see if these apply to later periods of time. To use these generalizations, the historian searches for explanations, and places the explanations in a hierarchical status. This hierarchy would “fix their relation to one another, perhaps to decide which cause, or which category of causes, should be regarded . . . in the final analysis” (Carr, 1961, p. 84). It is continued that the causes dictate the interpretation of the historical process and the interpretation dictates the hierarchical placement.

This check and balance system of objectivity should next be viewed through the historical interpretation of these events/causes. To do this, the historian must realize their “own situation in society and in history . . . to recognize (their) own involvement in that situation, to recognize . . . the impossibility of total objectivity” (Carr, 1961, p. 92). There is a caveat in searching for this interpretative truth, for the objective historian recognizes that progress is achieved through the interdependence and interaction of facts and values and to investigate this most thoroughly achieves the highest level of objectivity.

Barzun views the historian’s process as an act of science, the search for facts, and
an art, the organizing conclusive aspects after gathering these facts. To find these facts as to be reliable, it is important to define your subject area by “that group of associated facts and ideas which, when clearly presented in a prescribed amount of space, leave no questions unanswered within the presentation, even though many questions remain outside it” (Barzun, 1987, p. 17). It is continued that each researcher has a number of basic principles to adhere to in producing reliable history including accuracy, love of order, logic, honesty, self-awareness (making your assumptions clear to the reader), and imagination.

As the investigative process moves from the “objective” generalizations and search for causes, an additional factor supporting reliability is verification. In this the historian tries to reach a decision rationally acceptable to him/herself and others. “Verification . . . from getting an author’s first name correct to proving that a document is both genuine and authentic. Verification is accordingly conducted on many planes, and its technique is not fixed. It relies on attention to detail, on common-sense reasoning, on a developed ‘feel’ for history and chronology, on familiarity with human behavior, and on ever enlarging stores of information” (Barzun, 1987, p. 85). The use of probability of the explanation posited, leading to firm reliance on the evidence that is found and the degree to which this verification is needed, is dependent on the level of curiosity of the researcher, the level of knowledge of the subject in the beginning of the research project, common life grounds, general truths and other relevant topics of knowledge. To accomplish this successfully, an understanding of the time frame and societal/cultural environment is of paramount importance. “No historian can hope to unravel every mystery and contradiction or uncover every untruth, half-truth, or downright deception
that lurks in the raw materials with which he/she must deal. But his (her) unceasing
demand for accuracy must make him (her) put to the test all the materials he (she) uses.
There is no substitute for well-placed skepticism" (Barzun, 1987, p. 110). "An objective
judgment is one made by testing in all ways possible one's subjective impressions, so as
to arrive at a knowledge of objects" (Barzun, 1987, p. 140).

In searching for "truth in history" in supporting generalizations/causes within
historical analysis, there are critical questions and subordinate questions that are relied
upon to seek these answers (Barzun, 1987). Is the writing researched genuine? Is the
message trustworthy? How is this known? What does the writing say? Who is the
author? What is the relation in time and space between the author and the information?
How does the statement compare with other statements on the same point? What do we
know independently about the author and his/her credibility? "The historical method
ascertains the truth by means of common sense. When that sense is systematically
applied, it becomes a stronger and sharper instrument than is usually found at work in
daily life . . . methodological common sense takes in both what is usually known by the
well-educated and any special information relevant to the historical question being
studied, and to these bodies of facts and ideas it brings the habit of comparing and
judging with detached deliberation" (Barzun, 1987, p. 129).

It is continued that arriving at these causes/interpretations when investigating
history is sought through the identification of possibilities that have occurred within a
chain of events. This differs from a search within a closed system and requires the search
for patterns and biases in the system. It is the search for patterns that correlate to the
accumulated evidence that assist in the understanding process for the topic of inquiry.
The information is presented as in a story time-line and describes conditions and complications in reaching conclusions. "To be successful and right, a selection must . . . fairly correspond to the mass of evidence and it must offer a graspable design to the beholder" (Barzun, 1987, p. 150).

Organization of this method entails that the "chronology moves forward while embracing each topic and giving an occasional backward or forward glance as needed. Each small section of the work deals with a topic of one of its natural subdivisions at some length, and completely as far as that subject goes" (Barzun, 1987, p. 214). Fischer continues this with the belief that historical writing is "a process of adductive reasoning . . . so that a satisfactory explanatory fit can be obtained . . . history is a problem-solving discipline . . . the questions and answers are fitted to each other by a complex process of mutual adjustment . . . (and) is articulated in the form of a reasoned argument" (Fischer, 1970, p. xiv).

This is concurred by Shafer who sees that the stages "of an historical investigation cannot be delimited precisely into chronological blocks . . . collection merges into analysis when the first research note is taken that consists of more than simple copying" (Shafer, 1960, p. 39). This author continues with pointing to the basic steps of historical research including first learning what the categories of evidence are, the critical elements that differentiate them, and what these mean to investigators; secondly, collecting evidence; and lastly the communication of evidence.

The research question for this historical analysis is the following: what are the originsations of Conduct Disorder/Oppositional Defiant Disorder and how was this knowledge acquired? A follow up question asks what influences and factors have
impacted these diagnostic categories over time? The theme of this research is best described by Marius (a 1995 publication concerning the guide to writing about history) in stating “historians . . . like journalists, they ask who, what, where, when and why. What happened? Who was responsible? Where did these events take place? When or in what order did things happen? Why did they happen?” (Marius, p. 1).

Design

Previous Studies

This research uses methodology that is not unique to social science. Historical analysis has been increasingly utilized in many other social science fields over the past three decades. A number of related published studies set precedents for this research design and focus in regard to the using of historical methodology. Berrios (1996) published “The History of Mental Symptoms” and looked at descriptive psychopathology since the nineteenth century within psychiatry. This author examined and investigated published and archival documentary of what over time has been identified as signs and symptoms of insanity. This author researched post-1900 descriptive psychopathology through analyzing the clinical studies of the past twenty-five years, examining the samples and populations and tracing the results and conclusions of the descriptive categories over time to find what influences the culture, location and society had on the descriptive categories. The author organized and presented these findings through emotive, cognitive and behavioral categories.

Sagini (1996) utilized an historical analysis methodology in researching the African American University. This author utilized an interdisciplinary perspective
emphasizing the psychological, sociological and historical foci in critically analyzing this research topic. The data was presented within methodological and chronological blocks of writing showing the connections over time of the history of this area.

Inciardi, Block and Hallowell (1977) utilized historical analysis in an effort to reconceptualize the research on crime in the United States. Breaking from past research focused solely on social behavior, this research combined the “longitudinal view offered by the observation and documentation of phenomena through time (and desired to provide) for a more complete analysis and understanding of the emergence, scope, and persistence or change of given social organization and behavior, and as such, history becomes the very framework of detached inquiry” (Inciardi, et. al., 1977, p. 9). This historical analysis also stated that the use of this method can indicate the “possibility that certain consequences can issue from events comparable to past events, history . . . can generate an understanding of the processes of social change and demonstrate how a multitude of factors have served to shape the present” (Inciardi, 1987, p. 28). This research study analyzed historical data, documentary, literature, archival material, printed and published accounts and reconceptualized the focus of crime in three historical time periods within the United States over the past century. This author categorized the research within three separate thematic categories correlated to these time periods.

English (1985) published a dissertation focused on an historical analysis of punishment policy. This author utilized five methods for developing source material including tracing citations (within the history of punishment), review of periodicals, review of dissertations and bibliographies, review of legal documents and consultation with criminal justice experts to identify seminal works.
Chase (1993) published a guide to historical analysis as applied to the field of psychology. This author stressed the necessity of choosing a time frame of the phenomenon to be investigated as well as some definition of the group studied. Chase lists among available resources, books, manuscripts, official records, data archives and journals as prime sources for effective and appropriate historical analysis.

Sample Selection

In answering this research question there are a core of historical sources that will form the basis of the research for analysis. This search will utilize archival materials, organizations, individuals, clinical studies (published literature), and funding sources that were of impact on and traceable to the diagnostic system that was officially introduced as the Diagnostic and Statistical Manual of Mental Disorders (1952), and through four revisions dating to 1994. These sources in this methodological design will be differentiated into diagnostic classification systems, published clinical studies, associations (including the federal government), funding sources, and key individuals. These classifications meet Barzun’s (1987) criteria for logic and order in historical research. Shafer (1980) concurs with this method in differentiating what categories of evidence can be researched.

The research will begin at the time of the formation of official psychiatric nosologies, approximately 1880, and move forward chronologically (supported methodologically by Barzun, 1987), searching for references to the behaviorally based adolescent diagnostic categories of mental illness. The research will be categorized into the following areas for analysis: diagnostic classification systems existent and utilized
prior to 1952; studies referenced as supportive of this DSM system; associations involved in the formation and utilization of these classifications; funding sources that were important in the DSM system becoming the dominant diagnostic mental health system; and key individuals who emerge from this analysis.

Post 1952, this research focuses on the published revisions of the Diagnostic and Statistical Manual. This research is searching for how the categories of behavioral based adolescent disorders changed within the mental health field. The connecting theme for this historical analysis will be what is cited as support for the diagnostic changes within the DSM-II, III, III-R and IV. To be relevant and included in this research analysis, there must be a connecting theme or reference traceable to the current diagnostic system published by the APA for childhood/adolescent behaviorally based disorders. This coincides with Barzun's methodology (1987) of a storyline and in describing conditions of history.

Selection of Resources

Diagnostic Classification Systems

This historical search will focus on those published diagnostic categorizations that are utilized as predecessors and referenced by the Diagnostic and Statistical Manual of Mental Disorders (published by the American Psychiatric Association) as support for the introduction of the DSM (1952). These directly traceable systems (cited by the DSM, 1952) include (chronologically) the Statistical Manual for the Use of Institutions for the Insane (1918), the Statistical Manual for the Use of Hospitals for Mental Diseases (10 editions from 1923 to 1942), and the Standard Classified Nomenclature of Disease (1931
to 1952). These systems are those cited in the Diagnostic and Statistical Manual as historical support for the Manual published in 1952.

What is historically important is also a review of competing and complimentary systems of diagnostic classifications. From the 1880's through the 1950's there were numerous classification systems for mental disorders used in differing hospitals, states and organizations within the United States, as well as internationally. These categorizations will be reviewed to search for some of the beginning nosology for childhood or adolescents disorders, both referenced by the American Psychiatric Association and not. These categorizations identified through literature and bibliographic searches of psychiatric journals dated 1900 to 1952 include those published by Ackerman (1953), Brown (1937), Cameron (1955), Chess (1959), English (1937), Gerard (1947), Henderson (1932), Hutt (1957), Jensen (1959), Kanner (1935), Louttit (1947), Lowrey (1931), Miller (1936), Pacella (1948), Pearson (1920), Potter (1934), Ricker (1948), Strecker (1931) and Van Ophuijsen (1945). These diagnostic categorical systems represent a wide range of classifications in use prior to the introduction of the DSM in 1952, and will be searched to identify themes within the categories of behaviorally based diagnosis for children and adolescents.

This analysis will then use the DSM (1952) and the four revisions that were published by the American Psychiatric Association (1968, 1980, 1987, 1994). These Manuals will be used as the referential point in identifying the changes over time for adolescent behaviorally based disorders.
Clinical Studies

The prior referenced classification systems for adolescent behaviorally based disorders introduced before the publication of the first Diagnostic and Statistic Manual (1952), as well as the subsequent revisions, will be used as sources for narrowing references for the clinical studies chosen for analysis. The search for clinical studies will be limited to those cited as referential to the support of the classification system of the DSM. The earlier classification systems, association publications (primarily the American Psychiatric Association) and the Diagnostic and Statistical Manual of Mental Disorders (1952 through 1994) are the sources to be used in identifying these studies. This search is for studied results that are cited directly as a basis of clinically published support for these diagnostic categories.

The publication of clinical studies and trials after 1952 that are to be chosen for analysis, are those directly utilized as support for the nosological categories for mental disorders by the DSM (1952, 1968, 1980, 1994), and that are published through the American Psychiatric Association or its Committee member organizations.

Associations

During the time period of 1880 to 1952 various associations formed locally, nationally and internationally, looking at the difficulty and dilemma of categorizing mental illness. These cross-professional associations will be identified as to their impact on the nosology of childhood and adolescent disorders. The printed publications and meeting and conference writings of these associations will be utilized as historical data. The associations were chosen for research through their citation within the Diagnostic and Statistical Manual of Mental Disorders (1952 and 1968) as responsible for supporting
the introduction and publication of the Manual. The association’s archival and secondary
source data to be researched include the International Statistics of the Insane and
Classification of Mental Diseases (New York Medico-Legal Society), the International
Classification of Diseases (international system), the National Committee for Mental
Hygiene, the American Medico-Psychological Association (predecessor to the American
Psychiatric Association), the Committee on Statistics (APA), and the Group for the
Advancement of Psychiatry. These organizations were responsible for gathering
information and making recommendations on nosology prior to the introduction of the
DSM. After 1952, the American Psychiatric Association published the nosological
categorization predominantly used in this country and will be the organization researched
post 1952. The Committee on Statistics and Group for the Advancement of Psychiatry
who have had influence on this APA process, will also be included for research.

At certain time periods, the federal government has had a significant influence
upon the drive for a nosology and became a repository of quantitative data accumulated
through the United States Census Bureau. As referenced earlier, this authoritative body
greatly influenced the increased categorical information gathered on mental health
statistics and data. Data and information from these federal sources (U.S. Government
Printing Office, Commerce Department - 1880 to 1950) will be used as sources of
primary data collection.

Funding Sources

Which organizations produced and funded these nosology manuals during the
time period of 1900 to 1952 is to be researched. These previously listed associations and
diagnostic classification systems will be used as the sources to be investigated to gather information on who funded these nosologies. Post 1952, funding for the DSM was through the American Psychiatric Association. Funding focus for this later time period will include tracing the sources supporting those clinical studies cited as support for these diagnostic categories. The clinical studies identified in the earlier section will be the sources for analysis.

**Key Individuals**

Over this time period, it is hypothesized that key individuals, during the changes and modifications of the diagnostic system, may emerge through the analysis of the associations, clinical studies, and classification systems to have been important in how the system has changed over time. Coding and counting of these individuals will be performed throughout the research in these areas, and tallies will be kept as to the number of memberships in associations, committee member positions, citations referenced within association and Manual documents, published clinical studies authored and identified connections to funding sources. These individuals who emerge will be interviewed by this author (see Appendix A for more information) for relevant information, perspectives within this research area and directions for continued focus.

**Methodological Issues**

According to historian Sir James Fitzjames Stephen (1980, in Shafer), a complete account of an issue of study should include the following: 1) the history of the issue, 2) a statement of this issue of study as an existing system and 3) a critical analysis of the
impact. The analysis of this research emulates Berrios (1996) methods through the search for cultural impacts on clinical studies. This research expands this method through the identification of associations, funding sources and key individuals for study. Sagini’s (1996) research is similar in method format in searching for and identifying cultural and sociological factors impacting the content of analysis.

The coding for this analysis is based on identifying those items of study that have a thematic connection to the adolescent diagnostic behaviorally based categories. Reliability has been discussed by previous authors within the field of history. Carr (1961) finds that objectivity of this research method is found through the identifying of all relevant facts of your topic. Barzun (1987) writes that reliability in research is achieved through reaching an “exhaustive” point in your research, when you become repetitive in your findings or repetitive in your generalizations. This theme is mirrored in the qualitative method work of Grounded Theory. Sagani (1996) writes that through a sense of objectivity, an unbiased mind set and meticulously weighing of evidence, that fallacious and spurious testimonials can be discarded. Sagani continues in utilizing Barzun’s (1987) method of justifying findings through the answering of the who, what, when, where, how and why questions.

Limitations

There are a number of concerns/limitations of this methodology that need to be addressed, the first area being writer bias. It is not believed that impartiality should be nor can be achieved, for this interest in the topic chosen (causing bias) is the spark of research motivation (Fisher, 1970 and Sagani, 1996). To address this area the following
questions should be asked: Was the writer fastidious or crude in selecting the facts? Was self-awareness of the writer's assumptions clear? Does the writing on a whole show scholarly virtues? Were thesis conclusions supportable through the gathering of enough evidence and perspectives? (Fischer, 1970). Good (1972) conceptualizes this within a category called internal criticism and cites writer prejudice as a concern with which to be cognizant.

When focusing on the inquiry process of historical methodology, there are a number of key points to follow in adhering to a best practice model. When framing the question, it should be made operational and resolvable; it should be open-ended but not wide open; should be flexible throughout the research; must be analytical; must be explicit and precise; and must be tested. During the factual verification, a researcher must find evidence to the question asked; should provide the best relevant evidence; should find evidence that is affirmative; should know that all inferences from evidence are probabilistic; should understand that all information gathered is context related; and that an empirical statement is only as precise as its evidence. For facts to be significant it is important that they be substantive, must not be produced by the research procedures itself and need to be precise and explicit (Fischer, 1970).

During the explanatory/interpretation stage, a number of areas are important to keep in mind for historical inquiry. For narration of the research to be appropriate, it is important to distinguish between the process of the history as it becomes and the staid structure as it can be seen; it is important that logic of the narrative scheme coincide with the problem at hand; and that interpretation should not be influenced by bias of time frames in analysis. Causation is also postulated not as a single answer, but a process of
choosing a causal answer from the evidence gathered - the choice of explanation should be consistent with the effect that is to be explained. Motivation as a separate area of investigation can arguably be unique, learned, pluralistic, conscious, unconscious and unfixed and there is not going to be direct evidence of motivation. What can be hoped for is a process of using tacit logic of inference to attain a high probability of accuracy. When using analogies be aware to keep their form accurate and to apply their usage to appropriate purposes (Fischer, 1970).

A last area in support of a best practice model is addressing the limitations within arguments and conclusions. It is necessary to define terms for the focus of the inquiry consistently, not for eternity nor universally. It is incorrect to argue past the point of making your argument or to overwhelm the reader with inappropriate arguments not related to the question at hand. Finally, when drawing conclusions/thematic arguments, the relevance must meet logical standards as discussed previously (Fischer, 1970).
1880 - 1952 Diagnostic Classification/Associations

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>International Congress on Psychiatry and Neurology</td>
</tr>
</tbody>
</table>
| 1886 | International Committee on International Statistics of the Insane and Classification of Mental Diseases  
(Published by the New York Medico-Legal Society) |
| 1905 | Grob proposed a classification system of adult differentiation |
| 1913 | Committee on Statistics  
(Published by the American Medico-Psychological Association) |
| 1917 | Statistical Manual for the Use of Institutions for the Insane  
Differentiated for statistical purposes a category of “Under 15 years of Age”  
(Published by the National Committee for Mental Hygiene) |
| 1920 | Standard Nomenclature of Diseases and Pathological Conditions, Injuries, and Poisonings for the United States  
(Published through the United States Census Bureau) |
| 1926 | Statistical Manual for the Use of Hospitals for Mental Diseases  
First seven editions through 1933 did not reference adolescence.  
(Published through the United States Census Bureau) |

Table 4.1 Non-Youth Referenced Nosologies - 1880 to 1952
The development of adolescent diagnostic disorders (categorically) was not evident during the earlier years of the systemic changes that occurred within the field of medicine and psychiatry. There were many decades that numerous systems of psychiatric nosology were utilized throughout different parts of this country. These earlier 19th-century psychiatrists focused primarily on the disease entity, morality, and accumulated only demographic information on their work with patients. Categories that were included prior to the turn of the 20th-century included “simple, epileptic, paralytic, senile dementia, organic dementia, idiocy and cretinism” (International Congress of Alienists, p. 50). The International Congress on Psychiatry and Neurology in 1885 recommended “mania, melancholia, monomania, dementia, general paralysis of the insane, epilepsy, toxic insanity and congenital mental deficiency” as categorical descriptions (Channing, p. 365).

During this time period, the focus was on adult “mania” and “melancholy”, and was claimed to be firmly established through scientific basis. In 1886, the Committee on International Statistics of the Insane and Classification of Mental Diseases was organized by the New York Medico-Legal Society. Member representatives from Italy, Germany, Austria, Switzerland, Russia, and Holland recommended a nosological classification system that had the first reference to child or adolescent “disorders”. Within this presentation, “idiotic and imbecile” children are cited for the “evils” that prevail in the institutionalizing of these youth. This discussion cited differences among countries in the prevalence of institutionalized youth, yet did not list these children in the nosology.
directly (Channing, 1887, p. 377). This finding would coincide with the writings of Platt (1976) who discussed the changing nature of the punitive system (within the United States) toward a system of dependent and neglected youth.

There began a movement toward increased categorization and the separation of the medical from the psychiatric nosology, with pressure applied through the expansion of the disease model (Kraepelin) and the emerging medical model (Grob, 1983). Paton (1905) first conceded that classification in medicine and psychiatry differed and that a causal link in psychiatry was not possible to identify. A nosology recommended included dividing diseases into “defect psychoses (idiocy, imbecility), autointoxication and the groups of manic-depressive insanity and dementia praecox” (Grob, 1983, p. 424). There were no mentions nor differentiations within these writings pertaining to childhood or adolescent differences from these categorizations.

A predominant influence on the accumulation of data originated from the utility of the federal census and the growing faith in quantitative research to be merged with administrative rationality within the field of mental health (as well as medical health). This faith in statistical knowledge created much activity and writings in nosology of disease and spurred the formation of the National Committee for Mental Hygiene (1917). This committee was also motivated by the increasing despair and decline in institutional care (see Grob, 1983) and in its written proceedings was the first to point to the need to manage abnormal children as an appropriate role for psychiatry. The Bureau of the Census also asked the American Medico-Psychological Association (predecessor to the American Psychiatric Association) “to appoint a committee on Nomenclature of Diseases to facilitate the collection of data (1908)” (Grob, 1991, p. 425). This led to the formation
of the Committee on Statistics (1913) which agreed on the growing need to develop a uniform system to gather data on mental diseases and hospitals. This Association was founded in 1844 and originally named the Association of Medical Superintendents of American Institutions for the Insane, renamed in 1892 to the American Medico-Psychological Association and has been called its current retitled American Psychiatric Association since 1921 (Bibliography Directory, APA).

Through the cooperation of the National Committee for Mental Hygiene, the American Medico-Psychological Association's Committee for Statistics produced the first standardized psychiatric nosology in 1918, the Statistical Manual for the Use of Institutions for the Insane. This task was accomplished through "several prolonged conferences . . . and the recommendations of leading psychiatrists . . . (for) the classification finally adopted is simple, comprehensive and complete" (Hurd, 1917, p. 256). These diagnosis were categorized into twenty-two principle groups representing undiagnosed psychoses, psychoses, twenty categorizes with a biological base (mostly brain functioning), yet with no reference to child or adolescent diagnosis nor categorization. However, there were categorizations within each area of focus that differentiated from those younger than 15 years of age. Additionally, there were foci of concern for the individual diagnosis that included exploring the age of the individual as well as the degree of education, the environment and the economic condition upon admission (or diagnosis).

There was a related and somewhat repetitious association brought together through the Bureau of the Census that included the Departments of the Army and Navy, United States Public Health Service, Massachusetts General Hospital, Stanford
University Hospital, Prudential Life Insurance Company and the New York Life Insurance Company. This group produced the Standard Nomenclature of Diseases and Pathological Conditions, Injuries, and Poisonings for the United States (1920), which incorporated only Mental Deficiency, Borderline Conditions and Moron as categorical usage. No youth categories were referenced.

<table>
<thead>
<tr>
<th>Year</th>
<th>Nosology</th>
<th>Funding Source</th>
<th>Disorders</th>
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</thead>
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<tr>
<td>1920</td>
<td>Pearson Nosology</td>
<td>Funded by the Oxford University Research System</td>
<td>“Chronic Aggressive Reactions”</td>
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<tr>
<td>1931</td>
<td>Strecker and Ebaugh Nosology</td>
<td>Funding source not published/Classification published by APA subsidiary</td>
<td>“Protest and Negativism”</td>
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<tr>
<td>1932</td>
<td>Ackerman Nosology</td>
<td>Funded through the Illinois Institute for Juvenile Research in Chicago</td>
<td>“Habit/Conduct/Neurotic Disorders”</td>
</tr>
<tr>
<td>1933</td>
<td>Standard Classified Nomenclature of Disease</td>
<td>(Published by numerous associations and included four editions up through 1952)</td>
<td></td>
</tr>
<tr>
<td>1934</td>
<td>Statistical Manual for the use of Hospitals for Mental Diseases</td>
<td>(Published by the United States Census Bureau)</td>
<td>“Habit Disturbance/Conduct Disturbance/Neurotic Traits”</td>
</tr>
<tr>
<td>1935</td>
<td>Kramer Nosology</td>
<td></td>
<td>“Reaction Types”</td>
</tr>
</tbody>
</table>

Table 4.2 Youth-Referenced Nosologies - 1880 to 1952
Table 4.2 continued

1936 - *Miller Nosology*
   Disorders: “Objective Disorders/Bad Habits”

1937 - *Burt Nosology*
   Disorders: “Inhibited and Aggresive Types”

1937 - *English and Pearson Nosology*
   Funded by University Publisher
   Disorders: “Stealing/Delinquency”

1937 - *Brown Pollack and Cohen Classification System*
   Funded by the State of New York
   Disorders: “Habit/Personality/Neurotic/Conduct Disorders”

1939 - *Gordon Nosology*
   Disorders: Differentiated through physical, mental and social differences

1947 - *Gerard Nosology*
   Disorders: “Disturbances in Behavior”

1947 - *Louttit Nosology*
   Funded by the American Psychological Association
   Disorders: “Direct (Aggressive) and Indirect Behavior Disorders”

1948 - *Pacella Nosology*
   Funded by the American Medical Association
   Disorders: “Delinquent Reactions/Chronic Aggressive/Antisocial Behavior”

Table 4.2  Youth-Referenced Nosologies - 1880 to 1952

The Census Bureau continued to publish its own categorization of mental health focused on the institutional care of individuals, yet there is no differentiation for youth
The revision of the Standard Nomenclature of Diseases and Pathological Conditions, Injuries and Poisonings for the United States was reorganized and renamed the Statistical Manual for the use of Hospitals for Mental Diseases and became the predecessor to the DSM-I. This Manual was the definitive nosology over the next two decades through ten revisions. The first seven editions had no references to childhood or adolescent disorders, and it was not until the eighth edition (1934) that there was a first listing for this age category. The eighth edition published the category “Primary Behavior Disorders” which included the categories Habit Disturbance, Conduct Disturbance and Neurotic Traits, applicable to this age group. The later three editions (including the ninth and tenth, 1939 and 1942) began to reference psychoneuroses and Primary Behavior Disorders, both for adults and for children. The references for this information on childhood disorders are not listed and it is not until searching for clinical studies of this time period that this information can be traced.

The lack of the Census Bureau to differentiate at earlier times the childhood or adolescent age categories is surprising considering the work by Church (1976), Spring (1964) and Platt (1975) who point to the dominance of high school within the education of youth and the focus of the punitive system already designed with adolescence as a separate juvenile justice system. The concepts of adolescence were clearly established in both of these other systems, yet seem to have emerged at a significantly later stage within the field of mental health nosologies. Additionally, Hall (1906) writing within sociology and physiology, had already differentiated this age category as distinct in numerous emotive, physical, cognitive, social and developmental areas and this author’s work could have been applied to the mental health system at an earlier point.
Although the Statistical Manual for the Use of Hospitals for Mental Diseases became predominant, there was a competing system utilized in New York State known as the Brown, Potter, Pollack, and Cohen classification system (1937). This classification system differentiated between brain damage, central nervous system, physical illness and environmental facts impacting the categorizing of child psychiatry. This classification system is referenced in much later publications from the American Psychiatric Association (APA report #18, 1964) as supportive of the DSM diagnostic system as changes occurred within psychiatric nosology. A review of the original outline by Brown (1937) finds that the system was designed for applicability of youth under fifteen years of age. There was also a separate category for Primary Behavior Disorders. This system lists Habit, Personality, Neurotic and Conduct Disorders within this category. Within Conduct Disorders is nosology which included truancy, fighting, disobedience, untruthfulness, stealing, forgery, setting fires, use of alcohol, use of drugs, cruelty, sex offenses, and vagrancy. Brown et. al. say that this area of childhood categorization had not been included before but “should be classified as psychiatric problems” (Brown, 1937, p. 12).

There were prior to the Diagnostic and Statistical Manual of Mental Disorders (1952) publication, a handful of other categorical nosologies utilized in differing institutions for childhood and adolescent mental health diagnosis. Ackerman (1932) produced a much referenced clinical study (to be discussed in a later section) and categorized from this study primary and organic based diagnostic categories. Within the behavior categories were listed habit, conduct and neurotic disorders and traits, mirroring Brown (1937) to the earlier reference of using conduct disorder as applied to children and
adolescents. Within this category was listed defiance, disobedience, hyperactivity, lying, precocious sex activity, withdrawal, tantrums, cruelty, destructiveness and asocial behavior as individual characteristics.

Pearson (1920) printed one of the earliest diagnostic category systems for children and categorized a section on disorders of social behavior. Within this category is only one type, that of Chronic Aggressive Reactions. This diagnostic category does not specify to what age category this applies or in what form the behavior can be described.

Strecker and Ebaugh (1931) differentiate their categories for psychological problems of children into four areas including, reactive, physical and organic, mental deficiency and psychoses. It was purported that 70% of the difficulties fall within the first category (reactive) and it was within this area that a section titled “protest and negativism” encompassed the behaviorally based diagnostic categories for these authors. No referential sources were cited by the authors for this system.

Kanner (1935), through the writings of Adolph Meyer, proposed a non-disease based system that cited difficulty in adjusting for these adolescents as only reaction types to the culture around them. Within these writings are categories related to physical illness and outcomes to coping with these difficulties. There is brief discussion of the possibility of behavior problems of children as related to difficulties in coping with a previous illness (either physical or emotional), but not a reference directly to behavior disorders as an entity itself.

English and Pearson (1937) list Disturbances of Social Adaptation as a category for adolescents. There are two subtypes, Stealing and Delinquency, differentiated by occasional delinquency, feeble-minded children, neurotic or due to fear of punishment, as
psychotic symptom, environmentally conditioned or due to lack of love. No referential sources were cited by the authors for this diagnostic system.

Miller (1936) discussed this category through the terminology of “objective disorders”, or disorders of conduct which disturb others in various ways. These include bad habits, such as masturbation, fidgeting, nose picking, thumb-sucking, nailbiting, clothes picking, temper tantrums, destructiveness, cruelty, rebellion, delinquencies, lying, wandering, truancy, sexual offenses and succumbing to sexual stimulation by others. No referential sources were cited by the author.

Gerard (1947) reports on a range of categories for children and includes the category of “disturbances in behavior” for diagnosis. Cited within this category and subtypes are the specific actions of cruelty, destructiveness, stealing and food refusal.

Pacella (1948) organized childhood disorders for behavior problems under organic, functional, neurotic, conduct and psychoneuroses categories. Within Conduct Disorders the subtypes include delinquent reactions, chronic aggressive behavior and antisocial behavior. No referential sources were utilized as citations for this categorization.

Louttit (1947) lists both direct and indirect primary behavior problem categories. The latter a result of intrapsychic factors and the former from environmental forces upon the child. It is within the indirect problems that aggressive behavior is listed categorically. No referential material was cited for the formation of this categorization schema.
Introduction of the Diagnostic and Statistical Manual of Mental Disorders

1933 - *Standard Nomenclature of Diseases*  
(Published by various associations)  
   First Edition (1933) - No differentiation for Adolescents  
   Third Edition (1938) - same as second edition  
   Fourth Edition (1952) - listed “Conduct Disturbance” as separate category

1952 - *Diagnostic and Statistical Manual of Mental Disorders*  
(Published by the American Psychiatric Association)  
   Disorders: “Adjustment Reaction of Childhood”  
   “Habit Disturbance/Conduct Disturbance/Neurotic Traits”  
   “Adjustment Reactions of Adolescence”

Table 4.3 Introduction of the Diagnostic and Statistical Manual

Mirroring and influencing these increased movements toward categorization was the organization of the “Standard Classified Nomenclature of Disease”. The motivation for this nosological compilation arose from the confusion created from the late 1900’s through the 1920’s with many differing systems of medical diagnosis and disorders utilized in hospitals, organizations and differing sections of the country. There was an oligarchy of hospitals, health organizations and insurance companies (previously referenced New York Life Insurance and Prudential Life Insurance Company) who had been utilizing their own nomenclatures separately, and who over time worked together to form a singular system of disease and tracking of information. The New York Academy of Medicine organized the first conference on the compilation of these systems with the following groups in attendance: American College of Surgeons, the American Heart Association, the American Hospital Association, the American Statistical Association,
the American Surgical Association, the Association of American Physicians, several New York hospitals, the Bureau of the Census, the United States Public Health Service, the Medical Department of the Army and the Medical Department of the Navy.

The initial draft of this document (December, 1931) was circulated for review to representatives throughout the country and fourteen hospitals for actual trial usage. Criticism and recommendations for change were reportedly documented; however, the psychiatric field was not part of this consultative phase. The aforementioned associations, along with other clinics, voted approval of this nomenclature design. The American Psychiatric Association, via their Committee on Statistics who produced the Statistical Manual for the Use of Hospitals for Mental Diseases (1923, with editions through 1942), was involved in providing the Nomenclature information.

Interestingly, within the Nomenclature Manual the authors use mandates from the League of Nations who encouraged countries to begin standardizing their nomenclatures of diseases for future utilizations. There was an attempt to legitimize this publication through stating that the Manual “may therefore be regarded as a preliminary part of an international effort to simplify and facilitate the exchange between nations of information upon disease and its prevention” (Logie, 1933, p. xvii).

The first edition of this Nomenclature included sections within the psychobiological unit categorizing mental deficiencies as related to physical ailments and mental illness related to intoxication and addiction. There was no discussion nor differentiation for children or adolescents in this 1933 publication. Two years later in the second edition of the Standard Classified Nomenclature of Disease (1935 - presented as being utilized in over five-hundred hospitals), there was an expanded categorization of
Primary Behavior Disorders for children. The categorizations of Habit Disturbance, Conduct Disturbances and Neurotic Traits were listed and not referenced. In the literature up to this year, only one study was published searching for adolescent diagnostic categories, Ackerman’s Children’s Behavior Problems (1932), to be reviewed in the next section.

The third edition (1938) cites James May as the liaison from the American Psychiatric Association for this Manual and shows no differences in the diagnostic categories for children or adolescents. The Primary Behavior Disorders section repeats the categories of Habit Disturbance, Conduct Disturbance and Neurotic Traits from the earlier edition.

The fourth edition (1952) of the Standard Nomenclature of Diseases and Operations was published the same year the Diagnostic and Statistical Manual of Mental Disorders (first edition) was released. George Raines, chairman of the Committee on Nomenclature and Statistics (APA) was the central figure bridging these publications and mirroring their presentations. Through the chairmanship of this committee, Raines successfully incorporated the DSM material into the larger nomenclature on diseases aimed at the medical community as a whole. This fourth edition incorporated the rating system of mental deficiency and included the section on Transient Situational Personality Disorders wherein the adjustment reactions of childhood and adolescence include “Conduct Disturbance” as a disorder (Plunkett, 1952). The individual listing of Conduct Disturbance (within the Adjustment Reaction of Children diagnostic category) did not mark a change from the Third edition aside from the subsuming of the category into the larger range of adjustment reactions.
The culmination of the three decades of information was printed with the first edition of the Diagnostic and Statistical Manual of Mental Disorders (1952). Within this document was an introduction giving history as to the development of the Manual. It was pointed to that in 1948 there were three dominant nomenclatures in use throughout the United States, the Standard Nomenclature of Disease, the Armed Forces and the Veterans Administration, yet none were in concurrence with the International Statistical Classification. The World Health Organization had for a number of decades been organizing medical and mental health diagnostic classifications to assist in the communication and tracking of data and information. The result was the publication of the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death (1920 to present).

In 1950, the Committee on Statistics (of the American Psychiatric Association) had designed, through the consultation of the National Institute of Mental Health (Biometrics Branch - established in 1946), a revision of the Statistical Manual for the use of Hospitals for Mental Diseases (10th edition) for review. Two hundred forty-one questionnaires of the utilization of the Manual were tabulated from a portion of the APA membership (10%) with an approval rating not lower than 72% for usage of the Manual. With this simple survey, a recommendation of adoption for the Manual was made and accepted at the November 6th, 1950 APA Annual meeting. All the members of the Nomenclature and Statistics committee were also assigned the work for the Standard Classified Nomenclature of Disease (third and fourth editions).

The Diagnostic and Statistical Manual of Mental Disorders (1952) lists childhood and adolescent disorders under the heading “Transient Situational Personality Disorders”.
Within this category there is the “Adjustment Reaction of Childhood” which includes Habit disturbance, Conduct Disturbance, and Neurotic Traits as subcategories, and “Adjustment Reaction of Adolescence” with no subcategories. As can be seen in the tracing of these categories utilized within the DSM-I, this category of “Conduct Disturbance” is found throughout the literature since the publication of the Ackerman (1932) nomenclature.

Clinician Studies - 1920 to 1952

<table>
<thead>
<tr>
<th>Author</th>
<th>Funding Sources</th>
</tr>
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<tr>
<td>Ackerson</td>
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<tr>
<td>Jenkins and Ackerson</td>
<td>1934 1942 Illinois Institute for Juvenile Justice</td>
</tr>
<tr>
<td>Jenkins and Crudim</td>
<td>1942 American Orthopsychiatric Association</td>
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<td>Hewitt and Jenkins</td>
<td>1944 1946 Illinois Institute for Juvenile Justice</td>
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<td>American Orthopsychiatric Association</td>
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<td>Toppings</td>
<td>1942 1943 American Orthopsychiatric Association</td>
</tr>
<tr>
<td>Kanner, Meyer and Park</td>
<td>1942 n/a American Orthopsychiatric Association</td>
</tr>
<tr>
<td>Pearson</td>
<td>1949 n/a</td>
</tr>
</tbody>
</table>

Total = 11 studies Jenkins (co)authored 5

Table 4.4 Clinically Referenced Studies - 1920 to 1952

As was discussed in Chapter three, Methodology section, the studies chosen for review are those that are cited by the authors within the earlier discussed diagnostic categories for this time period as supportive of the system of nosology presented. These references are an exhaustive list of which studies these authorities cite within the diagnostic systems of this time period.

There are no references cited in the Diagnostic and Statistical Manual of Mental
Disorders (1952) as to where the diagnostic classifications have emerged from, yet there are a number of clinical studies published during this time period that were very important on the emergent design of childhood/adolescent nosology. As previously discussed, the Ackerson study from 1932 is the source for this first categorization of disorders of the DSM-I, though this study is not cited nor referenced by the DSM-I. It is this first volume by Ackerson, followed by a second follow-up study with the same data published in 1942, as well as a study by Hewitt and Jenkins (1946) that began the investigations into these categories.

Ackerson’s 1932 study was a case review of histories for five-thousand children who were admitted to the Illinois Institute for Juvenile Research in Chicago (from 1923-1927). Utilizing the reference of one source (“The Individual Delinquent”, Healy, 1915) as a basis for methodology, the author utilized the case history files to design lists of behavior traits that could be categorized for further segmentation. “This entailed the reading of the entire case records, all of which were read by one person, the writer. The reader called off each item which could conceivably be considered a behavior difficulty or reason for referring to an assistant who at the outset wrote down the item in full” (Ackerson, 1932, p. 39). The limitations to this procedure include the lack of uniformity in data gathering, the lack of objectivity, the overemphasis on undesirable traits, the difficulty of forming categories on nondiscrete items, the location of youth in the same facility, and the clinical judgment of one person.

Ackerson’s 1942 study utilizes the case information from the 1932 study and produced hundreds of correlation coefficients between the behavior traits identified earlier. While painstakingly detailed in results, the greatest difficulty with this
information is the inability to point to what behavior is affecting what behavior; in other words, no known causal arrow can be drawn between the behavior traits. It is hoped by the author that future researchers may utilize this data in this search, yet proposed that this data will "indicate the degree of the child's deviation from the conventional norm of acceptable behavior" (Ackerson, 1942, p. 7). However, a "norm" is not referenced and the basis for the study is the subjective categorization within the earlier study based on the reading of case material. What is produced is a three section correlation set based on "personality-totals", "conduct-totals" and "arrest records for misconduct". One interesting variant of difference from the 1932 publication is the omission of "negro children (408 of 5000) . . . excluded because it was found that in our population they appeared to show a somewhat different sort of behavior complex than the White children" (Ackerson, 1942, p. 7). A not so surprising sign of the times.

Hewitt and Jenkins published the next study in 1946 based upon an examination of five-hundred children with an average age of 11.5 (Ackerson's average age was 11.7). Richard Jenkins, as will be seen, emerges as the most prolific publisher of studies regarding childhood disorders through the 1960's and has a large influence on other researchers in the field (see Tables 4.7 and 5.4). This study took a step closer to searching for the origins of certain behavioral characteristics and used as a basis references of past literature much influenced by the Freudian era looking at maternal and paternal impact on these behavior characteristics. References included Ruth Topping's (1943) writing on case histories of delinquent boys and Ackerson's two publications (1932, 1942). The case record materials for this study are encouraging when that part of the data reviewed included economic conditions, school and neighborhood situations and
reflects a similarity to Ackerson’s search for environmental information. However, the limitations of this design include the admission selective factors for the clinical examination, the unknown factors of reliable reporting, prejudicial trends in data, and inadequate data in records (see Jenkins and Hewlitt, 1946, p. 13). The results of the study were concluded prior to the data analysis and presented as three possible hypothesis of categories that could be proposed from the data. These categories included 1) unsocialized aggressive behavior 2) socialized delinquent behavior and 3) overinhibited behavior. Not surprisingly, these were the published results of the case history summaries and were reportedly supported by the results of Ackerson (1932, 1942) and Topping (1942, 1943).

Ruth Topping is the third author prior to 1943 who had published studies on adolescents referenced by these two previous authors. Her focus was on the aggressive and gang-affiliated boy and she published her findings in the Journal of Orthopsychiatry. Both discussions of these youth were drawn from fifty-five case examples chosen from the New York State Training School for Boys and were selected for their “aggressive delinquent” behavior. There is limited discussion of the method for choice other than by the author and references to the therapeutic modalities attempted in helping these youth. One reverse similarity to Ackerson’s 1942 publication is that the sample chosen for review who were categorized as the “aggressive group” is 92% black of a population that averaged 50% black.

Kanner, Meyer and Park (1942) categorized the area of “antisocial trends” and gave a written description of subcategories. Within these subcategories are elaborate details as to the acts by children and adolescents and case histories given as referential
support for these descriptions. These subcategories include Disrespect of Authority/Disobedience, Lying (separated into wrong interpretations, reversal of truth, exaggerations, fabrications, confabulations, wrong accusations, lying in self-defense, lying in imitation of adult behavior and lying to receive attention), Stealing, Destructiveness and Cruelty, Truancy from School and Wandering from Home.

Pearson (1949) is referenced both during this time period and post introduction of the Diagnostic and Statistical Manual (1952) and cites as support for this source the Kanner (1942) publication. This source describes an “appropriate” way of examining a child, the diagnostic categories, the etiology, psychopathology and treatment of each diagnostic category. This discussion uses as sources of information one specific case study description for each category and follows these examples from diagnosis through treatment. The behaviorally based categories include Temper Tantrums, Antisocial Character and Delinquency. The discussions utilized a psychoanalytic Freudian basis of analysis.

Over the next ten years, through the introduction of the DSM-I, there is an inordinate influence within the published discourse by these authors (see table 4.4). Jenkins and Ackerson (1934) combined to publish a portion of the 1932 study focused on the behavior of encephalitic children. Jenkins and Crudim (1941) reviewed the literature on behavior problems for children with syphilis. Jenkins and Hewlitt (1944) recapitulated their 1942 study and printed a short version of their results for behavioral categorization. Jenkins and Glickman (1946), who happened to be the assistant to Ackerson at the Institute for Juvenile Research, reprinted Jenkins 1946 results once again and incorporated data from Ackerson’s 1942 data to categorically support these
differentiations. The authors simply utilized the definition assigned by Ackerson and reshuffled them within what made subjective sense for Jenkins' three categories of the overinhibited child, the unsocialized aggressive child and the socialized delinquent. What is interesting in surveying this sparse amount of studied information is that all of the clinical studies were published in the American Journal of Orthopsychiatry.

Building up to the introduction of DSM-I and the shift from using the Statistical Manual for the Use of Hospitals for Mental Diseases (reprinted within the later editions of the Standard Nomenclature of Diseases), the American Psychiatric Association proceedings began the stated need for the publication change forthcoming. The American Psychiatric Association was a member organization and part of the editorial board of this earlier Manual production. The APA went on to state that "an extensive knowledge of the properties of characteristics or objects is always necessary to make an efficient grouping. Social values do not constitute a safe basis for any classification of mental disorders as we understand them at present . . . it is recommended that the Committee (on Statistics of the APA) should review again the nomenclature of nervous and mental diseases . . . and ascertain what modifications are necessary" (APA Conference proceedings, June 1949, p. 930).

Not to be considered a clinical study, but also not to be categorized as a classification, the Group for the Advancement of Psychiatry (1950) published a position paper on the topic of Child Psychiatry. This discussion supports many aspects of the genetic dynamic concepts of psychoanalysis in regards to the application for children and points to the inability to apply adults concepts in working with children. There is a discussion of the clinical method of psychoanalysis, settings for this method, training
necessary for child-work, the importance of the intake process and the strong recommendation that the word “diagnosis” be seen as a dynamic rather than a static concept.

### 1952 to 1968 - Diagnostic Classifications

<table>
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<tr>
<th>Year</th>
<th>Source</th>
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| 1952  | *Diagnostic and Statistical Manual of Mental Disorders*  
(Published by the American Psychiatric Association) | “Adjustment Reaction of Childhood”  
“Habit Disturbance/Conduct Disturbance/Neurotic Traits”  
“Adjustment Reactions of Adolescence” |
| 1953  | *Skottowe’s Nosology*  
Disorders: “Disorders of Behavior/Maladjusted Child” |
| 1955  | *Cameron Nosology*  
Disorders: “Conduct Disorders - Delinquency” |
| 1957  | *Hutt Nosology*  
Disorders: “Conduct Problems (physical and environmental)” |
| 1957  | *International Classification of Diseases*  
Disorders: “Primary Childhood Behavior Disorders” |
| 1958  | *Chess Nosology*  
Disorders: “Reactive Behavior Disorder” |
| 1958  | *Jung Nosology*  
Disorders: “Developmental and Behavior Disorders” categories |

Table 4.5 Diagnostic Classifications - 1952 to 1968
Table 4.5 continued

1958 - *Rose Nosology*
Funded through Smith Kline and French Laboratories (pharmaceutical firm)
Disorders: “Acting Out Disorders/Major Delinquent Conflicts”

1959 - *Meyer's Diagnostic Scheme*
Disorders: “Neurotic and Maladjusted Children”

1959 - *Jenson Nosology*
Disorders: “Antisocial Behavior/School Problems”

1959 - *Van Der Horst's Classification*
Disorders: “Criminality (habitual delinquency)”
Disorders: “Asociality (delinquency)”

1959 – Selbach Nosology
Funded through the World Health Organization

1961 - *Standard Nomenclature of Disease and Operations (fifth edition)*
Disorders (same as earlier edition): “Adjustment Reactions of Adolescence”

1962 - *Beller Nosology*
Disorders: “Conduct Disturbances”

1964 - *Selbach Nosology*
Disorders: “Asociality (Asocial and Delinquent subtypes)”

1964 - *Diagnostic Classification in Child Psychiatry* (Jenkins and Cole)
(Published by APA Committee on Research)
Disorders: “Oppositional Personality/Anti-Social Personality”

Table 4.5 Diagnostic Classifications - 1952 to 1968
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<td>&quot;Aggressive Behavior/Antisocial Behavior/Oppositional Behavior&quot;</td>
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### International References Cited Without Adolescent Categorical Disorders

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Table 4.6 International Classification Systems
Table 4.6 continued

1954 - Ey's Simplified Scheme of Classification
1956 - Conrad's Scheme of Psychiatric Diagnosis
1956 - Langfeldt's Classification
1956 - Classification by Henderson and Gillespie
1956 - Leohardt's Classification of Endogenous Psychoses
1958 - Wurzburg Scheme (German Classification)
1958 - French Standard Classification
1958 - Classification of the Dutch Association for Psychiatry and Neurology
1958 - USSR Classification by Kebikov
1959 - Runke's Classification

Table 4.6 International Classification Systems

The publication and release of the Diagnostic and Statistical Manual of Mental Disorders (1952) was not a monumental nor nosologically changing event for the mental health diagnostic field. With the past four decades of differing nosologies and categorizations throughout the field, the impact in the beginning years of the American Psychiatric Association's publication was to begin slowly and build utilization over time. During this time period, the more current utilization of behaviorally based adolescent disorders began to form.

As the DSM (1952) was introduced and was still in its infancy of influence within the diagnostic field, there were competing and complimentary diagnostic systems.
proposed and implemented at varying levels. The following nomenclatures are reviewed for historical notation importance, but it should be remembered that as the next two decades progressed, no other nomenclature system was as endorsed or utilized as the Diagnostic and Statistical Manual of Mental Disorders (1952).

Chess (1958) had limited categories for children and included only “Reactive Behavior Disorder” within this area of nosology. While Hutt (1957) cites conduct problems both related to physical illness and environmental conflicts, but no specific diagnostic category for the disorder.

Jenson (1959) separates categories into psychosis, mental deficiency, psychosomatic and minor disorders encountered within childhood. It is within this latter classification that both antisocial behavior and school problems are listed as problematic areas of this category. Rose (1958) goes to extensive detail in listing diagnostic categories spanning the developmental of a child and adolescent (infancy through age 16). It is within the school age category (age 6-11) that “Acting Out Disorders” is first listed. For the next stage of Puberty and Adolescence (age 11-16), “Major Delinquent Conflicts” encompasses the behaviorally based diagnostic category.

Beller (1962) differentiated this category for children as a functional behavior disorder. The diagnostic category was titled “Conduct Disturbances” and included defiance, negativism, destructiveness, hyperaggression, cruelty, restlessness or overactivity and tantrums as defined traits.

Selbach (1964) lists in a diagnostic system mental disorders for children and adolescents under the categories of mental deviance, developmental defects, psychopathologies, neuroses and asociality. This last category lists only Asocial and
Delinquent as subtypes for this area. These nomenclatures include those categorizations that are not utilized nor referenced by the American Psychiatric Association’s publication of the DSM. What follows is a continuance of those referential sources used as support for the change in the diagnostic categories for behaviorally based disorders via the Diagnostic and Statistical Manual of Mental Disorders.

The publication of the Standard Nomenclature of Diseases and Operations (fifth edition) in 1961 continued to publish the area of mental disorders and made no changes within the categories for childhood and adolescent mental deficiencies. This nomenclature lists Adjustment Reaction of Childhood and Adjustment Reaction of Adolescence as the two categories, yet does change the title of this field to “Transient Stress Disorders without Clearly Defined Structural Change in the Brain”. There is not the expanded listing of “Conduct Disturbance” that was printed in DSM (1952), even though the editorial board members from the fourth edition remained the same and all were members of the Committee on Statistics of the American Psychiatric Association, responsible for recommending changes to this medical manual. Those individuals who were members of both the editorial boards (Standard Nomenclature of Diseases and Operations and the Committee on Statistics of the APA) included a select few: George Raines, Francis Forster, M. Frohlich, Lawrence Kolb, H. Houston Merritt and Harvey Tompkins.

In 1964 the American Psychiatric Association published the Diagnostic Classification in Child Psychiatry (APA report #18) edited by Richard Jenkins and Jonathan Cole (National Institute of Mental Health psychopharmacologist). These were papers and discussions at a regional research conference held at the State University of
Iowa (where Richard Jenkins has been employed since the early 1940’s) and sponsored by the APA’s Committee on Research. The stage for this conference was set for discussions regarding changes in the diagnostic system for behaviorally based childhood and adolescent disorders through the efforts of the American Psychiatric Association and the National Institute of Mental Health.

This report pointed to the lack of a comprehensive system of diagnostic classification to be available for this population. The report stated that the situation at this time was not as bad as it may have seemed, for “the increase in scientific knowledge does not yet permit a comprehensive statement of diagnostic and etiologically principles, we are nevertheless firmly on the road to discerning some of the basic concepts needed for the task” (Jenkins, 1965, p. 2). This group claimed to have researched the previous classification systems and to have relied upon only a handful as referential support for the future direction of diagnostic nosology, these included classifications by Brown (1937), Ackerman (1953), Stengel (1960), Cameron (1955), and the Group for the Advancement of Psychiatry Report #38 (1957). Through the first stage of this report an organizing schema was proposed, based on these previous Classifications, for future DSM publications that included “Oppositional Personality” and “Anti-Social Personality”, both listed under the diagnostic heading of personality disorders. What do these references say in support of these proposed categories?

Brown’s (1937) classification system has been cited earlier as a system applicable to those aged 10 to 15 years of age and lists disorders under the category of Conduct Disorders. Ackerman (1953) presents that the need for classification if “child psychiatry is to be dignified as a science, formulation of adequate criteria for diagnostic
differentiation is indispensable" (Hoch, 1953, p. 222). To assist in this process, Ackerman provides a guide for assessment of a child and relies upon the diagnostic classifications and references by Brown (1937) and Pearson (1920) as support for this assertion. It is stated in this report that the reasons for these references is that they are supported by the American Psychiatric Association. This author then presents an extended discussion of the categories of Habit Disorder, Conduct Disorder and Neurotic Traits (Ackerman, 1937) with the extension of psychodynamic assessments regarding the child’s relationship with his mother, dependence issues and differentiation from the parents. Ackerman quotes that this system is only applicable to those children of preschool and school age (not of adolescence), and Brown (1937) states that the diagnostic system is applicable for children over the age of 10 - leaving a small window of applicability ages 10 to 13.

Cameron (1955) cites as referential sources past clinical classifications by Gordon (1939) who differentiated through the physical, mental and social differences; Hall (1948) who utilized the element of development; Burt (1937) who used the polarization of inhibited and aggressive types; and Kanner (1948) who’s reaction types are considered too wide for practical usage. Cameron believes that if all aspects of a child are taken into account then “we would find that clinical relationships would appear and syndromes, or at least clustering of symptoms, manifest themselves” (Cameron, 1955, p. 68). This author then lists the categories of developmental, reactive and individual as a proposed classification, with no additional referential support. Under reactive categorization is listed “Conduct Disorders - delinquency” defined as “disturbed behavior of a sort that invokes social or moral condemnation, and in general is applied to children who have at
least reached school age. Both in its origins and results it is readily seen as a reaction of the child with the environment” (Cameron, 1955, p. 70).

Stengel (1959) presented a compilation of mental disorder classification systems utilized internationally up to this time. The sample for study resulted from inquiries sent to the statistical departments of national health authorities as well as to a number of leading psychiatrists (not specified). The justification was claimed necessary due to the lack of agreed upon diagnostic systems and lack of agreed upon operational definitions for disorders. This writing, published by the World Health Organization, was not specific to childhood and adolescent disorders, for the research presented in synopsis form all mental disorders categorized. The following citations include those published within this document and cited with childhood and/or adolescent diagnostic categories within these classification systems. The International Classification of Diseases (1957) cites “Primary Childhood Behavior Disorders” as behavior disorder of childhood not identified with psychopathic personality, mental deficiency or physical illness - listing jealousy, masturbation and tantrum as symptoms. The Diagnostic and Statistical Manual of Mental Disorders (1952) is listed and has been discussed earlier. The Diagnostic Classification of the Dominion Bureau of Statistics, Canada (1957) lists “Primary Behavior Disorders” with no additional information. The Classification of the Danish Psychiatric Society (1952) cites disorders for those under 15 years of age with no additional information. The classification in use in Japan cites “Behavior Disorders (in children) of Different Types, with no further reference. Van Der Horsts’s Classification (1959) lists “Criminality (habitual delinquency) as the only childhood disorder. Jung (1958) cites developmental and behavior disorders of children and adolescents as a category, with no
further printed information. J.E. Meyer's Diagnostic Scheme (1959) lists "Neurotic and Maladjusted Children". Selbach (1959) lists only "Asociality" with delinquency as a descriptor (as referenced earlier). Skottowe's Classification (1953) describes mental disorders in children to include disorders of behavior and the maladjusted child.

This Research Report #18 cites this source for documented assistance in researching mental disorders for children and adolescents uses this writing by Stengel (1959) as support for future utilization. However, the following systems (within Stengle, 1959) are those listed that give no reference to childhood or adolescent mental health diagnosis. These include the German classification (Wurzburg Scheme), French Standard Classification, Classification of the Dutch Association for Psychiatry and Neurology, USSR Classification by Kerbikov (1958), USSR Classification by Giljarkovskij (1954), Classification of Bosch and Ciampi, Ey's Simplified Scheme of Classification (1954), Kleist's Classification of Neuropsychiatric Diseases (1953), Kraepelin-Lange's Classification (1926), Krapf's Classification, Meyer's Classification, Classification Proposed for Official use in Norway, Rado's Classification (1953), Rumke's Classification (1959), Schneider's Classification (1950), Conrad's Scheme of Psychiatric Diagnosis (1956), Essen-Moller's and Wohlfahrt's Classification (1947), Classification by Hendeson and Gillespie (1956), Classification proposed by Ibor (1959), Kloos Classification (1951), Langfeldt's Classification (1956), Lecomte's Classification (1947), Leohhard's Classification of Endogenous Psychoses (1957), Lopez Classification (1948), Silva's Classification (1948), and Sjogren's Classification.

The next "seminal" study referenced is the Group for the Advancement of Psychiatry's Report #38 (1957). This publication's intent is to present "the diagnostic
study as a comprehensive dynamic medical process. "As in general medicine and other medical specialties, diagnosis in child psychiatry takes into account the multiplicity of etiologically factors" (GAP, 1957, p. 313). The report then discusses the clinical premise of presenting problems; the physical, psychological and psychiatric examination; diagnostic formulation; plans and prognosis; and all within an abstract presentation of possibilities in the field of diagnosis.

The American Psychiatric Association's Report #18 presents the following as supportive of the childhood diagnostic classification. Dreger (published in this APA Report, 1964) utilized a familiar format of other researchers in collecting demographic and parental behavioral complaint checklist data on a group of 6 to 13 year old youth for a study that then utilized factor analysis to identify ten indicators for childhood diagnosis. Fish (published in this APA Report, 1964) used a sample of 6 to 12 year-old inpatient psychiatric children and formalized a classification system in relation to autism and schizophrenia. Within the discussion section of this publication, Jenkins supports this report through the referenced study in 1946 (Jenkins and Hewitt) from the Michigan Child Guidance Institute. Additionally there is referenced a presentation given in 1964 to the American Medical Association by Dr. Donald Ross, "A Classification in Child Psychiatry". This source is referenced because it "has so many points descriptively and dynamically similar to our own" (APA #18, 1964, p. 118). The category "Negatively Organized Child" corresponds to Jenkins and Hewitt's (1946) "Undomesticated Group" and is "engaged in a battle of wills with one or more of the adults in his life. The child's opposition may be quite overt or it may be covert, with him dutifully going through the motions of carrying out his parents' wishes but accomplishing little" (APA #18, 1964, p. 92).
The American Psychiatric Association in November 1965 reprinted the Diagnostic and Statistical Manual with a "special supplement on plans for revision". This reprint of the Manual from 1952 prints an additional four pages in an appendix discussing the upcoming 1966 World Health Organization conference on the eighth revision of the International Classification of Diseases. There is a reprint of these proposed ICD revisions and states that the "Committee on Nomenclature will prepare recommendations on how best to bring a revised version of the APA classification into relation with the ICD, eighth revision" (DSM, 1965, p. 134). This category from the ICD lists only Behavior Disorders of Childhood as a diagnostic category.

In 1966, the Group for the Advancement of Psychiatry, published by the American Psychiatric Association Press, issued report #62 titled “Psychopathological Disorders in Childhood: Theoretical Considerations and a Proposed Classification”. This was the introduction of a committee called the “Committee on Child Psychiatry” who prefaced this report with a stated need for future nosologies to include descriptive-clinical, genetic and dynamic dimensions as well as the developmental nature of children. With this focus, the committee utilized the concepts of psychosomatic, developmental dimension and psychosocial aspects in their report recommendations. This report continued to point to stress, maturity, vulnerabilities, strengths, developmental patterns, parent-child relationships, pathogenics, family, and socioculture as guide posts for a diagnostic system. Within the personality disorders category are three subcategories related to behaviorally based disorders. “Aggressive Behavior” is divided into both externally (fighting, cruelty, verbal aggression, homicidal) and internally directed
(accident proneness, masochistic, self-destructive, self-inflicted injury, self-punitive behavior, and suicidal gestures and attempts). “Antisocial Behavior” is listed as cheating, fighting, forgery, lying, stealing, truancy, and vandalism. “Oppositional Behavior” is defined as disobedience, marked carelessness, negativism, passive-aggressive behavior (dawdling, passive), provocative behavior, quarrelsomeness, resistance to change, running away, and teasing. This report utilized as references previously listed categories of diagnostic classifications, including Ackerman (1955); Ausubel (1958), who presented a theoretical discussion of ego developmental, Behrens and Goldfarb (1958); Beller (1962), who presented a data tracking mechanism; Finch, (1960); Freudian reference to assessment (1962); the GAP diagnostic assessment report #38 (1957); the DSM (1952); and Voiland (1962).

1968 marked the year that the American Psychiatric Association published the second edition of the Diagnostic and Statistical Manual of Mental Disorders. The publication of this edition was forwarded as necessary to work and comply with the World Health Organization in the eighth revision of the International Classification of Diseases. The DSM-II (as it was referenced) proposed this classification based upon the international collaboration effort that started in 1957 and culminated in the revision published in 1965. This international classification may have been utilized for other diagnostic categories, but this is not the focus of this research. For childhood and adolescent disorders it is only the following that can be identified from these sources in support of the DSM-II.

with no referential material provided. The same Manual (1957 revision) changes this category to “Primary Childhood Behavior Disorders” with no additional information given. The Manual of the International Statistical Classification (1965) listed above as the collaborative reference for the introduction and utilization of the DSM-II does not expand upon this categorization for the application to children or adolescents, but does retitle this category to “Behavioral Disorders of Childhood” (ICD, 1965, Category 308). The only citation within this international publication as to the source of these categories is through “committee collaboration”, no additional information is given.

Prior to the introduction of the DSM-II, the following encapsulates the minimal effort forwarded by the American Psychiatric Association in expanding beyond this group for input into this expanding field of diagnostic psychiatry. “A draft of this Manual, DSM-II, was circulated to 120 psychiatrists in February 1967 with a request for specific suggestions to eliminate errors and to improve the quality of the statements indicating proper usage . . many valuable replies were received . . collated and studied . . . at which time the Committee formulated the present manuscript and submitted it to the APA Executive Committee for approval” (APA, 1968, p. ix). No mention as to these references were given and it is not known where the changes in the childhood and adolescent diagnostic categorization originated.

The DSM-II lists “Behavior Disorders of Childhood and Adolescence” within this Manual. Within this category are Hyperkinetic Reaction of Childhood (or Adolescence), Withdrawing Reaction of Childhood (or Adolescence), Overanxious reaction of Childhood (or Adolescence), Unsocialized Aggressive Reaction of Childhood (or Adolescence), Group Delinquent Reaction of Childhood (or Adolescence), and Other
Reaction of Childhood (or Adolescence) (APA, 1968). The Unsocial Aggressive subcategory is defined as “characterized by overt or covert hostile disobedience, quarrelsomeness, physical and verbal aggressiveness, vengefulness, and destructiveness. Temper tantrums, solitary stealing, lying and hostile teasing of other children are common. These patients usually have no consistent parental acceptance and discipline” (APA, 1968, p. 50-51). The Group Delinquent subcategory is defined as “individuals who have acquired the values, behavior, and skills of a delinquent peer group or gang to whom they are loyal and with whom they characteristically steal, skip school, and stay out late at night. The condition is more common in boys than in girls. When group delinquency occurs with girls it usually involves sexual delinquency, although shoplifting is also common” (APA, 1968, p. 51). No references are given for these definitions.
### Funding Sources

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Jenkins (co)authored 6  
Quay (co)authored 5  
Peterson (co)authored 4

Table 4.7 Referenced Studies - 1952 to 1968

Discussed within the methodology section for the design of this research, the criteria for the clinical studies chosen included only those studies that have a direct...
reference from the Diagnostic and Statistical Manual or the supporting publications of the history of this Manual cited as documentation for these adolescent diagnostic categories. These studies are cited by the authorities as supportive of this classification system and in this scope are an exhaustive list. However, these studies do not represent the entire literature of clinical studies available to the reader. To entail that scope of research is beyond the focus of this writing, and would consist of a dissertation itself to be comprehensive.

This was a stage of research studies when factorial analysis began to be utilized as a reinforcing method for categorizing these disorders. The first was published by Jenkins and Lorr (1953) using data from the same two studies from Ackerson (1942) and Jenkins and Hewlitt (1946), and included a reference to Jenkins and Glickman (1946) as a study that “confirmed the presence of these three major syndromes and two others as the only well-marked clusters of intercorrelated traits discernible” (Jenkins and Glickman, 1946, p. 16). This factorial analysis reportedly renamed and categorized the outcome to include “socialized delinquency, internal conflict, unsocialized aggressiveness, brain damage and schizoid reaction” (Lorr and Jenkins, 1953, p. 19).

Jenkins continued to publish his research based upon these earlier studies and offers no new additional clinical data (bar 1966) in the field. Jenkins (1954) focused on the clinical symptoms of the “sick” individual and follows the child through developmental stages in relation to these difficulties. Jenkins (1968) published the precise same report based upon his 1967 presentation at the 123rd Annual Meeting of the American Psychiatric Association published in the American Journal of Psychiatry. Jenkins (1964) recapitulates the data from the 1946 study (Jenkins and Hewlitt) and
simply expands upon the description of how these categories “look”. This publication states that “this material was the basis for two articles . . . which contrasted the three most prominent syndromes. The findings of the study have been confirmed” (Jenkins, 1964, p. 450). These confirmations are reportedly by his own published (1964) review, Saksida (1959) and Lewis (1954).

Gerard (1952) reinforced this focus of research through an application of psychoanalytic theory and dynamic psychiatry for children. This writing constructs the stages of psychoanalytical practice and applies these to the difficulties of childhood. This writing presents both the affirming nature of this type of inquiry and deconstructs the theory and practice as to difficulties in application. This reference does not bring any method to bear in supporting or not supporting a diagnostic classification system.

Gardner used the case study methodology and wrote of the case history, diagnosis and treatment for thirteen youth (in 1953) and fifteen youth (in 1956) ranging in categorical need. Within these case studies, a number were focused on behaviorally based disorders and included the following: Intensive Residential Treatment of a Nine-Year Old with an Aggressive Behavior Disorder, Ambivalence and Resistance to Treatment in a Delinquent Adolescent Boy, Residential Treatment of a Ten Year-Old Boy (Marked Destructive Behavior), Pupils Psychologically Absent From School, and Treatment of an Adolescent Delinquent. There is debate as to the usefulness and appropriate role of case studies ranging from supportive (Stake, 1984) to a minor addition to the field of research. What is seen in these reports are specific treatment applications over a period of time for five children and adolescents.

Robinson, et. al. (1957) published the proceedings from a conference sponsored
by the American Psychiatric Association and the American Academy of Child Psychiatry and funded through a grant from the National Institute of Mental Health on the topic of Inpatient Psychiatric Treatment for Children. This conference did not present any new studied material, only case examples of youth staying in residential facilities. The report discussed the course of treatment for these youth, yet primarily focused on the more global issues of designing, administrating and organizing the treatment for these institutions.

Van Amerongen (1954) sampled forty youth and families who had been unsuccessfully treated in a child guidance clinic. These families were interviewed with the parents alone, child alone, family together; and the youth was given psychological testing including the Rorschach, TAT and Stanford-Binet in a search for why there was not success over the treatment time period. No conclusions were printed, only case study material from these interviews, and it is unknown as to what percentage of these youth had behaviorally based disorders. This study was cited as supportive of the classification system formed during this time period, yet not enough data was presented to bridge the research results with the nosology.

Lewis (1954) utilized the same methodology in examining 500 children who were admitted to the Mersham Reception Center (residential facility in Kent, England) between a three year time period (1947-1950). Most of these children were admitted because of the effects of World War II (death of parents, fathers fighting in the war, mothers working in military factories) and not reportedly because of behavior problems in the home. The title of the report “Deprived Children” shows the outcome of this in depth analysis of these youth. Saksida (1964) reports from Yugoslavia a comparative
analysis of delinquent and nondelinquent youth, though does not give demographic sample information with which to review. Biological structure, social differences, intellectual differences and emotional poverty are identified as the predominant influences on differentiating these youth. In reviewing these publications, it is not possible to identify how they “confirm” Jenkins and Hewlitt’s 1946 study, for the authors offer reviews of studies that are different in design, search for different factors and do not discuss the earlier (1946) studied results.

Behrens and Goldfarb (1958) are referenced in the Group for the Advancement of Psychiatry Report #38, and it is not understood why this is included as supportive of typology for behaviorally based disorders for children. This study incorporates the observation of 20 families in their home environment, 10 diagnosed children with schizophrenia and 10 not diagnosed or in treatment. A three hour observation was claimed to have allowed for a rating scale showing the impact of the family on the etiology of the diagnosis of schizophrenia. There is no mention of behaviorally based diagnosis.

Lapouse and Monk (1958) focused on children aged 6 to 12 in performing a pilot study interviewing 412 mothers of these children. These child-report interviews took place over a six-month period and found two conclusions. One, is that mothers report a high percentage of behavior commonly thought of as pathological, and second that mothers’ reports compared to children’s tend to underestimate the prevalence. The most commonly listed behavior characteristics included worrying, bedwetting, nightmares, loss of appetite, temper loss, overactivity, restlessness, stuttering, unusual movements, biting nails, grinding teeth, sucking thumb, and biting.
Bennett (1959) utilized a sample of a rural community in England and focused on delinquent and neurotic children and adolescents. This research was conducted during 1946-1948 and consisted of examining case histories via a committee of staff members (the treatment team). From a pool of 1000 youth, this committee chose 100 youth for final analysis (50 neurotic and 50 delinquent) based upon criteria developed by Friedlander (1959) who worked at this guidance center. These categories were originally presented by the Jewish Board of Guardians in the United States and the Institute for the Scientific Treatment of Delinquency. After examination of these 100 youth, group characteristics of delinquent behavior were presented to include the following areas: stealing, lying, truancy, running away, aggressive or destructive behavior, quarrelsomeness, extreme disobedience and defiance, unmanageable, hostility to parents or teachers, cruelty to animals or younger children, incorrigible, gang member and verbally aggressive.

Thomas et. al. (1959) presented a study of 74 children ages birth to 2 years of age searching for parental reporting of activity level, withdrawal, responsiveness, mood, attention span and other areas. This study focused on the observable characteristics of these subjects and presented a biological analysis of the results. This same year reference is made to Jenkins and Glickman (1959) who republished the same data and conclusions of categories from the Jenkins and Hewlitt (1946) study utilizing the data from the study conducted in Michigan. There is presented no new information nor knowledge with which to base future considerations of typology.

Peterson and Quay published numerous referenced studies dealing with the issue of defining delinquency. These authors (1959) utilized a questionnaire matching
delinquents and nondelinquents and scored these results for factor analysis. The results are quoted to confirm Hewlitt and Jenkins (1946) results of the category of Unsocialized Aggression among this sample. The samples used included previous studies by Quay and Peterson (1958) which were behavior checklists. Peterson and Quay (1959) recapitulated the Hewlitt and Jenkins (1946) printed results and presented the subgroups of delinquency as the Overinhibited child, Unsocialized Aggressive child and Socialized Delinquent. These authors prefaced this with writing of the growing epidemic concern of juvenile delinquency and began a discussion of using factor analysis and the possibility of types or traits being identified as future subgroups for research. Peterson and Quay (1961) presented a study using 107 residential delinquent youth rated through behavior checklists and incorporated a factor analysis to conclude that the categorization of delinquents based on traits is unsubstantiated. The recommendation is to categorize this population on the behavior itself and to rely on theoretical underpinnings to support the conclusions or typology. This is one of the sole studies referenced to support the change toward descriptive psychiatry focused on the adolescent population.

Peterson, Quay and Tiffany (1961) followed up this focus with a review and study of 400 youth and did not follow their earlier printed recommendations for further research on behaviorally descriptive based typology. This study concluded confirmation of earlier delineations and called for the categories of "Psychopathology", "Neuroticism", and "Inadequacy" as future recommendations. Peterson (1961) also published the categories from Peterson, Quay and Tiffany (1961) study and presented the categories to a set of local elementary school children (ages 5-12), additionally asking for teacher ratings on a three point scale (no problem, mild problem or severe problem). Results
were reported to have been confirmatory. Quay (1964) next claimed confirmation of the additional category of “Inadequate-Immature” for the delinquent typology. Through a study of 115 institutionalized males using categories from the previous 1961 study (though using only 29 of the 58 behavior traits presented earlier), the results claimed that the factor analysis of this study identified “clearly . . . categories of socialized-subcultural, unsocialized-psychopathic, disturbed-neurotic and inadequate-immature” (Quay, 1964, p. 479).

Reiss (1961) used as a basis of support psychoanalytic theory to delineate delinquents on the basis of case reports into three groups: delinquents with markedly weak Ego controls, delinquents with relatively defective Super-Ego controls and relatively integrated delinquents. This is mirrored by Finch (1961) who presented the fundamentals of child psychiatry for the field. This author used psychoanalytic theory to describe child psychiatry from infancy to adolescence. What the author used as referential support are the precise categories of the Diagnostic and Statistical Manual (1952). This author takes these previously published diagnostic categories, incorporates the psychoanalytic concepts of the ego, superego and id in the explanation process and gives case study examples for half of these categories as research support.

In 1961, Robinson, Vitale and Nitsche made a presentation at the American Psychiatric Association’s Annual meeting on diagnostic categories for children and adolescents. Their reported samples included the review of a large number of case records, yet the number and location of these records is not provided. On this basis, the authors listed the behavioral patterns which were described and became “easily recognized: 1. Active Superficial, 2. Openly Antagonistic, 3. Active Control, 4. Passive
Control, 5. Passive Apprehensive” (Robinson, et. al., 1964, p. 806).

Voiland (1962) was cited in support of this research area for behaviorally based childhood and adolescent diagnosis, yet this study’s focus is family casework diagnosis. This study sought to organize types of family disorganization in looking at demographics, interactions, marital relationships, parent-child relationships, health and other areas; yet there was not any information that is able to be applied to form the referenced source.

Dreger et. al. (1964) used a sample of 6-13 year olds in south Florida and incorporated a behavioral checklist of fifty items developed in the Duval County Child Guidance Clinic by an interdisciplin ary committee. These ratings began with a larger list and through “logical analysis” decreased this to a reportedly manageable number by the authors. This list was then administered to the parents of children seeking services. The categories were analyzed through factorial analysis and five clusters were presented.

The earlier referenced APA Research Report #18 (1964) cited two clinical studies within this document. Dreger (1964) utilized a parental behavioral complaint checklist focused on children ages 6 to 13 and identified ten factors (through factorial analysis) that grouped these parental foci. Fish studied a group of 6 to 12 year old inpatient children in focusing on autism and schizophrenia in categorizing differences. Cited as seminal studies, these results rely on parental checklists and inpatient youth to categorize children and adolescents in all life settings.

Jenkins, Nureddin, and Shapkra (1966) published an expanded application of Jenkins and Hewlitt’s (1946) results of categorization into six diagnostic areas. This study is based on a group of 300 cases (ages not published) admitted to inpatient and outpatient services at one location from 1959 to 1961. The additional tool utilized was a
13-page intake questionnaire to be obtained from parents and investigating the social
history of the youth and family. All information is helpful in the diagnostic field;
however, this intake information was then placed in preexisting categories and did not
allow for modifications in the diagnostic impressions. The study was set up to support
these preexisting categories, and not to change or challenge the results.

Corresponding to the references of the International Classification of Diseases,
utilized in the changes from DSM-I to the DSM-II, the “committee” reference made in
this publication related to these behaviorally based diagnosis is traceable to only one
clinical source. Rutter et. al. (1969) looked at these classification systems with a
committee of 12 individuals from differing countries. Unpublished working papers were
cited as references for this categorization focused on children ages 3 to 12. The data was
gathered through each of the 12 committee members reviewing case histories of 12
children and using an inter-rater reliability procedure to find “remarkably good
agreement on the broad categories of diagnosis” (Rutter et. al., 1969, p. 43). This was
followed by the review of seven differing cases on video tape and completing a
questionnaire of analysis. Based on this procedure, changes were made to the nosology
which included incorporating some types of delinquency (see earlier references to
Peterson and Quay) which could be judged by the frequency, severity and type.

Funding Sources: 1900 to 1968

Classification Systems (see Tables 4.3 and 4.6)

The numerous nosological classification systems that emerged over this time
period were found to be funded distinctly through differing organizations. There were
numerous organizations which produced the classifications of childhood (predominantly) and adolescent diagnosis and this coincided with the overall growth of the field of psychiatry. The predominant category of diagnosis that emerged was the category listing through the American Medico-Psychological Association who convened a committee in 1918 to produce the “Statistical Manual for the Use of Institutions for the Insane”. The American Medico-Psychological Association was the predecessor to the American Psychiatric Association. This Manual became the Statistical Manual for the Use of Hospitals for Mental Diseases, also funded by the American Psychiatric Association. Not surprisingly, this Manual was the most influential upon the introduction of the DSM (1952).

These early stages of diagnostic classification systems were influenced by the desire of the federal government to accumulate quantifiable data through the United States Census Bureau. This entity specifically called upon the American Medico-Psychological Association to form this committee and financially supported the committee who was responsible for the production of the Manual. The Rockefeller foundation supported a majority of the grant moneys utilized during the use of this Manual from 1917 to 1942.

Differing hospitals and universities were responsible for the funding and production of other categories of diagnosis. Brown (1937) was financed through the State of New York and originated in the teaching of this Columbia University professor. Ackerman (1932) was financed through the institution that the case study materials originated from, the Illinois Institute for Juvenile Research in Chicago. Pearson (1920) was funded through the Oxford University Research System. Strecker and Ebaugh's
(1931) funding source was not traceable, though the classification system was published through a subsidiary of the American Psychiatric Association Press. English and Pearson (1937) were funded through the university publisher of their teaching institution. Pacella (1948) was funded through the American Medical Association.

Louettit (1947) was funded through the American Psychological Association. Ackerman’s (1953) research was supported and published by the American Psychopathological Association, a close cousin of the American Psychiatric Association, and a group that eventually merged with the larger APA. Cameron (1955) was financially supported by the Bethlem Royal Hospital in England. Stengel (1959) was supported through a grant from the World Health Organization, as were the International Classification of Disease Manuals, which reportedly were chosen as supportive of the diagnostic changes from the DSM (1952) to the DSM-II (1968). Selbach (1964) also received financial support from the World Health Organization. Rose (1958), not surprisingly, was financially supported through the pharmaceutical company of Smith, Kline and French Laboratories.

As referenced earlier, the American Psychiatric Association and the Group for the Advancement of Psychiatry published numerous reports citing supportive citations for the DSM changes during the time period of 1952 to 1968. These organizations on paper were distinct organizations, yet a comparative analysis of memberships shows that all Group for the Advancement of Psychiatry members were also members of the American Psychiatric Association. Funding for numerous of the GAP reports was supported by the American Psychiatric Association and/or grants from the National Institute of Mental Health, common funding ground.
The insurance company industry began to show involvement on this diagnostic process fairly early on in the formation of the diagnostic systems. The Standard Nomenclature of Disease and Pathological Conditions, Injuries, and Poisonings for the United States (1920) was the first indication of this industry being listed as a funder for diagnostic classifications. Both Prudential Life Insurance Company and New York Life Insurance Company gave funding to produce this manual, although amounts were not published. Dr. Frederick Hoffman of the Prudential Life Insurance Company and Dr. Arthur Hunter of the New York Life Insurance Company both had committee positions for this Nomenclature production, as well as the tremendously influential Standard Classified Nomenclature of Disease.

The Standard Classified Nomenclature of Diseases became the dominant source for all medical diagnosis and was originally organized by the Committee on Public Health Relations (of the New York Academy of Medicine). Many of the listed funders for this Nomenclature were private for-profit insurance companies including Metropolitan Life Insurance Company, Prudential Insurance Company of America and the Connecticut General Life Insurance Company. An additional listed financial supporter included the Commonwealth Fund (an organization affiliated with the American Medical Association) and member associations or various disciplines within medicine (American Psychiatric Association being included as a funder, Logie, 1933).

The introduction of the Diagnostic and Statistical Manual of Mental Disorders (1952) marked the domination of funding to be supported by the American Psychiatric Association for this publication and a relationship between the National Institute of Mental Health (a department of the National Institute of Health) that was established in
1946. This relationship is one of research dollars supplied to the American Psychiatric Association, supporting members and publications of this diagnostic system from this time forward. The National Institute of Mental Health is a federally funded department of the Department of Health and Human Services responsible for research and funding research in the field of mental health.

**Clinical Studies** (see Tables 4.4 and 4.7)

Ackerson (1932 and 1942) was funded by both the Illinois Institute for Juvenile Research and the Behavior Research Fund, state of Illinois dollars designated for work with delinquency. Hewlitt and Jenkins (1946) used clinical data from the Michigan Child Guidance Institute and the study published was financed through the State of Illinois. Topping (1943) was financed through the American Orthopsychiatric Association for her support of Jenkins typology. Her research though was published through her affiliation with the Chicago Home for Girls, located in Illinois, the site of all previous clinically published studies. This began a series of studies that were researched from these Institutions in Illinois and originated as a presentation at the American Orthopsychiatric Association. These include Jenkins and Ackerson, Institute for Juvenile Research in Chicago, who presented at the 1933 Annual meeting of the Association. Jenkins and Crudim (1941), a study presented at the 1941 Annual meeting of this Association. Jenkins and Hewitt’s (1944) who presented a study at the 1943 Annual meeting of this Association. Jenkins and Glickman (1946) who presented a study at the 1945 Annual
meeting and was followed by Van Emerongen’s results at the 1953 Annual meeting.

Lorr and Jenkins (1953) study of maladjusted children was funded through the Veterans Administration, as was Jenkins (1954) publication. Pearson (1949) was funded through the Philadelphia Psychoanalytic Institute where this author was employed.

Kanner, et. al. (1942) funding source for the study cannot be verified, yet it may be assumed that at this time the authors were all employed through Johns Hopkins University and the funding may have originated through this organization. The American Orthopsychiatric Association published Gardner’s (1953) compilation of studies.

LaPouse and Monk (1958) was supported by a grant from the Public Health Service.

Thomas, et. al. (1959) was funded through a grant from the National Institute of Mental Health (#M2805) and presented at the New York Divisional meeting of the American Psychiatric Association (November, 1959).

Peterson, Quay and Cameron (1959) were funded through a grant from the Institute of Research and Training in the Social Sciences, Vanderbilt University.

Peterson and Quay (1959) were funded through the Illinois State Training School for Boys for the resultant study. Peterson (1961) published through the receiving of a grant from the State of Illinois Department of Public Welfare. Quay (1964) was supported through a grant from the National Institute of Mental Health (grant #M5627) and studied at the National Training School for Boys in Illinois. Peterson, Quay and Tiffany (1961) also utilized this National Training School for Boys and received a grant from the University Research Board of the University of Illinois. Quay and Peterson (1960) also presented this earlier research at the Conference for Exceptional Children in 1960.

Lewis (1954) was supported by the Oxford University for the study on deprived
Behrens and Goldfarb (1958) received support from the Commonwealth Foundation and the Ittleson Family Foundation and first presented this study at the American Orthopsychiatry Association 1957 Annual meeting. Saksida (1957) was translated from Yugoslavia by Richard Jenkins and presented for additional clarity on delinquent stereotypes. Jenkins was also responsible for a similar study and translation from Japan (Kobayashi, et. al., 1967) who cite this author as primarily responsible for the publication in the American Psychiatric Press. Robinson, et. al. (1961) presented their results at the 1960 Annual meeting of the American Psychiatric Association and received funding from this organization. Jenkins (1964) again presented similar material from earlier studies to the American Medical Association Annual meeting in June, 1964.

Dreger (1964, APA #18) received two grants from the National Institute of Mental Health (#M6316A and #M5117A). Fish and Shapiro (APA #18, 1964) were supported by the American Psychiatric Association for this utilized research. Dreger (1964) also received a National Institute of Mental Health Grant (#M6316A) and a Public Health Service Grant (#M5117A). Jenkins, NurEddin and Shapiro (1966) was supported through a research grant from the Iowa Mental Health Research Fund (beginning professional source for earlier Jenkins research). Jenkins last impact during this time period was an additional study presented at the 1967 Annual meeting of the American Psychiatric Association (Jenkins, 1968).
Key Individuals: 1900 to 1968

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(A) Committee on Nomenclature and Statistics
(B) GAP’s Committee on Child Psychiatry

Table 4.8 Key Individuals - 1900 to 1968

During this time period a number of individuals have emerged as exceptionally important in the progression of this classification system for behaviorally based diagnosis. Nathan Ackerson is cited by the authors of the classification systems as the originator of the clinical studies and references to his 1932 and 1942 studies outnumbered all other citations within the literature (see Table 4.8). Following close behind Ackerson in citations to appropriate literature, yet outstripping this author in the proliferation of studies and published articles on behaviorally based disorders, is Richard Jenkins. Jenkins collaborated with numerous other authors over this twenty-five year period and his continued research and presentation at association meetings will continue into the next differentiated time period. What is interesting is how dominant these authors are in
being cited as the referential support for the exponential research in future decades and for the basis of behaviorally based disorders.

In the mid-1950’s, Donald Peterson and Herbert Quay emerged as equally dominant in their research on delinquency and the influence this reportedly has on the behaviorally based diagnosis. These authors bring a more punitive focus on the research outcomes incorporating harsher language and potentially allowing for this language used within categorization for future diagnosis.

George Raines was one of the most powerful members within the psychiatric community during the 1940’s through mid-1950’s. He served as the first Chairman of the Committee on Nomenclature and Statistics of the American Psychiatric Association. It was this Committee that was given the authority to produce the necessary categorical data and research for the first Diagnostic and Statistical Manual of Mental Disorders (1952). Raines also served as the liaison from the American Psychiatric Association in reporting necessary categorization to the American Medical Association’s Nomenclature of Diseases, the dominant health directory of the era.

There were two committees that had much influence on this area of research and discussion. The first is the aforementioned Committee on Nomenclature and Statistics, serving as the board of individuals responsible for recommending changes to the diagnostic system. This committee (1951) included Raines (Chairman 1946-1952), Moses Frohlich, Ernest Goddard, Baldwin Keyes, Mabel Ross, Robert Schwab, Harvey Tompkins, Franz Alexander (1947-1950), John Baird (1948-1951), Abram Bennett (1941-1946), George Brewster (1946-1948), Norman Brill (1946-1948), Walter Breutsch (1944-1949), John Caldwell (1948-1951), J. P. S. Cathcart (1941-1946), Sidney chalk
(1947-1950), Neil Dayton (1936-1949), Chairman 1942-1946), Clarence Cheney (1942-
1947), Jacob Friedman (1947-1949), Jacob Kasanin (1944-1946), Lawrence Kolb (1947-
1950), Nolan Lewis (1946-1948), James May (1937-1948), Houston Merritt (1946-1948),
J.Davis Reichard (1946-1950), George Sprague (1945-1948), Edward Strecker (1948-
1951) and Paul White (1946-1950). After the introduction of the DSM, this committee
significantly changed and the active members included the following individuals: Ernest
Gruenberg (Chairman after Raines), Richard Jenkins, Lothar Kalinowsky, Henriette
Klein, Benjamin Pasamanick, W.E. Slenger, Morton Kramer (consultant), Robert Spitzer
(consultant) and Edward Stainbrook. The only active members from the DSM committee
and the DSM-II committee were George Raines and Lawrence Kolb. Interestingly,
Richard Jenkins addition to this committee only reinforces this individuals influence
upon this nosology process. One individual, Robert Spitzer, will emerge from the next
time period as one of the most influential individuals on the changes for the DSM-III
(1980).

The second committee was the Group for the Advancement of Psychiatry’s
Committee on Child Psychiatry. The Group for the Advancement of Psychiatry (GAP)
was a small organization consisting of at most 180 individuals who desired to represent
progressive change in the field of psychiatry. This group began to form after World War
II and coincided with the growth of community based psychiatry. This group published
somewhat prolifically on topics including child psychiatry, aging, college students,
family, international relations, medical education, mental retardation, preventive
psychiatry, psychiatry and law, psychiatry and religion, public education, research, social
issues, therapeutic care, and psychiatry and social work. The GAP presented as an

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independent entity, yet this was not the case. The GAP was actually funded through the American Psychiatric Association and the publications from this group were published by the APA Press. The Group for the Advancement of Psychiatry was an underling of and part and parcel of the American Psychiatric Association, via this funding source. All the members of the GAP were also members of the APA.

The last individual who must be recognized as important for this era is Michael Rutter. Working out of London, this researcher played an important role with the World Health Organization in producing clinical trials using international standards and incorporating numerous co-authors. Rutter was the dominant person affecting the classification of mental disorders in childhood that was used by the World Health Organization’s International Classification of Diseases. With the American Psychiatric Association using this Classification predominantly for the introduction of the DSM-II, Rutter’s influence cannot be overlooked, even though he was not often referenced within literature in the United States. Rutter is pointed to by a later key individual (David Shaffer) as monumentally important in childhood psychiatric nosology.
Chapter 5
1968 - 1998

Diagnostic and Statistical Manual System

It is helpful that in order to support an investigation of specific diagnostic categories, that there be a review of the overall diagnostic system that set the framework for all diagnoses during this time period. It is the system of the Diagnostic and Statistical Manual of Mental Disorders that became the gateway for psychiatric diagnosis. It is important in answering the research questions of this writing to have an overview of the development of this system, in order for additional analysis to be more thorough and complete. What follows is an outline of existing documented literature cited by the authors of the DSM versions showing what supportive referential literature was utilized for the continued and revised publications of the Manual as an overall system for diagnosis. This review of the systemic cited support for DSM will give a contextual framework for then reviewing the specific adolescent behaviorally based disorders.
Published DSM System References - 1970 to 1980

<table>
<thead>
<tr>
<th>Study</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robin and Guze</td>
<td>1970 National Institute of Mental Health</td>
</tr>
<tr>
<td>Robin/Guze/Feighner</td>
<td>1972 National Institute of Mental Health</td>
</tr>
<tr>
<td>Spitzer/Fleiss</td>
<td>1974 American Psychiatric Association</td>
</tr>
<tr>
<td>Spitzer/Endicott/Robins</td>
<td>1975 National Institute of Mental Health</td>
</tr>
<tr>
<td>DSM-III Field Trials</td>
<td>1979 American Psychiatric Association</td>
</tr>
<tr>
<td>Spitzer</td>
<td>1979 National Institute of Mental Health</td>
</tr>
<tr>
<td>Russell</td>
<td>1979 n/a</td>
</tr>
</tbody>
</table>

Table 5.1 DSM System Referenced Clinical Support - 1970 to 1980

Prior to 1970, research on the formation of the diagnostic system and foundation is scarce. The literature focuses primarily on specifically utilized categories of mental disorders (schizophrenia and psychosis were two popular fields), and investigates these prevalence rates and characteristics with limited categorical questioning of the diagnostic system itself.

In the 1960’s and 1970’s, the American Psychiatric Association (APA), and key members of the Committee on Nomenclature and Statistics Task Force within the Association called for a change in the psychiatric field to move from a dynamic to descriptive system of categorizing disorders. The process began through the recommendation of the Task Force in proposing and preparing a categorical definitive description of mental disorders, the DSM-III. Kirk and Kutchins (1991) have effectively presented the rhetoric surrounding the introduction of the DSM-III, but what do we know of the publications supporting the change.

Of the literature published, a limited number of studies are referenced searching
for support of the categorical demarcations of the DSM system leading up to the introduction of the DSM-III. Robins and Guze (1970) present a study on schizophrenia and purport that a “valid classification (system) is an essential step in science . . . in medicine, and hence in psychiatry, classification is diagnosis” (Robins and Guze, 1970. p. 1). This study was referenced by Robert Spitzer as the first seminal study supporting this change. These authors propose a five-step process toward diagnosis including clinical description, laboratory studies, delimitation from other disorders, follow-up and family study. The support from the study originates from prospective and retrospective diagnosis based on “poor and good prognosis” for schizophrenia. This design, using clinicians as raters, not sampling subjects, and comparing studies from the 1950’s and 1960’s across numerous cultures poses limitations in supporting the claimed outcomes. The data is not presented for reanalysis and it is not possible to replicate and understand how the authors conclude that “the impressive results achieved . . . by using the method described in this paper for establishing diagnostic validity indicate that the method has great power” (Robins and Guze, 1970, p. 6).

The second “seminal” study referenced, also written by these two authors, in addition to a third (Feighner), was published in 1972. It is these two studies that are cited by the APA Nomenclature and Statistical Task Force (as well as by Robert Spitzer) presenting historical published support for the categorical design of DSM-III. This second study proposed diagnostic criteria for “14 psychiatric illnesses along with the validating evidence for these diagnostic categories” (Feighner et al., 1972, p. 57). The authors presented their earlier printed five-step process toward categorization, yet failed to publish (even as of today) the “study of interrater reliability and validation of
reliability with an 18-month follow-up study of 314 psychiatric emergency room patients, as well as a seven-year follow-up study of 87 psychiatric inpatients” (Feighner et. al., 1972, p. 58). The fourteen categories included the currently rejected diagnoses of “hysteria”, “transexualism” and “homosexualism”, whose diagnostic termination was arguably influenced by social and political forces, not published criterion (See Kirk, 1993; Caplan, 1995). The authors limit their conclusion stating “all diagnostic criteria are tentative in the sense that they change and become more precise with new data” (Feighner et. al., 1972, p. 62). It was this study that is discussed by Robert Spitzer as being an instrumental piece of research supporting the changes within the nosologies of diagnosis from DSM-II to DSM-III.

The literature over the next seven years leading up to the publishing of DSM-III field trials, comment specifically on the reliability of the proposed and metamorphosing categories, leaving validity as a fairly mute question. Perhaps it is assumed that the question of validity was resolved through the presentation and multiple referencing of these two prior studies (Robins, 1970; Guze; and Feighner, 1972), or perhaps reliability is a question that can more easily be empirically answered (see Kirk and Kutchins for this argument, 1991). Spitzer and Fleiss (1974) recapitulate psychiatric diagnostic reliability data dating from the early 1950’s. Through the introduction of a statistic called kappa (an interrater reliability measure), these authors find the seven studies analyzed had “obvious unreliability of diagnosis . . . yet there exists evidence for sensitivity to and agreement on the major psychiatric problems experienced by a patient” (Spitzer and Fleiss, p. 344 - 345). This finding led to a recommendation for structured interview schedules which “provides for a standardized sequence of topics, and ensures that variability among
clinicians in how they conduct their interviews and in what topics they cover is kept to a minimum” (Spitzer and Fleiss, p. 345). In the introduction of this study, the authors arguably begin to claim validity prior to the establishment of reliability. “A necessary constraint on the validity of a system is its reliability . . . studies of the reliability of psychiatric diagnosis provide information on the upper limits of its validity” (Spitzer and Fleiss, p. 341).

In July, 1975, Spitzer, Endicott and Robins (names of Task Force members that will continually appear) published a descriptive analysis set of diagnostic criteria, modified from the earlier Robins and Guze findings. This expanded list of “disorders” was published with kappa coefficients “supporting their reliability” and applied to a set of psychiatric inpatients. “In developing the Research Diagnostic Criteria (RDC), additional categories such as schizo-affective disorders, some personality disorders, and acute schizophrenia were added as were many different ways of categorizing major depressive disorders” (Spitzer, 1975, p. 23). What is not published is the corroborating data for reanalysis; what is printed is a list of research outcomes (kappa coefficients).

Spitzer, Endicott and Robins (November, 1975), for the first time, published discussion of the applicability of the previous findings toward the inclusion of these diagnostic criteria for the proposed and developing DSM-III (scheduled at this time for release in 1978). The authors cite their earlier study (Spitzer, 1975) as documentation that the Research Diagnostic Criteria shows “evidence that the use of the kind of operationally defined criteria discussed here greatly increase the reliability of diagnostic judgments” (Spitzer, Endicott and Robins, 1975, p. 1190). It was also suggested that these criteria would not replace but merely supplement the narrative definitions of the
current diagnostic criteria (DSM-II). We shall see that this did not occur. The blurring between validity and reliability continued through the author's conclusive argument that “on the basis of studies showing that the use of specified criteria increase the reliability of diagnostic judgments, (the authors) suggest that including such criteria in DSM-III would improve the reliability and validity of routine psychiatric diagnosis” (Spitzer, Endicott and Robins, 1975, p. 1187).

The Research Diagnostic Criteria was not published as an official document until 1978. The authors produced the RDC along with coverage’s, time periods, and narrative descriptions of the criteria to be met for diagnosing individualized mental disorders. Reliability of the system was touted as extremely strong; however, the studies cited as evidence were Spitzer (1975) and two NIMH conducted site analysis described in the writing, but not published. The authors define their own subjective terms for research stating “a crucial problem in psychiatry, affecting clinical work as well as research, is the generally low reliability of current psychiatric diagnostic procedures” (Spitzer, 1978, p. 713). These terms do not address the question of validity until the authors conclusively claim:

. . . it is reasonable to assume that whatever validity has been established for the category when it was not precisely defined, its correlates, will still be associated with the diagnostic category, and probably will increase because of improved reliability . . . A large number of studies using the RDC are under way and evidence regarding the validity of the RDC categories should be forthcoming very soon (Spitzer, 1978, p. 782).

This data does not occur in subsequent published literature.

The following year, the DSM-III field trials (1979) were published. Kirk and Kutchins (1991) have very thoroughly presented the “rhetoric” regarding the
differentiation and blurred demarcation between this diagnostic systems reliability and purported validity.

It is not only that they (mental health professionals) were predisposed to believe, but that the problem (of DSM reliability and validity) had been sufficiently mystified so that they could no longer seriously question whether the simple good news matched the methods and statistics on which it was based . . . important information about the methods and findings of the field trials has never been reported. The field trials themselves could more accurately be described as uncontrolled, nonrandom surveys in which several hundred self-selected and unsupervised pairs of clinicians throughout the country attempted to diagnose nonrandomly selected patients and, after some sharing of information, made “independent” assessments of these patients (Kirk and Kutchins, 1991, p. 142 & 167).

Published DSM References - 1980 to Present

<table>
<thead>
<tr>
<th>Study</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Francis</td>
<td>1980 n/a</td>
</tr>
<tr>
<td>Hyler</td>
<td>1982 n/a</td>
</tr>
<tr>
<td>Mellsop</td>
<td>1982 n/a</td>
</tr>
<tr>
<td>Mezzich</td>
<td>1984 University of Pittsburgh</td>
</tr>
<tr>
<td>Volkmann</td>
<td>1984 National Institute of Mental Health</td>
</tr>
<tr>
<td>Williams</td>
<td>1985 American Psychiatric Association</td>
</tr>
<tr>
<td>Fernando</td>
<td>1986 UCLA</td>
</tr>
<tr>
<td>Schroder</td>
<td>1986 n/a</td>
</tr>
<tr>
<td>Spitzer</td>
<td>1987 American Psychiatric Association</td>
</tr>
<tr>
<td>Rounsaville</td>
<td>1989 National Institute of Mental Health</td>
</tr>
<tr>
<td>Spitzer/Seigel</td>
<td>1990 National Institute of Mental Health</td>
</tr>
<tr>
<td>Zinbarg</td>
<td>1994 n/a</td>
</tr>
<tr>
<td>Frick</td>
<td>1994 University of Illinois</td>
</tr>
<tr>
<td>Lahey</td>
<td>1994 National Institute of Mental Health</td>
</tr>
<tr>
<td>Keller</td>
<td>1995 n/a</td>
</tr>
</tbody>
</table>

Table 5.2 DSM Referenced Clinical Support - 1980 to Present

During this time period, with the introduction of the DSM-III, there were categorical changes in how the diagnosis was presented per the clinician. This move
from dynamic to descriptive psychiatry was operationalized in the DSM-III, III-R, and IV via assigning a five axes grid to describe the diagnosis of the individual. This is referred to as a multiaxial system utilizing “assessments on several axes, each of which refers to a different domain of information that may help the clinician plan treatment” (DSM-IV, 1994, p. 37). These include the following:

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>Clinical Disorders</td>
</tr>
<tr>
<td></td>
<td>Other Conditions that may be a Focus of Clinical Attention</td>
</tr>
<tr>
<td>Axis II</td>
<td>Personality Disorders</td>
</tr>
<tr>
<td></td>
<td>Mental Retardation</td>
</tr>
<tr>
<td>Axis III</td>
<td>General Medical Conditions</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Psychosocial and Environmental Problems</td>
</tr>
<tr>
<td>Axis V</td>
<td>Global Assessment of Functioning (rated per overall level of functioning)</td>
</tr>
</tbody>
</table>

As the publications continued, the DSM-III introduction and categorization assisted in redefining how mental disorders are perceived and subsequently treated. Authors both within the APA publishing system and outside, began and continued to present limited data on the question of “validity” of the system. Mellsop et. al. (1982), APA Task Force members, studied the reliability of the diagnoses of Axis II of DSM-III by measuring the level of agreement among three psychiatrists who independently examined the same patients in everyday clinical settings. This weak non-independent, nonrandom study with a sample of 74 found “the kappa coefficient levels were lower than those reported from the field trials (yet who concluded) . . . Axis II of DSM-III represents a significant step forward in increasing the reliability of the diagnosis of personality disorder in everyday clinical practice” (Mellsop, 1982, p. 1361). A claim made without data or referential material as sources.
Hyler et. al. (1982, APA Task Force members) published a study using data from the original 1979 field trials. This report utilized the first 150 reliability interview data set comparing the use of case summaries to live interviews in the applicability of DSM-III diagnosis. This study was a response to criticism from Cantwell (1979) and Mattison (1979), who found low reliability results in analysis of childhood disorders. These rebuttals were partially dismissed by the authors through claiming they (Cantwell and Mattison) utilized an earlier draft version of DSM-III and concluded that in “using live patient evaluations, the reliability of the major diagnostic classes of DSM-III was extremely good. However, using the case summary method for the same patients, the reliability was only fair” (Hyler, 1982, p. 1276). Using data from flawed field trial designs can arguably lead to erroneous results. This study did however, assist in presenting claimed “validity” to the introduction of the National Institute of Mental Health’s Diagnostic Interview Schedule (DIS) released the previous year.

The Diagnostic Interview Schedule claimed that it was useful in making “diagnosis by all three prior systems (DSM-III, the Feighner Criteria and the Research Diagnostic Criteria) with a single interview because the three systems share a common heritage. All reflect that common heritage in the degree to which they address diagnosis in a descriptive rather than etiological perspective” (Robins et. al., 1970, p. 381). This represents the first published claim that these diagnostic systems can be utilized concurrently, yet the question of the validity of the criterion were not earlier resolved. These authors cite their study to support the validity of the DIS instrument. They “appointed the DIS in the hands of a psychiatrist as a yardstick against which was measuring its performance in the hands of a lay interviewer . . . The use of repeated
interviews with the same instrument has led some to say that we are studying reliability, not validity” (Robins et. al., p. 389). This question still remains, as does the assumption that the previous diagnostic criteria (Feighner, RDC and DSM-III) are valid for this application. If finding an interview to yield more reliable diagnostic results via a specified procedure, it is still not clear whether the category that is diagnosed from this interview is any more “valid” for study (see Kirk and Kutchins, 1991).

In a later review, Robins (1985) questions some of these assumptions he made as the principle architect of the DIS. Robins later believed “the design is found wanting on several counts: the reinterview may be answered differently because of clinical change . . . the clinician’s interview may be an erratic standard, and the statistics are affected by both prevalence and severity of disorder” (Robins, 1985, p. 918). Robins goes on to support his original findings citing that “these limitations on generalizing . . . are problems that are not unique to psychiatry or dimensional diagnoses. A screen for cancer that works well in a medical clinic may not be an effective case-finding technique in the general population” (Robins, 1985, p. 922). Spitzer (1982) also utilizes this rationale toward the practice of the medical field in general to support the defining of a “mental disorder”. This desire for face validity of the tools defining the mental disorder field is understandable, but is it appropriate to use the power of the medical profession (focusing on physical illness empiricism) to assist in supporting the definitive criteria of mental health? It is within this published writing that Spitzer (1982) continues with stating, “the degree of demonstrated validity for the different DSM-III categories varies greatly . . . (you) cannot wait until a category is fully validated before it is included in the official nomenclature that defines the conditions for which help is sought” (Spitzer, 1982, p. 30).
Williams (Task Force member) investigated the foundation for the use of the multiaxial system, the cornerstone of differential diagnosis introduced by the DSM-III. This system introduced a five-stage axis descriptor applied to mental health, and did not appear in the literature until the mid-1970's through publications by Task Force members (Cantwell, 1973 and Rutter, 1975). Williams (1985) reviews this limited development and reveals that the decision to include this structural format was adopted by the Task Force in 1976, initially focused on childhood disorders and later applied to all DSM-III included categories. The author claims “the separation of the mental disorders into two separate axes has contributed substantially (along with the provision of diagnostic criteria) to the increased reliability with which they are diagnosed. It has been demonstrated that it is now possible for ordinary clinicians to obtain levels of reliability that had previously been reached only by a few small, closely knit research groups” (Williams, 1985, p. 177). The references cited (Frances, 1980; Spitzer, 1979; and Russell, 1979) for this increased reliability of application all were published years after the inclusion of this multiaxial system was decided upon by the Task Force.

In a continuation writing, Williams (1985) spends considerable energy addressing reliability aspects of certain axes of the DSM-III. One reference cited investigates validity (Mezzich, 1984), a study that could arguably be exploring interrator reliability and not concurrent validity. Again, this study, not concerned with the area of discussion, was published four years after the introduction of the changed system. As with predictive validity, Williams says, “surprisingly, there are as yet no published studies exploring this” (Williams, 1985, p. 183).

As the DSM-III (and subsequent revisions) have exponentially grown in
application to mental health diagnosis, the most utilized sections of the system are Axis I and Axis II. It is these two diagnosed axis, focused on clinical syndromes (I) and personality disorders and specific developmental disorders (II), that are used as the primary diagnosis. Axis III (physical disorders), IV (severity of psychosocial stressors) and V (adaptive functioning level over the past year) are present in a full diagnosis, yet in practice do not carry as much diagnostic weight. Again the literature is scarce in searching the published support for the validity of Axis I, II and III, and reveals just two studies addressing either reliability or validity for axis IV and V. Fernando (1986) found reliability coefficients for ratings of the overall sample lower than the figure found during the DSM-III field trials. The authors went on to say “there seem to have been no published studies of the reliability and validity of axis V (apart from the field trials)” (Fernando, 1986, p. 753). Schrader (1986) found that “a major difficulty affecting the usefulness of Axis IV and Axis V data when they are routinely gathered according to the current DSM-III instructions is the stipulation that the clinician judge the etiological significance of a stressor before it is coded” (Schrader, 1986, p. 904).

DSM-III-R was introduced in 1987. Over the next three years, as the American Psychiatric Association was scheduling for the publication and next revision (DSM-IV), three field trials were published. Two of the studies (Spitzer and Seigel, 1990; and Rounsaville, 1989) were funded through moneys provided by NIMH to the APA for national field trials. The third (Spitzer, Williams and Kass, 1987) was fully funded by the Board of Trustees of the APA, in response to criticism “that there is a lack of data indicating the diagnostic concept (of self-defeating personality disorder) has any validity and that the category is inherently sexist and potentially harmful to women” (Spitzer,
Williams and Kass, 1989, p. 1561 - see Caplan, 1995; Rosewater, 1987 and Walker, 1988 for dissenting commentary). The field trials utilized self-referred samples by current American Psychiatric Association members who volunteered to be involved in the study. The field trials looked at only a few specific diagnostic categories and searched through interviewing and assessments for reliability of individual diagnosis among these APA volunteers. These field trials utilize nonrandom sampling designs, not allowing generalizability of the results to a larger population. By not randomly selecting the samples, nor manipulating an independent variable on one or numerous dependent variables, the authors are sacrificing their designs for much weaker studied results. A pattern that is continued through current research.

The development of the DSM-IV, and subsequent introduction, was presented as necessary for meeting "treaty obligations with the World Health Organization to maintain a coding and terminological consistency with the International Classification of Diseases (ICD-10)" (Frances, et. al., 1989, p. 373). The date of actual release was eighteen months after the introduction of the ICD-10. The DSM-IV was presented as an entity and outcome of "three stages of empirical documentation: systematic literature reviews, analysis of unpublished data, and field trials" (Frances, et. al. 1990, p. 1439).

The major innovation of DSM-IV is less likely to be any specific content changes than its emphasis on explicit documentation and review of evidence . . . the threshold for making revisions is much higher than it was for DSM-III and DSM-IIIR. Decisions must be substantiated by explicit statements of rationale and by the systematic review of relevant empirical data (Frances et. al. 1990, p. 1440-1441).

The authors (all Task Force members) go on to contradict in print that "placement in the DSM (IV) should not determine whether or not a disorder is studied and researched"
What do we know of the “systematic review of relevant empirical data”? The DSM-IV was released in the summer of 1995. Accompanying this release was the buildup of the supporting evidence to be published as Sourcebooks.

The major emphasis in the DSM-IV process has been empirical review and documentation, and the Sourcebook, published in five volumes, is an important means of presenting that documentation. The first three volumes contain the DSM-IV literature reviews and summarize the DSM-IV Work Groups’ efforts that led to the publication of the DSM-IV Options Book in 1991. The fourth volume contains the results of the DSM-IV data reanalysis, and the fifth volume contains the results of the DSM-IV field trials (Widiger 1994, p. xvii).

Sourcebooks Volumes 1 and 2 publish thorough reviews of specific “mental disorders” including substance-related, delirium, dementia, schizophrenia, medication induced, sleep, mood, dysphoric, anxiety, personality, psychiatric system interface, and sexual disorders; while Volume 3 focuses on disorders of infancy, childhood or adolescence. As comprehensively organized and reviewed as these compilations are, the basic question remains. By examining the parts and parcels of a diagnostic system, and concurring with past reliability and validity markers, does this assist in demarcating the overall system as more valid for utilization? It is unfortunate that the data reanalysis and additional field trials were not published before the release of DSM-IV as was presented (they were published four years later as a single Volume). This would be helpful in answering this question. This emerges as a pattern for the introductions of the revisions of the Manual, changes printed and presented without the reported data fully available for reanalysis. This is also seen in the introduction of DSM-III (see Kirk and Kutchins, 1991) and DSM-III-R.

(Frances et. al, 1990, p. 1442).
Of the individual field trials published from May of 1994 (none were published prior to this date) to August of 1995 (Volkmar et. al., 1984; Keller et. al., 1995; Zinbarg et. al., 1994; Frick et. al., 1994, Lahey et. al., and Lahey and Applegate et. al., 1994), four of the six focused on child and adolescent disorders (autism, attention deficit hyperactivity, oppositional defiant and conduct disorder), while two researched mood-disorder and mixed anxiety depression. Three of the field trials (Frick, 1994; and Lahey, 1995), utilized the same data set for their results. Though much information is published regarding the sample, no explicit description of the method in obtaining the sample is given. Thus, it is unknown whether random generalizability of the results is possible, one of the first steps toward “knowing” beyond your sample population. Keller et. al. (1995) conducted a multisite collaborative study “designed to explore the reliability of a course-based diagnostic classification system for major depression, evaluate the symptom criteria for dysthymia, and explore the need for additional diagnostic categories for milder forms of mood disorder” (Keller et. al., 1995, p. 843). Volkmar et. al. (1994) searched for “patterns of agreement among existing diagnostic systems . . . as was the rational for inclusion of other disorders within the class of pervasive developmental disorders” (Volkmar et. al., 1994, p. 1361). Zinbarg et. al. (1994) conclude that “a mixed anxiety-depression category be included in DSM-IV” (Zinbarg et. al., 1994, p. 1153), yet these previous study’s design methods utilizes a subjective and chosen (by the author) sample and does not address the question of the valid and/or appropriate placement of this proposed admission. This section has included an exhaustive list of those studies cited as referential support for the DSM-III, DSM-III-R and DSM-IV via these documents themselves.
Adolescent Behaviorally Based Disorders

1968-1998 - Diagnostic Systems/Associations - Behaviorally Based Disorders

<table>
<thead>
<tr>
<th>DSM-III</th>
<th>Conduct Disorder (separate category)</th>
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<tr>
<td></td>
<td>Undersocialized Aggressive Subtype</td>
</tr>
<tr>
<td></td>
<td>Socialized Aggressive Subtype</td>
</tr>
<tr>
<td></td>
<td>Undersocialized Nonaggressive Subtype</td>
</tr>
<tr>
<td></td>
<td>Socialized Nonaggressive Subtype</td>
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<td></td>
<td>Atypical Conduct Disorder</td>
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</table>

<table>
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<td>Added Mild/Moderate and Severe Descriptors</td>
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<td>Group Type</td>
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<tr>
<td></td>
<td>Solitary Aggressive Type</td>
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<tr>
<td></td>
<td>Undifferentiated Type</td>
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</table>

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>Conduct Disorder (same as DSM-III-R)</th>
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<tbody>
<tr>
<td></td>
<td>Oppositional Defiant Disorder (same as DSM-III-R)</td>
</tr>
<tr>
<td></td>
<td>Disruptive Behavior Disorder not Otherwise Specified (new)</td>
</tr>
</tbody>
</table>

Table 5.3 DSM Definitions of Conduct and Oppositional Defiant Disorders

The time period in-between the DSM-II (1968) and the introduction of the DSM-III (1980) marked a dramatic sea change in viewing diagnostic categories within the field of psychiatry and mental health. Kirk and Kutchins (1992) do a thorough review of this process of introduction in tracing the many dynamic influences and factors impacting the change from dynamic categorization (DSM and DSM-II) to descriptive categorization (DSM-III, DSM-III-R and DSM-IV). These authors point to the designs of the purported “empiricism” and collaboration used to justify this change in descriptive typology and the individuals primarily responsible for these changes. Within this time period of the
introduction of the DSM-III, references to the change began as early as 1973 and continued up through 1979.

Drafts were widely circulated for critical review and use by clinicians and investigators. In 1974 the American Psychiatric Association, through its Council on Research and Development, appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January, 1979... there was some concern that the ICD-9 classification and glossary would not be suitable for use in the United States... ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodological developments as specified diagnostic criteria and the multiaxial approach to evaluation (DSM-III, 1980, p. 1-2).

Kirk and Kutchins (1992) review the claims to validity based on reliability of the DSM authors as the basis of their disagreement with the appropriate legitimization of the DSM-III system.

This marked a significant change from relying upon the ICD-8 revision (1968) for the behaviorally based disorders for children and adolescents and opened the door for significant changes within the American psychiatric field. Both the American Academy of Child Psychiatry and the American Orthopsychiatric Association established liaison committees with the Task Force on Nomenclature and Statistics, which was responsible for the changes to the diagnostics system. This Task Force was appointed by and worked within the American Psychiatric Association.

One of the significant changes from the earlier versions of the DSM to the reintroduced DSM-III is the utilization of a multiaxial classification system. Researchers and publishers from the University of London greatly influenced this process and as early as 1973 were focusing on this application to child psychiatric disorders. Rutter, Shaffer and Shepherd (names also found very prevalent for the system revision overall) published
(1973) their earlier classification system (1969) in this report sponsored by the World Health Organization. This axis proposal was claimed to have been supported by the existent International Classification of Diseases (ICD-8) provision for only one code specifically for child disorders (308 - Behavior Disorders of Childhood). This new system utilizes four axes on which to diagnose the child or adolescent. These include the first Axis for clinical psychiatric syndromes which lists only Conduct Disorder as an option for behaviorally based diagnosis. Successive Axis were for intellectual levels, physical conditions and psychosocial factors impacting the child.

Achenbach and Edelbrock (1978), both working at the National Institute of Mental Health at this time, published a review and analysis of empirical efforts to date for the classification of child psychopathology. This review is included because of the reported influence the authors had for a period of time after its publication. The need for the review was reportedly based upon the situation prior to the DSM-II, where 70% of the "children seen in psychiatric clinics were either unclassified or were classified as having adjustment reactions . . . that the reliability of the DSM-II and current drafts of the DSM-III" show low reliability of the system (Achenback, 1978, p. 1275-1276). The conclusive recommendation by these authors is the utilization of similar instruments for diagnosis, based on behavior checklist tools utilized extensively up to this date. This procedure of utilization involved a "bootstrapping" procedure, the search for relationships among measures used in the past (not questioning whether the measures were appropriate).

The DSM-III was introduced through the presentation of necessary change, coinciding with international standards and reportedly to keep pace with the burgeoning empirical data emerging on specific diagnostic categories. In 1974, the Council on
Research and Development (appointed within the American Psychiatric Association) began work on the development of DSM-III under the premise that the ICD-9 classification system (scheduled for release in 1979) would not be suitable for use in the United States.

Many specific areas of the classification did not seem sufficiently detailed for clinical and research use . . . ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodological developments as specified diagnostic criteria and the multiaxial approach to evaluation . . . goals of the Task Force included: reliability of diagnostic categories, acceptability to clinicians and researchers, maintaining compatibility with ICD-9, reaching consensus of diagnostic terms, consistency with data from research studies bearing on the validity of diagnostic categories, etc. (DSM-III, 1980, p. 3).

The following groups established liaison committees with the Task Force during this developmental period: the Academy of Psychiatry and Law, the American Academy of Child Psychiatry, the American Academy of Psychoanalysis, the American Association of Chairmen of Departments of Psychiatry, the American College Health Association, the American Orthopsychiatric Association, the American Psychoanalytic Association and the American Psychological Association.

The 1980 DSM-III categories for behaviorally based disorders are separated into two categories, Conduct Disorder (listed as its own subcategory) and Oppositional Disorder (listed under Other Disorders of Infancy, Childhood or Adolescence subcategory). The support for this separation of Conduct Disorder into a separate entity is referenced to the Group for the Advancement of Psychiatry Report #62 (1966).

Conduct Disorder was changed and expanded to five separate diagnostic types and corresponding codes for the DSM-III system. The Undersocialized Aggressive Subtype is characterized by a “failure to establish a normal degree of affection, empathy
or bond with others. Peer relationships are generally lacking . . . egocentrism is shown by readiness to manipulate others for favors . . . a general lack of concern for others feelings and blame placing on others” is common (DSM-III, 1980, p. 45). The descriptive typology and diagnostic criteria included a persistent pattern of aggressive conduct toward others including vandalism, rape, breaking and entering, fire-setting, mugging and other violations. The youth must be under the age of 18 and this diagnostic category can be ruled out if any more than one of the following is indicated: has one or more peer-group friendships that have lasted over six months, extends himself or herself for others even when no immediate advantage is likely, apparently feels guilt or remorse when such a reaction is appropriate, avoids blaming or informing on companions or shares concern for the welfare of friends or companions.

The Socialized Aggressive Subtype shows evidence of social attachment to others and the violation of the rights of others through aggressive acts. This descriptive evidence through physical violence against persons or property and thefts outside the home involve confrontation with a victim. Two of the following behavior patterns must be present to have utilized this subtype: youth has one or more peer-group friendships over six months, extends themselves for no immediate advantage, feels guilt or remorse, avoids blaming or informing on companions and shows concern for others, and youth must under the age of 18.

The Undersocialized Nonaggressive Subtypes is characterized by a “repetitive and persistent pattern of nonaggressive conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated” (DSM-III, 1980, p. 48). Descriptive typology includes chronic violations of a variety of important rules at home.
or school, repeated running away from home overnight, persistent serious lying and/or stealing not involving confrontation with a victim. The Undersocialized criteria for ruling out this diagnostic category is the same as the Undersocialized Aggressive description.

The Socialized Nonaggressive subtype has the same descriptor criteria described within these three other typologies with the following diagnostic criteria for determination: youth has chronic violations of a variety of important rules at home or at school, repeated running away from home overnight, persistent serious lying and stealing outside of the home without the confrontation of a victim.

A fifth subtype is titled Atypical Conduct Disorder and is defined as a “residual category for illnesses in which the predominant disturbance involves a pattern of conduct in which there is violation of either the basic rights of others or major age-appropriate societal norms or rules but which cannot be classified as one of the specified subtypes of Conduct Disorder” (DSM, 1980, p. 50). These subtypes are reported (by DSM) to be far more common among boys than among girls by a ratio of 4:1 and ranging to 12:1.

The second major classification for childhood and adolescent disorders is Oppositional Disorder. The essential feature of this disorder is a pattern of disobedient, negativistic and provocative opposition to authority figures. Appropriate for a child or youth aged 3 to 18 who is oppositional “toward family members and toward teachers . . . (with) the most striking feature being the persistence of the oppositional attitude even when it is destructive to the interests and well-being of the child or adolescent” (DSM-III, 1980, p. 63). Tactics that are reportedly utilized and descriptive traits include a pattern persistent for a minimum of six months showing violations of minor rules, temper
tantrums, argumentativeness, provocative behavior and stubbornness. This diagnostic category is reportedly (by DSM) to usually be chronic and lasts for several years with a continuity toward adult Passive-Aggressive Personality Disorder.

Rutter and Shaffer (1980) publish a discussion of the utilization of the DSM-III, as to whether it is a step forwards or backward for childhood classification of diagnosis. A review of the changes in this classification scheme is followed by references to a World Health Organization study (Sturge et al., 1977) that reportedly mirrored the DSM-III field studies showing lower than acceptable reliability results. Additionally it is printed that rather few of the diagnostic categories (including Conduct Disorder) had been validated satisfactorily, but go on to say “it is recognized that there is a dilemma here in that it is not sensible or practical to demand that all categories be proved to the hilt before inclusion in a psychiatric classification” (Rutter and Shaffer, 1980, p. 385). These authors also review the DSM-III Field Trials in their analysis and found general satisfaction with the results, yet poor agreement on the subdivisions of more complex disorders - including Conduct Disorder. Yet it is concluded that this new DSM-III system be utilized and be considered a landmark in the development of psychiatric systems, with the DSM-IV release to be positively anticipated.

Spitzer and Cantwell (1980) published a review of the earlier published DSM-III which consisted of listing the changes in comparison to the DSM-II. The reasons for the change claimed by these authors included the following: the desire for the document to be clinically useful and valid for making decision; for increased reliability of categories; for acceptability to differing theoretical orientations; increased usefulness for education; for the Manual to be as compatible to the ICD-9 as possible; and to eliminate terms that
outlived usefulness. It was discussed that the DSM-III section on Disorders Usually First Evident in Infancy, Childhood or Adolescence was increased by a factor of four. These authors also spoke of some debate surrounding Conduct Disorders originating from antisocial behaviors in childhood or from the absence of social attachments in children. The inclusion of Oppositional Defiant Disorder was credited to the childhood classification proposed by the Group for Advancement of Psychiatry (Report #62, 1966).

The American Psychiatric Association published the DSM-III Case Book (1981) to be a learning companion to the Diagnostic and Statistical Manual of Mental Disorders. Written and compiled by two members of the DSM-III Committee on Infancy, Childhood and Adolescent Disorders, this publication used case histories and individual examples of diagnosis with this newly introduced system. This publication reprints the appendices of the DSM-III (decision trees and classifications) and then lists over 200 case examples for diagnosis. Of these, three are cited with behaviorally based disorders, two for Conduct Disorder (socialized aggressive type) and one for Conduct Disorder (undersocialized aggressive type). These vignettes were reportedly identified through the author's own experience and from the practices of a large number of clinicians. The introduction deems this book appropriate for all levels of clinical experience, and many other professional fields including law, medicine, educational settings, teaching, nursing and psychiatry.

A similar publication was also printed focused on training the mental health professional on the utilization and application of the DSM-III. The DSM-III Training Guide (1983) gave a recapitulation of the listings within the DSM-III (1980) simply organized in a more straightforward and easier to read organization. Although not
published by the American Psychiatric Association, there includes a forward and endorsement by the authors of the DSM-III Case Book.

Spitzer, Williams and Skodol (1983) were the editors of an International Perspectives Review of the DSM-III published by the American Psychiatric Press. Of the 24 areas reviewed by differing authors, one chapter dealt with the diagnoses of children in New Zealand and looked at the full range of possible diagnosis in one clinical study (to be reviewed in a later section) including Schizophrenia, Separation anxiety, Somatoform, Eating Disorders, Oppositional and Conduct Disorders, Encopresis and Enuresis, Attention Deficit and Overanxious Disorders.

Dreger, who supported his own variation of a behavioral classification project in 1964, also published a thorough review of classification systems, including behavior checklists and broader attempts to categorize youth, including the DSM. Dreger (1982) distanced himself from the earlier versions of the Diagnostic and Statistical Manual by quoting that the:

DSM-II classification drawbacks were considerable . . . For one, the system veered back and forth between syndromes and types without clear distinctions between them . . . (and later printed) the DSM-III itself is a very improved instrument for diagnosis and classification . . . whereas DSM-I devoted to children and adolescents about one and one-half pages out of 77 pages of text and tables, and DSM-II two and one-half out of 82, DSM-III utilizes 65 out of 472 pages for “Disorders Usually First Evident in Infancy, Childhood, or Adolescence (Dreger, 1982, p. 363-379).

The Diagnostic and Statistical Manual of Mental Disorders was again revised just seven years after the introduction of the vastly differing DSM-III. In 1987, the Federal Register printed new mandated definitions by the Federal government.

On May 20th (1987) the Substance Abuse and Mental Health Services Administration published federal definitions of “serious
mental illness” in . . . preparation for a congressional mandated estimate of the number of mentally ill children and adults . . . (these were defined as) Children with a serious emotional disturbance are persons from birth up to age 18 who are currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified with the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school or community activities (Social Legislation Information Service, 1987, p. 42).

A reprint of this specific definition was published during the first printing and attached with the introduction of the DSM-III-R.

The DSM-III-R was introduced in 1987 for a number of reported reasons, according to the American Psychiatric Association. “Data were emerging from new studies that were inconsistent with some of the diagnostic criteria . . . despite extensive field testing of the DSM-III diagnostic criteria before their official adoption, experience with them since their publication had revealed, as expected, many instances in which the criteria were not entirely clear, or were even contradictory” (DSM-III-R, 1987, p. xvii). “Therefore, all of the diagnostic criteria, plus the systematic descriptions of the various disorders, needed to be reviewed for consistency, clarity, and conceptual accuracy, and revised when necessary” (DSM-III-R, 1987, p. xvii). “Most of the proposal for revision came from advisory committee members; some came from other professionals with a particular area of expertise” (DSM-III-R, 1987, p. xx).

Two drafts of the proposed revised diagnostic criteria were made available to interested professionals and distributed for review (10/5/85 and 8/1/86) and quoted field trials were held for three areas of childhood and adolescent diagnosis were printed to have been held, though no references to finding these results are printed in the DSM-III-
R. The field trials for Disruptive Behavior Disorders, Pervasive Developmental Disorders and Generalized Anxiety Disorder (children and adults) are printed to be discussed in Appendix F of the Manual; however, this appendix lists that clinicians assessed 550 children in these diagnostic areas and follows this with a list of participants and locations only.

Final approval of the DSM-III-R was given by the Assembly of District Branches in November, 1986 and approved by the Board of Trustees of the American Psychiatric Association in December that same year. This final draft of the diagnostic criteria made significant changes to the behaviorally based disorders for children and adolescents. This version grouped these diagnostic categories under the heading of Disruptive Behavior Disorders and included both Conduct Disorder and Oppositional Defiant Disorder. This brought the two diagnosis for the first time within the same category of disorders, whereas earlier versions separated these two more distinctly.

Conduct Disorder also changed from five subtypes to three and moved away from the more extreme delinquent descriptors in the DSM-III toward more moderate offenses. This disorder is still defined as a disturbance of conduct lasting at least six months but consolidated the differentiated groupings into a main diagnostic criteria list requiring at least three of the following to be observed for the youth: stealing without confrontation of the victim on more than one occasion; run away from home overnight at least twice; often lies; has deliberately engaged in fire-setting, is often truant from school; has broken in someone else’s house, building, etc.; has deliberately destroyed others’ property; physical cruelty to animals; forced someone into sexual activity; has used weapons in more than one fight; initiates physical fights; has stolen with confrontation of a victim; or
has been physically cruel to people (DSM-III-R, 1987, p. 58). This list is presented in
decresendoing order of discriminating power reported by this Manual based on the
reported DSM-III-R field trials for Disruptive Behavior Disorders.

This disorder is next to be assessed a scale of mild, moderate or severe in degree.
Mild is defined by the DSM-III-R as “few if any conduct problems in excess of those
required to make the diagnosis, and conduct problems cause only minor harm to others”.
.. (moderate defined as) “number of conduct problems and effect on others intermediate
between ‘mild’ and ‘severe’” . . . (and severe defined as) “many conduct problems in
excess of those required to make the diagnosis, or conduct problems cause considerable
harm to others” (DSM-III-R, 1987, p. 59). The types that were changed significantly
from the DSM-III version are also given far less emphasis and focus in the DSM-III-R.
They include the following: Group Type, occurring within a group activity with and
without physical aggression; Solitary Aggressive Type, occurring as a predominance of
aggressive physical behavior toward both adults and peers; and Undifferentiated Type,
features that cannot be classified as either of the previous two typologies.

Oppositional Defiant Disorder differs in a number of ways from the DSM-III
version. The name was modified and the word Defiant was added to the title, as well as
the criteria was changed and the number of descriptor categories needed to be meet for
qualification for this diagnosis was increased from three to five of the following: often
loses temper, argues with adults, often actively defies or refuses adult requests, often
deliberately does things that annoy others, often blames others for mistakes, often touchy
or easily annoyed by others, often angry and resentful, often spiteful or vindictive or
Disruptive Behavior Disorders field trial for the list of criterion. This category is significantly shortened in comparison to the DSM-III version in the written description of the diagnosis, but also includes the additional mild, moderate and severe criteria of severity to be included in the diagnosis. It is interesting that these categories both cite the Field Trials for Disruptive Behavior Disorders as the source of these changes, yet this reference is not found in any section of the Manual except for the previous reference to Appendix F of the DSM-III-R.

Accompanying the DSM-III-R was the DSM-III-R Case Book (1989) published as a learning companion to this diagnostic categorization. This Case Book, published by the American Psychiatric Association Press, cites seven case examples of youth diagnosed either primarily or secondarily with Conduct Disorder or Oppositional Defiant Disorder. One of the youth was a case example cited in the earlier 1981 Case Book. The DSM-III-R Training Guide (1989), again endorsed by the Task Force members but not published by the APA Press, recapitulates the diagnostic categories in a more readable systemic order.

Within two years of the publication of the DSM-III-R, there appeared presentations by the Task Force (of the DSM) members in journals beginning discussions of the soon to be published DSM-IV. The DSM-IV committee members focusing on child and adolescent psychiatric disorders published a paper (Shaffer, 1989) stating that the views printed were not the official APA positions or its DSM-IV Task Force. However, only one author of fourteen of the article (Harold Pincus) was not a member of this Task Force. This presentation was published to begin discussing possible changes in the child and adolescent disorders for DSM-IV. Concerns presented by this group
included that the models used for the DSM-III-R for the diagnosis may be too narrow in
scope and could be somewhat restrictive, that some children with Conduct Disorder
symptoms will not meet criteria, that the age criteria may not be appropriate, that
comorbidity appears to be the rule rather than the exception and that there may be a case
made for eliminating Oppositional Defiant Disorder as a separate category.

Members of the DSM-IV Task Force (for the overall systemic changes) published
a "work in progress" report explaining the process for change. These Task Force
members explained the purposes and principles for DSM-IV which included its emphasis
on explicit documentation and review of evidence to be accomplished through Task
Forces for the individual diagnostic areas. "The threshold for making revisions is much
higher than it was for DSM-III and DSM-III-R. Decisions must be substantiated by
explicit statements of rationale and by systematic review of relevant empirical data . . .
placement in DSM should not determine whether or not a disorder is studied and
researched . . . (contradictorily the authors next say) but for the DSM-IV to have
credibility as a system of diagnosis, its clinical uses and foundation in research must have
priority" (Frances, et. al., 1991, p. 1441-1442). This report continues on to present the
increased explicitness of the descriptive categories as increasing reliability, "which may
or may not increase validity" (Frances, 1991, p. 1445).

This was followed by Widiger, et. al. (1990) Task Force members publication of a
review of the DSM-IV Literature in process. This review discusses the stages within the
review of literature process which included problem formulation, literature search,
quantification and cataloging of studies, analyses and presentation. This review did not
give specifics beyond this desired presentation but did reference a "Methods Conference"
that was for guiding direction (Frances, et. al., 1989) and reportedly outlined the three stages to be used for DSM-IV revision and criteria that included the anticipation “that in some cases a comprehensive review of available data will fail to identify a sufficient amount of supportive research to justify a revision” (Widiger, et. al., 1990, p. 198).

Widiger et. al. (1991) continued this discussion of the moving “toward an empirical classification of DSM-IV” with a similar review looking at the process change. “The major emphasis in the preparation of DSM-IV has been to maximize the impact of this accumulating research on the revision” (Widiger, 1990, p. 280). Data reanalysis, literature reviews and field trials were discussed with the field trials consisting of three methodologies: surveys, videotape reliability studies and focused field trials. The opinion surveys were to be focused on clinicians in the field who have utilized the past revision versions. The videotape studies will continue the past trend of utilizing interrater reliability as a measure of usefulness of the Diagnostic Manual and will focus on the major diagnostic categories (specific plans were not discussed). The field trials were to present reliability and validity data for proposed revisions, including disruptive behavior disorders for children. This article is a reiteration of previous presentations and continued to build the expectations of DSM-IV.

In 1991, the American Psychiatric Association published a “Work in Progress” DSM-IV Options Book, intended to educate the field on potential change to be found in the final DSM-IV Manual. Possible recommended changes for the behavior categories for children and adolescents included continuing the distinction between Conduct Disorder and Oppositional Defiant Disorder or conceptualizing these two disorders within one category with differing levels of severity. This latter option would create a
new disorder (named Disruptive Behavior Disorder) subsuming these two categories and
differentiating into three levels, Oppositional Defiant Type, Moderate Conduct Type and
Severe Conduct Type. Decision as to these possibilities are said to be made from the
results of the DSM-IV Field Trials and Data Reanalysis project. Additional changes
discussed included adding more extreme fighting behavior to the Oppositional Defiant
Disorder and adding sexual promiscuity to the Conduct Disorder category.

Lahey, Loeber and Quay (1992), Task Force members, published a discussion of
additional issues to be resolved for these diagnostic categories, also disclaiming that this
publication was in anyway expressing the full DSM-IV committee recommendations.
This writing continues the debate from the Options Book and discusses clinical studies
and conclusions as to the direction recommended from these authors (reportedly to be
reviewed in detail within the next clinical studies section). What is interesting to note is
that four years later under official printing from the American Psychiatric Press within
the DSM-IV Sourcebook (1996), one of the “clinical” supports for the changes in the
DSM-IV, this precise article (by the same authors) was published with only minor
verbiage change as the clinical data utilized to support the DSM-IV revisions (analysis of
referenced studies to be in next clinical studies section).

DSM-IV Draft Criteria (1993) was printed as a predecessor to the official
introduction of the DSM-IV and lists very similar criteria for both Conduct Disorder and
Oppositional Defiant Disorder. For Conduct Disorder the diagnostic criteria options to
choose from were increased from thirteen to fifteen with the addition of “often bullies,
threatens, or intimidates others” and “often stays out at night despite parental
prohibitions, beginning before thirteen years of age” (DSM-IV draft, 1993, p. 10). The
category of Oppositional Defiant Disorder has only one change, that being the noninclusion of “often swear or uses obscene language” as a diagnostic criteria. This draft criteria does add a third descriptor within these categories titled “Disruptive Behavior Disorder Not Otherwise Specified”. This category is for disorders characterized by these two disorders, yet do not meet the criteria for either.

These publications led to the introduction of the DSM-IV in 1994, claimed to have been supported by the work of 13 work groups who reported to the 27 member Task Force for the Revision of DSM-IV. These work group recommendations and publications were critiqued by between 50 and 100 advisers, who were chosen to “represent diverse clinical and research expertise, disciplines, backgrounds and settings . . . (these groups) reviewed all of the extensive empirical evidence and correspondence that had been gathered . . . more than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence” (DSM-IV, 1994, p. xvi-xvii).

The DSM-IV revision process was purported to revolve around literature reviews, data reanalysis and field trials. The literature reviews utilized “systemic computer searches and critical review done by large groups of advisers to ensure coverage was adequate and that the interpretation was justified . . . when a review of the literature revealed a lack of evidence for the resolution of an issue, we often made use of two additional resources, data reanalysis and field trials” DSM-IV, 1994, p. xix). These field trials and data reanalysis were coordinated by the individual work groups and were quoted to be published in Sourcebooks this same year.

The DSM-IV Sourcebook, published in five volumes, is intended to provide a comprehensive and convenient reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force. The first three volumes of
the Sourcebook contain condensed versions of the 150 DSM-IV literature reviews. The fourth volume contains reports of the data reanalysis, and the fifth volume contains reports of the field trials. . . in addition, many papers were stimulated by the efforts toward empirical documentation in DSM-IV, and these have been published in peer-reviewed journals” (DSM-IV, 1994, p. xx).

What is interesting is that all volumes were published significantly later than 1994, with the last Volume not being released until 1998. This pattern of introducing the Manual versions prior to all claimed supportive documentation was also true for the DSM-III (1980) and DSM-III-R (1987).

The category of Conduct Disorder for DSM-IV mirrored the diagnostic criteria changes recommended in the draft version printed in 1993. These changes incorporated included extending the minimum amount of time needed for the presence of the diagnostic criteria and was increased to twelve months, with at least one criterion present in the past six months. The fifteen criterion listed in the draft are duplicated and only separated into typology categories (aggression, destruction of property, deceitfulness or theft, and serious rules violations). There is an additional age of onset demarcation of “childhood or adolescent onset type” included with a cutoff age of ten years being the determinant time period. The additional descriptors of mild, moderate and severe are included and continued from the DSM-III-R (DSM-IV, 1994, p. 90-91).

The category of Oppositional Defiant Disorder mirrors the 1993 draft version with no changes to the wording or categories for DSM-IV. The recommendation for the addition of the category titled “Disruptive Behavior Disorder Not Otherwise Specified” is included as a third official disorder within the behaviorally based categories.
## Clinical Studies for Behaviorally Based Disorders - 1968 to 1998

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<td>Russo/Loeber/Lahey</td>
<td>1994</td>
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<td>National Institute of Mental Health</td>
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<td>Widiger</td>
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<td>MacArthur Foundation</td>
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Table 5.4 Clinical Studies and Funding Sources for Behavior Disorder - 1968 to 1998
The studies selected include an exhaustive list of the literature that is directly cited by the Diagnostic and Statistical Manual (III, III-R, and IV) and the supportive literature that is discussed in the previous section on the specific adolescent diagnostic categories. This section does not include the significantly larger pool of clinical studies within the literature, and has narrowed the research to those cited by the authors of the DSM.

Jenkins continued his writing with numerous published references cited by the Diagnostic and Statistical Manual of Mental Disorders sources. Jenkins (1969) discussed the categories of childhood disruptive behavior disorders listed from the DSM-II (hyperkinetic reaction, withdrawing reaction, overanxious reaction, runaway reaction, unsocialized aggressive reaction and group delinquent reaction) and discussed courses and difficulty in treatment of these children. The author cites that these reaction types (categories) "represent clinically recognizable symptomatic clusters supported by research studies" (Jenkins, 1969, p. 9). The studies that are referenced as supporting this typology include Hewitt and Jenkins (1946), Jenkins (1944, 1946, 1960, 1966), Kobayaski (1967) and Shamsie (1968), all studies that have been evaluated earlier with appropriate designs critically examined showing limited support for the diagnostic schema. Jenkins (1970 and 1971) published this same material in much more simplistic linguistics, relying on a few charts and pictures of youth, in describing and listing the six types of childhood behavior disorders for the Journal of Modern Medicine and Journal of Family Practitioners. These references include simplistic typology listings, case examples and treatment recommendations of psychotherapy, parental guidance and residential (foster care) placement for these children and adolescents.
Rutter, Shaffer and Shepherd (1973) continued their influence and recommendations for a multiaxial classification system. This study focused on child psychiatric disorders and was designed as a reliability study using case histories of seventeen patients and testing of the classification system in clinical practice. The first portion was reported to have used these case histories and presented the information to twenty-two child psychiatrists (not referenced how they were chosen) who used the proposed multiaxial classification in their diagnosis. The outcome was “found that the inter-rater agreement on symptomatology was moderate (most correlations were around .6) and was particularly low for antisocial behavior (.26)” (Rutter, et. al., 1973, p. 247).

The clinical study portion examined 225 referred cases within the participants practice or clinic and found Conduct Disorder to be one of the most common diagnosis. Recommendations were that this multiaxial system was shown to be superior in providing full and more systematic information and should be applied to adult psychiatry as well.

Achenbach and Edelbrock (1978) published a fairly thorough review of behavioral categorization and checklist procedures covering the prior two decades of other published work. These authors analyzed the clinical studies for childhood psychopathology (included all diagnostic disorders ranging from aggressive, delinquent, hyperactive, schizoid, anxious, depressed, somatic, and withdrawn) and drew conclusive categories from which to view this data. These authors took the previous studies from the 1950’s and 1960’s, reports from teachers observations, and reports from parental observations and employed a second-order analysis in searching for groupings from these results. The authors cite the risks involved in this procedure of utilizing vastly differing sampling procedures and corresponding lack of conformity, yet claim to have identified
four broad band and fourteen narrow band results with which to categorize the characteristics of all previous disorders listed.

The authors cite this second order analysis had been completed in earlier published studies by Achenbach, Edelbrock, Jenkins and Millman and revealed the following broad bands: Undercontrolled (aggressive, externalizing, conduct disorder), Overcontrolled (inhibited, personality disorder), Pathological Detachment and Learning Problems. What is also discussed by these authors is the procedure referred to as “bootstrapping . . . the attempt to establish relationships among measures, all of which are known to be imperfect” (Achenbach and Edelbrock, 1978, p. 1290). Yet claimed reportedly to be supported because of the inevitable utilization by researchers in the field. The authors conclude that based on the observations of this review, future study’s contributions will be far more valuable if the procedure includes one of these past utilized tools identifying behavior through a reported checklist.

Quay (1978) published a book chapter and discussed adolescent pathological disorders and continued to write of the need to increase the differentiations within the Conduct Disorders and to research for additional subtypes within this category. This author states that the undersocialized aggressive and socialized aggressive types are “well defined empirically . . . in contrast to many other childhood disorders, the central features of both types of conduct disorder are well established . . . the diagnostic criteria of DSM-III fairly well reflect these empirically established characteristics” (Quay, 1978, p. 35-36). What is interesting about these claims includes the publication of this review prior to the publication of the DSM-III, and it is not known whether access to earlier draft copies were available for this review. Also, the referential sources used by the author to
support these claims included only three references to his own published articles (previously reviewed Quay, 1964, 1966). Quay continues the discussion with a list of correlates corresponding to those diagnosed with Conduct Disorder. This review looks at cognitive functioning, instrumental learning, behavior in intervention programs and biology. This writing is one of the first that utilized the biology of the individual as a primary source of explanation for this childhood and adolescent disorder. "While biochemical theorizing of this nature is (difficult)... there is a developing attractive coherence between empirical fact and theory with respect to biochemical involvement in undersocialized conduct disorder... recent research has implicated psychophysiological and biochemical factors" (Quay, 1978, p. 52-64).

Cantwell, et. al. (1979) published prior to the introduction of the DSM-III the Field Trials for childhood psychiatric disorders. It is these field trials that were reported by the American Psychiatric Association to have been the empirical justification for the changes made in the DSM-III for childhood and adolescent disorders. These field trials consisted of a report comparing DSM-II and DSM-III psychiatric disorders for childhood categories. This was the first of four successive reports that utilized the same sample and methodology for comparative analysis.

The first published report focused on interrater reliability and comparative analysis of these diagnosis. The authors of the field trials (Cantwell, Russell, Mattison and Will) chose twenty-four case history examples as the "n" of the study. It is reported that these cases originated from actual child and adolescent patients seen in a psychiatric outpatient clinic (not revealed where) and the history and examination results were given as information to the raters. The raters were all from the same location (University of...
California at Los Angelos, Department of Child Psychiatry - where Dr. Cantwell was teaching full-time) and included eight child psychiatry faculty, two third-years, four second-year, and six first-year fellows in child psychiatry. It is reported that all participants were using DSM-III for the first time in comparison to the DSM-II. The instructions were for the raters to diagnose these twenty-four cases over a six-week time frame and to keep the information confidential and not discuss these with their colleagues or co-students. This methodology is questionable and potentially dubious at best with the inability to control for rater-collaboration, the same site usage for all participants and the unknown or reported impact that Cantwell had on the department where all the results emanated from.

Results of these participants' diagnosis were compared to an "expected diagnosis" discussed and determined by the authors of the field trial prior to the dissemination to the raters. Only two of the case histories were categorized as behaviorally based diagnosis and were found to have an agreement rate of .7 and .3 for a Socialized Conduct Disorder and Undersocialized Unaggressive Conduct Disorder, respectively. Overall results were equally sketchy and "suggests that a source of variation in diagnostic reliability may be the clinical complexity of the individual case rather than defects in the classification system itself. The hypothesis needs to be tested in field trials with large numbers of cases . . . not surprisingly the overall level of rater agreement with the expected diagnosis was less than 50% (49%). The raters were using DSM-III for the first time and were unfamiliar with many of the definitions and operational criteria for the various disorders" (Cantwell, 1979, p. 1213).

The second part of the field trials, published by Mattison (1979) as the lead author
reported to have used the same methodology and study data as the first published report. This trial focused on the interrater agreement of the diagnostic outcome and presented the results in corresponding diagnostic categories. Within the “Attention Deficit and Conduct Disorders”, two histories, case number four and seventeen, of the twenty-four total comprised the data and results for “Conduct Disorders”. This resulted in an interrater agreement of 63% for DSM-III criteria and 70% for DSM-II criteria for Conduct Disorders, while overall DSM-III results were a bit less reliable. “The average interrater agreement on childhood cases was only somewhat less than that for DSM-II . . . DSM-III appears to be as reliable as the older DSM-II” (Mattison, 1979, p. 1222). Again, these results based on the case histories of two nonreferenced youth, showing less reliable results, are the purported support for this category of changes for the DSM-III for behaviorally based disorders.

The third Field Trial (Russell, 1979) focused on the results of the multiaxial features for the DSM-III, nonexistent for the earlier DSM-II. Without any comparative data from the earlier system, the authors utilized this same methodological study data to conclude that the multiaxial system led to a more complete and reliable diagnosis of clinical cases. This was concluded through a comparison of DSM-II diagnosis and reviewing whether these diagnosis appeared in Axis I or Axis II of DSM-III. Through this comparison it was concluded that more frequently the diagnosis for DSM-III appeared more often in these two Axis as compared to the one option for DSM-II.

The fourth field trial (Cantwell, 1979) used the same studied results and discussed the difficulties in use, global comparison and conclusions of those involved in the study. The results were from discussions and comments made by the involved raters and found
“in addition to being reliable, (DSM-III) was easy to use” (Cantwell, 1979, p. 1227). It was written that overall the raters reported few difficulties, preferred DSM-III over DSM-II (though no reasons for this were given) and the authors in summarizing the results of the field trials “conclude that DSM-III, with additional refinements gives promise of being a very usable and reliable classification system for the diagnosis of psychiatric disorders for children and adolescents” (Cantwell, 1979, p. 1227).

The DSM-III was released in 1980, as previously referenced, and within this Manual were literature references to seven additional sources supporting the change in nosology from the DSM-II to DSM-III for behaviorally based childhood and adolescent diagnosis. This is realized to be unique in the DSM publications, for the DSM-III is the only one of the five versions that included literature references in any portion of the Manual itself. One of these references is the Group for the Advancement of Psychiatry’s 1966 Report #62 which has been discussed previously and which does not include any additional clinical study data or results with which to review. This report proposed revisions to diagnostic classification systems and incorporated numerous earlier classification systems as points of reference.

Robins (1966) was cited in the DSM-III references and produced a widely acknowledged and reprinted study. This study sought to compare the adult outcomes as compared to childhood descriptors in search of validating the emerging Sociopathic Personality. The author goes to great research lengths in using data from a large sample (over 500 cases) of children admitted to the St. Louis Municipal Psychiatric Clinic from 1922 to 1930. These individuals are then interviewed thirty years later in search for correlates to the purported adult negative outcome. This study does report that
conclusively the emergence of the Sociopathic Personality is traced to childhood psychiatric diagnosis and difficulties in need of referral to a hospital clinic, but it is difficult to find the purported support for the DSM-III.

The Group for the Advancement of Psychiatry (1973) published Report #87 focused on treatment planning and is referenced in the DSM-III. This report discusses the therapeutic aspects of effective treatment planning, an assessment of therapeutic potential, dynamics of small-group planning, treatment planning and the community, reporting the findings, treatment planning in practice, misconceptions about diagnosis and treatment and the vicissitudes of treatment planning. No additional clinical findings are presented nor are any recommendations to diagnostic nosology given.

Jenkins (1973) is also cited in the DSM-III, with a presentation of this author's earlier publications on childhood nosology. This publication recapitulates earlier diagnostic categories utilized in the Diagnostic and Statistical Manual of Mental Disorders (1968) and reported no new information beyond these typologies.

Mednick and Christiansen (1977) additionally brought nothing new to the research area for their study focused not on children or adolescents but on adults. This study and review were carried out in Sweden and searched for biosocial factors related to criminal acts. These researchers searched for answers and predictors to adult criminality which included psychopathology, parents impact, chromosome research, economic status, intelligence and differing risk factors. One of these same authors (Christiansen, 1978) published an additional DSM-III referenced study presumably in support of diagnostic changes for children and adolescents, although the study utilized data looking at sex differences in adult differences of antisocial personality, alcoholism and criminality. The
utilization of research on sets of twins reportedly revealed family related factors as predominant in predicting sex differences for antisocial adult personality and nonfamily factors impacting sex differences for alcoholism.

A DSM-III referenced study by Robins (1978) was published in Great Britain and focused on childhood and adolescent predictors of adult antisocial behavior. This study compared four male cohorts differentiated by race in different localities within the United States searching for predictor variables. The sample groups included ex-child guidance patients, young black men (aged 18 to 23), Vietnam veterans and a group of matched Vietnam veterans. Data sources included records from clinics, courts and police systems and interviews. Variables searched for included arrests, truancy, drinking, fighting, educational dropout rates, negative peers, incarceration and drug usage. This study concluded that all types of antisocial behavior in childhood predict a high level of antisocial behavior in adulthood and that these syndromes are very intercorrelated.

Achenbach (1980) published the same year of the release as the DSM-III, recapitulated information and data from his 1978 (Achenbach and Eldebrock) publication. This author cites the need for changes in the diagnostic classification for children and adolescents for the following reasons: children’s contacts with the mental health system are fundamentally different than adults, major adult disorders have no counterpart for children, developmental levels must be accounted for, and that child psychopathology “may require a taxonomic framework different from that needed in adult psychopathology” (Achenbach, 1980, p. 397). Achenbach then gave a review of the past empirical efforts including factor analysis, cluster analysis, behavior rating scales and reprints the four broad-band and fourteen narrow-band syndromes from his 1978
study. The author concludes with the need to continually challenge the current childhood diagnostic nosology (DSM-III) and supports the continued revision process, but generally endorsed the current system as very applicable for children and adolescents.

This promotional type publication for the DSM-III was replicated by Rutter and Shaffer (1980) in the same Journal volume. "The goals, as set out in the introduction of the Manual, include both a commitment to reliability and validity as determined from research findings" (Rutter and Shaffer, 1980, p. 371). This is followed by a list of "successes" of the DSM-III for childhood diagnosis that include the taking of a descriptive phenomenological approach untethered to a specific theoretical approach, that it is disorders and not individuals that are classified, that the use of a multiaxial framework is a step forward in clinical diagnosis, that DSM-III provides a much more comprehensive list of child psychiatric disorders than DSM-II, that diagnostic criteria provided by the better researched areas are a significant improvement, the addition of the coding of psychosocial stressors and the recognition that childhood disorders can continue into adulthood. These authors go on to state that "a careful review of the evidence indicates that rather few of the diagnostic categories have been validated satisfactorily... but that it is not sensible or practical to demand that all categories be proved to the hilt before inclusion in a psychiatric classification" (Rutter and Shaffer, 1980, p. 385).

These authors continued in reviewing the previously published DSM-III field trials for child psychiatric disorders (Cantwell, et. al., 1979) and claim that the system of classification for DSM-III was a more satisfactory coverage of disorders with the multiaxial approach. "There was also good interrater reliability for the broad groupings
of syndromes and . . . no justification for the great proliferation of new and unvalidated categories” (Rutter and Shaffer, 1980, p. 387). This is an interesting differing point of view not in support of the childhood and adolescent diagnostic changes. Yet, this tone is only temporary for the conclusive recommendation included that the DSM-III is a “landmark in development of psychiatric classification systems . . . this version constitutes but a stepping stone . . . for the much-improved DSM-IV version to which we now look forward” (Rutter and Shaffer, 1980, p. 392).

Another study was produced within the Department of Psychiatry at the University of California at Los Angelos (Strober, et al., 1981), cite of the DSM-III Field Trials for Children and Adolescents. This study was justified through a previous published discussion by Spitzer, et. al. claiming that “unreliable diagnostic judgments are due far less to substantive factors than to error variance inherent in limited experience or training of raters, contrasting notions of the essential symptoms of diagnostic conditions, etc.” (Strober, 1981, p. 142). This study utilized 92 consecutive referrals at the University’s Neuropsychiatric Institute and had two psychiatric fellows diagnose the youth within the first four days of admission. Reviewed data included history, interviews, use of the Schedule for Affective Disorders and Schizophrenia, psychological and medical examination. Overall concordance of the study equaled .74 (74% agreement on Axis I diagnosis) and .75 for specific Conduct Disorders. More positive results of this study could have been accredited to the larger number of older subjects, the utilization of two raters, the use of a joint interview by these raters and the standardized method of history taking.

Strober, et. al. (1981) continued the interrater reliability studies with a clinical
assessment of 95 inpatient adolescents in comparing two separate raters diagnosis through reviewing all relevant material, and after an examination. Overall concordance of diagnosis equaled .74 (alpha) and for Conduct Disorder equaled a similar .75, with this study reinforcing the recently introduced DSM-III system through a reliability focus.

Loeber (1982) reviewed childhood behavior in regards to the stability of symptomatology over time. This review of past literature points to the following: that children who display initially high rates of antisocial behavior are more likely to persist in this behavior; that chronic delinquents tend to have been children who showed these negative behaviors earlier on in more than one setting; and that once high levels of antisocial behavior are consistent; that these activities continue through adolescence and singularly surprising as a result is that youth who physically disrupt decreases between the ages of 6 and 16 as compared to the number of youth increased in more covert acts of antisocial behavior.

Werry, et. al. (1983) performed an interesting synopsis of the childhood and adolescent clinical studies up to this date that searched for interrater agreement. Compilation of the data comparing these previous studies found that the overall Kappa for childhood disorders equaled .7 (equal to Spitzer’s 1979 published minimum criteria for “valid” findings), yet for Conduct Disorders equaled only .52 for all studies combined. Werry finds that the better results by Strober as compared to the other authors, would require a significant change in structuring the psychiatric interview and keeping greater controls on the outcome of diagnosis.

Lewis et. al. (1984) continued some of the questioning postulated by Werry et. al. (1983) in regards to the diagnostic category of Conduct Disorders. These authors
conducted a study of psychiatric hospitalized adolescents with and without Conduct Disorders and found very little symptomatology differences. They pointed to the demarcation of violence as being the only characteristic difference and made a recommendation to have these disorders subsumed within other adolescent and childhood diagnostic categories.

Loeber and Schmaling (1985) sought to examine the differentiation made within the DSM-III between overt and covert antisocial patterns (although the DSM-III also distinguished between under and oversocialized traits, not addressed here). These authors utilized twenty-eight factor and cluster-analytic studies of child psychopathology already published and incorporated a multidimensional scaling analysis to differentiate traits that emerged from these studies. It was reported that one end of this dimension consisted of overt/confrontative behaviors (arguing, fighting, etc.) and the other covert or concealed behaviors (stealing, fire setting, truancy, etc.). The conclusion finds congruency with the differentiation claimed by the DSM-III and applies some of the recommendations to the expansion of treatment modalities to treat these differing types of youth.

The DSM-III-R Field Trials for behaviorally based childhood and adolescent disorder were published by Spitzer, et. al. (1990). It should be noted that these field trials were not published until three years post introduction of the DSM-III-R, when the buildup for the DSM-IV introduction was underway. Reported rational for the field trials is provided by Barkley, unfortunately the manuscript referred to is unpublished. The trials support this study reportedly to assist in resolving debated issues and to answer the questions of which diagnostic items meet sufficient discriminating power, what internal
consistency exists, what threshold should be utilized for making a diagnosis, what level of agreement exists between clinicians and whether there is there clinical support for the DSM-III-R. These field trials utilized clinical cites where various childhood DSM-III-R committee members were affiliated with including Loeber, Lahey, Shaffer and Spitzer. In listing the ten locations of the field trials, there is a notation of an error in the DSM-III-R Appendix F citing that the locations published and referenced in the Manual were incorrect. The difference is significant for the number of locations for the clinical trial (1991) is significantly different from what was presented as to be included in the field trials (1987).

This study utilizes these ten locations and totals 550 referrals with an average “n” ranging from 14 to 85 from each cite. It was reported that the goal for referral was at least ten consecutively referred cases be included for each diagnostic category of ADHD, ODD, CD and Other mental disorders. This was not accomplished at 30% of these cites who referred less than these number of referrals, and three locations accounted for over 50% of all referrals. These three locations includes the cites that Loeber, Shaffer and Spitzer are affiliated with at this time. The diagnostic assessments made for these children (so called for the average age of the sample equaled 9.2 years and the total number of subjects reviewed with CD and ODD equaled 275 youth) was based upon a clinical interview of the parent and child (p for 95% and 72% of all respondents).

The changes made to the DSM-III-R category of Oppositional Defiant Disorder (deletion of a number of items and increase to five of nine descriptors necessary for diagnosis) was based on an internal consistency of the study of .85. The items describing unusually early sexual activity and use of tobacco or drugs were deleted for not
describing risk factors for this disorder. The hierarchical relationships questioned between ODD and CD found that 84% of these youth met diagnosis for both disorders, but the recommendation for combining the categories was not made. Conclusively the authors state “the use of a large sample of children of varying ages drawn from a wide range of geographic and socioeconomic areas suggest that the results can be generalized” (Spitzer, 1991, p. 695). However, the results of intrarater reliability (an often utilized source to show purported “reliability and validity” by the DSM authors) was less than previous field trials for DSM-III for Conduct Disorder and Oppositional Defiant Disorder. This is explained by the assumption that this

probably reflects the considerably different item pool and more stringent cutoff score used in the new DSM-III-R criteria, as compared to the old DSM-III items for OD on which many of the clinicians probably relied. It is therefore quite likely that future studies of the interjudge agreement of the new DSM-III-R criteria will be at least equal to or better than those found for DSM-III (Spitzer, 1991, p. 695).

Additional limitations include the reliance by most clinicians on the DSM-III criteria, substantial familiarity of the judges with the new item pools being tested (DSM-III-R), the use of clinicians who are familiar with each other and the sample including only children referred to psychiatry/psychology clinics.

Werry et. al. (1987) published a review of research on differentiating characteristics of four separate diagnosis, Attention Deficit, Conduct, Oppositional and Anxiety Disorders of children. This review of past studies used the selective criteria of diagnosis including measured correlates independent of the syndrome itself, ordinary methodological criteria to be met, and children to be of school age. This eliminated the review of studies to only six groups of researchers, two in the United Kingdom (Sandberg,
1978 and Thorley, 1984), one in New Zealand (Reeves, 1987) and three in the United States (Loney, 1974; Stewart, 1983; and Koriath, 1985) with no more than 30 youth in any one diagnostic category. “This review failed to reveal much evidence, independent of the actual defining symptomatology itself, to confirm the validity of the diagnostic categories of ADD, CD, ANX and OPP, especially in confirming the hypotheses that previously observed differences from normal children are specific to any diagnosis” (Werry, 1987, p. 139-140). What is interesting is the introduction to this review that present the DSM-III as a “watershed” in diagnostic classification and that it offered the real possibility of a system that was universal and testable.

The second part of this review of DSM-III (Reeves, 1987) was a study of 105 youth, median age 8.5, carried out in Auckland, New Zealand. This study utilized child, parent, teacher questionnaires and the Diagnostic Interview Schedule for Children-Parents (DISC-C), and found that 52% of the referred children met criteria for a DSM-III diagnosis. Of these results, only four children were found to have a Conduct Disorder unaccompanied by another diagnosis and only two children an Oppositional Disorder alone. What was discussed at length was the predominance of attention disorders present in a vast majority of these diagnosis and the seeming presence of this disorder as an undercurrent for other diagnosis. Through this study the purported aim of the authors was to examine the “external validity of the four DSM-III major diagnostic categories of ADDH, CD, OPP and ANX Disorders by studying a larger number of their correlates” (Reeves, 1987, p. 145). The question to be asked is whether this singular review of a limited number of youth, primarily with such limited focus on Conduct and Oppositional Disorders, lends much support for systemic changes in the diagnostic system regarding
these diagnosis.

Loeber (1988) reviewed the developmental literature regarding the natural histories of conduct problems, delinquency and associated substance use. This author reviewed hypotheses that included early nonaggressive conduct problems predict a more serious substance use, whereas early aggression is a better predictor of more-serious substance use; that most violent and chronic offenders have been highly aggressive as youngsters; that early aggression is predictive of both violent and property offenses and that the more frequently violent an offender the more likely these acts correlate to earlier property and violence offenses. These are discussed and confirmation of them is not unexpected to have been positive in regards to face validity.

Rey, et. al. (1988) discussed the prevalence of Oppositional Disorder in regards to its demarcation as a separate diagnosis from Conduct Disorder. The origination of the disorder is credited through the Group for the Advancement of Psychiatry’s 1966 Report (#62) that utilized Levy’s (1955) theoretical proposition of aggressiveness being expressed through oppositional and passive natures. This study diagnosed 243 successive referrals to an adolescent unit and utilized criteria similar to Werry (1983 - behavior checklists, two raters, more controlled environment), finding the interrater agreement of Oppositional Defiant Disorder to equal .52, not acceptable by Spitzer’s (1979) DSM-III threshold standards.

Schachar and Wachsmuth (1990) studied prepubertal clinic-referred boys with DSM-III Oppositional Defiant Disorder and found parental psychopathology to be equal for those youth with Conduct Disorder. The highest frequency of diagnosis was for substance abuse and antisocial personality. This is concurred with by Faraone, et. al.
Loeber, Green and Lahey (1991) studied via a survey of 128 members of the Society for Research in Child and Adolescent Psychopathology (with a 74% return rate asking for information on youth aged 7 to 12 years) for clinicians' and researchers' perceptions of the usefulness of children, mothers and teachers as informants of diagnostic information. High levels of agreement are reported with children being the least reliable source in identifying attention or oppositional behavior. Teachers were identified as more reliable sources for identifying attention difficulties and mothers more effective identifying oppositional difficulties.

Faraone, et. al. (1991) searched for correlates of Oppositional and Conduct Disorder with Attention-Deficit/Hyperactivity Disorder and found the prevalence for parents did not differ significantly. However, the sample which compared three groups (control group for CD, control group for ODD and nondiagnosed clinical group) did find higher prevalence of substance abuse or dependence for parents of Conduct Disorder as opposed to Oppositional Defiant Disorder.

Continuing in the research inclusive of parental symptoms and adult outcomes, Harrington, et. al. (1991), found that the risk of criminal convictions for those with less than three symptoms for Conduct Disorder diagnosis was only 10%, while those with three or more criteria had a better than 50% chance of conviction. This sample was small and not randomly selected, but is an interesting if not an unexpected result of study. Similar design and results are reported by Walker, Lahey, et. al. (1991) who focused on a clinic-referred group of 7 to 12 year-old boys who met DSM-III-R criteria for Conduct Disorders and reported that 96% of the youth also met criteria for Oppositional Defiant
Disorder.

Loeber, Lahey and Thomas (1991) began the published clinical support for the release of the next diagnostic revision, DSM-IV. These authors claim to review the literature up to this date that identifies evidence for the diagnostic distinction of Oppositional Defiant and Conduct Disorder. These authors, while not significantly detailing their review, claim that these studies suggest that these two disorders are very related developmentally but are clearly distinct. These author’s factor analysis of the studies found similarities of mild aggression and lying but distinction among many other traits. It is claimed that age of onset for Oppositional Defiant Disorder is earlier, that most youth with Conduct Disorders also had Oppositional Defiant Disorder prior, that there is insufficient data on girls’ development of disruptive behavior, and that treatment should be directed at the earlier development of Oppositional Defiant Disorder.

Frick, Lahey, et. al. (1991) continued this documentation trend using a sample of 177 youth studied longitudinally over a three-year time period. This same sample was used for three other published studies (Frick, 1991; Loeber, 1993; and Frick, 1993), two of which were utilized as referential support for the DSM-IV Field Trials. This sample of youth were chosen from three university-based outpatient centers, locations where there were Disruptive Behavior Task Force members affiliated, and a sample median age of nine. The methodology included three separate interviews with the child, parent and teachers using the National Institute of Mental Health Diagnostic Interview Schedule for Children (DISC) and raters (a licensed clinical psychologist and a graduate student in clinical psychology), and the results were examined after being generated “by a computer . . . summary of parent, teacher, and child reports on the presence or absence of each
symptom. These summaries also contained the diagnostic parameters relevant to each disorder . . . with kappas for interdiagnostic agreement (not surprisingly) at .92 for CD (Conduct Disorder)" (Frick, et. al., 1991, p. 447-448). This study also reviewed family histories and concluded that after controlling for race and socioeconomic status, no link for Conduct Disorder was identified.

Frick, Lahey, et. al.(1991) again used this same sample information and published a factor analysis of the data relevant to Oppositional Defiant and Conduct Disorder. The results of this study were referenced as support for some categorical redefinitions with the DSM-IV. The factor analysis claimed to reveal two dimensions of conduct problems similar to the Oppositional and Conduct Disorder distinctions. Yet some differences pertained to individual symptom items including “bullying” and “violation of major rules” being more associated with Oppositional Defiant and not Conduct disorder, and “fighting” and “lying” having equal loadings in both Disorders, though are currently listed within Conduct Disorders. An interesting result was the lack of any clustering of youth for Oppositional Defiant Disorder (mean age of nine years), only occurring for Conduct Disorder.

Waldman and Lilienfeld (1991) published a study looking at diagnostic efficiencies of Oppositional Defiant Disorder and Attention-Deficit Hyperactivity Disorder (also quoted as referential material for Waldman 1994 “Design of DSM-IV Field Trials for Disruptive Behaviors”). This methodology included utilizing 104 nonreferred nonclinic boys ages 8 to 12 who were rated by their teachers from nine separate public and parochial schools in Ontario, Canada. Criteria from the DSM-III-R (lists of descriptive symptomatology) were rated by teachers on a 0 to 3 scale (not at all,
just a little, pretty much, very much) and claimed that with the positive descriptive results this “illustrates the utility of conditional probably indices in both the diagnosis and differentiation of childhood disorders” (Waldman, 1991, p. 732).

Within the DSM-IV Options Book Work in Progress publication (1991), the Task Force on the DSM-IV listed references in regards to the various committee/task force work that was underway. It should be noted that the only literature/clinical study references for the behaviorally based disorders within the Disorders of Infancy, Childhood, and Adolescence is Loeber, Lahey and Thomas (1991). Other references are addressed toward Attention-Deficit Hyperactivity Disorder, Gender Identity Disorder, Mania, Sibling Rivalry, Adjustment Disorder, Pervasive Developmental Disorders, Childhood Disintegrative Disorder, Autism and Overanxious Disorder.

Lahey, Loeber, Quay, Frick and Grimm (1992) published an interesting discussion of the issues to be resolved for the upcoming introduction of the DSM-IV. This publication is a compilation and review of literature to date attempting to resolve the issue of whether to differentiate or not to differentiate the categories of Oppositional and Conduct Disorder, and if so then to what distinction is most empirically supported. These authors cite Quay (1986), Lahey (unpublished), Loeber (1991), and Lahey et. al. (unpublished) as evidenced factorial analysis distinction of ODD and CD being separate syndromes. These authors continued this method by citing previously unpublished and reported data by Lahey et. al. that reported the possibility of a developmental progression from ODD to CD. The relation of ODD and CD being within a hierarchical situation is argued by these authors through conceptual terms, with no data nor references to support this argument. The article used this argument later to claim that these disorders “may be
related both hierarchically and developmentally” (Lahey, et. al., 1992, p. 541).

In examining the Conduct Disorder subtypes, this trend of referencing previously unpublished studies and new data continued to emerge through this article (Rogeness, unpublished; Rogeness, et. al., unpublished; Loeber unpublished). What is proposed is the possible expansion of Conduct Disorders into two developmental levels of severity and maintaining the category of Oppositional Defiant Disorder. These decisions will be supported through the “ongoing DSM-IV Field Trials, reanalyses of existing data sets, and other new studies will bring much new data to bear on these issues by the time these decision are made in 1992” (Lahey, et. al., 1992, p. 545). An interesting time table considering this article was published in 1992 and none of this information was released.

This article (Lahey, et. al., 1992) was republished in its entirety, with no changes bar a few introductory and conclusive remarks, in the DSM-IV Sourcebook, Volume 3 (Widiger, 1996). It is this article that is cited as sole and conclusive commentary on the empirically studied support for the DSM-IV. This is the one of only two references in the DSM-IV Sourcebook regarding Oppositional Defiant and Conduct Disorders. Not one additional reference since the original publication in 1992 was cited nor added during this four year difference in time.

Loeber, et. al. (1993) attempted to clinically study the possibility of what was proposed earlier with modifications and changes to these diagnostic categories. The authors used a sample of 177 boys followed over a 3-year time period and compared DSM-III-R diagnostic categories with an alternative diagnostic construct which subdivided into three levels according to developmental severity (modified Oppositional Disorder, and intermediate and advanced Conduct Disorder). Results were confirmatory,
though not enough details on sample selection were given for analysis for a review.

This clinic sample of 177 boys was utilized a second time by these authors in Frick, Lahey, Loeber's, et. al. (1993) meta-analysis. This review performed a meta-analytic summary of 60 factor analyses from 44 previously published studies and confirmed two dimension of behavior - overt/covert and destructive/nondestructive. To have been included in the chosen studies of analysis, a previous factor analysis of a parent or teacher behavior checklist needed to be included, as well as two behaviors from the descriptive list of DSM-III-R behaviorally based disorders (ODD or CD).

Russo, Loeber, Lahey and Keenan (1994) are referenced in the DSM-IV Field Trials for Disruptive Disorders and published a study making recommendations for developmental levels for Oppositional Defiant and Conduct Disorders. There is significant discussion in other publications regarding these recommended changes to the continuum of these disorders, but as to date these proposed changes have not been incorporated. The methodology included 503 thirteen year-old boys from the Pittsburgh Youth Study longitudinal review over a six-year time period and compared the DSM-III and DSM-III-R with an alternative diagnostic option which included the following; a modified Oppositional Defiant, an intermediate Conduct Disorder and advanced Conduct Disorder. The results showed differentiation of intermediate Conduct Disorder with youth having a police record and advanced Conduct Disorder showing consistent delinquent behavior over a three-year period.

Waldman and Lahey (1994) published an introductory description of the upcoming design of the DSM-IV Disruptive Behavior Disorder Field Trials. This article discussed the design, features and highlighted the outcomes of the field trials three
months prior to their publication, with a focus on marketing the technique of study and trumpeting in some ways the success of these upcoming publications. There is continued support claimed for the continued reliability of the field trials and a discussion of the increase in construct validity due to the need to “design the disruptive behavior disorders field trials with an eye toward validity from the start” (Waldman, 1994, p. 197). The methodology included a sample of 440 clinic-referred youth from the ages of 4 to 17, with an average age of 9.5. These referrals were claimed to have originated from child psychiatry inpatients (75), child psychiatry outpatients (177), child psychology outpatients (19), school psychology evaluations (30), pediatric psychology outpatients (57), forensic psychiatry referrals of juvenile sex offenders (26) and state juvenile detention (56). The primary tool used to establish the presence of symptoms and diagnosis was the Diagnostic Interview for Children (DISC-2). Clinicians were instructed to feel “free to ignore (DSM criteria they were familiar with) in assigning diagnoses and simply to follow whatever criteria they thought were applicable” (Waldman, 1994, p. 200).

The addressing of the question of validity was reportedly focused on construct validity and handled through an iterative multiple bootstrapping strategy. “In this approach, we bootstrapped toward enhanced construct validity for disruptive behavior disorders by conducting the primary field trials analyses not just once but multiple times. . . this cycle of analysis in which symptoms were added or deleted were adjusted for each disorder until no further changes in diagnostic criteria appeared to be beneficial from the standpoint of enhancing validity or reliability” (Waldman, 1994, p. 201). The question posed is whether using the same tools, raters and youth at differing time frames does
increase this purported validity. The analysis of the data included utilizing the DSM-IV Options Book and reanalysis of large data sets (not referenced for publication); choosing appropriate symptoms based on theoretical support; provisional cut-offs were set via impairment indices; clinicians’ diagnoses and test-retest reliability; and utility analyses were conducted comparing to earlier diagnostic versions.

Results of the field trials are claimed to be an increase to a 12-month time frame criteria as well as a distinction of childhood and adolescent onset subtypes of Conduct Disorder to be found. A third result was the support of the counting of Conduct Disorder symptoms toward the diagnosis of Oppositional Defiant Disorder was “validated . . . (but) it was decided not to include this change to ODD and CD in the DSM-IV owing to the complexities that would result for clinicians in assigning these diagnosis” (Waldman, 1994, p. 205). Why make the decision based on the discounting of the ability of those for whom the Manual is designed? Is this area any less confusing than the concept of validation through “iterative multiple bootstrapping strategy”? Other questionable limitations include the reliance on one research and diagnostic tool in gathering information, the lack of sufficient sample size to investigate more thoroughly the areas of interest and the focus on data collection as opposed to analysis.

The Diagnostic Interview Schedule for Children which originated from the National Institute of Mental Health (via publication) was originally predicated on the DSM-III criteria and designed to narrow the differences in diagnosis among clinicians through the common interview procedure. Post-introduction of this Schedule there was published (Shaffer, et. al., 1993) a revised version (DISC-R) and a discussion of accurate preparation, field testing, interrater reliability and acceptability (concurrent validity).
accomplish this "validation" revision, a field study of 74 parent-child pairs were utilized. Diagnostic interviews using this DISC-R were compared with a lay-structured interview procedure for an array of childhood and adolescent disorders. There were 10 cases diagnosed with Oppositional Defiant Disorder and five with Conduct Disorder and both showed high interrater reliability as well as being more reliable than the validation interview.

This was followed by a publication of the Field Trial Task Force one month later, a discussion of the DSM-IV Field Trials symptom utility estimates. The authors cited that complete descriptions of the field trial data was forthcoming, that the proposed changes are based on review of the literature (in press) and reanalysis of existing data sets (Loeber, 1993) and confirmed through the "iterative bootstrapping strategy". This analysis then proceeded to incorporate what is called positive predictive power (PPN) and negative predictive power (NPP) and "relied on PPP and NPP statistics to guide the development of diagnostic criteria" (Frick, 1994, p. 530). Widiger, et. al. (1984) first discussed this procedure as a proportion, PPP is the "proportion of individuals with the symptom who have the disorder. In contrast, NPP refers to the conditional probability of the disorder being absent given the absence of the symptom" (Frick, 1994, p. 530).

This article next incorporates the same methodological description of the field trials and utilizes a diagnostic threshold of three symptoms to be used for inclusion, based on earlier analysis of the field trials (unpublished at this time and not available until 1998). What was then utilized were the existing descriptive traits and syndromes from earlier versions of the DSM (III and III-R) and were subjected to the statistical analysis of PPP and NPP defined as "the number of agreements that exceed the expected number of
chance agreements, expressed as a proportion of the maximum possible number of agreements that exceed chance expectations given the base relates of the symptom and the diagnosis” (Waldman, 1994, p. 532). The results of this more than elaborate discussion and presentation was the inclusion of more restricted definitions of “lying” and “truancy” with Conduct Disorder and the elimination of “swearing” for Oppositional Defiant Disorder as symptom descriptions.

The DSM-IV Field Trials for Oppositional Defiant Disorder and Conduct Disorder were released in August, 1994 (Lahey, 1994). The trials began with a discussion as to the “validity” of differentiating Oppositional Defiant and Conduct Disorders by citing the research performed by Lahey (1992, 1994), Loeber (1991, 1993) and Russo (1994). The methodology was discussed (see earlier references) and it is reported that regression analysis was performed to identify the threshold for these symptoms of the disorders (these are not printed, yet are written to be available from Dr. Lahey upon request). Interrater reliability and kappa scores were utilized in determining the diagnostic thresholds for these disorders for DSM-IV. Changes included four symptoms of Oppositional Defiant Disorder through improved agreement among raters with somewhat better test-retest as compared to DSM-III-R. For Conduct Disorders, the time window for symptoms was changed to twelve months from six, a diagnostic threshold of three symptoms maximized accurate identification and showed slightly better test-retest agreement among raters. “DSM-IV definitions of oppositional defiant disorder and conduct disorder are somewhat better than DSM-III-R definitions in terms of internal consistency and test-retest agreement, and the validity of the DSM-IV definition of oppositional defiant disorder is slightly better than that of DSM-III-R”"
(Lahey, 1994, p. 1163).

Referenced within the DSM-IV Field Trials for Oppositional and Conduct Disorders (1994) included Lahey's (1990) discussion of prepubertal changes; Robin's, et. al. (1991) discussion of adult disorder prediction by childhood conduct problems; Lahey et. al. (1992); Loeber, et. al. (1990, 1992, 1993); a reference to the literature reviews of the DSM-IV Sourcebook (Volume 1) with which there is no article in this Volume related to this area (for this actually was not printed until Volume 3 in 1997); Russo (1993); Frick, et. al. (1993, 1994); APA DSM-IV Options Book; Shaffer's Diagnostic Interview Schedule for Children (1992); Hart, et. al. (in press); an article on complex algorithms (Piacentini, 1992); epidemiology studies by Bird, et. al. (1992 and 1990); and the Children's Global Assessment Scale (Setterberg, et. al., 1992).

Lahey, Loeber et. al. (1995) published a chapter review focused on the psychobiology of Conduct Disorders. This writing discussed the biological correlates of CD and common traits including familial connections and the desire to develop hypotheses regarding treatment. The authors discussed various studies that reviewed skin conductance, cardiovascular measures, catecholamines, setotonin, neurohormones and event-related potential impacts and characteristics of identifying these individuals. This review utilized current diagnostic criteria (DSM-IV) as identifying past research for discussion and claim that these results show a demarcation between the earlier and later onset types of Conduct Disorder.

Lahey, Waldman and Lilienfeld (1995) interestingly published, after the DSM-IV Field Trials for these disorders, a review of this process toward construct validity and discussed where the field trials fell short in reaching many acceptable empirically valid
plateaus. These authors reviewed the overall construct validation process within science, described the rational and design of the DSM-IV field trials within a construct-validation framework (citing as success the differentiation of child and adolescent onset typology for Conduct Disorder), discussed unresolved issues on validation, and discussed recommendations for the future.

The data and results of the referenced literature reviews, data-reanalysis and field trials were reported up to the introduction of the DSM-IV to be the basis for the revisions, and as referenced earlier, was going to support substantial increases in empiricism to the diagnostic process and categories (both through reliability and validity).

The major emphasis in the DSM-IV process has been on empirical review and documentation, and the Sourcebook, published in five volumes, is an important means of presenting that documentation. The first three volumes contain the DSM-IV literature reviews and summarize the DSM-IV Work Group’s effort that lead to the publication of the DSM-IV Options Book (1991). The fourth volume contains the results of the DSM-IV data reanalysis, and the fifth volume contains the results of the DSM-IV field trials (Widiger, et. al., 1994, p. xvii).

These methodological plans are referenced to have emerged from two conferences held in August, 1994 and November, 1994 with strict guidelines for objective research and not position papers to be submitted by the Task Force Committees.

The first three volumes of literature reviews were to identify gaps and inadequacies in the research areas and the second stage of reanalyzing multiple data sets to address these gaps were to be presented in Volume 4. "Summaries describing how the information from the literature reviews and data reanalysis aided the Task Force and Work Groups in developing options are presented in the Sourcebook" (Widiger, et. al., 1994, p. xix). The third stage of the DSM-IV process was the development of the field
trials to “assess the extent to which proposed revisions would actually improve the reliability and/or validity of criteria sets” (Widiger, et. al., 1994, p. xix).

Volume 1 (Widiger, et. al.,) was published in 1994 and includes Substance-Related Disorders, Delirium, Dementia, and Amnestic and other Cognitive Disorders; Schizophrenia and other Psychotic Disorders; Medication-Induced Movement Disorders; and Sleep Disorders. There is no mention of childhood or adolescent behaviorally based disorders referenced earlier to have been included in this Volume. Volume 2 (Widiger, et. al., published in 1996) reviews the Mood Disorders, Dysphoric Disorder, Anxiety Disorders, Personality Disorders, Psychiatric System Interface Disorders and Sexual Disorders. Volume 3 (Widiger, et. al., 1997) presented the reviews for Childhood Disorders, Eating Disorders, Family-Relational Issues, Multiaxial Issues, and Cultural Issues related to the DSM-IV. All reviews included the sections of Statement of the Issues, Significance of the Issues, Methods, Results, Discussion, and Recommendations.

Lahey, Loeber, Quay, Frick and Grimm (in Widiger, et. al., 1997) authored the literature review for Oppositional Defiant and Conduct Disorders for Volume 3 of the Sourcebooks. This volume chapter summarized the literature and issues that were presented for resolution for these disorders and the “most fundamental issue facing the DSM-IV Disruptive Behavior Disorders Committee is the clinical utility of the distinction between oppositional defiant disorder and conduct disorder” (Lahey, et. al., 1996, p. 189). Three options within the literature for diagnostic changes are reviewed and included continuing the DSM-III-R categories as is, to retain these categories with criteria changes if supported by data from the DSM-IV Field Trials, or to eliminate the distinction between these two categories and consider them as developmentally staged
levels of one disorder. "This review is based on relevant literature accessed using a combination of computer searches and reference to personal libraries" (Lahey et. al, 1996, p. 191). The details of this methodology are not given.

The American Psychiatric Association had originally commented on the plan for publishing five Sourcebooks supporting the release of DSM-IV. This changed in 1998 with the publication of DSM-IV Sourcebook, Volume 4 (Widiger, 1998) which was a combined publication of the data reanalysis and field trials for certain disorders and categories. The Volume comments that decisions for inclusion or change for diagnostic categories for DSM-IV were to be based on this increased empirical data generated; however, only a little over 20% of the disorders receive clinical documentation in this Volume.

Specific to Conduct and Oppositional Defiant Disorders, the data analyses utilized two previously reviewed clinical sample studies (Loeber, et. al., 1993 and Lahey, 1990) and concluded that changes from the DSM-III-R were unnecessary, except for the addition of a few descriptive new symptoms of "bullies". The field trials were a reprint from Lahey, Applegate and Barkley (1994) reviewed earlier in this section.

**Funding Sources**

**Diagnostic Classification and Systems**

Post-1968, this review utilizes only the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (1968, 1980, 1987, 1994) as referential material for review of behaviorally based child and adolescent diagnostic mental health disorders. Each of these Manuals is fully published by the American
Psychiatric Association Press, and this Association makes all decisions on the inclusion criteria, release dates, reprints and revisions. Funding for differing portions of the Manual and research for the field trials, literature reviews, clinical studies and other supporting documentation is reviewed in the following section.

Clinical Studies (see Table 5.4)

In review of the funding for both the previously discussed DSM system and studies for the specific adolescent diagnostic categories of Conduct and Oppositional Defiant Disorders, the predominance of two institutions is striking. Of the system references for clinical published support, six of the seven reports were funded either by the American Psychiatric Association or the National Institute of Mental Health. The seventh study did not cite a source of funding.

In review of the larger body of clinical studies cited as supportive of these behaviorally based disorders, twenty-six of the forty-nine studies (53%) are funded by either the American Psychiatric Association or the National Institute of Mental Health. This represents a tremendous number of cited supports funded solely by these two organizations. What follows is a closer review of these studies and specific funding connections.

Jenkins (1969) review of classifications for behavior problems was initially read at the 124th annual meeting of the American Psychiatric Association (May, 1968) and printed by the American Journal of Psychiatry. This trend of presentations at the APA and publication in the Journal, which is owned by the American Psychiatric Association, is a trend also found in the earlier time period of study. Jenkins (1970) publications are
similar releases to the 1969 publication, only that they are reprinted in two separate medical journals for wider dissemination to the medical field, no funding references are differentiated.

Rutter, Shaffer and Shepherd (1973) in their multi-axial research were funded through a grant from the World Health Organization (WHO). This coincides with numerous additional referential support for Rutter, working out of London in close collaboration with the WHO over many years.

Achenbach and Edelbrock (1977) were supported and both employed by the National Institute of Mental Health for their review of child psychopathology and empirical efforts. Cantwell, et. al. (1979) were funded by the same University (University of California at Los Angeles) Center for Health Sciences where the DSM-III Field Trials for youth disorders was conducted.

The following included the studies referenced within the DSM-III as supportive of the diagnostic categories for disruptive behaviorally based youth disorders. Cloninger et. al. (1978) were supported by the Department of Psychiatry, Washington University School of Medicine and the Jewish Hospital of St. Louis. Mednick and Christiansen (1977) were supported by a grant form the Center for Studies of Crime and Delinquency in Copenhagen, Denmark. Jenkins (1973) reprint of behavior disorders was supported by the University of Iowa and State of Illinois Delinquency Department. The Group for the Advancement of Psychiatry Reports over time (1957, 1966, and 1973 - cited as referential support for DSM-III) included an interesting array of sources which included the following: CIBA Pharmaceutical Company, a handful of foundations spanning the mental health spectrum, Geigy Pharmaceuticals, Roche Laboratories, Sandoz
Pharmaceuticals, Schering Corporation, Smith Kline and French Laboratories, Whyeth Weinberg and Harper and Row Publishers. Information that is not released is the percentage of contributions these for-profit organizations gave in relation to the nonprofit foundations. Robins (1966) was also funded through the Foundations Fund for Research in Psychiatry, the National Institute of Mental Health and United States Public Health Grant #MH-5938.

Achenbach’s (1980) review of the DSM-III was written while he was an employee of the National Institute of Mental Health and supported through this organization. Rutter and Shaffer (1980) were supported by the Grant Foundation, the Foundation for Child Development, the Spencer Foundation, the National Science Foundation (BNS-7824671) and the National Institute of Mental Health (MHO-7715-17). Strober, et. al. (1981) research on interrater reliability was supported through the University of California at Los Angeles Center for Health Sciences.

Loeber (1982) was funded through Grant #32857 from the Center for Studies in Crime and Delinquency at the National Institute of Mental Health. Werry, et. al. (1983) received a grant from the Medical Research Council of New Zealand the Mental Health Foundation of New Zealand for their research. Lewis, et. al. (1984) review of Conduct Disorders validity first presented their findings at the 136th (1983) annual meeting of the American Psychiatric Association and were funded by grants form the Field, Grove and Kenworthy-Swift Foundation. Loeber and Schmaling (1985) were funded through Grant #32857 (same as Loeber, 1982) from the Center of Studies in Crime and Delinquency (NIMH) for the meta-analysis of antisocial conduct problems. Werry, et. al. (1986) were supported by a research grant from the Medical Research Council of New Zealand for
both article reviews of childhood disorders, as was the discussion by Rey, et. al. (1987). Cantwell and Baker (1988) were funded through the University of California at Los Angeles Neuropsychiatric Institute.

Spitzer et. al. (1990) Field Trials for DSM-III-R funding source was not identified in the study itself, yet in the DSM-III-R Manual the National Institute of Mental Health is cited as the source of financing. The assumption that could be made through referential material of these field trials is that the employing institution (New York State Psychiatric Institute and University of Massachusetts Medical Center) supported the research. Frances et. al. (1990) discussion of DSM-IV was funded through the New York State Psychiatric Institute. Loeber and Lahey (1990) received a grant form the National Institute of Mental Health (#42529) for their survey data. Articles introducing the changes to the DSM-IV system (Widiger, 1990 and 1991) do not cite funding sources.

The following studies included those referenced in the DSM-IV as clinical support for the diagnostic changes for Disorders first Occurring in Childhood and Adolescence. Frick, Lahey, et. al. (1991) received Grant #42529 (same as Loeber, 1990) publication for their study of biological components of childhood behavior problems. Frick, Lahey, Loeber, et. al. (1991) also cite this same Grant (#42529) as financially supporting their study. Russo, Loeber, Lahey and Keenan (1994) received a Grant (#86-JN-CX-009) from the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U. S. Department of Justice. Loeber, Lahey, and Thomas (1991) cite Grant #42529 from the National Institute of Mental Health and Grant #86-JN-CX-0009 (already cited) supporting their study. The publication by the DSM-IV Task force (Work in Progress, 7/1/91) was financed through the American Psychiatric Association. Lahey,
Loeber, Quay, et. al. (1992) received Grant #42529 from the National Institute of Mental Health. While Loeber, Keenan, Lahey, et. al (1993) also cite this same grant along with the John D. and Catherine T. MacArthur Foundation as funding sources.

The DSM-IV Field Trials (Lahey, et. al., 1994 and Waldmen and Lahey, 1994) were supported by Grant #47200 (to Allen Frances) from the National Institute of Mental Health. Within the first three DSM-IV Sourcebooks, the reported sources for empirical clinical data supporting the changes within the DSM-IV. Funding for the field trials (published in 1998) is through the National Institute of Mental Health in collaboration with the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. The first three volumes of the Sourcebooks (1994, 1996, and 1997) was supported through a grant from the John D. and Catherine T. MacArthur Foundation. Additionally (in the DSM-IV, 1994) the funding for the upcoming data reanalysis (Volume 4) was reportedly provided also through a grant from this same John. D. and Catherine T. MacArthur Foundation.

One interesting area to be highlighted is that the American Journal of Psychiatry is published (and owned) by the American Psychiatric Association, the editorial board of this journal are members of the Association itself. Of the studies that qualified for review under the methodological design of this research (those cited as referential through the DSM system), there were only a limited few published by this Journal (5 of 46, or approximately 10%). However, these references were all published in post-1990 and support for the changes in the DSM-IV, the same era when the American Psychiatric Association made a concerted effort to document "empirical" findings for the DSM diagnostic changes.
These published studies included the field trials claimed to support the changes to both the diagnostic system (DSM-IV) and to the specific Conduct and Oppositional Defiant Disorders. The authors of the studies included Spitzer, Lahey and Loeber (along with numerous co-authors of these field trials). These three individuals were all appointed by the executives of the American Psychiatric Association for their involvement with the revision process of the DSM(s) and the Association also provided specific funding for these printed results. These results then happened to be cited as almost sole support by the DSM for the proposed changes incorporated for the DSM-IV.

**Child and Adolescent Psychiatrist in the Field (1900 to 1990)**

Data on the early decades of the field of psychiatry is limited and information on the number of practitioners and areas of psychiatric focus is sparse. The only area of data to be identified includes the number of residencies and trainings available to this professional field. During the 1930’s to 1960’s there was a transfer of focus on institutional care by the psychiatric field toward community based expansion. The National Institute of Mental Health provided grants and subsidized undergraduate and residency trainings during this time period to encourage the expansion of the field. In 1946, 155 residencies programs existed for medical students which by 1956 grew to 294 - this translated into the actual number of residencies growing from 758 to 2983 (Boyd, D.A.). Data from 1956 to the 1970’s is not available according to the American Psychiatric Association.

The American Psychiatric Association began accumulating data on their membership in regards to areas of training again in 1974 (although there are numerous
roster lists of bibliographic memberships without areas of specialty available for review, but not helpful in identifying trends or the focus of this research). These records of annual surveys which began for data collection in 1974, found a total of 522 child and adolescent psychiatry residency programs located within the United States. This number of residencies increased significantly over the next two decades from 669 placements in 1980 to 749 in 1990 and 767 in 1996 (APA, Directory 1972 to 1997). This represents a 50% increase in the number of psychiatric training programs focused on child and adolescents available to the field over the past twenty-five years. This compares to the overall number of residencies within psychiatry that remained constant over this period of time.

NIMH Research Dollars for Children and Adolescents (1946-1990)

The National Institute of Mental Health was established in 1946 and began as a relatively small department of the National Institute of Health’s fiscal budget. By 1959 the fiscal allotment to the NIMH was $52,419,000 and this exponentially grew over ten-fold to $740,000,000 for the budget year 1998 (U.S. Government Budget, 1959-1998).

Archival information from the National Institute of Mental Health reveals little in trends for funding research on adolescents. There are grant fundings that are identified throughout the 1950’s and 1960’s on adolescent mental health, yet a majority of these grants are related to as earlier stages of adult disorders (i.e. schizophrenia). There is a difference noted during the 1970’s as youth and crime received funding as compared to earlier decades, yet no clear pattern emerged. These earlier years (1946 to 1980) of budgeting for the National Institute of Mental Health did not differentiate by age where
the research dollars were designated.

This age demarcation began in the 1980's as accumulated by NIMH. For children age 0 to 12 research funding for childhood disorders increased from $74,073,000 in 1991 to $114,000,000 in fiscal 1998. Correspondingly for adolescents age 13 to 18, research dollars increased from $39,000,000 to $61,000,000 over this eight-year time period, for a total increase of over 65% funding during this decade of budgetary allotments. More dramatically, dollars spent since 1985 for all youth age 0 to 18 increased from $37,478,000 to $175,725,000 for fiscal 1998, an almost six fold increase for these available and allocated research dollars (NIMH Budget Office, 1998).
### Key Individuals

(From 1900-1968)

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<td>A D</td>
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<tr>
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<td>G</td>
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(From 1968 to 1998)

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<td>Thomas Achenbach</td>
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<td>F G H</td>
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<td>J</td>
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<td>Rolf Loeber</td>
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<tr>
<td>Janet Williams</td>
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<td>E F G I</td>
</tr>
</tbody>
</table>
Table 5.5 Key Individuals for this Time Period - 1968 to 1998

| Individuals cited by these Key authors as most important in the development of the DSM or Behaviorally Based Adolescent Disorders |
|---|---|---|---|
| Spitzer | Cantwell | Spitzer |
| Shaffer | Williams | Michael First |
| Achenbach | | |
| Tony Costello | Rutter (Did not respond to inquiry) |
| Feighner (criteria) |
| Rachelle Klein |
| Lahey | Spitzer |
| Allen Francis | Achenbach |
| Shaffer |
| Loeber | Shaffer |
| Spitzer | Shaffer |
| Rutter |
| Spitzer |
| Endicott (with Spitzer) |

(Did not seek interviews with Quay and Peterson)
(Cantwell, Ackerson, and Jenkins are deceased)

Table 5.6 Citations by Key Individuals

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During this time period there were additional individuals involved in the revision process of the DSM and the changes for the behaviorally based adolescent diagnostic categories. This era was a time when hundreds of individuals were cited as members of Task Forces and Committees involved in the revision process for DSM-III, III-R and IV. These individuals participated at varying levels and degrees of involvement. Beginning with the DSM-III and the process of the build up and introduction of the Manual, there was the Task Force on Nomenclature and Statistics that worked throughout the decade prior to the introduction of the DSM-III who were involved in the change from dynamic to descriptive psychiatry for diagnosis. These individuals included Robert Spitzer, M.D. (Chairperson); Nancy Andreasen, M.D.; Robert Amstein, M.D.; Dennis Cantwell, M.D.; Paula Clayton, M.D.; Jean Endicott, Ph.D.; William Frosch, M.D.; Rachel Gittelman, Ph.D.; Donald Goodwin, M.D.; Donald Klein, M.D.; Morton Kramer, Sc.D. (consultant); Z. J. Lipowski, M.D.; Henry Pinsky, M.D.; George Saslow, M.D.; Michael Sheehy, M.D.; Robert Woodruff, M.D.; and Lyman Wynne, M.D.

Within the DSM-III design for modifications there were differentiating advisory committees that addressed specific areas of diagnosis. The Committee for Infancy, Childhood and Adolescent Disorders included Robert Amstein, M.D.; Justin Call, M.D.; Dennis Cantwell, M.D.; Stella Chess, M.D.; Everett Dulit, M.D.; Rachel Gittelman, Ph.D.; Richard Jenkins, M.D.; J. Gary May, M.D.; Joaquim Puig-Antich, M.D.; David Shaffer, M.D.; Richard Ward, M.D.; and Paul Wender, M.D. This committee was charged by the Task Force on Nomenclature and Statistics to make the recommendations for change for the DSM-III.
After the introduction of the DSM-III, the name of the Task Force on Nomenclature and Statistics changed to the Work Group to Revise DSM-III. This group was once again given the authority for directing the revisions and changes for this revision and consisted of Robert Spitzer, M.D. (Chairperson); Janet Williams, D.S.W.; Dennis Cantwell, M.D.; Allen Frances, M.D.; Kenneth Kendler, M.D.; Gerald Klerman, M.D.; David Kupfer, M.D.; Roger Peele, M.D.; Judith Rapoport, M.D.; Darrel Regler, M.D.; Bruce Rounsaville, M.D.; George Valliant, M.D.; Lyman Wynne, M.D.; Harold Pincus, M.D.; and Steven Sharfstein, M.D. The advisory committees for specific disorders for Disorders Usually First Evident in Infancy, Childhood, or Adolescence responsible for recommendations included Thomas Achenbach, Ph.D.; Dennis Cantwell, M.D.; Donald Cohen, M.D.; Anthony Costello, M.D.; Rachel Klein, Ph.D.; Joaquim Puig-Antich, M.D.; Judith Rapoport, M.D.; David Shaffer, M.D.; Robert Spitzer, M.D.; and Janet Williams, D.S.W. There was a subcommittee focused on Disruptive Behavior Disorders within DSM-III-R which included all of these Committee members with the following additional individuals: Russell Barkley, Ph.D.; David Berndt, Ph.D.; William Chambers, M.D.; Felton Earls, M.D.; Harriet Hollander, Ph.D.; Maria Kovacs, Ph.D.; Jan Looney, Ph.D.; William Mitchell, M.D.; Daniel Offer, M.D.; Eric Ostrov, Ph.D.; William E. Pelham, Ph.D.; Herbert Quay, Ph.D.; Lee Robins, Ph.D.; Bennett Swhaywitz, M.D.; James Swanson, Ph.D.; A. Hussain Tuma, Ph.D.; Gabrielle Weiss, M.D. and Paul Wender, M.D.

The Appendix of DSM-III-R lists Field Trial participants for the childhood and adolescent diagnostic categories (the same referenced list that was substantially changed by the time the Field Trials were published in 1990). Members of these Advisory
Committees who were also involved in the Field Trials as participants included Thomas Achenback (University of Vermont), Thomas Pelham (Florida State University), Judith Rapoport (National Institute of Mental Health, Child Psychiatry Branch), Rachel Klein (Long Island Jewish Medical Center), Russell Barkley (University of Massachusetts Medical Center), Anthony Costello (University of Pittsburgh School of Medicine) and Donald Cohen (Yale Child Study Center).

In the continual revision process of the DSM, the Work Group to Revise the DSM-III changed its committee name to the Task Force on DSM-IV. This Task Force included Allen Frances, M.D. (Chairperson); Harold Pincus, M.D. (Vice-chairperson); Michael First, M.D.; Nancy Andreasen, M.D.; David Barlow, Ph.D.; Magda Campbell, M.D.; Dennis Cantwell, M.D.; Ellen Frank, Ph.D.; Judith Gold, M.D.; John Gunderson, M.D.; Robert Hales, M.D.; Kenneth Kendler, M.D.; David Kupfer, M.D.; Michael Liebowitz, M.D., Juan Enrique Mezzich, M.D.; Peter Nathan, Ph.D.; Roger Peele, M.D.; Darrel Reigier, M.D. John Rush, M.D.; Chester Schmidt, M.D.; Marc Schuckit, M.D.; David Shaffer, M.D.; Robert Spitzer, M.D. (Special Advisor); Gary Tucker, M.D.; Timothy Walsh, M.D.; Thomas Widiger, Ph.D. (Research Coordinator); Janet Williams, D.S.W.; John Urbatis, M.D.; James Hudziak, M.D. and Junius Gonzales, M.D. The Work Group responsible for the Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence for DSM-IV had some familiar names with some newly listed individuals and included David Shaffer, M.D.; Magda Campbell, M.D. Susan Bradley, M.D.; Dennis Cantwell, M.D.; Gabrielle Carlson, M.D.; Donald Cohen, M.D.; Barry Garfinkel, M.D.; Rachel Klein, Ph.D.; Benjamin Lahey, Ph.D.; Rolf Loeber, Ph.D.; Jeffrey Newcorn, M.D.; Rhea Paul, Ph.D.; Judith Rapoport, M.D.; Sir Michael Rutter,
M.D.; Fred Volkmar, M.D.; and John Werry, M.D. Again, the DSM-IV revision also had a group for the Disruptive Behavior Disorder Field Trials with Benjamin Lahey (Project Director), and the following are who reported as Site Coordinators: Russell Barkley, Joseph Biederman, Barry Garfinkel, Lawrence Greenhill, George Hynd, Keith McBurnett, Jeffrey Newcorn, Thomas Ollendick, Paul Frick, Peter Jensen, Lynn Kerdyk and John Richters.

These lists of individuals includes the category of those involved in the diagnostic system changes for childhood and adolescent behaviorally based disorders, yet there is still a much smaller list of individuals who emerge as yielding a tremendous and inordinate amount of influence on these system and diagnostic changes. These individuals were determined through an analysis of this larger pool of individuals involved over this two decade period. Criteria included the number of clinical studies published that are referenced by the DSM, number of citations within DSM references, number of and role on various DSM planning committees and task forces and citations by key individuals (see Table 5.5 and 5.6).

The first individual cited for this time period is Thomas Achenbach, often referenced for his work on categorical and behavioral checklists. It was his work in the 1970’s that is utilized reverentially (see Table 5.5) as support for later diagnostic interview schedules employed by many in the field that assist in higher interrater reliability ratings for the DSM. This reliability is what is touted throughout the years as immensely supportive of the DSM and changes in the nosology. Achenbach’s (1977) review of childhood empirical psychopathology to date was very influential on the field (accordingly to the published literature) and cited in many writings introducing the DSM-
III in regards to childhood disorders. Achenbach was employed during this research time and into the 1980's by the National Institute of Mental Health which lended not only the research dollars for his efforts, but also credibility that many other writers and researchers, who did not work at NIMH did not receive. Achenbach had two published studies in addition to this (1977) article that are directly referenced in the DSM versions as supportive clinical documentation, and he served on three committees charged with responsibility to change the diagnostic system.

In the analysis of Achenbach's influence on the earlier DSM versions (III and III-R), including the high number of references to his research as well as the invitation from the APA to be a member of the committees designed to revise the behaviorally based adolescent diagnostic categories, this author has emerged as very influential in the changes of these disorders. However, there is some irony in discussing these changes with Thomas Achenbach (2/28/99) who gives a decidedly more skeptical perspective of the committee process and the DSM system as it has grown over the past three revisions. It is Achenbach's perspective that the DSM versions became a commercial and not a scientific process over the past two decades and that the changes made to the system overall and in childhood/adolescent disorders are not supported by empirical data. This author reports that the work generated from the committees he served on was never utilized in the decision-making process for the revisions of the behaviorally based adolescent disorders and that the data is presumed to still "be in Robert Spitzer's office". Achenbach summarizes the DSM as a political document that reflects a large number of personal researcher/author investments in receiving recognition with certain disorders published in the Manual.
The second individual, Michael Rutter, was one of the early names in the changes for the diagnostic system form the dynamic (DSM and DSM-II) to the descriptive Manuals (DSM-III, III-R, and IV), and it was his preliminary proposal (1973) that was utilized as a foundation for the eventually incorporated multiaxial system. Rutter was a child psychiatrist working out of London and was also affiliated (funded) through the World Health Organization, a body that the DSM reportedly relied upon for guidance and direction for the timing of the introduction of the revised Manuals. Rutter was a member of the DSM-IV Work Group to revise Disorders usually Diagnosed in Infancy, Childhood or Adolescence and the DSM-IV Data Reanalysis project for Childhood and Adolescent Disorders. In addition, this author had three studies referenced as supportive documentation within the DSM-III, III-R and IV revisions, which taken by themselves are not a large number. What Rutter gave to the field was the diagnostic framework with which to base the DSM-III system. His proposal (1973) was cited by the authors of the DSM-III has the most significant contribution made in changes to this diagnostic system from a dynamic to descriptive system, and confirmed in interviewing Robert Spitzer.

The third individual, David Shaffer, in the 1970’s was affiliated with Michael Rutter and was a co-author of the proposal for a multiaxial classification system for children. As discussed earlier, it was this system that was utilized by the revisionists of the DSM as a model for the diagnostic changes to occur for the DSM-III (1980). Shaffer is a child psychiatrist affiliated with both the Biometrics Research Department at New York State Psychiatric Institute (along with Robert Spitzer and Janet Williams) and also with Columbia University. Shaffer served on a majority of the powerful committees responsible for the changes to the system. Shaffer was a member of the DSM-III
Committee on Infancy, Childhood and Adolescent Disorders. Additionally, Shaffer was a Cochairperson of the Work Group to Revise Disorders Usually Diagnosed in Infancy, Childhood or Adolescence and a member of the Task Force to Revise DSM-IV responsible for recommending and commencing changes for this revised Manual. This author also published significantly influential studies impacting the field of childhood diagnosis. Six of these studies are quoted directly in the DSM-III, III-R and IV Manuals as referential support. The Symptom Utility (report) for the DSM-IV Field Trials and two references are reportedly included in the DSM-IV Field Trials for Oppositional Defiant and Conduct Disorders.

In interviewing David Shaffer (3/29/99), he places most of the credit for the strides the DSM diagnostic system has made squarely on the work of Mike Rutter. Through Rutter’s 1965 “classification” publication, a framework was designed with which to begin. Additional and other work credit was given to Robert Spitzer and two co-authors of his, Janet Williams and Jean Endicott. Shaffer claims the earlier DSM versions and behavior disorder categories were appropriately maligned for political reasons. However, Shaffer believes that with the introduction of the DSM-IV, the “rigors of science” have been able to raise the credibility of the diagnostic system. Concerns expressed included the high comorbidity rate (80%) of childhood diagnosis, validity of separation of ODD and CD, and stigmatization of diagnosis. In the end; however, strong support of continued DSM usage is expressed by Shaffer.

The fourth individual, Dennis Cantwell, had an influence throughout the revisions of the descriptively based DSM versions. Cantwell was the lead author of the DSM-III Field Trials for Child Psychiatric Disorders (1979), a member of all significant
committees (bar one) and Task Forces responsible for the changes to the diagnostic system (DSM-III, III-R and IV). These included the Task Force on Nomenclature and Statistics for DSM-III responsible for recommending the major revisions, the DSM-III Committee on Infancy, Childhood and Adolescent Disorders, the Task Force to Revise the DSM-IV and a member of the Work Group to Revise Disorders usually Diagnosed in Infancy, Childhood and Adolescence (DSM-IV).

The fifth individual, Robert Spitzer, has had the greatest influence on the diagnostic system changes over the past three decades within American psychiatry and the industry of mental health. As a child psychiatrist, Spitzer was the consultant hired by the American Psychiatric Association to lead the push for the changes within the diagnostic field from a dynamic to descriptive diagnosis. Spitzer's employment with the American Psychiatric Association began in the early 1970's, and he was the Chairperson for the Task Force on Nomenclature and Statistics for both the DSM-III and DSM-III-R. This role was arguably the most influential in regards to formal and informal power on the decision making process for diagnostic changes and systemic revisions (as confirmed by Achenbach). He was also a member of powerful committees including the DSM-III-R Advisory Committee for Children and Adolescence, the Task Force for Revising the DSM-IV and the DSM-IV Work Group to revise Disorders Usually Diagnosed in Infancy, Childhood and Adolescence. Spitzer authored the DSM-III-R Field Trials for Childhood Disruptive Behavioral Diagnosis, the DSM-III and DSM-III-R Case Books, and in one published article (1979) set forth the utilization of the Kappa coefficient as supporting the reliability of the system at certain levels to “validate” studied results. In addition, he worked during the same time period at the Biometrics Research Department
of the New York State Psychiatric Institute with both David Shaffer and Janet Williams.

In discussions (2/24/99), Robert Spitzer cites that his involvement with the DSM stemmed from his association with one of his mentors early in his career, Dr. Ruinberg, whom he worked with during his psychiatric residency years in the 1960’s. Dr. Ruinberg was involved in the publication of DSM-II and Robert Spitzer was able to write an introductory chapter for his Manual version reportedly with the assistance of Dr. Ruinberg. Over the next five years, Spitzer reportedly was influential in his advocacy work to remove homosexuality as a diagnostic category for the DSM. Spitzer reports that this work assisted in the American Psychiatric Association leadership taking notice and chose Spitzer for the consultant role for the Committee to revise the DSM during the 1970’s. Spitzer cites the basis for the systemic changes for DSM-III to rely on the Feighner Criteria, as an increase in reliability for the system. It is Robert Spitzer’s belief that DSM-III and the future revisions have moved psychiatry away from being an art and becoming a science through increased data based decisions and descriptive methodology, leading to the increased ability to study causality. Because of these changes, Spitzer reports that there is planning and discussions for a DSM-V, possibly scheduled for release between 2004 and 2010.

The sixth individual for this time period was Benjamin Lahey, a child psychologist, who made a later influence on the DSM system (along with the appearance of Rolf Loeber, next reviewed). Lahey was the project director of the DSM-IV Disruptive Behavior Advisory Group; member of the DSM-IV Work Group responsible for revising Disorders usually Diagnosed in Infancy, Childhood and Adolescence; member of the DSM-IV Data-Reanalysis Project for Childhood and Adolescent
Disorders; and prolific author with ten studies included as referential support within the DSM revisions. These writings include the article in the DSM-IV Sourcebook (Volume 3) reviewing literature for Oppositional Defiant and Conduct Disorders, authoring the design of the DSM-IV Disruptive Behavior Field Trials and the Symptom Utility Estimate for the DSM-IV Field Trials and two additional studies reportedly referenced in the DSM-IV Field Trials (unpublished).

Lahey, in discussions (3/2/99), reports that he believes the goal of his work is to reach valid and reliable criteria for the diagnostic categories of the behaviorally based disorders for adolescents. Lahey’s involvement originated from an invitation in 1990 from Allen Francis, editor of the DSM-IV of the American Psychiatric Association to be on the Task Force for the Disruptive Behavior Field Trials (Francis was the successor for Spitzer). Lahey claims that this Task Force utilized all existing data in the recommendations made for these diagnostic categories and attempted to incorporate as much of the data available to present as up to date of knowledge as possible. Lahey believes that this was not always the procedures for all the Task Force committees formed for empirical documentation of changes for DSM-IV. He believes that the work groups recommendations ranged from the level of data his Task Force utilized, to partial incorporation, to no use of data whatsoever in the recommendations made for changes to disorder categories.

Lahey believes that the utilization of a nosological system is necessary within the field of mental health, for the defining of dimensions separating normal from abnormal and the choice of professionals to have an ability to treat or not to treat others. There is concern on Lahey’s part in the data for the disruptive behavior disorders for adolescents
of those individuals who meet criteria for diagnosis of Oppositional Defiant and Conduct Disorders, yet who are on the low end of the threshold. It is this niche of diagnosis that is somewhat arbitrary, according to Lahey. Additionally, Lahey voices criticism and concern that one organization (the American Psychiatric Association) has full authority and power in the publication of the Diagnostic and Statistical Manual. It is reported that this type of monopoly tends to lead to myopic views and decision-making and would be true if any one organization accumulated this level of power. Lahey's recommendation would be to emulate an organization such as the World Health Organization, a separate body representing many organizations and interests in the production of a manual such as the DSM. Lahey believes that capitalism is working against the individual within this diagnostic system.

The seventh individual, Rolf Loeber, also has had a more recent impact on the DSM-IV system revisions and worked closely in publication with Lahey. Loeber was a member of the DSM-IV Disruptive Behavior Disorder Advisory Group, the DSM-IV Work Group responsible for revising Disorders usually Diagnosed in Infancy, Childhood and Adolescence and DSM-IV Data-Reanalysis Project for Childhood and Adolescent Disorders. Loeber is the author or co-author of nine clinical studies referenced in the revised DSM's, co-authored (with Lahey), the DSM-IV Sourcebook (Volume 3) article reviewing the literature for Oppositional Defiant and Conduct Disorders and has reportedly three references in the DSM-IV Field Trials.

The eighth individual, Janet Williams, had an interesting role over the past two decades of involvement with the DSM revisions. Originally working at the Biometrics Research Department of the New York State Psychiatric Institute performing research on
childhood and adolescent disorders, her involvement increased during the 1980's and culminated with her membership on the Task Force for Revising the DSM-IV and as a member of the Committee of Contributors for the Work Group responsible for revising Disorders usually Diagnosed in Infancy, Childhood and Adolescence. Williams co-authored (with Spitzer) the DSM-III Case Book and the DSM-III-R Case Book within this revisionists time period. Janet Williams is the only non-medical doctor or psychologist involved on any of the existing or past existent Task Forces, Work Groups, or Committees responsible for researching and recommending changes to the DSM over the past thirty years and the lone voice from outside the medical or psychology fields. Janet Williams is also the wife of Robert Spitzer, and has been since the late 1970's. In speaking with Janet Williams (2/22/99), she deferred commentary to Robert Spitzer, as the expert in the field.

**Committee Memberships**

What emerges from this analysis is the importance and impact the various committees and task forces had on the process of change within the diagnostic system. The individuals listed above point to those who have had the greatest influence on the process of change within the behaviorally based diagnostic category for adolescents. This analysis includes twelve committees and task forces that were formed and convened to guide changes in the diagnostic system, both at a system and individual disorder level. According to the American Psychiatric Association and Dr. Robert Spitzer, the most influential of these of these committees were the Committee on Nomenclature and Statistics, its change of titles to the Task Force on Nomenclature and Statistics and the
Task Force on DSM-IV. It was these three Committees that were charged with the responsibility to recommend changes to the overall diagnostic system. The specific diagnostic category Work Groups and Task Forces were authoritative for their own areas and produced significant recommendations that were given to these three committees for approval/disapproval for the separate revisions of the DSM.

Prior to the introduction of the DSM-III, Richard Jenkins is the only individual who emerges as having membership on the Committee on Nomenclature and Statistics and also as a committee member for the specific disorders of childhood and adolescent disorders. After the publication of the DSM-III, David Shaffer, Robert Spitzer and Dennis Cantwell emerge as the individuals who held committee positions bridging both the diagnostic system changes and individual adolescent disorders. Robert Spitzer, in particular, held the chairperson positions for both the Task Force on Nomenclature and Statistics and Work Group to Revise DSM-III. As pointed to by Kirk and Kutchins (1993) and confirmed through interviews with key individuals, the Task Force on Nomenclature and Statistics was the committee responsible for the overhaul changes to the diagnostic system for DSM-III. Both DSM-III-R and IV are modeled from this earlier design.

Dennis Cantwell (deceased in 1996) was pointed to by Robert Spitzer as a very influential member for the process of change within the diagnostic system. Cantwell held more committee appointments than any other individual and was part and parcel of all the decisions regarding recommendations to changes of the overall system. He also was pointed to as very influential in his views and opinions of the childhood and adolescent disorders and how they modified from the earlier to later time frames.
Janet Williams was also involved on the committees during both time periods, but in interviewing her, she declines to have had much of an impact on the process and deferred her comments to Robert Spitzer, stating his involvement was significantly more important. She also deferred her current role to Dr. Michael First, who took over her responsibilities on the later committees.

**Spitzer, Shaffer and Williams**

In reviewing the historical development of the Diagnostic and Statistical Manual(s); the literature documenting changes, committee and Task Force memberships; interviews of the surviving individuals who emerged as influential in this process via their publications, committee appointments and citations by others; the key decision-makers over the past three decades in this area emerge to be Robert Spitzer and David Shaffer. There is some support for discussing the later influence of Michael First and Allen Francis who took over key decisions for the DSM-IV, yet this analysis finds the DSM-IV to not offer significant changes for the adolescent behaviorally based disorders, hence decreasing their historical impact. This is confirmed by a number of key individuals who find First and Francis to hold significant influence currently, but who were not involved during the significant growing years of the DSM.

Key decision recommendations for these diagnostic categories of Conduct and Oppositional Defiant Disorders emerged from the Work Group to Revise DSM-III, the Committee on Childhood and Adolescent Disorders and Subcommittee on Behaviorally Based Disorders and forwarded to the Work Group. From analysis of data from these committees that was not published and perspectives of numerous committee members,
Robert Spitzer held a very solid grip on the recommendations approved for DSM-III. This was also true for the revisions in DSM-III-R which were comparatively minor for these adolescent Conduct and Oppositional Defiant Disorders.

Within these committees, was the presence of David Shaffer. Although most of the recommendations were not applied from the data generated within these groups according to Lahey, yet what is pointed to is the influential relationship that Shaffer has had with Robert Spitzer through their employment over the past fifteen years at the Biometrics Research Department of the New York State Psychiatric Institute. What emerges are decisions made that may be influenced by this relationship.

The process of gaining this level of influence by these two individuals began with the invitation from the American Psychiatric Association to both Spitzer and Shaffer to be involved in the revision process from DSM-II to DSM-III. Through this invitation and the timing of the revision process, combined with what others point to as the cultural and political timing of the growth and influence of the APA and the revisions of the DSM, Robert Spitzer and David Shaffer became inordinately influential.

Appointments of these individuals originated from the American Psychiatric Association and included only members of the association working within this field of inquiry. Committee individuals and chairpersons were chosen with no apparent criteria, yet were all connected by the theme of having respect among peers within the field and to have had some connection to individuals involved in the DSM-II. Most times this respect reportedly emanated from research published, although this was not the situation with the appointment of Robert Spitzer. This appointment is presented by others as political, and in who worked with whom, as responsible for the recommendation. This route repeated
itself with Robert Spitzer's invitation to join committees to both David Shaffer and Janet Williams. It is found that after Robert Spitzer became the Chairperson of the lead committees, he was able to ask other individuals to join the Committees (without peer of committee review). One of the interesting themes of these three individuals is that they had been working together at the New York State Psychiatric Institute at the time of the invitations to Shaffer and Williams. Also a review of public documents in the State of New York finds that a marriage license between Robert Spitzer and Janet Williams predated the invitation of Williams to the Committee and future involvement in revisions.

These three individuals, working from the same location (with both Spitzer and Shaffer also teaching at Columbia University over the years), in addition to two of the individuals being married (Spitzer and Williams), represented a loci of decision making and power that existed from the late 1970's through to almost 1990 when Robert Spitzer was replaced by Allen Francis as Chairperson for DSM-IV. Post-1990, this triangle of individuals became less important because of this change; however, during the more formative years of impact and transition to the DSM-III system, their role was very inordinate.

**Lahey and Loeber**

From the analysis of the committees and task forces and interviews with key individuals, there emerged a post-1990 influence of Rolf Loeber and Benjamin Lahey that was inordinate compared to other researchers in the adolescent behaviorally based disorders. Their research, number of citations and studies utilized and influence on the Task Forces that made recommendations for changes was greater than any other in the
field after 1990. In discussions with key individuals, the influence of these two was confirmed and agreed with by the authors themselves. What is seen in the publications is a large number of studies that are co-authored together and that these authors have published many other articles (per their reports and literature review) outside of the scope of this methodology commenting on the adolescent field. Others in the field point to these two individuals as experts in the area of Conduct and Oppositional Defiant Disorders.

An interesting point reported by a number of key individuals is that the work of the Task Force members and recommendations within this system (of which Loeber and Lahey were very influential) made to the DSM Revision Committee(s) were not necessarily implemented. The authority to accept or reject the recommendations rested in the DSM Revision committees.

Additionally, what is found in the research and work reported by the Disruptive Behavior Disorders Field Trials (DSM-IV, 1993-1996) and the Data Reanalysis Project for Childhood and Adolescent Disorders (DSM-IV, 1997) are that the locations of the projects and field trials consisted of the locations of the members of the these two committees. The data and field trials did not include information from other locations or cites, and as discussed in earlier sections this may or may not be prohibitive in nature to the concluded results. This should be kept in perspective in regards to an overinfluence of the committee memberships recommendations, considering the previous discussions of the authoritative power of the DSM Revision Committees.
Overall

In discussions with the committee members identified as important during this process, there emerged a dichotomy of perspectives and answers in regards to the DSM and the process of change within this system. Those interviewed fell into two differing camps of researchers and contributors. The first group presented as supporting the process of recommended changes by Task Force and Committees as contributing greatly to the increasing accumulation of knowledge in relation to the areas studied. Not surprisingly, these individuals included those who were associated with the American Psychiatric Association more extensively and over longer periods of time (Shaffer, Spitzer, Williams)

The second set of individuals included those who joined the process of research at a later stage and were decidedly more critical of the process of recommendations and changes to the DSM system and to the diagnostic categories of Conduct and Oppositional Defiant Disorders. This set also included a majority of individuals who were not psychiatrists (Lahey, Loeber, Achenbach) and had less affiliation with the American Psychiatric Association.
Chapter 6
Conclusions

Purpose

The purpose of this research is to search for the historical acquisition of knowledge and how this knowledge was acquired within the mental health field in relation to behaviorally based disorders for adolescents. This research seeks to bring a level of knowledge to the field not previously known regarding how the specific diagnostic categories of Oppositional Defiant and Conduct Disorders are defined today and how these disorders emerged and changed over the past century.

These two diagnostic categories are the most prevalent for adolescents over the past twenty years (post introduction of the DSM-III in 1980) and if these diagnosis affect as many youth as identified epidemiologically; then knowledge of the history, changes and originations of these disorders would be beneficial to those in the field working with these youth. This additional purpose is to give a perspective regarding these disorders, as to the historical development of the knowledge relating to this field of adolescent mental health.
Research Questions

As discussed in previous sections, the research questions for this project are two fold. The first question asks what are the originations of the most prevalent psychiatric diagnostic labels for adolescents - Conduct and Oppositional Defiant Disorders? A follow up question asks what influences and factors have impacted these diagnostic categories over time?

Methodology

An historical analysis looking over a one-hundred year time period was chosen to answer these questions. With the theoretical support of critical (social construction) theory, this historiographical research was designed to search for key individuals, associations, nosology systems, clinical studies and funding sources that may emerge as influential on the design of the classification system that became most powerful (the Diagnostic and Statistical Manual of Mental Disorders), and on the specific adolescent diagnostic categories of Oppositional Defiant and Conduct Disorders.

Prior to the introduction of the DSM (1952), this methodology searched for diagnostic classification systems utilized and found to have influenced the formation of the first DSM. Also included in this search were classification systems that included diagnostic categories for behaviorally based adolescent disorders. Post 1952 (introduction of the DSM), the classification systems researched included only the DSM and subsequent versions, but expanded to include all clinical research studies cited as referential support by these Manuals for both the overall system itself and the specific adolescent disorder categories. Additionally, during this period, focus was placed on the
impact and sources of funding for these areas and the emergence of key individuals important in the formation of the diagnostic system and adolescent behaviorally based disorders (Conduct and Oppositional Defiant). Extensive published literature, U.S. federal governmental sources, archival data and interviews with key individuals were used during this analysis.

Major Findings

Originations of Conduct and Oppositional Defiant Disorders?

In answering the research question of what are the originations of Conduct and Oppositional Defiant Disorders, there emerges a theme of definitions describing behaviors associated with predelinquent and delinquent behavior that has been utilized over the past eighty years in the nosologies. In the years prior to the formation of the dominant categorization by the Diagnostic and Statistical Manual of Mental Disorders (1952), there existed and were utilized dozens of differing and sometimes competing nosologies throughout different parts of the country. These nosologies were identified by state, hospital, association or individuals and had varying levels of impact. Some of the early important nosologies that discussed adolescent conduct based disorders included the Standard Nomenclature of Diseases and the Statistical Manual for the use of Hospitals for Mental Diseases. The categories during this time period for adolescent behaviorally based disorders were similar in theme across the classifications in having identified illegal or amoral behavior in relation to these adolescents as common ground for diagnosis.

With the introduction of the Diagnostic and Statistical Manual of Mental
Disorders (1952), those nosologies not published by the American Psychiatric Association, increasingly became irrelevant to the field of mental health. By the 1970’s, the Diagnostic and Statistical Manual of Mental Disorders system was the most highly endorsed and utilized diagnostic schema within this country. This process was reinforced through the funding of mental health services being increasingly necessary to have a specific diagnosis only from the DSM.

For the specific categories of Conduct and Oppositional Defiant Disorders, there was a mirrored change from the dynamic categorization of DSM-I and II to the descriptive characteristics of DSM-III to the present. The two earlier versions identified these disorders somewhat subjectively with flexibility in the diagnosis. The later versions gave the criteria for diagnosis a specific number of behavior and descriptive characteristics with which had to be met in order to qualify for the diagnosis. This was also to differentiate the less intense diagnosis of Oppositional Defiant Disorder with the more intense diagnosis of Conduct Disorder.

The originations of the specific language and descriptive characteristics identified by the early versions of the DSM for these two adolescent diagnosis is attributed to a limited number of studies by a select few authors published during the 1930’s and 1940’s. Jenkins, Topping, Ackerson, and Hewitt are identified as early pioneers in their research identifying characteristics for these later categorized disorders. It is these authors and their limited number of research studies that are relied upon for support of the adoption of Adjustment Disorders and Conduct Disorders for adolescents. As the DSM was introduced in 1952 and the DSM-II in 1968, the reliance on this limited research by a small number of authors is discussed as disconcerting.
Another area researched and influential in guiding these specific disorders definitions, and the overall system changes, included the referenced clinical studies. This review and analysis found a number of interesting findings.

A review of the early clinical studies, referenced as sources of support for the Diagnostic and Statistical Manual of Mental Disorders (1952, 1968) revealed a number of trends. The diagnostic category related to behaviorally based disorders of children and adolescents during this time period showed a vast majority of the referenced clinical support focused on children up to the age of 12. Later studies, post 1968, actually had a younger average age (between 9 and 10 years) for the field trials and clinical documentation cited as supportive of the diagnostic categories. However, the behaviorally based diagnosis used by the DSM are applied to all youth up through young adulthood. The question that is asked is whether it is supportable or appropriate to use clinically-derived criteria from one age group (children aged 4 to 12) and apply this to a differing age category (adolescents aged 12 to 18), as was performed by the authors of the DSM.

These studies also had a predominant focus on male subjects. This may possibly be explained from the nature of defining behaviorally based diagnosis as they have been in the DSM (1952, 1968, 1980, 1987, 1994) as acting outside of acceptable norms within homes, schools or society. Much of the research was confirmatory in nature and not exploratory; not questioning the presentation of categories of earlier authors and not questioning their applicability. The early diagnostic categories did change through the influence from the World Health Organization (1968), yet as the build up to the DSM-III began, the categories of Conduct Disorder (and the emerging Oppositional Defiant
Disorder) were researched to confirm findings. There was limited critical challenge to these categories either from within psychiatry or psychology. What is interesting is that as late as 1990 research used as supportive of the diagnostic categories, Jenkins (1934, 1944), was still cited as valid clinical historical documentation. This pattern is continued with the field trials for DSM-III and DSM-III-R which are reported as significant research supporting the diagnostic changes also follow this pattern of examining only existing diagnostic categories searching for criterion additions or deletions, but not concluding with any significant modifications.

Many times throughout these clinical studies there are references used by the authors basing their need for further research and support on what these same authors published earlier. Some of the authors (Jenkins, Ackerman, Hewlitt) used one of their previous studies as a sole citation of reliable published literature as supportive of this current research.

Another finding included the predominance in the study methods of using individual case study examples to reinforce the behavior diagnosis for the adolescent. A majority of studies in the first three decades of research found in support of the proposed categories of diagnosis with one case study example of a youth being followed from diagnosis through treatment. This method is evident in early research and throughout the revision process, and can be seen continuing through the publication of Case Books and training documentation through this decade.

What also emerged as concerning is the significantly limited amount of data that the revisions of the diagnostic categories of the DSM with which they are based. In tracing the clinically studied references through the DSM versions itself, the clinical
trials, reviews, case studies and referential material represented limited sources with which to base such significant decisions on these Conduct and Oppositional Defiant Disorders. The changes in the diagnostic categories (and the originations of the categories themselves) are found to be supported with limited studied means.

In reviewing this research, it has been noted that there are intermittent significant references to studies and articles that are “unpublished”. These include the following: two National Institute of Mental Health studies reportedly focused on site analysis; Barkley; Lahey (twice); Lahey et. al.; Rogeness (twice) and Loeber. Contacts in writing and over the phone were made to these authors in attempting to gather these information. As of this date, none of these “unpublished” reports have been received by this author. It is reported by Lahey and Loeber that these documents will be made available. It is found that the references to Lahey, Rogeness and Loeber all focused on supportive data in separating both Conduct and Oppositional Defiant Disorders along developmental time frames; yet this cannot be confirmed.

One of the most glaring difficulties of research conducted within this field over this time period was the assumption of the existence of a “normal child”. It was presumed that these behaviors, defined as conduct and oppositionally difficult adolescents, were somehow “abnormal”. Granted the behavior may be defined as amoral or illegal, but there exists a chasm to connect these behaviors to “abnormal”. Critical theory challenges this assumption on the basis of incorporating the differences that exist across families, neighborhoods, cultures, regions, income levels, the background of the researcher and impacts upon results, and other factors affecting the research on the youth in the process. This perspective requires an incorporation of these other dynamics and
acknowledgment of these categorical impacts on what is deemed "normal" in basing publishable and supportable results.

**What Influences and Factors Impacted these Disorders/Categories over Time?**

The research question asking what influences and factors impacted the formation of these disorders over this period of time, has diverse findings. One focus of this analysis (and methodology) was the search for key individuals important to this area of research and identified a score of men and women who emerged as most influential via their publications, references within the literature, positions within associations, memberships on DSM Committees and Task Forces, and self reports.

These individuals yielded tremendous influence and impact on the research, outcomes, categorization and directions of not only child psychiatry, but the mental health field itself. These individuals (along with strong support from the American Psychiatric Association and financial backing from the National Institute of Mental Health) managed over a 60-year time period to have brought the psychiatric field into a dominant position within this country’s mental health system, and to have produced Manuals necessary for utilization by all workers in the mental health field. These individuals have knowingly and unknowingly (depending on the person and role) set the foundations for child and adolescent psychiatry regarding behaviorally based disorders. This list includes Luton Ackerson, Richard Jenkins, Herbert Quay, Donald Peterson, Michael Rutter, Robert Spitzer, David Shaffer, Dennis Cantwell, Janet Williams, Rolf Loeber, Thomas Achenbach and Benjamin Lahey. Nine of these twelve individuals are psychiatrists (a majority being child focused), two (Loeber and Lahey) are child
psychologists and one (Williams) is a D.S.W.

One very interesting impact by a number of these individuals was their influence on the overall diagnostic system, not simply the changes within the childhood and adolescent field. Over time and with the growing predominance of the Diagnostic and Statistical Manual of Mental Disorders, the era of change from the first two versions began through the concentrated efforts of a few. These early pioneers and proponents in the 1970's advocated (published) for a descriptive and multiaxial system of diagnosis to be utilized for the DSM versions beginning in 1980. These individuals were successful in bringing about this change to a descriptive multiaxial system and each individual was originally from the child and adolescent field of psychiatry. These individuals who were the most highly influential in this process included David Shaffer, Robert Spitzer, Dennis Cantwell and Michael Rutter - child and adolescent psychiatrists or psychologists and whose writings and roles greatly impacted the diagnostic schema incorporated and adopted by the APA's DSM-III.

Another interesting finding was the potential impact of one institution having a significant influence on research in the child and adolescent psychiatric field at a time of great flux and search for "reliable and valid" answers within the field. During this key era in the nosological changes of the DSM (later 1970's and early 1980's), three of these individuals (David Shaffer, Robert Spitzer and Janet Williams) were all affiliated with (employed by) the Biometrics Research Department of the New York State Psychiatric Institute. Each of these authors published significant reported research (referenced earlier) while colleagues within the same Department of this Institute. Two of these researchers (Spitzer and Williams) were married to each other and it can only be assumed
that there was coalescing of ideas and focus of research ideas within this department. In addition and as previously discussed, the ultimate decision regarding inclusion or exclusion in the DSM revised Manuals rested in the hands of the DSM Revision Committees of which Spitzer chaired two of the most recent three.

This connection of research relationships was also apparent among the larger circles of individuals involved over the past two decades in producing the relied upon clinical studies and results used for support of these diagnostic categories for Conduct and Oppositional Defiant Disorders for children and adolescents. The field trials, clinical studies, data reanalysis and other referenced results published through the American Psychiatric Association (and related associations), were designed, reviewed and evaluated all within the same research circles. The field trials were organized and researched by the Task Force and Work Group members of the American Psychiatric Association and conducted at these individuals’ research institutes (universities, guidance centers, etc.). While reviews were conducted by these same individuals who had a vested interest in the outcomes and results. Much of the funding for these supportive field trials, clinical studies and data reanalysis emanated from a few institutions with which these individuals many times were affiliated. These institutions were often times receiving grants from the National Institute of Mental Health, or funding from the American Psychiatric Association.

For the mental health field to be of such vast dimensions and incorporating many fields including counseling, social work, psychology, psychiatry, and other areas, the dominance of one field and particularly of a few individuals is a concept that most workers would not be comfortable. The presentations of the DSM revisions and
diagnostic categories for adolescents over time has incorporated the aura of the involvement of many, through Work Groups, Task Forces and hundreds of listed individuals and groups associated and affiliated with the process of change. However, this change has throughout the decades been directed by the American Psychiatric Association, and only a few individuals had emerged as dominant in their role with the publishing of the Diagnostic and Statistical Manuals, and specific behaviorally based adolescent disorders.

The predominance of the American Psychiatric Association during this process was responsible for the results of the insular professional politics of including colleagues and collegial institutions within reported research. Additionally, with the credentials of the APA behind the research and funding limited to a few sources, this outcome can be argued as predictable. This does (and did) not need to be the outcome. An additional possibility could have resulted in a conglomerate or oligarchic association of leading mental health groups working in tandem in these DSM design and revisions over time. The American Psychological Association, the National Association of Social Workers and other interested groups could have been involved early on in the design and research to have produced a Manual with incorporated (different) perspectives.

This was not the way history occurred, for the revisions of the DSM and consequential changes to the individual categories was begun, directed and driven by the American Psychiatric Association who's authority, prestige and power coincided with the success of this diagnostic publication. This history occurred with the predominant influence of a few key individuals, who with the backing of the leadership of the American Psychiatric Association, had the DSM become the dominant vocabulary
utilized within mental health over the past thirty years.

An additional finding in regards to the specific disorders since the release of DSM-III, is how Conduct and Oppositional Defiant Disorders have changed so insignificantly. There have been numerous differing proposals over this period of time, but only minor changes in the individual diagnostic categories that were approved and implemented. This reinforces the notion that there has not been an agenda of challenging the criteria first introduced within DSM-III with significant changes. Yet what is interesting is that the vast majority of research for these two disorders has occurred post 1980, causing an imbalance in available research as opposed to implemented change.

Related to this finding, yet on a larger system scale, is the pattern of DSM revisions. This pattern consisted of introducing the “new” diagnostic categories in revised DSM version, claiming the superiority of this newer DSM, yet in analysis finding insignificant changes overall to these two behaviorally based adolescent disorders.

Kirk and Kutchins (1991) discussion of the introduction of the DSM-III to much fanfare of increased “reliability and validity” to the diagnostic system can be applied throughout the revision process for the introduction of the DSM-III-R and DSM-IV for child and adolescent behaviorally based “disorders”. The “selling” of these revisions continued with the dominant utilization of interrater reliability studies to document the increasing sophistication and “empiricism” of the diagnostic categories. Additional supports are reportedly given through insular studies of existing categories of diagnosis and the desire to determine the diagnostic ability of individual criterion for these disorders. Literature reviews, data reanalysis and field trials are purported as steps increasing the merit of these revisions.
As each DSM revision is introduced, there is a short lapse of time before there is published (by the American Psychiatric Association) the additional need for changes and revisions to keep up with either international standards or the continually emerging research in the field for differing disorders. The need to trumpet these revisions’ introduction as the best knowledge that is known to date (through the studied results, cooperation among many organizations and the best efforts of hundreds of individuals) is quickly deconstructed into an unacceptable version of outdated research. The need for a change is predicated on highlighting the weaknesses of this current system and setting out an improved empirical design for the next, to be introduced, revision.

A pattern emerged from this continual push for revisions to begin as quickly as the newest Manual was introduced. This pattern is one of data from past studies and purported available information not being available for review by outside sources (outside of the authors). This is discussed in Kirk and Kutchins (1991) review of the introduction of the DSM-III, in the lack of any published references for how to locate the Field Trials for the DSM-III-R (which were not published until 1990, three years after the release of DSM-III-R) and the promise in 1994 (through the DSM-IV introduction) that the results of the data-reanalysis and field trials would be available that same year. These supportive results for DSM-IV were not published by the APA until 1998.

In regards to overall funding patterns, there was no clear pattern found among individuals or organizations. What is found is the predominance of funding support for research, committee work and published studies from the American Psychiatric Association and the National Institute of Mental Health.

In summary, the major findings of this research revolve around the following
areas: the originations of the Conduct and Oppositional Defiant Disorders are dubious at best, that the Disorders have changed little over time and that the significant amount of research on these disorders has been confirmatory in nature; the Disorders originated from only a small number of studies by a few researchers during the 1930’s and 1940’s; a number of key individuals held inordinate power and control over the process of change for both these Disorders and the DSM system revisions over time; and the American Psychiatric Association became the most powerful component in the field of mental health during the revision from DSM-II to DSM-III and that to have had influence on the specific diagnostic categories required a close relationship to this Association (either by individuals or institutions).

Limitations of this Research

The first limitation of this research is writer bias. In any historiography and analysis of past events, it is difficult to separate interest in the field of research and methodology of outcomes to bring an objective point of view to the area. Fisher (1970) and Sagani (1996) agree that this interest in the research field is essential for quality work and believe that without this motivation the research is incomplete. The first method to address this area of writer bias is to be fastidious and complete in your research, and to exhaust all relevant sources in your attempt to understand differing times in history and fields of focus. A second method employed is to know as the writer your assumptions, which for this research included a deconstructivsts perspective on mental health disorders and a critical eye toward the process of the diagnostic system development. A third method is to assure that enough evidence and perspectives were gathered to support the
conclusions.

Closely related to this limitation is the concern for this research of “setting up a strawman” for review. More specifically asked, was this writing designed from the onset planning as a way to “prove a point” concerning the biases against a diagnostic system, which is not also coexistent with social work perspectives and values. Is this research methodology designed in a way to identify only those areas that are weak in support of the system and to identify what was presumed in the motivation for the research? Granted there is much interest in this area for writing this research and that there are some antithetical views in regards to the diagnostic field by this author, yet it is argued that the methodology designed is solid within qualitative historiography standards and results that were found were not what was expected from the outset. These standards match what Morrow (1994) designed and structured to include interviewing (key individuals), archival searches (National Institute of Mental Health), governmental and other statistics, reviews of published literature and presented within an historical reconstruction.

It was hoped in the design phases of this project that there would be interesting conclusions that would emerge as the sources and process of change was reviewed, but the much more cynical conclusions and outcomes surprised this writer. If any conclusion can be drawn, it was that this writer set out to find where and how these behaviorally based disorders originated form and how they changed over time. What was revealed was a much less optimistic outcome than expected, and the dominance of a few individuals and clinical research on the foundation of child and adolescent psychiatry.

An additional limitation is that the literature selected for review was narrowed to
those clinically supported research results that are directly identified through the Diagnostic and Statistical Manual of Mental Disorders versions (1952, 1968, 1980, 1987, 1994) or its predecessors. There was potentially much clinical data that is not reviewed. There exist hundreds of additional research studies, analyses, conclusions and results that this project does not have the breadth to review and this may impact knowledge generated from this research. This area is one for future research and would be valuable to have as additional research, yet is too extensive for this project.

Closely related to this limitation is that the designed methodology limits the review of sources to those directly connected to the formation of the Diagnostic and Statistical Manual of Mental Disorders over the past sixty years. This limits the review of sources to those within the field of psychiatry (primarily), and does not expand the review with other fields over this six-decade time period. There may be some very interesting research, data and additional perspectives in related fields that would be important for future research to review within this context.

A few final comments on limitations are more specific in nature. It is important that the research question postulated should be operational, open-ended, resolvable and flexible throughout the research. It is presumed that this was the case, yet arguments to the flexibility portion can be debated due to the narrow focus of the research question. In claiming verification, the research must remember that all inferences are probabilistic, that the information gathered is context related and that the results must not be produced by the methodology. A claim can be made against this methodology that writer bias chose areas to review with a presumed deconstructive focus and motivation to find certain results; however, this claim can be negated through the perspective that all
methodology has its design flaws.

**Implications for Social Work/Mental Health**

The field of mental health incorporates many differing professions with purported similar goals of assisting others in need. This field includes psychiatry, psychology, social work, and other counseling services and can be expanded to work within and include school, agency and community settings for adolescents. These fields within mental health bring differing perspectives to their work with adolescents and their families and have complimentary roles, with divergent in work paths to achieve the goal of improvement for the youth. There exist only a few common denominators within each of these fields, with possibly the most significant being the need for diagnosis when working with the adolescent.

As has been discussed in the research findings, diagnosis of adolescents (both at the system and individual diagnostic category level) has had a history of subjectivity, lack of clear research supporting diagnosis, and influences of associations and individuals that at times is inordinate compared to the overall mental health field. The field of mental health diagnosis and role of psychiatry has become very intertwined, particularly with the rise and influence of the Diagnostic and Statistical Manual of Mental Disorders and acutely since the introduction of the DSM-III (1980). With DSM diagnosis a required component for a majority of funding sources (public and private), and the majority of mental health education training programs requiring training in this field, it is easy to see how the system of diagnosis can have a great impact on the perceptions, training and work that the field performs.
Professional Politics/Professional Knowledge

This research is written to bring an additional perspective to the child and adolescent workers in the mental health field. To identify how certain “knowledge” is gathered, where this “reliable” knowledge originates from and how it is supported is important for the field. To utilize a system with which you are not fully informed may be a disservice to those whom you call your “clients”. What is seen is that the hierarchical status of psychiatry in the mental health field has, over time, succeeded in a perception that what is true for psychiatry is also true for other mental health professions. Yet what is drawn from this research is an implication that the professional knowledge that is utilized for adolescents through our current diagnostic framework (true for psychiatry), is as much a reflection of the professional politics involved over time in the formation of the system and individual diagnostic categories.

There is a pattern regarding the history of diagnosis of behaviorally based disorders for adolescents (and a similar pattern for the formation of the diagnostic system via the American Psychiatric Association). This pattern finds that these Disorders formed from the writings and research of a limited number of individuals in a limited number of professional settings; that these settings were predominantly psychiatric in model; that the disorders had only minor modifications up through 1980; that a few individuals were very influential to the changes to a descriptive typology of describing these disorders; and that the control over describing these disorders (via reported research) was by the American Psychiatric Association, with little input outside this small circle.
The current professional knowledge of these disorders, having a history as discussed, is found to be a product of professional politics. With the appointment of influential positions within the diagnostic planning system and for specific disorders relied through personal network contacts, almost always within the field of psychiatry, finds that a network of individuals already known to each other were able to produce knowledge for the mental health field. This knowledge has been accepted through the dominant usage of a system, very interconnected to the APA and funding sources. Funding for the DSM publications, task force, committees and consultants for the projects were supplied fully by the American Psychiatric Association. It is found that the politics of the rise of this diagnostic system has been tremendously influential in the system becoming a cornerstone of necessity for the mental health field.

The disorders themselves do not have a substantial history (in the early days or through the more recent revisions of the Diagnostic Manual) of support from a research or “valid” knowledge building process, and formed more through consensus and reliance on dominant individuals influence on the field. This reflection of the politics of power must be noted as a significant impediment to unconditional acceptance of these adolescent behaviorally based disorders. Although there are many critics of the diagnostic system and disorders as presented in the field, utilization of the system is in many ways unavoidable. By the simple utilization of the language, assigning of diagnostic codes and debate among professionals over appropriate diagnosis, there is continual acceptance of professional political knowledge that has emerged and been presented more as “fact” than the argued for “fiction”.

At this point in the development of the diagnostic system, and the powerful
position the DSM has in the mental health field, changes to address some of these inadequacies would be difficult at best. Unrealistic expectations would range from discontinuing the utilization of the Manual to converting to a different diagnostic system to not using diagnosis in the field. More moderate expectations would include working from where the current utilization of the Manual is and looking at how additional changes can be incorporated.

For starters (and for the next Manual revision, claimed by David Shaffer to be upcoming over the next decade for DSM-V), the American Psychiatric Association could form partnerships with the American Psychological Association and the National Association of Social Workers in collaborating on this next project. Funding for the committees, revisions, consultants and printing would be a joint effort with a leadership council (could be a renamed Revision Committee for DSM-V) consisting of equal representation and authority on decision making for this Manual. The committees would also include individuals from all three organizations with equal participation in research deemed appropriate for differing diagnostic categories. The recommendations from different committees would be reviewed but not discounted as has occurred in revisions for DSM-III-R and DSM-IV, with all results open for peer review. A federal governmental oversight committee could be assigned as a "watchdog" on this process.

An additional recommendation would be to realistically present the Diagnostic and Statistical Manual of Mental Disorders to the field of mental health and the public at large. To represent the Manual as a guidepost of current knowledge to date and the best representation of what collegial collaboration can produce on specific disorders, and not as a finitude and definitive answer of objectivity. To represent the Manual as an important
tool in communicating what is known to date concerning what the field calls mental disorders, and to allow those who utilize the system an opportunity to know that the industry is young and still has much to learn of a majority of "mental disorders", would be helpful.

It is far more difficult to address the realities of capitalism and the influence that this laissez-faire economy has on this system. To discount the impact that financial reimbursements have on the survival of the mental health system could potentially threaten the foundation supporting these services from being delivered. Diagnosis serves as the gateway to these reimbursements for both public and private dollars, and the DSM has a monopolistic utilization of the vocabulary and codes necessary for these dollars.

In light of these structural realities and of the current system of mental health in this country, to more effectively address the problems of adolescents is a challenge. On the positive perspective of this system, diagnosis is part of the system of accessing treatment services for adolescents. While this is obviously necessary to continue to offer at levels concurrent with youth’s needs, there are drawbacks and side effects to this diagnostic-laden system. Helpful measures to address adolescents needs could include recognition of the current level of knowledge of our diagnostic areas. If when servicing youth, words and vocabulary are presented as what we understand to date and not as known entities of disorders, could assist in a better understanding for the youth. This could also incorporate presentation of the fact that almost all adolescents “outgrow” Conduct and Oppositional Defiant Disorders by the time of young adulthood.

For the mental health practitioner, a full breadth of the historical knowledge of these adolescent disorders would be helpful. One of the goals of this project is to bring a
broader level of knowledge to the field of adolescent mental health and to give additional perspective to individuals working to assist youth. What would be most helpful for children and adolescents is to not incorporate a system that views disorders as an individual problem. This diagnostic system when applied to youth must not be presented nor incorporated as a reason for the difficulties, but should be used as an educational and communicative tool to assist in understanding. This represents a lofty goal and a long distance from the application of the diagnostic system and individual disorders as applied to children and youth within current standards.
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Appendix A

Interviews with Key Individuals


2. Dr. Robert Spitzer - (2/24/99).

3. Dr. Janet Williams - (2/22/99).

4. Dr. Benjamin Lahey - (3/2/99).

5. Dr. Rolf Loeber - (3/15/99).
