

**Exploring the impact of multidisciplinary examination and family risk factors on
diagnoses for children with MBID**

Master's thesis

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Abstract

Background Diagnosing children with mild and borderline intellectual disability (MIBD) and behavioral problems has proven difficult due to overlapping and transdiagnostic symptoms in different diagnoses. In addition, externalizing behaviors seem to be recorded more often because they are the most salient, causing internalizing and attachment problems to be overlooked. A multidisciplinary team that attends more to these risks may be possible; however, this care is expensive, and society favors supporting children in their natural environment. Potential family risk factors (FRF) may be causing the internalizing and attachment problems. **Aims** This study looks at the difference in primary diagnoses before and after multidisciplinary examination (MDE) and whether these are explained by FRF. **Methods and procedure** 131 casefiles of children with MIBD ($n = 131$) were analyzed quantitatively. In addition, test data from care workers, teachers, and parents ($n = 322$) were used to measure the difference in internalizing and externalizing behavior. **Outcome and results** The results indicate a significant change in primary diagnose after MDE using a chi-square independence test. A change in the primary diagnosis after MDE was more frequent in attachment disorders. Using repeated measures ANOVA there was no difference found in internalizing behavior pre- and post MDE. However, a significant decrease in externalizing behavior was found. Boys show more externalizing behavior than girls did. Due to logistic regression it appeared that exposing children to conflict can increase the change of primary diagnosis. Gender also influence the change, possibly because boys are more likely to show externalizing problems.

The impact of multidisciplinary examination and family function on diagnoses

With the increasing complexity of society, children with mild intellectual disabilities or borderline intellectual functioning find it increasingly difficult to function in everyday life (Woittiez et al., 2014). Children with intellectual disabilities (ID) have significant deficits in both intellectual and adaptive functioning (APA, 2013). Mild and borderline intellectual disability (MIBD) have similar risk factors (Eerson et al., 2010; Nouwens et al., 2016). Several studies show that the needs, mental health problems, and challenging behavior of people with MIBD are insufficiently addressed in practice (Chaplin, 2009; Nieuwenhuis et al., 2017). In the Netherlands, there has been an increase in the number of people with MIBD who are entitled to specialist long-term inpatient care (Eggink et al., 2017). From 2007 to 2011, residential care saw a 7.1% increase in people with MID and a 14.9% increase in people with BIF (Wottiez et al., 2014). The high cost of children using residential care (1.5B in 2005; Pires et al., 2013) has fueled debate about eliminating or reducing residential services for troubled youth (Wittaker et al., 2016; Noonan & Menashi, 2010; Pires et al., 2013).

In addition to high costs, there is also a moral conflict about the impact of institutional care on children (Goldman et al., 2020; Van IJzendoorn et al., 2020). Children have the right to grow up in a family environment to stimulate a harmonious and complete development (UNICEF & Child Rights Connect, 2021). Negative associations have been found between institutional care and the course of children's development, particularly in cognition, physical growth and attention (Van IJzendoorn et al., 2020). Incorrect diagnoses can lead to longer admissions and poor treatment outcomes (Jensen- Doss & Weisz, 2008). De Bildt and colleagues (2005) concluded that when there is a clarification of the (underlying) diagnoses, individual support needs can be better addressed. Improved alignment of needs and provided care should result in shorter admissions and better treatment outcomes.

Differentiating diagnoses

However, overlapping diagnoses, and transdiagnostic symptoms in different diagnoses, make distinguishing diagnoses a difficult and confusing process (Weinstein et al., 2000). For example, there is a large overlap between attachment problems and neurodevelopmental disorders, such as ADHD and ASD (APA, 2013; Dallos & Smart, 2011; Follan et al., 2011; Minnis et al., 2009; Storebo et al., 2013). This makes it difficult to distinguish between different kinds of mental health problems in children (Klein et al., 2014; McKenzie & Dallos, 2017). In addition to diagnostic overlap, difficulty may stem from comorbidity with ID and other mental health problems (Lai et al., 2019; Simonoff et al., 2008; Thapar & Cooper,

2016). There may also be a misdiagnosis when the differential diagnoses is not based on detailed information. Moreover, externalizing diagnoses are more likely to be registered and noted by the diagnostician, while internalizing behavior can easily be overlooked.

To avoid problems with incorrect diagnoses, Sparrow (1997) recommended using a multidisciplinary team for diagnostic research. The team consists of various care professionals who, through intensive observation and diagnostics, paint a clear picture of a child's diagnoses. Multidisciplinary examination (further: MDE) appears to be necessary to gain sufficient insight into a child's support needs. When this is clear, children and their environments can receive the desired support (De Bildt et al., 2005; Nouwens et al., 2016).

Aim of the study

The current study focuses on the differences in diagnoses before and after MDE of children with MIBD receiving residential care. Research shows that externalizing problem behavior often indicates underlying systemic and attachment problems (Klein et al., 2015; Thompson et al., 2009). Therefore, this study investigates whether a multidisciplinary approach, with more attention to systemic factors, leads to other diagnoses. The following research question were formulated 1) What are the differences in diagnoses of children with MIBD before and after MDE? 2) Do family risk factors explain changes in diagnoses after MDE in children with MIBD?

Family risk factors

Childhood adversity results in an increased likelihood of placement in residential care (Morris et al., 2020). Exposure to adversity within the family effect's children's functioning (Scully et al., 2019). These effects are considered family risk factors (further: FRF). Vervoort and colleagues (2021) concluded that children with MIBD are often subjected to several FRF, such as family debt. Nouwens and colleagues (2016) found that in half of the families they studied ($N = 525$), at least one parent was absent and that one-third of parents had mental health problems. Negative family experiences can lead to severe forms childhood psychological problems in children with MIBD (Felitti et al., 1998; Mills et al., 2019). Children with MIBD were also found to be at higher risk of trauma-related symptoms or PTSD than children were without ID (Mevissen & De Jongh, 2010). FRF are a possible predictor of internalizing and attachment problems (Dekker & Koot, 2003; Emerson et al., 2010; Klein et al., 2015; Thompson et al., 2009; Wallander et al., 2006). Practitioners (Augeo Magazine, 2021) found that externalizing behavior (e.g., associated with ASD) was often based on attachment and/or internalizing problems because children felt unsafe in their family and were in survival mode. However, traumatic childhood events and/or FRF can also

manifest as externalizing problems (Klein et al., 2015; McNally et al., 2021; Rittmannsberger et al., 2020) rather than internalizing problems. Furthermore, the most common predictors of internalizing diagnoses and attachment problems in children were witnessing conflict (Nouwens et al., 2016), financial problems (such as debts and housing; Merrick & Guin, 2018), parental alcohol use (Felitti et al., 1998), parental mental health problems (Jaffee et al., 2013) and absence of at least one parent (single parent; Carr, 2009). Therefore, it is possible that during MDE these “underlying” traumatic experiences and internalizing and/or attachment problems surface. Based on these research findings, FRF is expected to be associated with change in diagnoses following MDE.

In sum, MDE is expected to lead to changes in diagnoses, because more system-oriented disciplines are involved in the diagnostic process rather than disciplines that mainly look at child-specific factors. More specifically, it is expected that attachment and/or internalizing problems that underlie initially diagnosed externalizing problems often come to the surface after MDE. Hardly any literature exists on this subject, however, indicating that there is an “empirical gap” regarding this issue. The knowledge gained from this study contributes to both science and to the practical youth care. If the current research confirms that internalizing and attachment problems underlie externalizing problems and FRF explain the changes in diagnoses, underlying problems in families and children can get attention at an earlier stage of care (e.g., in a class or outpatient care). Care professionals can provide treatment to children and their families focused on possible underlying traumas, preventing out-of-home placements.

Method

Participants

Two data sets were used for the current study. To examine the difference in primary diagnoses and if FRF explain these changes, the first dataset was used. The sample consisted of casefiles of 134 ($N = 134$) children between the ages of 2 and 17 ($M = 11.08$, $SD = 3.46$). The participants were 44 girls and 90 boys. These children underwent an MDE in a national residential youth center in the Netherlands that specializes in clinical observation, diagnosis and treatment for children with MIBD between 2016 and 2019. The children all had an ID (APA, 2013) and complex behavioral or psychiatric problems (Koraal, 2019).

The second data set was used to investigate possible changes in internalizing and externalizing behavior signified by care workers (who observed the children at the group home), parents, and teachers during MDE. Data were collected from $N = 323$ participants as

part of Routine Outcome Monitoring (ROM) procedures. These children with a ID also underwent an MDE in a the national residential youth center in the Netherlands. The internalizing and externalizing scores of boys (236) and girls (87) were measured by care workers, parents and teachers during MDE between 2016 and 2022.

Measures

Shifting diagnoses

This study focused on possible changes in primary diagnoses. Therefore, the diagnoses before and after MDE in the case file were coded based on the Diagnostic and Statistical Manual of Mental disorders (5th version, DSM; APA, 2013) and divided into the most common diagnoses in children with MIBD (Dekker & Koot, 2003; GGZ-standaarden, 2019; KKJ, 2022): 1: ASD, 2: ADHD, 3: ODD, 4: depressive disorders, 5: anxiety disorders, 6: trauma and PTSD, 7: attachment disorders, 8: disruptive, impulse control and conduct disorders (e.g. OCD, CD). For each of the eight types of diagnoses it was examined whether the primary diagnoses had remained the same (0) or had changed (1) after MDE. To illustrate, for all children who received a primary diagnosis of ASD before MDE, it was determined whether they still had this primary diagnosis after MDE (0) or not (1). Descriptive statistics (percentages) were used to get a more detailed impression of the changes in diagnoses.

To investigate whether internalizing behavior was signified or more visible in reports of care workers' evaluations after MDE, results from the Child Behavior Checklist (CBCL; Achenbach, 1991) completed by care workers, teachers, and parents were used. The CBCL is a measuring instrument that provides insight into the problem behavior and skills of the child based on 120 items with a 4-point answer scale about emotional and behavioral problems (Achenbach, 1991). Using data from the first measured score (usually at the start of MDE) and the last measured score (an interim measurement or final measurement of MDE) with this questionnaire, a continuous score was calculated. This score reflects the changes in the CBCL score before and after MDE (CBCL internalizing T1- CBCL internalizing T0).

Family risk factors

The most common forms of FRF in children with MIBD were used to determine what factors affect whether the primary diagnosis were retained after MDE. Based on the literature, the following FRF were included: having witnessed conflicts, familial financial problems (debts and housing), parental alcohol use, parental mental health problems, and absence of at least one parent (single parent families; Carr, 2009; Felitti et al., 1998; Jaffee et al., 2013; Merrick & Guin, 2018; Nouwens et al., 2016; Vervoort- Schel et al., 2021). Data were collected through file review where it was established whether the FRF occurred (1) or not (0) in the

child's family. For example, each file was examined to see whether or not the child had a parent with mental problems, and so on. If it remained unclear from the datafile, the variable was coded as "0" (non-present).

Procedure

The participants in this study received care from a national residential youth care center because of families' or care organization' inability to act or other risks due to children's behavioral problems. The purpose of this admission is to use specialist observation and diagnostics to determine the cause of complex behavioral problems (Koraal, 2021).

Data were collected with the approval of the Ethical Review Board of the University of Amsterdam (2018-CDE-8871). In addition, approval was obtained by the Ethical Review Board of the Faculty of Social and Behavioural Sciences of Utrecht University (22-0374) for Secondary use of existing data. Parents provided parental consent by signing a form to indicate whether they agreed to the use of their child's file data. Parents could change their decision at any time, even after they had already given consent. In that case, their child would be removed from the dataset. All child files had the same structure and contained relevant information on pre-admission youth and family care records and multidisciplinary care plans during admission. Data were collected through a file review in which variables were coded according to a codebook (as noted in the Measures section). The file study was carefully coded by multiple reviewers to increase inter-rater reliability.

Analyses

The first research question (What are the differences in diagnoses of children with MIBD before and after MDE?) is a comparative question that was examined by combining quantitative and qualitative data analysis (Morling, 2020). Using the first dataset, percentages of the different diagnoses (per type of diagnosis) were given to measure the degree of change in primary diagnosis after MDE and to show for which types of diagnoses the changes were most pronounced. Additionally, a Chi2 test (Field, 2017) was performed to determine whether the change in primary diagnosis after MDE was a significant change. Subsequently, a more descriptive analysis was conducted to examine which the more qualitative shift in diagnoses. The nature of the change was coded in the program *InVivo*. These results are presented in Table 2 to illustrate the nature of change in primary diagnoses.

In addition, using the second data set, pre- to post-MDE changes in internalizing and externalizing behavior were examined using repeated measures ANOVA (Field, 2017) for each reporter group separately: professionals, parents and teachers. Test subjects had to be independent and could not influence other people's measurements (Field, 2018). In addition,

the before and after measurements came from the same test subjects. Finally, the differences needed to be normally distributed. This was checked by means of Mauchly's sphericity test (Field, 2017).

The second research question (Do FRF's explain changes in diagnoses after MDE in children with MIBD?) is an exploratory question (Morling, 2020). To test this question, a multiple logistic regression was performed in *SPSS Statistics 27* using the first data set. Multiple logistic regression is a parametric analysis used to explain an outcome (Field, 2017). In the model, the FRF were included as independent variables and the change in diagnoses as the dependent variable. For control purposes, gender was included as a factor in the model. The assumptions appropriate to the multiple logical regression were controlled in advanced.

Results

To answer 'what are the differences in diagnoses of children with MIBD before and after MDE' the differences in primary diagnoses were examined. Table 1 shows the frequencies and percentages of diagnoses before and after MDE.

Table 1

Primary diagnosis before and after multidisciplinary examination; frequencies and percentages

	Before MDE Frequency	Percent	After MDE frequency	Percent
ASD	39	29.1	39	29.1
ADHD	19	14.2	15	11.2
ODD	4	3	1	.7
Depressive disorders	1	.7	1	.7
Anxiety disorders	4	3	0	0
Trauma and PTSD	4	3	3	2.2
Attachment problems	16	11.9	58	43.3
Behavior disorders	0	0	1	.7

Other	3	2.2	6	4.5
No diagnoses	44	32.8	10	7.5
Total	134	100	134	100

A chi-square independence test showed that there was a significant difference between the primary diagnoses before and after MDE, $X^2(64, N = 134) = .37, p = <.001$. In total, 44.8% ($N = 60$) of the children, the primary diagnoses remained the same. A change in primary diagnoses was seen in 55.2% ($N = 74$) of children. Table 2 shows the nature of those changes.

Table 2

Nature of change in primary diagnosis before and after MDE

Before MDE	After MDE	Frequencies	Percent
No diagnoses	Attachment problems	14	18.9
	RAD	10	13.5
	ASD	4	5.4
	ADHD	1	1.4
	PTSS	1	1.4
	Behavior problems	1	1.4
	Regulatory problems	1	1.4
	Eating disorder	1	1.4
	Language disorder	1	1.4
ADHD	Attachment problems	7	9.5
	RAD	2	2.7
	No diagnoses	2	2.7
	ASD	1	1.4
	Eating disorder	1	1.4
ASD	Attachment problems	4	5.4
	ADHD	3	4.1
	No diagnoses	2	2.7
	RAD	1	1.4
	ODD	1	1.4
ODD	ADHD	2	2.7
	Attachment problems	2	2.7

Anxiety disorder	Attachment problems	2	2.7
	ASD	1	1.4
	McDD	1	1.4
Trauma and PTSS	RAD	2	2.7
	Attachment problems	1	1.4
Attachment problems	ASD	2	2.7
RAD	PTSS	1	1.4
Regulatory problems	ASD	1	1.4
Language disorder	ASD	1	1.4

Examining the changes in primary diagnosis after MDE, the 31.4% increase in attachment disorders is the largest (see Table 2). When focusing specifically on the nature of the primary diagnoses (shown in Table 3), it becomes clear that a considerable proportion of the children ($N = 28$, 42%) did not have a diagnosis before they received a primary attachment diagnosis. Among the children whose primary diagnosis had changed to attachment disorder after MDE, 9 children (12.2%) were originally diagnosed with ADHD, 5 (6.8%) ASD, 2 (2.7%) ODD and 2 (2.7%) with anxiety disorders at the start of MDE.

A total of 44 children (32.8%) did not have a primary diagnosis at the start of MDE; after MDE there were still 10 (7.5%) who did not receive a formal DSM- 5 classification (APA, 2013). In addition to the increase in attachment disorders after MDE, results showed an increase of 17.9% in primary diagnosis of ADHD. Changes to a primary diagnosis of ADHD mainly involved initially diagnosed neuropsychological disorders, such as ASD ($N = 3$, 4%) and ODD ($N = 2$, 2.7%). Additionally, the frequency of an ASD primary diagnosis was identical before and after MDE as seen in Table 1. However, Table 2 shows that changes had taken place. For example, there was a change in primary diagnosis from ASD to attachment problems ($N = 5$, 6.8%) and ADHD ($N = 3$, 4%) and from no diagnosis ($N = 4$, 5.4%) or attachment problems ($N = 2$, 2.7%) to ASD after MDE.

To determine if, internalizing and externalizing behavior increased or decreased after MDE, a repeated measures ANOVA was used to measure the pre- and posttest scores on the CBCL internalization and externalization scale, completed by care workers, teachers, and parents. Prior assumptions regarding normality and sphericity were checked and not violated. Gender was included in the repeated measures ANOVA. Significant differences in internalizing behavior were not found based on the CBCL reports. No effect of gender or

interaction effect between time and gender was found.

After internalizing behavior, externalizing behavior was examined. The difference over time as reported by care workers was significant, $F(1, 149) = 19.329, p < .001$. The means showed that the children's externalizing behavior was higher before MDE ($M = 64.81, SD = 0.83$) than after ($M = 61.65, SD = .62$). Parent reports also showed a significant effect in time of the difference in externalizing behavior $F(1, 87) = 62.525, p < .001$. The parents report means showed that the children's externalizing behavior was also higher before MDE ($M = 69.52, SD = 94$) than after MDE ($M = 62.36, SD = 0.78$). No significant effect of gender or interaction effect of time and gender was found in the reports of care workers and parents. Teachers also reported a significant change over time ($p = .03$) and gender ($p = .02$). Girls' averages were higher at their first measurement ($M = 64.31, SD = 12.29$) than at their last measurement ($M = 59.48, SD = 7.7$) and boys' averages were similar at the first ($M = 62.42, SD = 9.25$) and last measurement ($M = 62.48, SD = 7.89$). A significant interaction between gender and time was found among the teachers' reports, $F(1, 1) = 5.402, p = .022$.

The second research question "Do FRF explain changes in diagnoses after MDE in children with MIBD" was examined by means of multiple logistic regression. Table 3 shows the descriptive statistics (percentages) for the different FRF variables per group.

Table 3

The percentages of families in which the different family risk factors variables were present.

Family functioning	% (FRF)
Witnessing conflict	31.3
Debts	25.4
Housing	9.7
Parental alcohol use	13.4
Parental mental health problems	39.6
Single-parent families	45.0

Assumptions regarding multicollinearity were controlled beforehand. Statistical data are presented in Table 4.

Table 4*Effect of family risk factors and gender on change in primary diagnosis*

Variable	<i>B</i>	<i>SE</i>	95% CI		<i>p</i>
			LL	UL	
Witnessing conflict	.971	.434	1.127	6.185	.025
Family debts	.406	.503	.560	4.023	.420
Housing problems	.139	.755	.262	5.048	.854
Parental alcohol use	-.437	.565	.214	1.955	.439
Parental mental health problems	-.534	.396	.270	1.275	.178
Single parent families	.572	.414	.788	3.988	.167
Gender	-1.026	.419	.158	.815	.014

The results of multiple logistic regression with the FRF and gender on the change in primary diagnosis showed that single parent family, debts and housing, parent alcohol use and parental mental health problems did not explain the change in primary diagnosis ($p > .05$). However, the variables gender $F(1) = 5.994$, $p = .014$, and seeing conflicts, $F(1) = 4.999$, $p = .025$, significantly explained change in primary diagnoses after MDE. The odds indicate that boys exhibit a change in diagnosis more often than girls do. In addition, the odds of change in primary diagnosis were higher for children who had witnessed familial conflict than for children who had not witnessed such conflict.

Discussion

The general aim of the current study was to investigate the effect of FRF on change in primary diagnosis after MDE. In addition, the study examined whether there are signs that externalizing behavior underlies internalizing and attachment problems. From the analyses can be concluded that a change in primary diagnosis was seen in 55.2% of children with

MIBD after MDE ($N = 131$). This study shows an increase in attachment problems and neurological diagnoses. In addition, no differences were found in internalizing behavior and gender as reported by care workers, parents, and teachers ($N = 322$). A reduction in externalizing behavior was found after MDE as reported by care workers, parents, and teachers. Boys were found to score higher on externalizing behavior than girls did. The present study showed that children who had seen or experienced family conflict were more likely to exhibit a change in primary diagnosis. Finally, it appeared that boys made a change in primary diagnoses after MDE more often than girls did. The results were partly consistent with the hypotheses that underlying attachment and internalizing problems would surface and would be the nature of change in primary diagnosis. Not all FRF were found to explain the change, except for exposure to witnessing conflict.

The mutual changes in neurological diagnoses and attachment problems can be explained by the transdiagnostic symptoms that make differentiation of diagnoses difficult (APA, 2013; Dallos & Smart, 2011; Klein et al., 2014; Minnis et al., 2009; McKenzie & Dallos, 2017). No significant difference was found over time based on the ROM scores in internalizing behavior, but there was a difference in externalizing behavior. A possible explanation for this is that children are often taken out of their context (e.g., from their family), so that they can experience less tensions. It is possible that there was a decrease in externalizing and internalizing behavior because children experience fewer external stimuli from this (unsafe) context (Merrick & Narayan, 2020; Staunson et al., 2020) or because they received the appropriate care and support because of the correct underlying primary diagnoses (Zoon, 2015). An effect of gender was also found on externalizing behavior. The interaction effect found on externalizing behavior by the reports of teachers refers to the fact that the decrease may depend on gender. Boys scored higher on externalizing behavior than girls. This could be because girls generally internalize their problems more than boys do (Leadbeater et al., 1999; Mesman et al., 2001; Zahn-walker et al., 2008).

Not all FRF were found to influence change in primary diagnosis. A possible explanation could be that the children's parents are securely attached; this appeared to be a protective factor in girls (Formoso et al., 2000). In addition, the connection between children and parents can have an effect on children's behavior, so that internalizing or attachment problems are not the primary diagnosis (Braithwaite et al., 2015). The change in primary diagnosis after experiencing conflict is thought to be due to the high susceptibility to internalizing problems and trauma after experiencing stressful situations (Grasso et al., 2012; Masten & Narayan, 2012).

There are some limitations to this study. First, while scores from the ROM data set were labeled as first (often at the beginning of the MDE) and last, the last score noted was not always at the end of the MDE. Thus, there were times when it was an intermediate measurement rather than a final measurement. The reliability of the CBCL scores may have been affected by the personal connection that respondents had with the participants (Morling et al., 2020). In addition, the study was based on a convenience sample (Morling et al., 2020) in a national center of excellence. The results should be interpreted with some caution regarding other populations of children with MIBD.

Some strengths of the study can be identified. The large sample size ensures that the results can be generalized. In addition, the ecological validity of this study is high: participants were tested in a familiar environment, making it likely that the tests and diagnoses were recorded truthfully. Each document within the file study was carefully coded by multiple reviewers to ensure inter-rater reliability. They had no contact with one another about the data set.

This was the first study of differences in primary diagnoses after MDE and FRF in children with MIBD in which different methods and types of analysis were used to gain more insight into the nature of the change. It showed that more than half of the children with MIBD experienced a change in diagnosis, mostly toward attachment problems. In addition, it was also found that boys experienced a change more often than girls did. Experiencing conflict within the family also appeared to explain change in primary diagnosis after MDE. In practice, more attention can be paid to these possible underlying problems and to providing appropriate support for children with MIBD who experience conflict. Future research may still focus on providing insight into the effect of gender on change in primary diagnosis. It is possible that each gender has different support needs and that these can be met by providing more information. Understanding the effect of FRF can ensure that children experience a secure foundation and that the healthy development of the child is promoted (Merrick & Narayan, 2020).

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Appendix A

Codebook

Codebook – Variables

Personalia
Gender
Age

Variables system		
Label SPSS	Operationalization	Source
Single parent families	1= present 0= non present	Dossier
Witnessing conflict within the family	1= present 0= non present	Dossier
Debts problems	1= present 0= non present	Dossier
housing problems	1= present 0= non present	Dossier
Parental alcohol use	1= present 0= non present	Dossier
Parental mental health problems	1= present 0= non present	Dossier

Variables child		
Label SPSS	Operationalization	Bron
Primary diagnosis at the start of MDE	DSM-IV classifications: 1= ASD 2= ADHD 3= ODD 4= Depressive disorders 5= Anxiety disorders 6= Trauma and PTSD 7= Attachment disorders 8= Disruptive and conduct disorders	Dossier
Primary diagnosis at the end of MDE	DSM-IV classifications: 1= ASD 2= ADHD 3= ODD 4= Depressive disorders 5= Anxiety disorders 6= Trauma and PTSD 7= Attachment disorders 8= Disruptive and conduct disorders	Dossier
Change of diagnosis	1= primary diagnosis has change 0= diagnosis remained the same	Dossier