ABSTRACT: The literature has yet to reach a consensus as to the stability of severe psychiatric diagnoses in youth. Previous studies among youngsters tracked over set follow-up periods have reported diagnostic stability estimates that are similar to or slightly lower than those of adults. Less is known, however, about the stability of youth psychiatric diagnoses across multiple episodes of psychopathology, such as recurrent inpatient hospitalizations. The present study investigated diagnostic stability among inpatient youth with multiple hospitalizations through longitudinal and cross-sequential designs. Results indicate that diagnostic stability, as measured by positive concordance rates and the kappa coefficient, is highest for mood disorders, especially bipolar disorder. Externalizing disorders and schizophrenia displayed moderate to low stability, with oppositional-defiant disorder displaying the lowest stability. Substance use disorders were found to have moderate stability. Overall, across-episode diagnostic stability among hospitalized youngsters appears to be lower than that of adults. This finding appears to be due to lower stability among certain externalizing disorders and substance use disorders, whereas mood disorders display stability rates resembling those of adults. Potential explanations for and implications of these findings are discussed.

KEY WORDS: diagnosis; stability; inpatient; child; adolescent.
made between different ways of conceptualizing stability and different ways of measuring stability. Diagnostic stability can be conceptualized in terms of temporal stability over set follow-up periods or across multiple episodes of psychopathology. Temporal stability, which is the most commonly assessed form of diagnostic stability, simply refers to the presence or absence of a disorder at two distinct time points. For example, a youngster who meets diagnostic criteria for Major Depressive Disorder (MDD) when assessed at age 14 and again meets diagnostic criteria when assessed at age 17 would be considered to demonstrate high temporal diagnostic stability. High temporal stability may reflect either a lengthy course of a disorder or an episodic, recurring course of a disorder.

In contrast, across-episode diagnostic stability refers to the recurrence of specific symptom patterns over distinct episodes of psychopathology, with intermittent periods of reduced or no psychopathology. For example, a youngster who displays MDD at age 14, but does not meet diagnostic criteria from ages 15 to 16 (i.e., is in remission), then again meets diagnostic criteria for MDD at age 17 would be considered to demonstrate high across-episode diagnostic stability. Conversely, a youngster who displays MDD at age 14, is in remission from ages 15 to 16, then meets criteria for schizophrenia at age 17 would be considered to demonstrate low across-episode stability. That is, despite multiple episodes of psychopathology, changes in the form of psychopathology indicate low diagnostic stability. This latter form of stability (i.e., across-episode) will be the focus of the present study.

In addition to the type of stability, it is important to distinguish between methods of estimating diagnostic stability. Positive concordance rates provide one estimate of diagnostic stability, in that these rates describe the percentage of those diagnosed with a disorder at one time who manifest the same disorder at a later time (i.e., present–present). Positive concordance rates, while the most commonly reported form of diagnostic stability, may be misleading because they fail to account for the introduction of new cases of a disorder. The kappa coefficient corrects for this problem by accounting for positive and negative concordance rates, as well as rates of discordant cases. Kappa is generally preferable to concordance rates because it provides a more comprehensive estimate of stability and corrects for agreement due to chance. When reported alone, however, kappa may provide somewhat deceptive estimates of stability because it is overly reduced by high incidences of new cases and is unduly inflated by high negative concordance rates. As such, it is important to use these methods in conjunction with other approaches to estimating diagnostic stability.