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Settled debate or second wave? : clinical social workers' roles in treatment with youth who take ADHD drugs

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ABSTRACT

The purpose of this exploratory study was to gain a deeper understanding of social workers' roles in treating children who take attention-deficit hyperactivity disorder (ADHD) drugs. The study used semi-structured in-person and telephone interviews with twelve licensed clinical social workers to gather qualitative data about their experiences with children and families of children diagnosed with ADHD and their reflections on their roles in treatment, in particular those regarding medication prescribed to mitigate the child's ADHD symptoms. The findings suggested that social workers experienced difficulty teasing out ADHD from issues known to commonly co-occur as well as from a history of trauma. In cases where a child with a history of trauma had already been diagnosed with ADHD, social workers struggled with ambivalence when treating certain symptoms as ADHD rather than as trauma. Social workers' roles in treatment were found to be varied and complex and beyond the scope of the current literature. The clinical setting was a prominent theme in this study, with all participants identifying some way in which it affected their roles in assessment and diagnosis, medication, and other treatment approaches. Social workers in community-based agency settings generally defined their roles quite differently from those in private practice. The data also highlighted the disparate ways that racism and dynamics of oppression manifest within the broader query. A framework of four intersecting themes is offered to guide clinical practice and social work policy with children with ADHD symptoms.

SETTLED DEBATE OR A SECOND WAVE? CLINICAL SOCIAL WORKERS' ROLES

IN TREATMENT WITH YOUTH WHO TAKE ADHD DRUGS

A project based on an independent investigation,
submitted in partial fulfillment of the
requirements of the degree of Master of Social
Work

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I chose to be a social worker because
I believe in the "it takes a village" piece.
- Participant 6

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CHAPTER I

Introduction

Some sources estimate the rate of ADHD diagnosis in children in the United States to be as high as 14% (Watson, 2014) and as low as 5% (American Psychiatric Association, DSM-5, 2014). As of 2011, approximately 11% of children ages 4-7 (6.4 million) in the United States had an ADHD diagnosis; over half were prescribed medication to treat it (CDC, 2014). Rates of ADHD diagnosis have increased from an average of 3% per year (1997 to 2006) to 5% per year (2006 to 2011) (CDC, 2014). Social workers make up about 60% of mental health professionals in the United States (NASW, 2014), providing the largest proportion of therapeutic services than any other group of professionals (Probst, 2013). Their involvement in the psychotropic medication treatment process with children, families, and doctors is likely to increase in attempts to save health care costs (Moses & Kirk, 2008). Given this, and how commonly children diagnosed with ADHD take medication, it only stands to reason that many children who present for mental health care will work with a social worker at some point during their treatment. Despite this, social work academe has yet to publish any studies specific to its work with this population.

Psychiatrists and psychologists published a wave of research questioning the validity or at least overdiagnosis of ADHD in children in the late 1990s and early 2000s (Tamimi, 2003) (Cohen & Leo, 2002). Early criticism was rooted in the idea that ADHD illustrated a broader

cultural trend toward "medicalizing" ordinary problems of children and families (Cohen & Leo, 2002). However, over the last ten plus years this first wave of critique seems to have died down. This study situates itself among a possible second wave of research that has emerged "once again sounding a cautionary alarm" (LeFever, 2014) but with a different set of cautions from this first. These cautions pertain to a range of external factors (societal and economic) associated with ADHD (Russell, Ford, Rosenberg & Kelley, 2013). In addition, trauma research focusing on children over the past decade has led researchers to examine the relationship between past trauma and symptoms of ADHD (Fuller-Thomson, Mehta, & Valeo, 2014).

This purpose of the study is to understand how social workers understand their role vis-à-vis medication in the treatment of youth with ADHD. The overarching research question is: how do social workers understand their role in the treatment of youth who take medication typically prescribed to treat ADHD? This study explores the research phenomena through an inductive, qualitative research method. One of my aims in this research is to remain close to social workers' voices by using qualitative research methods.

For the purpose of this study, children have been broadly defined as individuals younger than 18 or who is not an emancipated minor in accordance with guidelines established by the United States Department of Health and Human Services (HHS, 2014). The word "treatment" depending on the context may refer to either 1) the entire length of care the social worker provides or 2) the particular phase of care that is commonly understood to happen following the assessment phase. Using this broad definition allows participants to identify with multifarious experiences of the work with this population rather than conform to a single treatment approach. The concept of "role" in this study applies to any aspect of the social worker's involvement with children with ADHD and their family. For example, existing literature on social workers and

drug treatment with youth more broadly has categorized their roles as *monitor, physician's assistant, advocate, educator* and *collaborator* (Moses & Kirk, 2008) (Bentley & Walsh, 2006).

As the following literature review indicates, research around ADHD diagnosis and treatment in youth has yielded some contradictory and incomplete findings. For one, there is some debate as to the reason behind the gradual rise of ADHD diagnosis in children that has occurred over the past couple decades. One explanation entails greater awareness and improved detections of the condition, which somewhat contradicts theories asserting the impact of environmental factors whose role in the development of ADHD that "require further research to establish" (American Psychiatric Association, 2013). Regarding treatment, one the one hand credible parent resources and research guidelines indicate that "medication alone is a proven treatment" and "most effective" for reducing symptoms of ADHD (Parent Resource Guide, American Psychiatric Association, 2013). Indeed, those studies measuring outcomes of stimulants on children generally conclude they are "safe" and pose minimal risk. On the other hand, other equally reputable sources recommend behavior therapy as the "first-line treatment" for preschoolers (4-5 years old) (American Academy of Pediatrics, 2011). In addition, there appear to be no studies with more than five years follow-up on the potential long-term impact of continuously medicating children in these ways, although many children take medication way beyond five years.

The researcher's anecdotal observations in a community-based mental health clinic yielded an alarming lack of curiosity and dialogue around this very issue—begging the question of how, in the face of uncertainty, clinicians conceptualize this phenomenon during treatment. In what ways, if at all, do clinical social workers help clients make meaning of an ADHD diagnosis and navigate its course of treatment? This research project encourages the social work field to

address the implications to clinical practice of three major issues: trauma and ADHD, racial and class disparities in clinical settings, and emerging holistic supportive measures to treatment.

      The following chapters describe the rationale for this study and the current literature that relations to the different components of it, the methodology used for this study, the demographic and qualitative findings of the study, and finally a discussion that assesses and interprets the meaning of those findings.

CHAPTER II

Literature Review

Introduction

The following literature review discusses the theoretical literature and empirical research relevant to the question: *How do social workers understand their clinical role with youth who take medication to treat ADHD?*

The first section of this chapter contextualizes ADHD and its prevalence among children in the United States and abroad. The second section reviews the current treatment options available for children diagnosed with ADHD with particular attention to the benefits and risks associated with psychostimulant meditation. As a means to justify the relationship that clinical social workers have to this population, the third section provides an overview of their roles in the mental health field and, by extension, the care of medicated children about whom the study is concerned. The section that follows provides an overview of existing research on social workers' general attitudes toward psychotropic medication—bridging the gap in the literature specific to their attitudes toward psychotropic for treating youth, especially those with ADHD, which comprises the final section.

Prevalence of Attention Deficit Hyperactive Disorder (ADHD) in Youth

ADHD is the most common psychiatric diagnosis in children today. Estimates of diagnosis in children in the United States range as low as 3% to as high as 14%— and almost

20% of all boys in some figures (CDCP, 2014; Watson, 2014). ADHD "narrowly trails asthma as the most common long-term medical condition in children" (NYT, 2014). In contrast to these national figures, the worldwide prevalence of ADHD is about 5.29% (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007). Polanczyk et al. (2007) attributed the large variability of ADHD worldwide prevalence estimates to the methodological characteristics of studies rather than geographic location, which the same authors asserted played only a limited role. Still, prevalence estimates of ADHD both nationally and internationally are heterogeneous and discrepancies remain poorly understood (Polanczyk et al. 2007). Due in part to the national shortage of child psychiatrists, pediatricians and family doctors most commonly diagnose ADHD in children and write stimulant prescriptions for them (Garfield et al., 2012). This trend has given rise to a new wave of media speculation regarding the adequacy of training to prepare for today's rising number of families asking for mental health evaluations (NYT, 2014).

The Evolving Definition of ADHD

The variability of ADHD prevalence relates to how its definition has changed over time and a trend of broadening diagnostic criteria. *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) is the most widely accepted nomenclature clinicians and researchers in the United States use to classify and diagnose mental disorders. The *International Classification of Diseases* (ICD-10-CM) published by the World Health Organization serves a similar function as the DSM but operates on a global scale. In October 2014 the U.S. health care system aligned the DSM coding system with the latest version of the ICD (ICD-10-CM) for classification and billing purposes. US-based clinicians have expressed sentiments that the ICD lacks the same level of detail and extensive criteria, which reflects potential discrepancies between the ICD and the DSM in the diagnosis of ADHD. For example,

in addition to the criteria the DSM-5 also provides what researchers assert are developmentally appropriate examples of how every symptom might manifest according to age (American Psychiatric Association, 2013). However, as it concerns services for children and families aligning with the ICD codes probably will have little actual impact on access to special education services (such as classroom accommodations, specialized instruction, or referrals for therapy, counseling, or psychiatric services) because Federal education laws (such as No Child Left Behind) allow states to define their own admission criteria, typically on the basis of adverse affects the child's educational performance, rather than mandate use of DSM, ICD, or any other diagnostic manual. Regardless, three federal statutes protect children with ADHD: Individuals with Disabilities Education Act (IDEA) Part B, Section 504 of the Rehabilitation Act, and the American with Disabilities Act (Gregg, 1994). Regulatory bodies implementing IDEA now list ADHD as a condition that can make a child eligible under Other Health Impairment (OHI). While some states use the DSM, most state laws and regulations *do not specify diagnostic criteria* any further than federal law and instead use "professional expertise" as the determinate (American Psychiatric Association 2013).

The DSM-5 saw some important changes to the diagnostic criteria of ADHD. The major changes involved reducing the number of symptoms (to 5) for adults 17 and older to meet the diagnostic criteria and raising the age of onset from 7 to 12 years old (CDC, 2014). This change reflected the DSM's attempt to capture research's assertion that ADHD often persists into adulthood and causes significant impairment in social, academic or occupational functioning yet diagnosed *half* as frequently in adults than in children due to age at onset criterion and problems with retrospective recall (Keiling, Kieling, Rohde, Frick, Moffitt, et al., 2010; Polanczyk et al.

2007). The APA has suggested that adults simply develop coping skills that minimize their symptoms in later life (American Psychiatric Association, 2013).

There has been some debate in the literature regarding the potential for the age at onset criterion change in particular to impact the prevalence rate of ADHD in the United States. For example, Zinkstok and Buitelaar's 2014 study, found that clinical and epidemiological data supported the DSM decision and would be "unlikely to result in over-diagnosis." On the contrary, Vande Voort et al.'s 2014 study found that the age of onset criteria change has already led to a marked increase in the prevalence rate of ADHD: from 7.38% in the DSM-JV to 10.84% in the DSM-5. Vande Voort et al. (2014) and others suggest that age of onset and other criterion changes reflect a turn toward greater lenience in diagnosing ADHD. A linguistic example that might reflect this trend is the change from requiring ADHD symptoms cause "clinically significant impairment" (American Psychiatric Association, 2000) to "interfere with, or reduce the quality of" functioning in a given setting (American Psychiatric Association, 2013).

The DSM-5 classifies ADHD as a "neurodevelopmental" disorder defined by impaired levels of either "inattention" and/or "hyperactivity/impulsivity" (American Psychiatric Association, 2013). There are discrete diagnostic codes for Predominately inattentive Presentation (314.00/F90.0), Predominantly hyperactive/impulsive presentation (314.01/F90.1) and Combined presentation (314.01/F90.2). Interestingly, calling three kinds of ADHD "presentations" instead of "subtypes" as they had in the previous edition may reflect the DSM's attempt to capture the fluid nature of the disorder over time. For all three presentations, symptoms much persist for at least 6 months "to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities" (APA 2013. There are several tools most notably Connors and Vanderbilt that the field relies on for

assessing ADHD in children the details of which are beyond the scope of this literature review. Kieling et al. (2010) noted that the DSM also made a "conceptual point" of differentiating symptoms from onset of impairment, because the latter may reflect environmental demands such as school. I will now briefly discuss these two presentations and their symptomology.

The DSM-5 defines symptoms of the inattentive subtype as "wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension." Due to impairment in mathematics and sensory information processing associated with the inattentive presentation, children with this presentation sometimes meet criteria for a learning disability (LD) (CDC, 2014; NAMI, 2014). Kieling, et al.'s 2010 study suggested that the inattentive group (then referred to as "type") exhibited a later age of onset than the hyperactive/impulsive type (Kieling, et al. 2010). The symptoms of both inattentive and hyperactive/impulsivity presentations vary only slightly from the previous DSM and, as stated, now provide developmentally appropriate examples of different ways symptoms might manifest according to age in order to help guide clinicians evaluating older adolescents and adults.

Hyperactivity/impulsivity is conceptualized as one presentation in the DSM-5. "Hyperactivity" might be reflected in excessive motor activity at inappropriate times, or excessive fidgeting, talking, and interrupting conversations. "Impulsivity" could refer leaving one's seat unexpectedly, running or climbing in inappropriate situations (CDC, 2014). This may manifest as a child running out into the street without looking (American Psychiatric Association, 2013). "Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification," or "social intrusiveness" (Jensen, 2004). It might be said the child is "always on the go," acts as if "driven by a motor," or makes odd noises (CDC, 2014; American

Psychiatric Association, 2013). Thus for both ADHD presentations in young children, the peer-review literature appears to find the ADHD symptom criteria sufficient. However, critics have suggested that the previous lack of attention to appropriate developmental context is critical to diagnosing ADHD in children and its absence can lead to misdiagnosis (Cohen & Leo, 2002). For example, the symptom examples groups together children ages 6-12, a wide developmental span, leading to potential expectations that a 6 year old behave like a 12 year old.

Risk Factors

The DSM-V specifies several risk and prognostic factors that increase a child's chance of acquiring ADHD. The degree to which ADHD is "genetic" is also unknown, however the DSM-5 cites first-degree biological relatives as a risk factor: "heritability of ADHD is substantial" (American Psychiatric Association, 2013). However, environmental factors such as low birth weight and smoking, which "may also increase the risk of ADHD," complicate the theory of its "heritability" (American Psychiatric Association, 2013). "Temperament" may "predispose" some children to ADHD, but is not specific to the disorder (American Psychiatric Association, 2013). Other noteworthy "environmental" risk factors include a history of child abuse, neglect, and multiple foster placements (American Psychiatric Association, 2013). Without citing much literature, the DSM leaves social workers and other clinicians to do their own research to sort out the validity and potential misinformation surrounding these claims of risk. There are many ambiguities embedded in the DSM's discussion of ADHD risk factors, for example, "family interactional patterns in early childhood are unlikely to cause ADHD but may influence its course." While DSM hesitates to attribute environmental factors to the etiology ("cause") of ADHD, very recent researchers in examining the co-occurrence of ADHD and a history of trauma have strengthened this "likelihood" (Fuller-Thomson, Mehta & Valeo, 2014).

Issue in diagnosing ADHD

The DSM-5 refers to discrepancies based on aspects of identity as "issues in diagnosing ADHD. The main issues, in the order in which they will be discussed in brief here include co-occurring diagnoses, gender, and race. Neurodevelopmental disorders frequently co-occur, and in childhood, ADHD often overlaps with "externalizing disorders" such as Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (American Psychiatric Association, 2013). However, ODD is significantly more common among the Combined (50.7%) and Hyperactive (41.9%) presentations as compared to the Inattentive presentation (20.8%) (Elia, Ambrosini and Berretini, 2008). Anxiety and depression are the two most common co-occurring disorders after ODD that clinicians may have difficulty differentiating from ADHD (Elia et al., 2008). Elia et al.'s 2008 study found that while over 20% of children diagnosed with ADHD also met criteria for Minor Depression/Dysthymia (MDDD) and 15.2% met criteria for Generalized Anxiety Disorder (GAD). Similar figures were found with a more diverse population in a follow-up to the 1992 MTA Study (Jensen, Hinshaw & Kraemer, 2001).

There are higher rates of ADHD in boys than girls, however this may be due to under-diagnosis in girls, and indeed diagnosis in females rose in recent years, possibly due to greater public awareness (American Psychiatric Association, 2013). Biederman, Spencer, Monuteaux, et al.'s (2010) 10-year longitudinal, case-control study of boys and girls with and without ADHD asserted that among subjects with ADHD, significantly larger weight in females and smaller height in males was associated with comorbid major depression. These findings suggest that cultural expectations around gender and certain growth characteristics put children with ADHD at higher risk for comorbid depression (Biederman, et al. 2010).

Aside from comorbidity and gender, a child's race appears to have some bearing on diagnosing ADHD as well. The DSM attributes the tendency for higher rates of ADHD diagnosis among White children than African American and Latino children to "culture" (American Psychiatric Association, 2013). In fact, the so-called "cultural" issue appears to be a consequence of issues of "discrimination" and structural racism insofar as people of color tend to have less access to various resources that might lead to thorough assessment and diagnosis of ADHD (Miller, Nigg & Miller, 2008).

Although not captured as an "issue," the DSM asserts elsewhere that the variance regarding *how* a given setting can affect the child's ADHD symptom presentation is an important issue in diagnosis (American Psychiatric Association, 2013). According to the DSM-5, "manifestations of the disorder must be present in more than one setting (e.g., home and school)" (American Psychiatric Association, 2013). Reliable informants such as teachers, who have seen the child in the alternative setting, must be consulted in order to satisfy this criterion. Some examples of contexts that may "minimize" a child's symptoms are close supervision, a novel setting, especially interesting activities, consistent external stimulation (e.g., via electronic screens), and one-on-one situations such as the clinician's office. (American Psychiatric Association, 2013).

A range of challenges facing the diagnostic criteria, limitations in the current understanding of risk factors as well as issues in diagnosis have been discussed. Social workers face particular challenges, as they must work both within the 'party line' and outside it, helping those who may be misdiagnosed *or* underdiagnosed. This review will turn now to how the literature recommends treating children with ADHD and its implications for social workers' roles therein.

Treatment of ADHD in Youth

Social workers who work with this population may face challenges in navigating treatment options. Increasingly complex mental health research standards and greater importance placed upon "evidence-based research" may also impact social workers seeking to stay abreast of latest treatment (Adams, Matto, & LeCroy, 2009). Some of this research endorses only medication and, secondarily, behavior therapy to treat ADHD in children (APA Parent Guide, 2013) while other literature recommends behavioral therapy as a "first-line" treatment as in the case of preschool-aged children (American Academy of Pediatrics, 2011; Heriot, Evans, and Foster, 2008; CDC, 2014). Given the discrete research discussing treatment options for younger versus older children those under age 6 are considered separately from older children and adolescents. The literature regarding medication will be discussed first followed by non-pharmacological interventions.

Medication

Pharmacotherapy is an umbrella term used to refer to medical treatment that alters brain chemistry by means of prescription drugs. The American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics and National Institutes of Health all support the use of pharmacotherapy as one of several treatment options for ADHD in children and adults (CDC, 2014; American Academy of Pediatrics, 2011). Psychostimulants are the most frequently prescribed drug to reduce or eliminate ADHD symptoms.

Stimulant medication is the most common treatment for ADHD in both children and adults. Currently, psychiatry guides the treatment recommendations for ADHD and endorses medication but with some poorly defined parameters. According to the American Psychiatric Association's "Parent Medication Guide" (2013) stimulant medication is "most effective in

treating the symptoms of ADHD." The APA's recommendations rely on the 1992 National

Institute of Mental Health (NIMH) Multi-modal Treatment Study of Children with ADHD—or

the MTA study. However, the MTA study only measured and compared its effectiveness to

behavioral therapy, the implications of which will be discussed later in this section. The APA

summarized the study findings in a Parent Medication Guide thus:

> Data from this 14-month study showed that stimulant medication is most effective
> in treating the symptoms of ADHD, as long as it is administered in doses adjusted
> for each child to give the best response – either alone or in combination with
> behavioral therapy. This is especially true when the medication dosage is
> regularly monitored and adjusted for each child.

The writing at times is vague, as in the excerpt above, where it is unclear what aspect of the "best

response" to medication is "especially true." Moreover, these guidelines often note aspects of

ADHD treatment as uniquely important, such as adjusting to a child's developmental status and

needs, which in clinical social worker is considered standard procedure. The justification for

stimulant medication as a "first choice" for treatment is that it "reduces hyperactivity and

impulsivity, improves attention, and increases the ability to get along with others." (Parent

Medication Guide, 2013).

Children with ADHD are believed to have abnormal functioning or "dysregulation" of

certain brain chemicals called neurotransmitters (Bohkari & Fournier, 2013). FDA-approved

ADHD drugs target these particular neurotransmitters in the central nervous system and therefore

sometimes call them "CNS stimulants" (Bohkari & Fournier, 2013). CNS stimulants, synthetic

compounds based on either methylphenidate (MPH) (found in Ritalin) or amphetamine, inhibit

the brain's dopamine transporter, increasing dopamine and noradrenaline (norepinephrine) levels

in the prefrontal cortex, which is the widely accepted as the site of attention, memory and executive functioning (Huang & Tsai, 2011). Increasing activity in the prefrontal cortex helps to "enhance mental alterness and wakefulness, improve concentration, decrease antisocial behavior, aggression and impulsivity and reduce the level of physical activity"—all symptoms associated with ADHD (Huang & Tsai, 2011). MPH and other products are available in short acting (immediate release) taken up to 3 times daily or longer-acting (extended-release) doses. The latter, which have been on the market for the past 15 years, allow for once-daily dosing and potentially eliminate the need for medication at school. Common side effects include anorexia (due to decrease in appetite), sleep disturbances, insomnia, tachycardia (rapid heart beat), CNS overstimulation and irritability (Huang & Tsai, 2011).

Research has documented the frequency with which children and adolescents with ADHD report sleep problems in mental health practice settings (Owen, 2005). To address sleep problems that resulted either organically or from adverse effects of stimulants, clinicians may notice physicians prescribe a sleep aid such as melatonin or clonidine in over 20% of children with ADHD (Efron, Lycett, & Sciberras, 2014). Although poorly understood, the importance of sleep and deleterious consequences of poor sleep, especially in children with ADHD, is well known and increasingly documented (Efron et al. 2014; Owen, 2009). Owen (2009) described the relationship between ADHD and sleep as "a complex one that poses many challenges in clinical practice." Owen (2009) also described many issues clinicians may face in clarifying the etiology of the sleep problems of children with ADHD. Insofar as sleep and other side effects might exacerbate the very symptoms the medicine aims to treat, clinicians face potential complexity in helping patients weigh the pros and cons of medication interventions.

Non-CNS stimulants are a second, less common, but equally effective class of drugs prescribed to treat ADHD symptoms in children and adults (Huang & Tsai, 2011). These include atomoxetine and guanficine and work slightly differently to achieve the same effect as CNS stimulants, namely to reduce or eliminate symptoms related to the inattention or hyperactivity/impulsivity ADHD presentations. In 2009, the FDA approved extended-release guanfacine to control symptoms of ADHD in children and adolescents 6-17 but not adults (Huang & Tsai, 2011). In addition to psychostimulants, there are a few off-label treatment options for ADHD in children for when the FDA-approved drugs discussed above are not effective—such as buproprion and tricyclic antidepressants—but studies asserted they are only partially effective and poorly tolerated (Huang & Tsai, 2011). For the remainder of this paper, both CNS-stimulants and non-CNS stimulants are referred to interchangeably either as "stimulants" or "psychostimulants." While there is no "cure" for ADHD (American Psychiatric Association, 2013), several medications are approved for potential long-term use.

Prevalence of ADHD medication. Over the past decade, and the last few years in particular, the demand for drugs to treat ADHD and ADHD symptoms in children in the United States has grown rapidly. In 2003, the Center for Disease Control published a national survey that found that 4.3% of children ages 4 to 17 took medications specifically to treat ADHD, representing about 56% of the children with a history of ADHD diagnosis (CDC, 2005). This finding was relatively consistent with a 2007 study measuring ADHD treatment prevalence and drug use from 2000 to 2005, which claimed that 4.4% of children (ages 0 to 19) used ADHD medications (Castle, Aubert, Verbrugge, Khalid & Epstein, 2007). Of those 4.4%, treatment rates were found to be higher in boys (6.1%) than in girls (2.6%). In terms of age, Castle et al. (2007) found that older boys, age 10-19 showed the highest prevalence of medication use

(8.1%), which speaks to the disorder's perceived gender bias discussed earlier. According to the testimony of DEA Deputy Director Terrance Woodworth (2000) before the House Subcommittee on Early Childhood, Youth and Families, between 1990 and 2000 the MPH quota in the U.S. increased from 1,768 kilograms to 14,957 kilograms, and the amphetamine quota increased from 417 to 9,007. In the same testimony, Woodworth quoted the United Nations as reporting that the U.S. produced and consumed as much as 85% of the worlds' production of Ritalin (Woodworth, 2000).

Castle et al. (2007) also captured the tremendous annual increase in psychopharmatherapy prevalence (11.8%) per year for the population as a whole. The study asserted that "improved identification" (increased diagnosis) of ADHD in adult and female patients has contributed to the rapid growth in ADHD medication use (Castle et al. 2007). The paucity of research after 2007 suggests a shift in public perception around the safety and efficacy of stimulant medication. Regardless of what factors contributed to the rise in medicated adults, in 2013 an NIMH-funded study found that the rate of prescription stimulants to treat ADHD in children rose from 56% (CDC, 2005) to 75-80% with wide regional variance (Bohkari & Fournier, 2013). Unfortunately these national studies do not capture wide regional variances and clinicians' experiences may vastly differ depending upon the state in which they work (Bohkari & Fournier, 2013) (CDC, 2014). A complex matrix of factors including the change in age of onset criteria discussed earlier has contributed to the increased demand for psychostimulant drugs to treat ADHD. Some authors speculate that the shortage of child and adolescent psychiatrists and reliance on lesser-trained, over-burdened family doctors has led to prescriptions for children who have not met the full diagnostic criteria (NYT, 2014). Other researchers

contend that a "cultural shift" around the ethics of medicating children has influenced some parents who might have previously viewed it as wrong (Cohen & Leo, 2002).

Long-term ADHD Drug Use. Huang & Tsai's 2011 review found that long-term trials of stimulant medication on children with ADHD have not been as widely studied as efficacious short-term findings. Evaluating the long-term effects of ADHD medication has been difficult for researchers because of the wide range of ADHD's symptoms, medication compliance, "and the significant influence of social and environmental factors" discussed above (Huang & Tsai, 2011). Given the potential for prolonged use, the 1998 NIMH consensus conference on ADHD emphasized the need for long-term studies of stimulant medication with children. Huang and Tsai's (2011) overview of open-label, longitudinal case-controlled, meta-analyses or randomized control trials of at least 6-month's duration (from 2001 onward) about long-term adverse effects of stimulants and non-stimulants used to treat ADHD showed that stimulants, along with non-stimulants atomoxetine and extended-release guanfacine, are continuously effective for 24-month treatment periods with few tolerable and adverse effects (Huang & Tsai, 2011). Studies that have measured the potential impact of ADHD drugs and serious cardiovascular events (discussed below) also had limited information for longer durations of use (Cooper, Habel, Sox et al., 2011). According to Huang and Tsai (2011), there are "very few" controlled, long-term studies of more than 5 years of treatment for childhood ADHD, which may factor into how social workers approach their work with this population.

ADHD Treatment with Children under age 6. Even though many of the findings related to long-term ADHD drug use refer to "children," many studies apply only to older children and adults. Therefore, the nuanced research related to drug treatment standards for preschool aged children necessitates brief discussion. In a comparative effectiveness review of interventions for

preschoolers at risk for ADHD sponsored by the US Agency for Healthcare Research and Quality, Charach, Carson, Fox et al. (2013) surveyed comparative studies of children under 6 conducted between 1980 and 2011. Out of the 55 studies surveyed, 8 studies examining parent behavior training (PBT) and only 1 study evaluating MPH met criteria for the global grade of "good" study quality, which led the authors to conclude that PBT interventions have greater evidence of effectiveness than MPH for treatment of preschoolers at risk for ADHD (Charach et al. (2013).

Findings from that singular "good" quality study evaluating MPH in preschoolers highlighted in Charach et al.'s (2013) survey—the multisite National Institute of Mental Health (NIMH)-funded Preschool ADHD Treatment Study (PATS)—raise a range of possible implications for social workers' roles in treatment. The PATS study, the largest randomized clinical trial of immediate-release MPH administered 3 times daily, included several stages. Before the trial, parents were offered 10 weeks of Parent Behavior Training (PBT) sessions. During the open-label safety lead-in phase, 17.5% percent of the 183 children reported adverse reactions: "a substantial proportion of preschool children experience moderate to severe adverse events with doses of MPH within recommended range of doses" (Charach et al. 2011). The side effects of emotionality/irritability were the most common reason that families discontinued MPH treatment during the early stage of medication use. In these cases, as noted above, ADHD medication potentially exacerbates the very symptoms they seek to address.

During the subsequent stage of PATS—a double-blind titration trial—parents of children on MPH reported a range of side effects. These included trouble sleeping, appetite loss, being dull/listless/tired, stomachache, social withdrawal, and buccal/lingual movements (involuntary rolling of the tongue and slight twitching). In addition, consistent with reported growth effects

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of MPH on some older children, Swanson, Greenhill, Wigal, et al. (2006) found stimulant-related reductions of growth rates in the PATS over 12 months of trial and open-label extension. PATS also suggested that preschoolers with zero or only one comorbid conditions are more likely to benefit from MPH than children with three or more comorbid conditions at baseline (Charach et al. 2013).

Another important finding in the PATS study related to disagreement between teacher and clinician versus parent ratings. Teachers and clinicians rated MPH as having a more positive effect on children than parents. In fact, parental stress did not improve at all and rated their child's mood as worse (Charach et al. 2007).   While the parents' screening measure may have been less accurate, this discrepancy highlights an important tension that social workers must navigate in treatment with this population. Charach et al. (2007) recommend that clinicians acknowledge parents' concerns about their child's ability to tolerate medication as well as their treatment preferences as "an important part of providing optimum care for young children with ADHD." Thus the literature reveals parental challenges and environmental complexities with medication that implicate further exploration of the roles of social workers.

Controversies. ADHD research is riddled with controversy both past and present. This section will address those controversies relevant in today's literature in order to clarify any confusion or concerns clinicians and other readers may have about the presumed risks of stimulants including adverse effects, substance abuse, and quality of life issues.

Significant research has been devoted to queries related to the purported adverse effect stimulants on children's growth (both height and weight). On the one hand what has been named the "Growth-Rebound Hypothesis" asserted that the delay in a child's growth after taking stimulants could be "caught up later" (Huang & Tsai, 2011). The field's longest prospective, a

10-year longitudinal, case-control study, found no association between deficits in growth

outcomes and either ADHD or psychostimulant treatment for ADHD—neither with trajectories

of height over time nor differences at follow-up (Biederman, et al., 2010). On the other hand, a

follow-up to the same MTA study discussed earlier in this Chapter, found significantly decreased

growth rate of participants' in the newly medicated subgroup, contradicting Biederman et al.

(2010) and the growth-rebound hypothesis (Swanson, Elliott, Greenhill, et al., 2007). In spite of

a lack of consistency in the medical research, recent reviews of these studies assert that this

adverse effect is not an issue (Huang & Tsai, 2011).

Serious cardiovascular events (including sudden cardiac death, myocardial infraction, and stroke)

is another controversial side effect among children and young adults who take ADHD drugs.

Results from a large, retrospective cohort study using automated data from four geographically

diverse health plans showed no evidence that current use of MPH—the most frequently used

ADHD drug, as data for other ADHD drugs was too sparse to fit the regression model—was

associated with an increased risk of serious cardiovascular events (Cooper et al. 2011). Cooper et

al.'s (2011) alternative analyses, which included only children aged 2 to 17, also found no

association between MPH and serious cardiovascular events. Although numbers were very

small, a site-specific analysis did suggest a potential difference between Medicaid and non-

Medicaid sites (Cooper et al., 2011), implying ways that dynamics of oppression might influence

the quality of assessment and treatment discussed earlier in the Chapter.

Current research regarding stimulants and youth also debates the risk of potential drug

abuse. The United States Drug Enforcement Administration classifies MPH as a Schedule-II

substance and notes its "high potential for abuse," which "produces many of the same effects as

cocaine or the amphetamines" including binge use, psychotic episodes, cardiovascular

complications, and severe psychological addiction (US Drug Enforcement Administration, 2014). The increased use of methylphenidate to treat ADHD in children "has paralleled an increase in its abuse among adolescents and young adults who crush these tablets and snort the powder to get high" (US Drug Enforcement Administration, 2014). While most studies suggested that stimulant treatment in childhood does not increase the risk of substance abuse in adulthood, these were mostly long-term follow-up studies instead of long-term stimulant treatment studies (Huang & Tsai, 2011). Regardless of the cause, substance abuse disorder is a common co-morbidity of ADHD that clinicians "should acknowledge" (Huang & Tsai, 2011).

Huang and Tsai (2011) also cite what they call "quality of life" issues related to ADHD drug treatment for children. Some researchers suspect that the failure of our contemporary "educational/cultural system" to meet the needs of its students creates the perceived need to diagnose and medicate children for ADHD, though these critiques are not yet widely embraced. Cohen and Leo (2002), prolific authors on this side of the debate, continue,

> The suspicion is simply that diagnosing children with ADHD and medicating
> them with psychotropics has less to do with treating genuine medical disorders
> than with controlling and altering children to meet the demands of our
> contemporary educational/cultural system. Not surprisingly, the bulk of
> professional and scientific literature on ADHD, with its extremely restricted focus
> on the short term modification of 'target symptoms,' glaringly omits to appraise
> this suspicion seriously. (p. 189-190)

Symptom reduction, rather than underlying causes, is a primary goal of both stimulant medication and behavioral therapy. Moreover, in spite of the precipitous rise in medication use,

social workers also work with a considerable percentage of children diagnosed with ADHD who

are *not* prescribed medication (presumably 20-25% according to the Bohkari & Fournier study).

Behavioral Therapy

The APA asserts that behavioral therapy in combination with medication "sometimes"

enables children to take lower doses of medicine (APA Parent Guide).   The MTA study suggests

that children with ADHD who had co-occurring conditions such as depression and anxiety were

especially helped by the combination of behavioral therapy and medicine. The MTA study

asserted the superiority of medication over behavioral therapy based on studies that have

measured the impact of behavior therapy on children of families who refused medication (APA

Parent Guide, 2013). While important research comes from this refusal population especially

when unable to conduct placebo trials, it also might lead to sample bias and impact the

generalizability of the findings. Although the MTA study was published over 15 years ago, no

national studies since have matched its impressive scale and thus it remains relevant to social

workers and clinicians who currently work with this population.

Some social work research takes a cautious or critical stance toward behavioral

interventions because it tends to locate the problem within the individual rather than their

environment and focus on symptom reduction rather than underlying causes of symptoms

(Adams et al. 2009).   The APA Parent Guide defines the goals of the behavioral model as

"manage and modify the behaviors that cause problems at home and at school" (APA Parent

Guide).   The three behavioral interventions for ADHD are parent training, child-focused

treatment, and school-based interventions. In parent training, the parent learns about ADHD and

ways to manage their child's problematic behaviors (referred to as "behaviors") that are believed

to be ADHD symptoms. In this approach parents are given "techniques" to achieve position

interactions with their child, thought to motivate children to meet their parents' expectations of behavior. Similarly, behavioral interventions focused on the child teach them "skills" to manage their behaviors in social, academic, and problem-solving settings where they might be compromised. Finally, behavioral interventions in schools teach teachers "skills" to manage their students' behavior in the classroom thought to be symptomatic of ADHD. Some techniques include rewards, consequences, classroom seating, and daily report cards sent to parents. Literature focused on marginalized populations has critiqued this approach given the reality of classroom settings in public education (Russell, et al. 2014).

Aside from behavioral therapy, which includes parenting education or "psychoeducation," non-pharmacological interventions are outside the scope of this literature review. According to Jensen (2004) empirical research has shown "disappointing" results of the impact of non-behavioral psychotherapy for children with ADHD because they "may not possess the cognitive ability to rely on their own internalized speech" central to this approach.

This section highlighted several complex factors associated with the treatment of childhood ADHD that social workers might also navigate in their work. Despite the assertion found in the scientific literature that psychostimulants are the most effective form of treatment for children with ADHD (American Psychiatric Association, 2013), perhaps except for preschoolers (CDC, 2014; American Academy of Pediatrics, 2011), it seems critical to explore more deeply the roles of social workers and their responsibility regarding the needs of the significant percentage of those who do not respond well to medication, factors that increase or ameliorate vulnerability to adverse effects, increased symptom expression with medication, and families with children who may be at a developmental level at which medication is not

appropriate. While physicians are leading the way in this discussion, their role in diagnosis and monitoring may be less embedded in these complexities as compared to social workers.

Clinical Social Workers in Mental Health Care

In anticipation of how social workers have dealt with issues in diagnosis and treatment, this section presents an overview of clinical social workers in the mental health care system in the United States. Social workers provide the largest proportion of therapeutic services than any other group of professionals in the United States (Probst, 2013). There are more clinically trained social workers in the field than psychiatrists, psychologists and psychiatric nurses combined. According to the National Association of Social Workers (NASW), clinically trained social workers make up 60% of mental health professionals, while 10% are psychiatrists and 23% are psychologists (National Association of Social Workers 2014). Nearly every social worker practicing with youth has worked with a medicated child or adolescent (Moses & Kirk, 2006). Clinical social workers interact with medicated youth in myriad ways: they provide psychoeducation, monitor of side effects, adherence and effectiveness and collaborator with physicians (Moses & Kirk, 2006). Patients frequently discuss thoughts and feelings about their medication with social workers. Within the field there have been sharp differences of opinion about the proper role of social workers in the treatment of youth who take psychotropic medications; these varied views will be discussed in the next sections.

Social Workers and Drug Treatment

Overall, social workers' general attitudes toward drug treatment have shifted over time (Moses and Kirk, 2006). Early social work literature from the 1970s and 80s was focused on adult clients and held "suspicious and negative" views of psychotropic medication treatment (Moses & Kirk, 2006). Historically, social work perceived the "medical model" as apolitical,

decontextualized, and deficit-oriented—focusing on "fixing" the individual. This literature tended to focus on adverse effects of psychopharmacology and about possible drug misuse resulting from inadequate assessment, overmedication, and infringement on patients' rights (Moses & Kirk, 2006).

Moses and Kirk (2006) found that more recent studies examining social workers' attitudes towards drug treatment have identified a shift to a more positive or favorable view. Social workers seem to subscribe, at least to some extent, to the medical model and support as well as facilitate the use of drug treatment for adults with mental illness (Moses & Kirk, 2006). The adoption of evidence-based practice in social work academe and dramatic rise in the use of psychiatric medications may have contributed to this shift in perspective (Adams et al. 2009; Moses & Kirk, 2008). Social workers in psychiatric settings have more exposure to interdisciplinary views, medical training, and psychopharmacology, which may also positively influence their views (Moses & Kirk, 2008).

Literature has also explored the evolution of social work ethical principles upon attitudes toward drugs (Moses & Kirk, 2006). For example, some have interpreted the value of "self-determination" as the right to refuse medication while those who at times believe in medicating clients without their consent turn to the value of "beneficence." While the latter example tends to deal with more acute mental illness than ADHD, it illustrates a tension around the trend to incorporate the medical model into social work. Opponents the medical model view it as de-contextualized of socioeconomic and political factors as well as pathologizing in its over-simplification and reductionist interpretation of human problems. These critics tend to see prescription drugs as an extension of it and thus potentially coercive and controlling of clients (Cohen & Leo, 2002). The medicalization of social work also brings up widely contentious

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issues of "professionalization" of the field as a whole (Adams et al., 2009) in which opponents view drug treatment practices as a compromise of values in exchange for acceptance into the medical field (Cohen & Leo, 2002). Particularly pertinent to psychostimulants, Moses and Kirk (2006) found that social workers felt it was unethical to reject a drug when its efficacy has been "substantively" demonstrated.

Along these lines, recent social work literature encourages clinicians to become better educated and assume more active roles to promote better psychopharmacological treatment for clients (Moses & Kirk, 2006) (Bentley, Walsh, & Farmer, 2005). Moses and Kirk (2006) found that social workers, sensing these "mixed messages," commonly struggle with ethical and professional dilemmas surrounding psychiatric drug use. A 2003 study by Walsh, Farmer, Floyd-Taylor et al. reported that more than 60% of sample social workers experience at least two types of ethical dilemmas about clients' drug treatment per month. Many of these dilemmas stemmed from conflicting values (for example, humanistic versus functionalist), role confusion, and lack of confidence in one's ability or knowledge in the area of medication treatment (Walsh et al. 2003).

Despite the literature that calls for expanded roles, only one national study empirically attempts to address what social workers actually do in daily practice with respect to psychiatric medication. A 2001 national survey examined specific social work practice roles and activities (and their frequency) that relate in some way to psychiatric medicine Bentley, Walsh, & Farmer, 2005). Bentley et. al (2005) asserted,

> If clinical social workers are to embrace expanded opportunities for enhancing
> interdisciplinary collaboration and serving clients more responsively with regard

to medication-related issues, then they must start with a more accurate

understanding and appreciation of their firsthand experiences. (p. 295-296)

To that end, Bentley et al. (2005) also measured the extent to which social workers experienced

these roles and activities as "appropriate" and themselves as "competent in carrying them out."

Social workers' perceived self-competence and appropriateness were positively associated with

frequency of roles performed, such as discussing with a client his or her feelings about taking

medication (80% frequency, 91% competence, 96% appropriate); helping a client consider the

'pros' and 'cons' of taking medication (52% frequency, 68% competence, 76% appropriate); and

suggesting to a physician that s/he adjust client's medication dosage (15% frequency, 33%

competent, 46% appropriate) (Bentley et al. 2005).   Based on qualitative pieces of the written

survey, the authors categorized social workers' roles in drug treatment with youth in five major

categories: "monitor," "physician's assistant," "advocate," "educator" and "collaborator*"*

(Bentley et al. 2005). Three clear themes emerged from Bentley et al.'s (2005) content analysis

regarding desired changes in standard practice. These include 1) more thorough and in-depth

education for social workers about psychiatric medication; 2) more extensive interaction with the

medical community; 3) and better definition of appropriate role of social work regarding

psychiatric medication.

In addition to Bentley et al.'s look at roles, one other related national study examined

social workers attitudes toward psychiatric medication. Moses and Kirk (2006) associated social

workers' views about psychotropic drugs with several personal and professional factors

including the primary theoretical framework, context of treatment setting, and the nature or

severity of the targeted behavioral problem. Walsh et al. (2003) found that women experienced

ethical dilemmas with regard to the drug treatment of adults more frequently than did men and

were much more bothered by ethical struggles than were men. Social workers from the Moses and Kirk (2006) study who perceived benefits from medication to treat youth were more likely to be male, have more direct clinical experience, practice in school social work with a proportion of medicated clients, report having received some training or education in psychopharmacology and to rate themselves as more knowledgeable about psychopharmacology. Study participants who perceived the opposite, more harm, tended to be older social workers with less post-MSW experience who did not report consulting with physicians as a means of education in psychopharmacology, who had an existential-humanistic orientation, who had a caseload with a lower proportion of medicated clients, and who rated themselves as less knowledgeable about psychotropic medications.

Social Workers' and Drug Treatment for Youth

If social workers' current views toward psychopharmacological treatment with adults are somewhat unclear, there is even less information about their attitudes toward drug treatment with youth (Moses & Kirk, 2006). One exception is Johnson, Renaud and Schmit's (1998) study which found that social workers are very much divided on this issue: slightly more than half of social workers in their study disagreed or strong disagreed with the statement "For many psychological disorders in children and adolescents medication is necessary." However, more than two-thirds agreed that drugs are "often helpful" in treating children with mental illness. In other words, some believe medication is helpful but not necessary; others believe that it is neither necessary nor helpful; and still others agree that medication may be both helpful and necessary (Johnson et al. 1998). In addition, Johnson et al. (1998) found that the treatment setting was a particularly influential factor for how social workers treated young people. Social workers who viewed medication as helpful were more likely to be working in a child mental health inpatient

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setting than in a school social work, family and children's outpatient services, criminal justice or health care setting. Implications from Johnson's study are that inpatient social workers may be more aligned with the medical model than outpatient social workers (Johnson et al. 1998).

Moses and Kirk's (2006) cross-sectional survey of a national sample examined social workers attitudes toward medication in the treatment of youths. The authors measured attitude because they assumed it might shape clinicians' communication, behavior, and ultimately, treatment outcomes (Moses & Kirk, 2006). Their findings suggest that social workers "hold complex views that recognize both the potential benefits and harms of psychotropic medications, but overall they seem to support their use in a judicious manner" (Moses & Kirk, 2006, p. 211). The study reported that the majority of sample clinical social workers agreed that medication is often used as a substitute for other treatments and that replying on psychotropic treatment offers an easy distraction from the broader social problems occurring in our society. A substantial proportion agreed that medication is often prescribed to youths when the underlying problem is parental inadequacy. Nevertheless, the vast majority disagreed that the primary motivation for prescribing medication was for the purpose of "control." Moreover, most disagreed that providing medication sent the "wrong message" to youths or that psychotropic drugs tended to exacerbate young clients' psychosocial disturbances (Moses & Kirk, 2006).

Even social workers who perceived medication as necessary or helpful may not identify medication as sufficient or the most effective way of dealing with behavioral problems (Moses & Kirk, 2006). For example, 81% of Moses & Kirk's (2006) survey participants believed that medication was a "necessary" component of treatment for "many disorders," while only 9% agreed that it was the most effective way of getting young people's "behavior" under control. As discussed earlier in this Chapter, scientific literature embraces the use of stimulant medication to

"manage" ADHD symptoms in children and adolescents called "problem behaviors" (Parent Medication Guide, 2013). Thus, although Moses and Kirk (2006) do not address social workers' views specifically toward stimulant medication, their findings would suggest that social workers might be especially ambivalent about its use insofar as it directly aims to "manage behaviors" associated with ADHD.

To date, no studies have examined social workers' roles regarding ADHD medication, however, one peer-reviewed study has examined social workers' attitudes around medication to treat ADHD in youth. A 2002 survey of 440 British social workers' knowledge and perceptions about ADHD reported over a third of participants were "unsure" about the appropriateness of treatment with stimulant medication, while the large majority felt that psychosocial interventions involving the family (parent guidance, parent training, family therapy, social skills training) were appropriate (Pentecost & Wood, 2002). In terms of factors associated with those attitudes, Pentecost and Wood (2002) asserted that professional experience (6-10 years and 10+ years) was more positively correlated to knowledge about ADHD and openness to a range of interventions than those with 1-5 years' experience. However, experience or expertise was not necessarily associated with perceptions about medication for ADHD.   In addition, women, tended to be less likely than male participants to endorse stimulant medication for ADHD and more likely to support the alternative treatments described above (Pentecost & Wood, 2002).

In light of the literature, social workers indeed make particular meaning out of the role within the process of work with youth who take medication to treat ADHD, which is as of yet untapped in the literature.

Summary

      The empirical literature since 2005 indicates that little has been done to examine the status of the changes to standard practice that social workers desired at least a decade ago (Bentley et al. 2005). In particular, little has been done either internally or in collaboration with medical associations to more clearly and formally define the appropriate roles of social workers working with children who take psychiatric medication. This chapter contextualized ADHD, its prevalence, and current treatment options for children diagnosed with ADHD with particular attention to the benefits and risks associated with psychostimulant meditation. In contextualizing ADHD, this chapter has captured the "first wave" of early controversies around its validity as a diagnosis, as well as some of the most recent literature about ADHD published by allied mental health professionals suggesting a "second wave" of critique may be bourgeoning in connection with new understandings of the possible effects of trauma on children (Watson, 2013; Fuller-Thompson et al., 2014). It also justified the relationship between clinical social workers and the population at hand, reviewing the literature examining social workers roles and attitudes toward psychiatric medication with youth (Bentley et al., 2005) (Moses & Kirk, 2008), as well as their knowledge and attitudes toward medicating ADHD (Pentecost & Wood, 2002). However, to date, no studies have examined social workers' roles regarding ADHD medication specifically. This study seeks to address this gap in the current social work literature and to determine where in this debate the field currently stands.

CHAPTER III

Methodology

Research Purpose and Question

This purpose of the study is to understand how, in light of medication, social workers understand their role in treating youth diagnosed with ADHD. The overarching research question asks how social workers understand their roles in the treatment of youth who take medication typically prescribed to treat ADHD. From this study I hoped to glean the particular ways clinicians interact with clients regarding medication during treatment, the important themes that surrounding their experiences, and provide a framework to guide clinical social work education with this nuanced yet sizable client population.

Design

To answer the research question I conducted a qualitative method of inquiry in order to gather rich data and highlight factors that might not have been captured from a quantitative approach. Consistent with the principles of inductive research I made no formal assumption about the actual nature of the relationship between clinical social workers and a particular psychotropic intervention used for children. It is important that participants' voices remained central because this is the first study to qualitatively examine this issue with the potential to generate new theory and potential areas for research not previously identified in the literature.

As discussed in the literature review, there is a gap in the literature that addresses both the actual and perceived role of social workers in treating children with ADHD alongside a psychotropic intervention. Yet social workers' make up more than half of mental health professionals in the country, suggesting that they may interact with upwards of half of children receiving treatment for ADHD, especially in settings that require therapy in order to receive psychiatric services. Therefore the study served as a platform to highlight a broader question about how clinicians manage (and what they feel is at stake) when their role (vis-à-vis drug treatment for youth) is not clearly defined.

I conducted a combination of twelve, one-hour in-person and telephone interviews with participants, depending upon geographic location, using a semi-structured interview guide with open-ended questions. My methodological choice to conduct personal interviews was informed by a national survey of social workers' attitudes toward drug treatment for youth conducted in 2001 with a written instrument. In that survey, the authors reported that their "preliminary inquiries" with individuals from social work and allied fields were met with enthusiastic responses—suggesting the need for further personal research (Bentley, et al. 2005). I audio recorded interviews and completely transcribed them with the help of a transcription service for analysis of content-themes to help illuminate patterns in the data. I analyzed the data for themes and patterns using manual coding, a process described in greater detail below. Finally, I created a pictorial representation of the themes as a "framework" in order to succinctly translate the research findings to a wide audience of practitioners.

For this study I operationalized the term ADHD medication using the two broad categories (stimulants and non-stimulants) and subcategories within each category (class, trade

name and generic name) approved by the United States Food and Drug Administration (FDA) and outlined them in the following figure.

Table 3:1

Operationalized definition of ADHD Medication

Stimulants		
Class	**Trade Name**	**Generic Name**
Amphetamines	Adderall	mixed amphetamine salts
	Adderall XR	extended release mixed amphetamine salts
	Dexedrine	dextroamphetamine
	Dexedrine Spansule	dextroamphetamine
	Vyvanse	Lisdexamfetamine (extended release)
Methylphenidate (MPH)	Concerta	methylphenidate
	Daytrana	methylphenidate (patch)
	Focalin	dexmethylphenidate
	Focalin XR	extended release dexmethylphenidate
	Metadate ER	extended release methylphenidate
	Metadate CD	extended release methylphenidate
	Methylin	methylphenidate hydrochloride (liquid & chewable tablets)
	Quillivant XR	extended release methylphenidate (liquid)
	Ritalin	methylphenidate
	Ritalin LA	extended release methylphenidate
	Ritalin SR	extended release methylphenidate
Non-stimulants		
Class	**Trade Name**	**Generic Name**
Norepinephrine Uptake Inhibitor	Strattera	Atomoxetine
Alpha Adrenergic Agents	Intuniv	extended release guanfacine
	Kapvay	extended release clonidine

Sample

The sample universe for my study topic was licensed, masters-level social workers in the United States who work with children prescribed medication to treat ADHD. The sample

population for my study included clinical social workers who either received an email with my recruitment letter or a personal telephone call regarding my study. Recruitment is discussed in greater detail in the next session of this chapter. For this study I interviewed 11 Licensed Clinical Social Workers (LCSW) and 1 Licensed Social Worker (LCW) who either currently work with at least one child prescribed medication to treat ADHD and/or have worked with at least 5 such children in the past three years. Findings related to the demographic data are discussed in the following chapter.

The study criteria unfortunately may have excluded a number of exceedingly experienced social workers. Professional licensing, which ranges from state to state, raised a two-fold potential limitation of the study criteria. In several states including North Dakota, where two potential participants with several years of professional experience contacted me, bachelors in social workers (BSW) are eligible for licensure (LSW) and thus qualified to work in schools. Nonetheless, the scope of allowable practice with a BSW degree was too comparatively limited to a MSW degree for it to have made sense to broaden the study to include these two school-based social workers at the Bismark School District. A second issue emerged around class: the prohibitive (and in some states, unnecessary) cost of both a master's education as well as the supervision for which many now pay out-of-pocket because clinical positions no longer provide enough supervision for accrued hours to count toward licensure (LCSW). I grappled with this issue regarding one participant with a master's level LSW with relevant experience but no plans to pursue her clinical license (LCSW) because supervision through the outpatient setting where she worked did not meet the state's licensure requirements. The fact that she was also a clinician of color became relevant to her not meeting this aspect of the criteria because only 14% of all licensed social workers (LSW) in the United States are people of color, less racially and

ethnically diverse than the U.S. population as whole (NASW, 2006). A recent study reported that White social workers were most likely to be certified in clinical social work (48%) and independent practice (24%), while African American social workers were least likely (42% and 11%, respectively) (NASW, 2006).

Thus, licensure raises issues of both class and race. While the clinical license addresses a well-documented desire among some to "professionalize" or legitimize social work within the health care field, in the case of my study and perhaps many others, it might have sacrificed a highly valuable perspective on the topic especially as it relates to children of color. Ultimately, I decided to include her in my study precisely because she illuminates this otherwise taboo issue in the field tied to dynamics of race- and class-based oppression.

Several LCSWs who contacted me with interest in participating in the study did not qualify because their experience working with medicated children with ADHD was not in the last three years. This reveals two potential weaknesses in the criteria: the potentially arbitrary eligibility requirement to have worked with five such children in the past 3 years. This may have led to turning away the important voices of those LCSWs who may have retired, transitioned away from clinical work, or transitioned to a full-time supervisory role in the last five years. Several of these people contacted me who believed themselves abreast of changes in the guidelines for the treatment of ADHD (for example, changes to the DSM, managed care, etc.). Nonetheless, by relying on a standard procedure the inclusion criteria ensured that participants had working knowledge of the current treatment landscape, which those who it excluded might not have been able to offer.

Another potential limitation of my criteria was inconsistency of interview style. Initially, I strived to recruit within the Philadelphia region in order to conduct face-to-face interviews. I

saw that in-person interviews offered advantages that telephone interviews could not; for example, many clinicians felt more comfortable talking in a space that reinforces their professional identity and expertise. Ultimately, to recruit a sufficient number of participants, I broadened my recruitment effort geographically and in those cases relied on phone interviews. The tradeoff of potential opportunities lost without local, face-to-face interviews may have been made up by extending my sample to a larger area to enhance the other dimensions named above. As discussed in detail in the Findings Chapter later in this paper, even within the same region participants' demographics varied widely. Moreover a broad sample still addressed the unique situation in the United States with regard to ADHD prevalence, discussed in the literature review, which far exceeds worldwide estimates.

Recruitment

I used snowball sampling methods to obtain a convenience, non-probability sample. I recruited through a handful of key informants who were either licensed clinical social workers or worked closely with children who might take medication to treat ADHD in an allied profession (a psychologist, a teacher). These key informants reached out to potential participants by sending the recruitment letter in an email to colleagues as well as and community members whom they believed might have access to additional participants.   Pennsylvania Society for Clinical Social Workers (PSCSW), Alumni of University of Pennsylvania SSP, and Philadelphia Society for Psychoanalytic Psychotherapists (PSPP) also distributed the study recruitment email over their listservs. The recruitment email detailed the criteria in three prongs so that participants could quickly assess whether they were eligible for the study. I recruited 15 participants, 12 of whom followed through with returning the consent forms and participating in the study. All of the social workers in the study have a master's degree in social work (MSW)

with either LCSW (n=11) or LSW (n=1) credentials and self-selected, meaning they freely consented to participate in the study.

Once participants learned about the study they contacted me through my confidential Smith College email address or my personal cell phone number listed on the recruitment email (Appendix A). In my initial email response to participants I attached a digital copy of the consent form and asked them to take part in a brief screening phone call (less than 10 minutes) to doubly ensure their eligibility, review the consent form and demographics form, and expedite scheduling of the interview itself. Participants were asked to sign the consent form at the interview and offered a copy to keep for their records. I asked participants of telephone interviews for an address to send a hard copy of the informed consent form (and in some cases, for those who requested it, a hard copy of the demographics form) with a self-addressed stamped envelope and instructions to sign and date it, make a copy for their record if they wished, and return it (along with the demographics form, when applicable) in the envelope.

Ethics and Safeguards

Three major ethical concerns arose during the design of this study: consent, confidentiality, and the potential for researcher bias. To address these ethical concerns I built several safeguards into the study design and carried them out throughout recruitment, data collection, analysis, and reporting. These safeguards are outlined in the following paragraphs.

While medicating youth and to some extent ADHD itself can be controversial and raise anxieties, the study's risk of harming participants was relatively benign. The demographics form reflected an effort to be sensitive to discomfort that even basic identifying questions could raise potentially for some participants. Thus, it made for better rapport and saved time during the interview. Given that participants were clinical social work professionals, it was reasonable to

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assume that they knew how to access support about personal or professional issues that arose from the study. Participants identified themselves as "experienced" with these issues therefore rather than assume that they wanted or needed resources upon request I provided a resource sheet with training opportunities for ADHD.

    Potential for researcher bias. Snowball sampling establishes the possibility that the researcher and potential participant are acquainted, and although I targeted two participants, there was no relationship between us that might have led to the appearance of coercion. To ensure that these participants in particular represented their own views and were not influenced by mine, as we were acquainted, I took care not to speak them about the study and/or share potential bias. At the same time, Engel and Schutt explain that the informed consent standard "cannot be met in a meaningful way if researchers do not disclose fully their identify." (Engel & Schutt, 2013). Thus, when participants directly asked how I became interested or why I chose to pursue this particular topic, I tried to reply to these requests in the spirit of qualitative research "lessening the boundary between 'researcher' and 'research subject'" (Engel & Schutt, 2013). I might have said something to the effect of "after the interview, your time permitting, I would be glad to share my story. I want to make sure that my experience does not to influence your responses." At that point I shared that I was an Outpatient Therapist intern at a mental health clinic serving low-income children and families where most of my caseload was diagnosed with and prescribed medication to treat ADHD. I shared that I often felt confused about my roles with these clients in light of literature touting medication as the "most effective" treatment, and wondered whether dynamics of oppression might be involved in certain of my, perhaps implicit, medication management roles. Furthermore, neither clinicians at the clinic nor the social work literature seemed to mirror my discomfort. This dissonance gave me the impression that this

debate was either "settled" or that it was taboo—perhaps part of a nascent second wave of critique—and I was interested to find out from the source.

That I could actually influence my participants—experienced professionals many in practice for upwards of three decades—felt presumptuous at times, but protected my study from incurring bias. I chose not to disclose that I do not have a person history of ADHD diagnosis or psychotropic medication because it did not feel relevant or necessary. The potential for participant bias based on a personal history of ADHD and medication to treat it will be discussed in the findings section.

All participants read and signed informed consent forms approved by Smith College School for Social Work (Appendix B) before participating in the study. I reviewed the informed consent on multiple occasions (email correspondences, the screening call, etc.) with all participants, including reminders that I would be audio recording interviews, that they could refuse to answer any questions felt to be uncomfortable and that they could drop out even after the interview up until April 30th. Before beginning the interview itself I invited any questions, and verified whether they were ready to proceed.

To address issues of confidentiality, I kept all research materials including the demographics sheets, key code, consent forms, transcriptions, digital recordings of interviews (only until transcribed), and written notes stored in a secure location during the thesis process and for three years after, as per federal regulations. In the event that materials are needed beyond the three-year period, they will be kept secured until no longer needed, and then destroyed. Any digital copies of transcriptions will be saved on a password-protected computer in the above-mentioned secure location.

During data analysis I used a key code to de-identify all study participants and protect their confidentiality during the reporting process. I assigned every participant a number (01-12) using his/her original signed consent form, which was kept separate from all other printed materials. This number solely identified all subsequent digital and hard copies during the reporting process as well as for the label of audio files stored on electronic devices. In addition, audio files were password protected.

The researcher alone had access to the audio recording of the interview, with the exception of a transcriber, who signed a confidentiality agreement (Appendix F). Immediately following transcription, interviews were permanently deleted from the recording devices.

I collected limited demographic data, but used this data only to describe the sample in the aggregate. Given that this was a qualitative study and a small sample I used caution when comparing certain responses based on demographics. I did not connect the demographic data to specific study participants consistent with maintaining participant confidentiality. In this report quotes from participants are used to illustrate the research findings, but these quotes are not connected to the demographic data and are assigned a number, e.g. "Participant 4."

Participants may have benefited from participation in this study in many ways. First, it afforded them the opportunity to explore the complexities of their role in a confidential environment. Participants may also have gained satisfaction knowing that their perspectives benefited research aimed at better supporting children and families. Finally, the summary of the study results may have normalized or validated participants' experiences, or offered them ideas on new ways of navigating struggles in working with this client population.

Data Collection

In this research study I used semi-structured, in-depth interviews to collect qualitative data about how social workers understand their clinical role with children who also take medication to treat ADHD from January 2015 to March 2015. Five interviews were conducted in-person and 7 were conducted over the phone. For in-person interviews, participants were afforded the choice of any public, quiet location, and most chose their office. Three of the 5 in-person interviewees chose their professional office, a setting that I felt helped established intimacy and connection to the topic: it allowed participants to pull up computer files or books off their shelves when they wanted to remember something, demonstrate play techniques, etc. The other two in-person interviews did not have this privilege because we met outside their workday when their office was not accessible; potential ramifications of the date/time the interview took placed are discussed below. The interviews were audio recorded for transcription and qualitative analysis. The data was analyzed using manual coding; a process described more in depth in the following section.

Participant interviews lasted around 60 minutes in length, though a few lasted up to 75 or 90 minutes. In the interest of quality disclosure of factors that may have influenced the data (how they respond to either ADHD and/or medicating youth), I collected demographic data (Appendix C) prior to the start of the interview via a form that included both general and targeted personal information including participant current age, race, gender, class, professional and personal history with respect to ADHD and medication to treat it – including their children, if applicable. The interview guide (Appendix B) was divided into themes: Social Worker Views of ADHD: Causes and Appropriate Treatment Strategies, which included two questions; How Social Workers Navigate the Current Treatment Culture, which included four questions; and

Challenges to the Work, which included four questions. Several questions contained multiple parts and some were considered miracle questions that began with the phrase, "In an ideal world…" Given that the interview may have interrupted participants from their daily activities, it began with a question about how they came to be involved in the treatment of children with ADHD in order to help them "warm up" and focus-in on the topic.

To try and ensure validity of my research, I relied on bracketing, a method used to "mitigate the potentially deleterious effects of preconceptions" that may taint the qualitative research process (Tufford, 2011). My "preliminary jottings" consisted of any preliminary words or phrases for future codes, collected in a field notebook or noted as I transcribe interviews (in margins or bolding) (Saldaña, 2009). This included immediate impressions during the interviews as well as reflections following the interviews.

Data Analysis

The interview was audio recorded, transcribed, and then reviewed and coded according to the conventions of thematic analysis. At the beginning cycle of data analysis and discovery, I used specific coding methods aimed to "explore such phenomenon as participant process, emotions, and values" (Saldaña, 2009). The field notebook in which I recorded jottings and other impressions were also subject to thematic analysis. Given the scale, funds and time available, I used manual coding as opposed to electronic CAQDAS coding programs. Saldaña suggested that for first-time or small-scale studies, manual coding allows "more control over and ownership of the work" (Saldaña, 2009). Themes, "outcomes of coding, categorization, and analytic reflection" (Saldaña, 2009), were written about in aggregate or disguised to further protect the identity of individual participants. The researcher strived toward Saldaña's seven "necessary personal attributes for coding" including being organized, dealing with ambiguity,

and exercising perseverance, flexibility, creativity, and rigorous ethical standards (Saldaña, 2009).

CHAPTER IV

Findings

The purpose of this research project is to explore how social workers understand their role in the treatment children who take ADHD medication. This chapter outlines the findings of this exploratory, qualitative study based on 12 interviews with LCSWs who either currently work with at least three such children or five in the past three years such and explores these findings related to the research question.

The data presented in this chapter was collected through in-person and telephone interviews that were fully transcribed and then analyzed using manual coding. The interview was centered on three broad areas of inquiry, with several questions for each area of inquiry. The areas of inquiry were: social worker views of ADHD (causes and appropriate treatment strategies); how social workers navigate the current treatment culture; challenges to the work with this population. Demographic data were also collected during interviews.

Four main themes emerged from the data during analysis, each theme encompassing several subthemes. This section will explain and describe the four main themes and their respective subthemes using examples from the interviews in the service of maintaining fidelity to the participants' voices. The four main themes this section describes are: *Clinical Setting, Teasing Out ADHD: Issues in Assessor and Diagnostic Roles, Roles Regarding Medication*, and *Various Treatment Approaches*. This study also generated some themes that were not related to

the research question about social workers' role with this population. This section will focus specifically on reporting themes related to the research question. Themes not related to the research question will be discussed in the following chapter. This chapter begins with an explanation of the demographic findings.

Demographic Data

A total of 12 individuals participated, 5 in in-person interviews, 7 in telephone interviews and 83% (n=10) answered all demographic questions. One participant declined to answer certain demographics questions related to their own children and one participant failed to return the demographics form entirely. Eighty-three percent (n=10) of study participants identified as white and the remaining 17% (n=2) identified as people of color (1 African American and 1 Afro-Caribbean Garifunas). Eleven out of 12 participants identified as female, and the one remaining participant identified as male.

At the time of the interview, the participants' age ranged from 31 to 64. The average current age for participants was 52.5, with a median age of 60 and a mode age of 62. That is, the majority of participants were in their fifties and sixties. Eleven out of 12 participants resided in the Northeast United States (3 in New England, 8 in the Mid-Atlantic), and 1 participant resides in the South Atlantic United States. Consistent with national statistics of LCSWs, all who indicated their class status on the demographics form defined it as "middle," "upper-middle," or "professional." Ninety-two percent (n=11) held the LCSW title while the remaining participant was a Master's-level LSW. Those 11 participants had licensure as a clinical social worker for an average of 19.9 years. Further discussion of the implications of this sample bias can be found in the following chapter.

The participants practiced in a variety of outpatient settings including private practice,

independent and charter schools, community-based mental health clinics as well as government agencies. Thirty-three percent (n=4) of participants worked only in private practice, 42% (n=5) worked only in agency or school settings, and 25% (n=3) of participants worked in both a school or agency setting *and* conducted a private practice. For the remainder of this paper, the first cohort will be referred to as private practice clinicians and the second cohort as agency clinicians and those that overlap will be weaved in where most appropriate. In the interview participants were asked to identify factors that have influenced their practice with this population. Their responses fell into three broad categories: personal experience, professional experience, and personal interest. Twenty-five percent (n=3) fell into the first category and disclosed either personal or family history of ADHD. Seventy-five percent (n=9) fell into the second category, referring to knowledge accumulated over time within the field. Finally, several participants from both of the first two groups also identified obtaining influential information largely out of personal interest through graduate, post-graduate and/or ongoing learning opportunities such as fellowships, trainings, workshops, conferences, supervision groups, professional affiliations and list serves.. These participants said they pursued this interest for its own sake and it was something they "enjoyed." Although there was no direct inquiry into the participants' potential theoretical orientation or background, several participants (n=3) identified a "Family Systems" and other broad, generalist social worker perspectives not specific to their work with this particular population but whose values possibly influenced it nonetheless.

In the following sections outlining the four main themes and their respective subthemes, all participants are referred to by the number in which they were interviewed to protect confidentiality.

Clinical Setting

The clinical setting in which participants worked varied so widely in its implication on how participants understood the actual roles that they fulfilled within those settings (discussed below) that it merits its own discussion. The clinical setting then highlighted the disparate ways that race and class manifest within the broader query. First, clinicians in private practice tended to work with predominantly white children from middle to upper class families, while clinicians in outpatient and public and charter school settings tended to see racially and ethnically diverse children from lower-income families. It became clear that these children, typically on Medicaid or public insurance, were almost never eligible to see LCSWs in private practice because their families could not afford out-of-network rates. Participants commonly reported that their agencies assigned clients with public insurance to graduate student interns while their supervisors, typically more senior, experienced clinicians, were designated to serve clients with private insurance. By contrast, children whose families could afford private insurance or out-of-network rates typically saw more experienced, less burdened clinicians in private practice. This seldom discussed phenomenon in discourses around medicating children as well as social work as a field has potential major implications in the quality of their assessment and treatment will be discussed in greater detail in the following sections of this chapter.

The relative privilege of the client population in the private practice (or affluent school) setting allowed those clinicians a more prominent role in assessing ADHD than their counterparts in settings with managed care constraints. Referrals to boutique referral services, a role that only private practice clinicians described, illustrated an example of one such inequitable contrast within the clinical setting. These referrals included services such as psychiatric and neurological evaluation, psychological testing for learning disabilities, occupational therapy for

sensory integration assessment, genetic testing, and naturopathic doctors. For families of children amenable to holistic approaches to assessing (and treating) ADHD symptoms, private practice clinicians reported making referrals for nutritionists, yoga, and other organized physical activities. These referrals often aimed to rule out several potential diagnoses other than ADHD (which will be highlighted in the next theme) and to avoid preemptively medicating children. In contrast, participants in agency settings rarely described such a complex and extensive referral process perhaps because low-income parents and guardians could not afford out-of-network services for their children.   Participant 2 shared her perspective of the cultural context in which diagnosis occurs in her fee-for-service community-based setting.

> [Diagnosis] happens in a context in which African Americans, specifically African American males, are diagnosed from a young age and labeled as having "behavior disorders"…it gets into issues of poverty, and race, and class, and all that, which is so very political in this country and very loaded. So I think [diagnosing ADHD] occurs kind of in the backdrop of that larger system, larger context.

The requirement that clients must have a diagnosis to be eligible to receive care posed a dilemma for agency clinicians like Participant 2, who saw herself as complicit with a form of structural racism and class-based oppression. In addition, such policies were found to function as a potential barrier to fulfilling the full spectrum of possibility within their roles because agencies circumscribe, to varying degrees, what treatment of ADHD looks like and, perhaps less directly, what it is not. It was noted that in managed care settings participants were prohibited from making or changing a diagnosis without permission of a psychiatrist, who assumed ultimate legal responsibility for patient care. In addition, participants shared concerns about the accuracy of preliminary diagnoses made in agencies with time constrained intake assessments that could take

months to rectify in a formal psychiatric evaluation.

By contrast, the private practice setting empowered clinicians to use referrals and other interventions to maintain a stance of curiosity rather than certainty about diagnosis, which often manifested as lengthier, richer assessment phases in which psychiatric consultation was looked to as a "last resort" rather than standard procedure. Agency clinicians often shared this perspective about delaying medication but typically did not have such a robust role in assessment or diagnosis. Where private practice participants called the client's first visit with a psychiatrist a "consultation," the agency therapist had no part in the psychiatric evaluation was routine requirement. The role of referral making will be discussed in more depth in the theme *Various Treatment Approaches* below.

The clinical setting also impacted the reporting and documentation responsibilities that participants faced and that many believed affected their role in treatment insofar as more paperwork reduced their availability to clients and rate of burnout. The setting and its associated demands impacted the pace at which clinicians worked and how they conceptualized treatment. A clinician of over twenty years and currently in private practice, Participant 11 reported having less "paperwork" than in the agency where she used to practice.

> I don't have the burden of reams and reams and reams of paperwork because an
> agency requires it of me.

Even in-network private practice clinicians beholden to insurers expressed more sense of empowerment about their roles in the treatment than those in agency settings. Participant 4, a clinician trained in Family Systems who accepts insurance in her private practice, explained how she manages obligations to insurance companies,

> I know we have to write a treatment plan, but I'm writing the treatment plan for

the sake that it has to be done, but that's not how I work. I don't work according

to the treatment plan: I work according to the child and the parents and what I

think is needed at the time.

Unlike the rigid treatment plan formula beholden to agency clinicians, private practice clinicians

who did not accept insurance described loftier, less specific goals, such as helping a child be

aware of their own style of thinking and learning. In addition, the funding source of agency

settings were found to impact those clinicians' burden insofar as government funded agencies

required more extensive and tedious reports than privately funded agencies. This setting factor

may also have influenced their role in the work.

Overall, clinicians in private practice settings appeared to have more robust and

influential roles in assessing ADHD and talked less about the impact of external factors such as

race and class than their counterparts in agency settings.   Agency based clinicians, who tended

to serve more marginalized client populations, seemed to have less power in assessing and

diagnosing but more readily identified the impact of racism and class-based oppression on the

diagnostic picture (misdiagnosis and over-diagnosis) and problems in treating ADHD.

"Teasing Out ADHD:" Challenges in Assessor and Diagnostic Roles

All participants in the study described some role in assessing for and diagnosing ADHD

in this population. This section will highlight some of the unique challenges participants faced

while ruling out or "teasing out" ADHD from differential diagnoses as it was commonly referred

to during interviews. The process of teasing out ADHD was not straightforward but manifested

in different ways and to varying degrees based upon many factors including, for one, the clinical

setting already described. This section is broken down into subheadings to try and capture the

varied ways that participants teased out ADHD during early phases of treatment. The three main

subheadings I will discuss in this section are *co-occurring disorders, sleep,* and *trauma*.

      Co-occurring disorders. The co-occurring or co-morbid disorders clinicians identified alongside or as mimicking ADHD differed slightly according to clinical setting. In agency settings clinicians reported Oppositional Defiant Disorder (ODD), Disruptive Behavior Disorder (DBD) (renamed in the DSM-5), and Mood Disorder as common co-occurring disorders alongside ADHD. Clinicians who worked with clients with both ADHD and ODD diagnoses tended to perceive the latter as an ineffective diagnostic tool, in that it merely described very broad symptoms many of which clinicians believed were associated with trauma (see below). However, generally clinicians felt more seriously concerned with their clients' histories of co-occurring mood related symptoms. Participant 8, a clinical supervisor for a governmental agency that serves children in the foster care system, noted a trend in which the same very young children diagnosed with ADHD later get diagnosed with bipolar disorder as teenagers, suggesting they were initially misdiagnosed.

> I just think that [ADHD] is over-diagnosed, and I really do feel strongly that when I see kids, so many of them who have been diagnosed ADHD when they're younger, five, six years old, that's treated all those years [with medication], and now I see them being diagnosed as bipolar, I have to think that there is some kind of connection there, and that they were misdiagnosed from the get-go…Not enough was done to help them with either that anxiety or the depressive disorder that maybe the ADHD med made it worse.

Participant 8 highlighted the perception that settings serving children from low-income families tend to under-diagnose and under-treat anxiety and depression. Instead, she went on to report, their "irritability" is misinterpreted as ADHD. Also problematically, clinicians reported the

same children typically had a "history of trauma," and although settings are increasingly "trauma-informed" rarely is trauma the focus of treatment for ADHD when they do not also meet the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). This issue will be discussed in the subheading *trauma* below.

In contrast, anxiety and depression were the two *most common* diagnoses that private practice (and independent school) clinicians tended to tease out or notice co-occur in this population. Some clinicians cited Generalized Anxiety Disorder or Depression NOS whereas others understood them as "issues" rather than formal DSM diagnoses. In addition to anxiety and depression, a small but noteworthy number of participants reported that sensory integration issues (labeled as Sensory Processing Disorder in the DSM-5) frequently co-occurred or went undiagnosed in children with ADHD symptoms or diagnoses. Participant 4 describes what this looks like in practice,

> I see [ADHD] as a self-regulation issue, and all the things these kids are doing—if they're tapping, if they're talking, if they're spinning, if they're—whatever they're doing fits into the sensory integration. Some of these kids need de-pressure stimulation. Some of them they're literally bouncing off the couch and what that tells me is that that's a gross motor—they're seeking sensory input and if they can get the sensory input in a more organized fashion that's less haphazard sometimes these kids calm down. So yeah, I would encourage everyone to get some knowledge about sensory integration and have a more open mind to being inclusive of the whole child, not just attention deficit piece or the hyperactivity piece, because something's driving that, not just neuro-induced synapses not working properly.

Participant 4 described the sensory processing problem as possibly "driving" or creating the illusion of ADHD symptoms such as inattention and hyperactivity. She also critiqued the medical or neurobiological explanation of ADHD as shortsighted. Participant 6, the CEO of a unique organization serving mainly adopted and foster children, also described the importance of teasing out ADHD from sensory integration by, in her perception, locating the "stimuli."

> Do they have ADHD or do they have a sensory problem? Let's find out what those precipitants are, what their vulnerability factors are that make them fidgety little kids. Is it the crowd, is it the hot, is it the cold, is it the hunger, is it the thirst? What is it? I don't know what it is for every kid, but I damn sure find out before I say 'he has something.' And if it's a sensory issue then treat the sensory system because you can give a kid – you can take a heavy pillow, a weighted pillow, you can heat it up and that warmth and that weight calms their system right down and their able to focus. Is that ADHD or is that sensory based? It's sensory based, because if it's ADHD, you're still going to be not able to focus. It has nothing to do with how your body is feeling. It's an internal stimuli.

Participant 6 illustrates how consideration for the context and triggers (whether the child may be hot, cold, hungry, thirsty) of the child's symptoms is an important role embedded within her larger role assessing ADHD. She uses the warm, weighted pillow as a creative diagnostic tool to assess whether the child's hyperactive or "fidgety" symptoms emanate from "internal stimuli" thought to characterize ADHD or external stimuli that would suggest problems regulating/responding to sensory stimuli (touch, sound, movement, etc.). Thus she suggests that ADHD diagnostic criteria alone are not sufficient to make the diagnosis because other issues, here sensory ones, could have overlapping symptoms.

The perceived limitations in the field's current understanding of ADHD and its symptoms drove many clinicians to question the validity of the diagnosis. They critiqued the DSM-5 diagnostic criteria as vague and "catch-all." Participant 4 described ADHD as

> this catch-all thing, like Pervasive Developmental Disorder: you don't exactly
> know what's going on, [so] we'll throw it in this category. I just don't think we
> know enough.

Participant 7, a senior clinician in an elite, independent school for children with reading difficulties with a small private practice, reiterated the "catch-all" perception of ADHD,

> I feel like [ADHD and ODD] are catch-all labels that are not particular helpful to
> clinicians to know *how* to work with it, which is what I teach my graduate
> students. You have to use those terms, but you can't buy into them. You have to,
> sort of, look *beyond* them.

In the face of insufficient or inconclusive medical understanding of ADHD Participant 4 maintains "openness" to nuances not captured in the DSM.

> I think the DSM-V likely falls short and I think that as a profession we need to
> expand our…openness. We need to be more open to understanding that ADHD
> encompasses not just attention, not just hyperactivity, but 'where and why are
> those [symptoms] coming from and why is this happening?'

However, not all participants took issue with the diagnostic criteria or DSM understanding of ADHD. For example, Participant 12, a clinician in a private, independent school, explained that the factors influencing ADHD diagnosis was consistent with her understanding,

> I don't see the DSM saying that [ADHD] is caused by any one thing, so that's

consistent. The way the DSM presents it, of course, influences how I assess for it.

Learning disabilities were another major co-occurring issue that clinicians struggled to tease out in assessing ADHD. Complicating their role, many clinicians reported that their clients had an (IEP) on the basis of a learning disorder rather than ADHD which, as discussed in the Literature Review, typically did not typically qualify a child on its own. Participant 6 discussed the importance of psychological testing to rule out both learning disabilities and executive functioning difficulties from ADHD.

> So we make sure the kid gets tested and see what we're looking at as executive
> functioning [and] what we're looking at as learning disabilities that are causing
> the kid to look like they have ADHD. [Is it] their executive functioning, is it
> expressive?

Participant 4 reiterated her perception that ADHD, learning disabilities and sensory integration issues frequently co-occur.

> I don't think that [ADHD] is inclusive and it doesn't exist in a vacuum, and I
> would urge any clinician to find a child who has just ADHD because it's usually
> in threes: you've got ADHD, a learning disability, and sensory integration. And if
> you don't have all three of those, then there are other nuances.

In addition to executive functioning, Participant 6 also addressed the importance of testing for expressive and receptive language disorders in relation to her role in teasing out ADHD.

> A lot of times you have kids with expressive or receptive language disorders and
> because it takes them a while to process and they don't understand what's coming
> in or they can't find the words to get what's going out, they get misdiagnosed.
> "They can't pay attention." Well, it's not that they can't pay attention; they don't

understand what's coming in and they can't find the words to tell you that. If you give them speech and language services then they'll be able to understand your world and they'll be able to function.

Here she suggested another way symptoms of inattention have the potential to mask expressive or receptive language disorders. She also highlighted the ambiguity of the diagnostic criteria (how a child "pays attention") can easily obscure the need for, in this case, speech and language services, and lead to misdiagnosis.

In sum, clinicians identified anxiety, depression, ODD, Mood disorders, sensory integration, learning disabilities and language disorders as the most common diagnostic issues either co-occurring or untreated alongside ADHD.

Sleep. In assessing for ADHD, clinicians reported a role in helping children with ADHD symptoms and their families understand the importance of and improve "sleep hygiene," or sleep habits. For example, Participant 7, senior clinician at a private, independent school for children grades 1-8 who learn differently, discussed symptoms of sleep deprivation as critical to tease out from symptoms of ADHD.

We now know (it's so clear in the literature) how much sleep deprivation creates symptoms that mimic what they call ADHD. So one of the things that I've been doing in the last 10 years has been spending a lot more time talking to people about sleep hygiene and sleep behavior as part of the diagnostic understanding and workup.

Similarly, Participant 8 shared her perception that parents often fail to understand the importance of their children's sleep, which could potentially mitigate what otherwise appear to be ADHD symptoms.

> I don't think [parents] give their kids enough of the quality stuff that they need.
>
> [For example,] I don't think kids get enough sleep.

Clinicians working with children in households with less access to resources, such as information about the importance of sleep hygiene or the means to create a more sleep-friendly environment, were less able to rule out sleep deprivation from the diagnostic picture, particularly symptoms of irritability and inattention. In general, the more rule out issues such as sleep hygiene clinicians perceived the more they hesitated to make a (or questioned an existing) ADHD diagnosis.   In addition to sleep, clinicians teased out from ADHD the potential impact of several external factors including particular elements of the child's home and school environments. Although these factors had some bearing on the clinicians' roles in assessment they will be reported in more detail in the *Various Treatment Approaches* theme where they were found to have the most significance.

Trauma. The majority of clinicians discussed a role particular to identifying any history of trauma when assessing for and diagnosing ADHD in children. A phenomenon embedded within this finding is that the majority of children with ADHD from impoverished neighborhoods with high rates of violent crimes have also, as reported by clinicians, experienced trauma but do not necessarily meeting the DSM criteria for PTSD. Participant 10, a clinician in a public charter school serving mostly low-income children of color, described how she perceived the relationship between trauma and ADHD diagnosis:

> I think [ADHD] can be influenced by trauma and symptoms of trauma. I think it
>
> can be environmental. For a lot of the kids when you're on alert so much, the
>
> idea of sitting quiet is not comfortable or familiar and I think a lot of the
>
> movement that we see is also just kind of a recreation of the environment they're

used to being in.

She suggested that the ADHD-like behavior ("movement") observed in children can mimic behavioral responses learned from trauma in the environment. She also stated that she rarely sees children with what she referred to as "purely ADHD" because there is almost always a documented history of trauma in children in her setting. In these cases it was difficult if not impossible for her and others to determine the precise etiology of the symptoms. When in doubt, it was felt that the established culture fixated on ADHD symptoms to the detriment of vital trauma-based work. This suggests a broader finding that social workers at times experienced a dilemma when working with children with ADHD because it made it difficult to honor the complexity of the child's presentation.

Participant 6 was among the participants who felt more confident that symptoms of trauma histories in children lead to the misdiagnosis of ADHD. She contextualized the environment in which these symptoms manifest, particularly those in the foster care system.

> Most of the kids that are referred here have some kind of trauma history and a good 50% of the kids—easy 50% of the kids—that come through the door are misdiagnosed with ADHA or ODD…You have the other factor of kids that have multiple homes. It's six homes in four years or six homes in six months, they're going to get misdiagnosed with ADHD and they're going to get put on medication so that they can be successful in the next foster home. So, circumstances.

In keeping with Participant 6's depiction of the way that the traumatic effect of living in the foster care system gets deployed as misdiagnosis of ADHD, Participant 2, a therapist at a fee-for-service outpatient mental health clinic for children ages 3-21 typically involved in the child welfare system, shared her perception of the effect of the DSM-5's failure to capture what she

60

calls "developmental trauma."

> It's always challenging for me when I have to actually come down to making a preliminary diagnosis, because of the fact that I end up using ADHD, ODD – all these [DSM-5 diagnoses] that I have to use—but it's hard because I seriously just want to put Developmental Trauma. Period. So it's challenging, it's challenging.

Participant 2 described a correlation between settings requiring a DMS-5 diagnosis and misdiagnosis of ADHD. ADHD might get misdiagnosed when diagnosis must be made (for insurance purposes) and a more appropriate diagnostic label is not available. To underscore the co-occurrence of multiple traumas with ADHD, Participant 3, also a fee-for-service therapist at an outpatient mental health clinic for children located in a neighborhood with high rates of poverty and violent drug crime, described a clinical vignette that represented a typical background of children with whom she works.

> When I first started working with her mom was incarcerated... Bio father was in and out of jail… [she] lived in a neighborhood where people were often shot, killed. Her brother was a few years younger, he was incarcerated—caught selling drugs and with a gun. And so, so much trauma: she was also a victim of physical abuse by a boyfriend. So, a lot of trauma in her life.

Participant 3 illustrated how social workers see what the medication model calls environmental factors such as incarceration, substance abuse, domestic violence and more as part of the work of treating what is called ADHD. Embedded within the large role of assessing and diagnosing ADHD, clinicians struggle to tease out ADHD from a range of co-occurring issues and disorders, environmental factors such as sleep, and trauma.

Following assessment, clinicians face a range of roles in treatment. Even though

participants did not often associate the services they provide related to medication as a "role," it was often the first thing they did because of the ubiquity of this form of treatment. These varied roles regarding medication will be treated first followed by other roles in treatment unrelated to medication.

Clinicians' Roles Regarding Medication

In spite of the complexity involved in diagnosing ADHD in children revealed in the first theme, all participants also described their multi-faceted roles in treatment with this population in rich detail. Clinicians' understanding of their roles in treatment, particular vis-à-vis medication management, registered in different ways for different clinicians. This section will outline four subheadings of the umbrella theme of Clinicians' Roles Regarding Medication. These five subheadings, *referrals, managing parent medication expectations, collaboration with providers, monitoring side effects, and psychoeducation* articulate the different ways that clinicians described how they experience their roles in the work.

Referrals. The majority of participants discussed the process of making referrals in the context of their work with these children and their families. However, as described above, this process was highly informed by the clinical setting and client's socioeconomic status. Clinicians in private practice often conceptualized psychotherapy as the first step in treating ADHD and a medication consult referral as a second step. Participant 9, a private practice clinician serving a predominantly White, upper-middle class population, illustrated the application of this theoretical approach to her role with children with ADHD,

> My feeling is always 'let's see what we can do in therapy first. Let's see if
>
> therapy alone can do it and then, if we're still having the same problems and

we're doing everything else we can do, then we go to step two, which is a

medication consult.' So that's my kind of theoretical way that I work.

Moreover, Participant 9 felt that immediate psychiatric referrals should be reserved for severe or

"extreme" symptoms. Participant 6 shared her view that a psychiatry referral might either reflect

a last resort in treatment options or reflect the fact that the family could not afford alternative

methods to rule out other issues.

> If a kid is totally unable to socialize, to make friends, to be in a group setting, to
>
> be able to have a rewarding life and we've ruled out sensory disorders and we've
>
> ruled out all the other kinds of things, and they can't afford to go the homeopathic
>
> or naturopathic kind of way then we send them to a psychiatrist. My view is
>
> always, 'let's get them to slow down so we can teach them the skills and see if
>
> they can go [without] meds.' Some kids can and some kids can't.

As Participant 6 and Participant 9 demonstrated, experienced clinicians used an implicit yet

deliberate approach to making referrals for a medication. Their insistence that it be a

"consultation" reflected a tendency, or perhaps bias, toward medicating children for ADHD.

Moreover, they often had a hand-selected cadre of preferred psychiatrists to whom they refer

their clients. Participant 11, a private practice clinician with 25 years of experience, preferred to

refer to psychiatrists whose work she experienced as "conservative." She, like many others,

expressed some doubt as to whether family doctors, although technically qualified, were as

adequately trained as psychiatrists to assess, treat, and in particular monitor ADHD medication

in children.

> I never, *never* say to someone, 'go to your family doc and ask them for a
>
> psychostimulant.' I *always* go through a psychiatrist who I know is thoroughly

trained in the assessment of Attention Deficit Disorder and who won't—who also

isn't inclined to over-medicate. Because I want [to refer to] someone who's

conservative enough to really evaluate carefully what I can't.

Similarly, Participant 7 described those psychiatrists to whom he has typically referred clients as

his "army of physicians."

In my private practice, I have an army of physicians that I use [and] that know my

work.

The idea of the psychiatrist and therapist "knowing each other's work" was also an important

factor in Participant 11's referral decision-making process:

In the course of my practice I've identified psychiatrists who know my work well

and whose work I know [and] who I can have a really collaborative relationship

with."

Good communication skills were another important quality participants looked for in

psychiatrists and prescribers to whom they might refer their clients. Participant 9 describes what

this looks like for her,

When I have the opportunity to make a referral, I make a referral to a psychiatrist

who I know is a good communicator, meaning she is going to return parents calls

quickly, she's going to talk directly to the teenager or the child, she's going to

communicate well with me. I think that's really important.

Referring to a psychiatrist who was perceived as dedicated to working with children, parents, and

the psychotherapist was a value clinicians in school settings echoed as well.

You try to find psychiatrists who have been to the school, know what we're doing, value it, understand why when we make a recommendation for a kid to be medicated that it's not done lightly, and that this is what we're seeing.

Clinicians in agency settings generally did not report making referrals perhaps because it was not perceived to be an option for those families. However, Participant 6 was an exception in that she believed making referrals for low-income children with ADHD seen in agency settings is possible when clinicians are creative.

The fact is, there are organizations that do do neuropsychs [testing] and take all the insurances: you just have to know where they are. You have to do your homework to understand where resources are for people so that we can get them done. You also can advocate at the school if that's where you think it needs to be done. But there's not reimbursable money for a lot of what I'm talking to you about. [For example,] That case management piece you do not get reimbursed for.

In spite of this anomalous perspective in these findings, the overall absence of this role as defined by clinicians in agency settings reveals how economic disparity may impact the assessment and treatment.

Managing Parent Expectations of Medication. All participants reported, to varying degrees, difficulty negotiating their roles within the context of their clients' parents, many of whom shared strong views either in favor of or opposition to psychotropic medication. To simplify the language for this discussion, those parents who participants described as adamantly opposed to medicating their child are referred to as having a "negative bias," and parents who, by contrast, were described as inflexibly opposed to trying anything else, including therapy, I refer to here as having a "positive bias."

Clinicians reported helping parents explore feelings "helpless," "worn down," lacked "effective tools" to manage their children's ADHD symptoms. Others reported that parents' exhaustion as well as pressure from the child's school could give rise to their positive bias. In response to parents whose positive bias comes from feeling overwhelmed about their child's problems and lacking support from the community, Participant 6 described helping parents sort through their feelings and make changes to accommodate their child. Participants described working with parents whose positive bias merely reflected cultural values about medication ("quick-fix culture" or "pop-a-pill culture"), competition and success, as well as fear that their child was not conforming to societal standards of normalcy.

Helping parents parse out information and informal recommendations about medication from schools and teachers was another unique finding within clinical social workers' understanding of their roles with this population. Participant 10, a school-based therapist at an urban charter school in a neighborhood with a high poverty rate, reiterated the "quick fix" idea to express the ethos in public education toward medicating youth.

> I think a lot of people think that medication is a quick fix. Like a teacher will say, 'Oh I heard [this student] is going to be trying a new medication so this is going to get better. Oh they have a psychiatry appointment. Oh they're going to have an intake, it's going to get so much better.' It's like, well, it might help, it's a tool, but it's not going to magically make this person have all of these skills and attention and focus and go from an A reading level to on level.

When parents exhibit this bias, Participant 10 described helping them to readjust their "magical" expectations. Participant 6 also described negotiating her role managing parents expectations within raised the issue that the culture of the medical model that views medicine as the "quickest

way" to help a child calm down.

> They [families] go to treaters who follow a medical model where that's the
>
> quickest way to help a child is to medicate them and to get them to calm down.
>
> I'm not disputing that. It's true that if they're calmer they will learn faster.

Many participants recognized the real calming effect of medication on children, however, they also held the tension (that sometimes parents were too emotionally invested to hold) of whether it was for right reason. Still, others did not take as much issue with parents' positive bias. Regardless, participants consistently described a role in honoring parents' righteous desires for their child to succeed and a role in helping them differentiate when meaning was interpreted from facts and when from observations. Participant 9 provided an example of how she responds to a troubling trend in teachers to espouse this "quick-fix" cultural view:

> So I'd say [teachers making informal diagnoses and medication
>
> recommendations] happens too often, in my view…When it comes up, I usually
>
> take the position with parents that, 'Well, you know, teachers certainly have a
>
> right to tell you what they're seeing, but teachers can't diagnose.'

Equally as important as countering a parent's indiscriminate positive bias, clinicians emphasized the importance of their role countering irrational negative bias. Clinicians speculated that parents' negative bias came from a variety of sources and can present an equal amount of challenges to navigating their role within the child's best interests. Real and perceived side effects were the most common source, according to clinicians, of negative bias. Ways they helped parents negotiate those concerns are addressed in greater detail in the next theme. In addition, parents' opposition may reside in the fact that they are children with "developing brains." The perception that stimulant medication has been "overused," "thrown at

kids," and ADHD "over-diagnosed" were other parental fears that participants described. Participants also navigated parents' negative bias deriving from a history of addiction or multigenerational influence in the family, as well as religious reasons. Other times, clinicians responded to and educated parents whose reluctance to medicate their children comes from a lack of awareness about the possible neurobiological component of some ADHD presentations. Participant 12 stated that parents

> recognize the medications are very powerful and they're not convinced that a pill can help because they can't *see* it [the problem]. It's not like a broken arm. So you kind of have to educate them at that point about, "Well this is what ADHD kind of looks like."

In addition, clinicians described navigating their role with parents whose children have already tried medication and experienced it as either ineffective or the side effect too unmanageable or had a history of family suicide. Participant 11 illustrated how she navigates her role managing parents' negative bias using a case example of an 11-year-old girl whose school psychologist recently made an informal ADHD diagnosis following observation, talking to the teacher, and a written measure.

> Her father is very against medication, and I said to him in the beginning, 'it's my job to really try to tease out what's going on and to do everything I can to make *her* life more manageable and her learning more successful and anything I can do. But if I really in my heart of hearts think she could possibly benefit from the medication I will *urge* you to consider that by assessing it further, by meeting with someone and talking with someone more knowledgeable than me about the risks and benefits.'

Some participants allow parents' biases to inform the treatment plan more than others. For example, Participant 4 described how she incorporates parents' negative bias by initially implementing more alternatives to medication that she might otherwise early in treatment: a kind of if-then approach.

> [I] explain to the parents, 'here's what's going on, here's what I think we can do without medication, here's what I think we can do with medication'…I think that if a parent comes in and is adamantly opposed to medication I'll do everything I can to help them and to coach them and to help the child succeed without it…And so when they come in, if we put into place many different ways to help this child and they try everything and we're all out of ideas and (your word) interventions, then I think that they're ready to try medication. And certainly the family doctor, the psychiatrist needs to be in on that decision.

The caveat about the doctor needing to be included in decisions about medication implied important issues of scope of practice pertinent to this aspect of social workers' roles. Although expected to be conversant in psychopharmacology (see below), helping parents manage expectations of medication raised challenges for social workers in terms of understanding their professional and ethical limits. Participant 7 explained,

> [I'm] mindful of my training background and role. On the one hand, I'm more than just the ordinary consumer, but on the other hand, I'm not a physician, and so I need to be careful that people don't see me as more than I am…it's really knowing my limits… I think you have to be able to help them understand that you can't medicate away everything.

Similar to Participant 4, Participant 7 described staying within these "limits" by directing parents' specific medication questions to psychiatrists as well as posing his own set of questions to help parents explore potential underlying or unrealistic expectations of medication. Ideally, Participant 7 explained, talking through these thoughts and feelings helps parents become

> thoughtfully protective of their kids. That they do not see medication as a panacea, but that they are also open to the possibility it can be a real *aid* for many kids when it's properly managed and it works.

Regardless of the dilemmas presented by parents' views or biases, clinicians strived to be "mindful" and "respectful" of the range of attitudes about medication ADHD.

> **Collaboration with Prescribers.** Participants voiced concerns about the barriers to interdisciplinary collaboration, especially with prescribers. Many described a particular quality of interaction, a distinctive "team" feel, as integral to effective collaboration felt to be part of their role. Other attributes that supported collaboration across settings were clinicians' longstanding, positive relationships with prescribers as well as their willingness and sense of ethical mandate, particular to social work, to collaborate in spite of lack of compensation. Participant 11 strived for relationships with psychiatrists characterized as "collaborative," "mutually respectful," and "trusting."

> It would be a collaborative, mutually respectful relationship where the prescriber was comfortable being in the role of expert around the medication and its monitoring… they're comfortable working with someone else who they trust and doing just the medication.

Participant 11 emphasized as necessary for collaboration what she and many participants perceived as a sharp distinction between her and the psychiatrist's role regarding medication.

The distinction is one in which the psychiatrist does "just the medication" and the therapist "does" the therapy, suggesting that collaboration might not actually refer to medication management. However, elsewhere in the interview, she complicated this distinction by describing her (additional) role in monitoring side effects (See below). Similarly, several clinicians identified "communication" as an important theme of the collaborative relationship. Participant 9 felt that collaboration about potential directions for a case was especially useful when some aspect of the presenting problem was unclear.

> Regular contact. If I have a concern and I call them, they actually call me back. And some are very good about that and some are not. I like to be able to either talk with them or communicate by e-mail about what I'm seeing and what they're seeing. Sometimes if I'm stymied, I want to be able to consult with them a little bit about next steps. So yeah, I think just communication is really important.

Participant 9's description underscores the persistence this role required of social workers when, for example, psychiatrists were difficult to reach. Clinicians generally felt that discussing with the prescriber particular facets of medication—such as a new prescription, a change in dose, a new side effect, behavior changes—supported good collaboration. Perhaps in slight contradiction to this more standardized approach, Participant 11 described how the quality or nature of the conversation with the prescriber about the client was more important than the quantity or frequency of contact.

> I may not be needing to talk to the psychiatrist that often—and that's related to any medication that they're on [not just ADHD medication]—but I have to have the feeling that there's an open door, which there always is, and that the working understanding is that if there's anything noteworthy then we share it with each

other. And so it varies with every professional that I work with, but in the

beginning, when they're getting the med on the right dosage it's more frequent

because they want to know what I'm seeing.

Here, collaboration was likened to the "feeling of an open door" for "anything noteworthy."

Others respondents echoed the finding that therapists used a kind of intuition to determine when

and how to reach out and communicate with the prescriber—often when treatment was felt to be

"not going well" (Participant 4) or when a client was "having trouble adjusting" to new

medication (Participant 12). A smaller proportion of interviewees, like Participant 6, more

actively discussed the client's medications with prescribers.

We play a pretty active role…I had a lot of conversations with a lot of doctors

about what meds I think are appropriate or not appropriate or [asking] why is a

kid on this med, it's not appropriate.

Participants described ideal professional qualities in a psychiatrist that support collaboration as

availability for clients and a genuine interest in the child's life.

Both implicitly and explicitly, they described factors that hinder collaboration, such as the fast-

paced nature of the medical model, which consequently limits time for patient visit. Participants

experienced the prescribers' accessibility—to both the therapist and the patient—as a key feature

in potential collaboration. Participants in agency practice preferred working with "in-house" as

opposed to external prescribers because it fostered more (and more meaningful) opportunities to

collaborate. Participant 10 described how weekly access to her in-house school's psychiatrist

fostered collaboration.

We have a psychiatrist who comes to the school once a week... So I work closely

with her and I can explain to her what I'm seeing with the parents and teachers

and then she writes an assessment. So I get to collaborate with her directly, which

is nice.

As compared to being able to explain what she's seeing in-house, however, Participant 10 and

other experienced completely different barriers to collaboration with outside psychiatrists.

I rarely ever talk to anybody's [outside] psychiatrist unless I go to an intake with

them and I'll speak to the person during the intake. I usually speak with the

outpatient therapist.

She and many others noted in-person or "direct" communication versus phone or email

communication was a supportive factor in collaboration. Indeed, many participants expressed a

sense of dissatisfaction and frustration with attempts to organize and communicate with

providers from "outside" agencies.

If I want to talk to a psychiatrist once a week I'll make sure I talk to the

psychiatrist once a week. If I want to talk once a month, I'll make sure it

happens…People just don't have the time and energy…Ideally, it would great if

once a week all of us could have a conference call and all of the treating people—

the school, the psychiatrists, me, the pediatrician, the OP—if we could all have a

conference call and discuss each case that we share. I don't see that happening,

ever.

Here, Participant 4 summarized the sentiment among respondents that in addition to a lack of

time, prescribers may also lack a certain "energy" or spirit that social workers believe is vital for

collaboration. Thus, in spite of succeeding to correspond with psychiatrists when she felt it

necessary, Participant 4 expressed frustration about the inability to facilitate the treatment team

conference that ideally would be part of her role.

The national shortage of child and adolescent psychiatrists is another structural barrier participants directly and indirectly identified as hindering collaboration. Participants generally felt that as a result of the shortage, family doctors and pediatricians, as mentioned in the previous section, now the predominant prescribers of stimulant medication were not properly trained or less experienced when it comes to monitoring psychotropic medication in children as thoroughly as they experienced psychiatrists to do. This exacerbated some participants concerns about the prescriber's already limited time. In addition, participants perceived prescribers' priorities— record keeping, being on call, over-schedule, making profit—as ancillary to the institution rather than the client and prohibitive of collaboration.

Participants identified other issues that hindered collaboration, such as institutional models of care that failed to compensate therapists for collaborative (often called 'collateral') work on behalf of their clients. Participant 6 described the inability to bill insurance providers for time spent in collaborative efforts as a barrier or possible disincentive among clinicians to make those efforts,

> So there's things you cannot bill for so you just have to do them, you have to suck
>
> it up. As the owner, I can 'say suck it up,' and my people don't mind doing it
>
> because they believe in that system. They get paid anyways, so it doesn't matter.

This "suck it up" attitude toward their role raised the question of how insurers, and by extension the clinical setting, can limit/define the social workers' roles in treatment. In contrast to therapists protected by the unique structure of Participant 10's agency, participants providing therapy in fee-for-service models, by contrast, cannot get reimbursed or bill for such efforts. Participant 2, currently an intake therapist at a fee-for-service clinic, characterized these settings as ones in

which erratic scheduling patterns make it difficult to find mutually available time for any type of collaboration. Describing her past role as an outpatient therapist at the same agency,

> [Individual sessions] are pretty much all I could bill for. So that's difficult for me to—and just again, lack of time—because of the fact that I wasn't there full time it was very hard for me to communicate with the psychiatrist. Even though on my treatment plans I would outline that that's something I would do… Often, it just wasn't the case simply because the days that I'm there the psychiatrist was not there. I know at [name of agency], for example, the psychiatrist is only there twice a week for only half a day and those were the days I was not there. *Laughs*. So you know, logistically I don't think it's really set up to have that kind of collaborative relationship.

Participant 2 echoed the aforementioned difficulty in accessing psychiatrists even when they are on-site. Moreover, she raised ethical concerns about discrepancies between what she must report on the treatment plan and what actually happens in practice due to the all limitations described in this section. Participant 2 captured the overall sentiment expressed by the study participants that despite the view many prescribers and therapists share—that interdisciplinary or team approaches are preferable or idyllic—"logistical" or structural barriers indirectly tied managed care deeming collaboration medically unnecessary often prevents it from happening.

Monitoring Side Effects.   Participants often said that they relied primarily on prescribers to monitor side effects of medication their clients may experience and furthermore, underscored prescribers legal responsible for doing so. However, many respondents also reasoned that, because they saw the child more "frequently" or had more "access" to the child than the prescriber, they experienced themselves as responsible, to varying degrees, for

monitoring side effects as well.   Participant 11 applied that logic to distinguish between her

roles and the roles of a psychiatrist in monitoring side effects:

> I'm probably seeing the kid more frequently, so if I hear things that could be a
>
> side effect then I'll contact the psychiatrist or I'll say to the parent 'you need to
>
> give so-and-so a call and let them that we're seeing this symptom,' or '*you* see the
>
> symptom…' So I guess I see myself as part of the team that is monitoring the
>
> medication even though I'm not prescribing it. And I'm not primarily responsible
>
> for monitoring it—the psychiatrist is. I am responsible for monitoring it in the
>
> sense that I have access to the child in ways that they may not. So I kind of see it
>
> as my role to have my antennas out for that, if I know they're on a medication.

Even though clinicians "constantly" monitored adverse effects of psychostimulants in children,

they frequently did not experience themselves as "primarily responsible" for doing so—

sometimes without any sense of obligation from external forces. Participant 4 reiterated this idea

that performing the task itself does not indicate a formal responsibility or "accountability"—

including the rational that the psychotherapist's frequency or access to clients justifies her

involvement in medication.

> I don't know that I'm held 'accountable' [for monitoring side effects] in that
>
> sense of the word. I always ask [kids] how they're doing because oftentimes
>
> they're not following up with the prescribing doctor for maybe for 4 or 6 weeks.
>
> So when they come in I'll ask about side effects or I'll ask how it's going…Yeah,
>
> I mean, I'm constantly monitoring that.

Another indirect factor that influenced the role of a few participants was a phenomenon in which a

psychiatrist directly communicated that monitoring side effects or collaborating about side effects was

not necessary because the parent would call if the side effect were serious or concerning. Perhaps uncomfortable with this assumption, in spite of its perceived superfluity, these social workers generally continued to ask clients certain routine questions or "check in" about side effects. When asked how she understood her "roles" in treating this population specifically related to medication, Participant 5 a private practice clinician serving predominantly White middle to upper-class families replied, "it's not my expertise and I always tell [clients] 'when it comes to medication I always refer to the doctor.'" Yet, when asked if she ever monitored side effects she somewhat contradicted this stance.

> Yes in that case I would be checking with the family…I will give Dr. X a heads
> up. Again he trusts me, and he'll say, 'you don't have to call me just let the
> family call,' you know. But yes I would always be checking in, I think all social
> workers [should ask], how is the medication working? Do you feel any benefits?
> And then report to the doctor.

Interestingly, Participant 5 did not resonate with the idea that her time dedicated to this "check-in"—questions that she believes all social worker "should ask" children about their ADHD medication—constituted one of her formal or even informal "roles" as their therapist.   Similarly, when Participant 10's school's policy changed to no longer require therapists to monitor side effects, she nonetheless continued to follow up with parents when she noticed them.

> That was a [monitoring side effects] requirement for some time but it's not
> anymore just because there was a lot of repetitiveness, like me asking, and then
> two weeks later the psychiatrist asking [the client about side effects]. But I think
> a lot of times when we do see a side effect we'll let parents know [to report it the
> doctor].

Again, although the policy sought to eliminate "repetitiveness," Participant 10 and other interviewees revealed some sense of ambivalence about the relevance/value of a psychotherapist to also monitoring efforts. These findings seem to reflect a lack of clarity at times about the boundaries of social workers' role even in instances where institutions or other providers have created certain boundaries.

In monitoring side effects of medication, clinicians also helped parents explore concerns about how it affected their child's lack of enjoyment in food, weight loss, and even mood. Many interviewees shared strategies they use to help clients and parents mitigate this particular side effect. Participant 1, a clinician in agency and private practice serving children from a range of racial and class backgrounds, described one such technique she learned from a teen client with ADHD with whom she worked for many years.

> She would be starved at 11 o'clock at night and she would tell me she had one bowl that she used and she would take the Quaker instant oatmeal, she would open three packets and put it in her bowl and put it in the microwave. At 11 o'clock at night she's having oatmeal. Like, that's fine, right, that's her third mean, that essentially was her breakfast. That's why I say [to parents], 'there are ways to work in that third meal.'

Participant 1 described an approached to reframing parents concerns about a child having "missed a meal" by helping them identify other times of day, such as before bedtime, when they can creatively substitute it.

Psychoeducation. Most clinicians felt clinical social workers should have a role in psychoeducation about the neurobiological of ADHD as well as the drugs prescribed to children to treat it. Participant 7, like many, believed specifically psychopharmacology to be helpful if

and when psychiatrists consult them regarding some change in the client's medication.

> I think there's a value for social workers to really being comfortable with psychopharmacology, having some working understanding of these medicines, having some experience to know what a reasonable dose is and to be able to have a conversation [with prescribers who]…want to know what I'm hearing, what I'm seeing, and what my thoughts are: 'does the dosage need to be upped or not?'

In addition to the potential use of psychopharmacological knowledge in collaboration with the prescriber, many participants felt that social workers should be able to offer information to parents and children. Clinicians found also psychoeducation-related knowledge relevant to their role when evaluating if and when a medication appeared to be harming a child. For example, Participant 7 described how his "awareness" of psychopharmacology allowed him to intervene in a recent case with a boy who experienced drastic side effects (grandiosity, posturing, fighting, etc.) from an excessive dose of Lexapro, an SSRI sometimes used off-label to treat ADHD symptoms in children when stimulants were ineffective.

Participants also used psychoeducation to help clients understand the neurobiological of ADHD. Participant 1 described her method of teaching young clients about the brain,

> Early on, when I work with a child, I have this big whiteboard, I sit on the floor with the kids, I use a lot of colors that is actually deliberate—I use different colors to demonstrate different ideas because it catches their attention and I want them to focus and to pay attention. And when I explain about ADHD, I will typically draw a brain and I'll tell the kid, "this is the side view of your brain."

This example could also illustrate how participants often used psychoeducation as a way to offer their clients additional resources about issues related to ADHD or more generally about the

challenges associated with growing up, identity formation, or "going through it." For example, clinicians noted that adolescents with prescription ADHD medication are at an even higher risk for drug abuse than their counterparts. Participant 11, like several others, strived to provide psychoeducation by reinforcing to teen clients the psychiatrist's warning about "dangers" of medication.

> I have to have conversations with teenagers who are on those medications to make sure the psychiatrist has talked about mixing things, or the dangers of the medications they're on in light of the fact that some of the medications are used as street drugs…The psychostimulants continue to be appealing to a lot of kids as a recreational drug.

Indeed, clinicians cited several ways that kids or their parents might abuse ADHD drugs. Clinicians struggle to help especially teens understand the risks of selling, experimenting, and using ADHD drugs pro re nata (PRN) rather than as prescribed.

Participants spoke in myriad ways about medication their clients took to treat ADHD. These roles with medication management manifested in five subthemes including referrals, managing parent medication expectations, collaboration with providers, monitoring side effects, and psychoeducation. Involvement in medication was only one small role within clinicians' approaches to treatment, which will now be discussed.

Various Treatment Approaches.

Clinicians shared a variety of empirically supported, traditional, nontraditional, as well as alternative or holistic interventions as part of their role in treatment with this population. These diverse approaches under discussion include Evidence Based Approaches, Alternative Approaches, Structuring the Home Environment, and Advocacy in Schools.

Evidence-Based Approaches. Many clinicians reported using Play Therapy, including art therapy techniques, with children diagnosed with ADHD. Although not formally endorsed in the literature as a treatment for ADHD, many participants justified this intervention based on a general understanding that, when offered a space to explore their past or present experiences, children's behavioral symptoms tend to improve. Participant 1 explained how this approach influences the way she works with a child in the session,

> With the kids [with ADHD and others] I use a very non-directive psychoanalytic type play therapy. With the play therapy I wait and see what they'll choose and then I don't have an idea of what we're going to work on at the beginning of the session right, I let the child choose. And then I might weave in the global goals of helping the child to learn more about him or herself.

Participant 10 described a storytelling technique she has used to help kids with ADHD "slow down" in order to focus and stay on task,

> I ask them to tell a story from beginning to middle, and end. And often you see kids [with ADHD] starting with their beginning and middle and then starting a new story from there. In this modality you kind of say, 'Oh that sounds like a different story. Let me get it right. So what happened first? Okay, and what happened?' You really slow it down for them.

In addition to storytelling, Participant 10 listed an array of interventions including sand trays, art, music, yoga, and more, highlighting the great number of options clinicians drew upon in order to tailor their work with a given child with ADHD symptoms. Participant 12 also described a rich variety of toys and objects available to children with ADHD that included Rubic's cubes, pennies in a jar, stress balls, clay, shells, knitting, collage and other art materials. Of note, she

and two other clinicians (n=3) also specifically reported often using a Whiteboard, different colored pens, and pennies with this population to accommodate difficulties focusing or paying attention.

Several participants reported that they use specifically cognitive behavioral approaches and techniques to help kids address issues other than symptoms commonly associated with ADHD, like low self-esteem and negative self-talk. Often, the way they applied this theory to practice highlighted places participants saw as needing intervention that are not addressed by a purely medical model. Participant 11 discussed how she integrates "empirically supported programs" such as CBT into her practice using "tools" tailored to the particular child.

> I'm not by training nor do I think of myself as a cognitive behavioral therapist, but…you have to work with the empirically supported programs. You can take those tools and integrate them into your practice. And that's what I try to do. So based on what I see going on I pull in the tools that I've learned over the years and I try to get a sense of what tools that *particular* child can effectively employ because it varies widely.

More important than the mechanics of using CBT, Participant 11's description here—of the imperative to contextualize and individualize ADHD treatment based on the belief that not all kids respond in the same way to a particular approach—reflects a uniquely social work perspective and, perhaps, role. In a similar vein, participants also shared working with clients with ADHD on peer relationship skill building, academic skills, time management, and stress management.

Many participants reported playing certain games in the session as a metaphor for children with ADHD to be able to recognize and become more aware of their surroundings.

Participant 1 described this process,

> Certain board games—I don't like to use too many games—but certain board
> games are helpful, like Sorry. When you play Sorry, you really have to look at
> the *whole,* the whole board. You have to keep track of your four pawns, and know
> who's where. So that's a practice kind of a game for a kid with ADD to look at
> the whole….if I send a child's pawn back to the Home, and the child said, 'oh
> wow! I didn't even realize that was there! I forgot about that guy!' I have a
> moment where we can talk about that.

The role of contextualizing the needs of the particular, individual child inspired many
clinicians to use mindfulness technique to again help kids with ADHD address issues other than
symptoms commonly associated with the disorder. Participant 12 explained that sometimes her
ADHD clients feel

> really overwhelmed and they come to my office and just need a quiet place to be
> *quiet*. That's fine. I have beanbags, kind of like a little meditation area: a quiet
> space that's dark where they can be alone to kind of self soothe.

Though not specifically questioned about mindfulness practices, the majority of clinicians (n= 9)
reported using formal and informal mindfulness or meditation techniques in session with
children with ADHD—whether informal, like Participant 12's "meditation area," or a formally
led meditation activity. Participants often used research to support claims about the therapeutic
value of mindfulness.

> I do a lot of mindfulness and meditation with these kids, too…Mindfulness is just
> something that I [learned] through work, trainings, and readings and my own
> interest, I guess. There's a lot of science on that and the effects on the brain.

Interestingly, in addition to scientific research, Participant 10 also indirectly identified her

personal interest in mindfulness to justify her treatment approach. When directly asked what

factors influenced their practice, rarely did participants share such beliefs. However, while

exploring their roles in actual treatment they often revealed a significant relationship between

their beliefs and intervention choices. Participant 7 described the role of mindfulness in her

organization's approach to treatment,

> As part of our curriculum, we do teach mindfulness techniques here, and there has
>
> been some benefit. I mean it's a long-term kind of thing. The whole staff has
>
> been to mindfulness training.

Respondents generally perceived mindfulness as effective and beneficial in mitigating ADHD

symptoms within reason. At the same time, clinicians were aware of the limitation and wary of

mindfulness when applied as an alternative rather than in addition to a doctor's recommendations

for ADHD medication. Participant 11, who had said mindfulness was "a really important piece

when working with kids with attentional deficit," shared this caveat:

> Now remember that with hyperactivity, that's a little different: the use of
>
> psychostimulants [as opposed to mindfulness or other alternatives] becomes more
>
> obvious when you're looking at kids who have very disruptive behavior and who
>
> are getting in their own way and in the way of other people with their behaviors.

Clinicians reported using a combination of play therapy, cognitive behavioral and mindfulness

treatment approaches partly because it resonated with them on a personal level and partly due to

its evidence based and acceptance by the medical model.

Holistic Treatment Approaches. Several clinicians recommended or supported families

to supplement medication and traditional ADHD interventions with treatments they identified as

"alternative" or "holistic" approaches. As discussed under the *Clinical Setting* theme, the

implementation of these holistic approaches were almost always correlated with the setting and

delimited by the client's family's ability to pay out of pocket for the services. The most common

holistic approaches highlighted throughout this section related to nutrition, exercise/outdoor

activity, and electronics.

Many clinicians described a correlation between poor nutrition and ADHD, and thus

encouraged clients and their families to improve nutrition in order to support symptom reduction.

Participants who promoted nutrition tended to espouse common wisdom that nutrition was

important for the functioning and wellness of all children, perhaps especially those facing

particular challenges like ADHD. However, they did not endorse particular elimination diets

such as sugar, food dyes, gluten and dairy to mitigate a child's behavioral problems. Participant

7 noted the lack of evidence base for eliminating sugar in particular,

> Show me a controlled study that shows that there is a correlation between sugar
>
> intake and behavior—because it doesn't exist, despite all the things you hear
>
> otherwise. If you do this long enough, you've gone through blue algae and
>
> fangled diets and all sorts of other programs none of which seem to have much
>
> [efficacy].

On the contrary, others, like Participant 9, more actively respected the choices of those parents

who expressed more interest and willingness to try changes to their child's diet when they were

wary of medication.

> I've seen some parents who really feel that diet affects their kids, and they control
>
> sugar more, or they might control gluten, or they might take a child off dairy. I've

seen that, and some parents report that they see some major improvements with

that. Sometimes they try it and they don't see any big improvements.

As described earlier in these findings, the discrete client population of the study participants

revealed that access to good nutrition intersected with issues of class. Participant 6 describes this

finding in relation to naturopathic doctors:

I work with more naturopathic doctors now for people who can afford them. The

problem with going naturopathic is that insurance doesn't cover it and a good

percentage of my kids are not in a socioeconomic class to be able to afford special

diets, supplements, or all of those things.

Participant 1 echoed the impact of sociocultural factors on a child's diet,

Now the School District of [name of city] is *so impoverished*: there's not always heat, the

school lunches are horrible. These kids are not—nutritionally their brains are not being

fueled.

Alongside diet, many clinicians often identified improved exercise as a factor that could

potentially mitigate a child's ADHD symptoms. Participant 12 explained her perception that

some children "need" exercise and movement in order to expend "emotional overload"—again,

addressing issues not commonly associated with ADHD symptoms that may be unique to social

workers' role in treatment.

Other kids need to play basketball. I have a little hoop outside my office. They

can burn off some energy that way and just get rid of their emotional overloads.

Participant 6 believed many public school systems do not adequately prioritize exercise

especially for young children.

We have kindergartners that are getting 20 minutes worth of exercise a day:

where's what everybody needs according to the stage of development?
She seems to assume that it is obvious or common knowledge that young children need to move their bodies for far more than "20 minutes" per school day. The idea of age-appropriate "developmental" expectations reflects a hypothesis about a possible etiology of ADHD or a factor that can exacerbate it in very young children. Several other participants (n=4) shared these concerns, some gleaned from research and others anecdotal, that current trends in physical education meant that children are not getting enough exercise at school and shared concerns about how this might impact their wellbeing in general and specifically in the home environment.

In addition to nutrition and exercise, many clinicians also saw a correlation with the use of electronics and ADHD, and therefore advocated for parents to set limits and model the responsible use. Participant 1 noted all three alternative approaches,

> I try to help the parents understand about neurological fatigue. That [ADHD] child's brain is so exhausted, so when the kid comes home let's give him a little break, without the television or computer, no video games, sit with him, run outside, and give him a nutritious snack.

Participant 6 identified a link between the proliferation of electronics among families and failure to teach children social cues, a symptom commonly associated with ADHD.

> If [kids] go out to dinner and see everybody in the family playing on their electronics, [but] nobody knows who their neighbor is [or] plays a board game with their kids [then] they're not learning how to socialize or how to read social cues…If there's a disconnect then they are going to present like they have ADHD.

Participant 6 and others attributed ADHD misdiagnosis to a "disconnect," which could be a

disrupted attachment between the child and a caregiver or dysfunction in the child's family

system, manifesting in ways that are similar to symptoms of ADHD.   Unlike Participant 6, most

clinicians did not believe these approaches could "cure" ADHD or become alternatives to

medication. Overall, clinicians integrated holistic approaches such as nutrition, exercise, and

electronics when the child and her family were open to complementing more traditional or

evidenced-based approaches. Clinicians also believed that schools were potentially the most

beneficial place to implement holistic treatment approaches for a child with ADHD.

Advocacy in Schools. Clinicians reported advocating for clients within the school

system in a myriad ways. Participant 12 described her role as "advocate" and someone who

"watches out" for children:

> I'm available to them, on-call 24/7 whenever they need me during the academic
>
> year… That's what a kid needs, I think, so that they don't have to feel that when
>
> they come here there isn't somebody who knows what's going on with them, an
>
> advocate for them, and somebody to watch out for them…[That is] one of the
>
> perks of going to an independent school.

Participant 12 said that the school provided her with a cell phone specifically for this purpose,

and although children (or parents) rarely used it, she felt it symbolized her availability to them.

She was aware that this "perk" was unique to independent school settings, reflecting another

instance of disparity in roles in treatment depending on the clinical setting discussed above.

Coordinating with the school nurse for medication support was an important type of

advocacy several participants named. Participant 10 explained how administering medication at

school could ensure consistency for a child living between two homes,

> They come in after breakfast or go home between mom and dad, which it's easier

to have it at school rather than, 'Oh let's bring it here, Bring it there, Oh we ran
out.'

Several participants discussed collaboration with teachers (with the clients permission) to help

them understand a child's strengths and difficulties related to their ADHD diagnosis. Participant

12 described the kind of information she has shared to help teachers make accommodations,

Information about where the strengths are for the kids in terms of academic
achievement and cognitive achievements…if they tend to be visually oriented or
if they tend to be auditorally oriented or they have processing speed difficulty.
Do they have trouble sitting in a particular area of the room? Do visual materials
help them better than auditory?

However, she and others suggested that even after they share that information teachers often lack

the training to implement their recommendations in the classroom, particularly for students with

ADHD but without individualized plan such as an IEP that could enforce the implementation of

special accommodations. In addition to teacher training, several participants identified other

barriers to advocacy in school settings. Participant 4 perceived certain trends in public education

as a challenge to accommodating children with ADHD.

If schools were going to make accommodations for these children they'd have to
change the curriculum.

Many participants discussed advocating in school for a combination of the alternative approaches

discussed above, especially providing healthier foods and recess or physical activity.

We also go to schools and make sure that they're putting in more holistic kind of
interventions and positive interventions for kids as opposed to treating them
punitively. That they're giving them sensory breaks, that they're giving them

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exercise, that they're giving them more time to move their bodies and to fidget and not expect them to sit still. That they're giving them breaks to drink, to eat, to snack, to chew gum—to do all those things that might help their bodies without having to take medication, without having to be penalized.

Here, Participant 6 framed her advocacy as an effort to realign the school administration and teachers' approach to students from one that was "punitive" to a more "positive" outlook, focusing on students' age-appropriate, developmental needs. She suggested that the restrictions the school imposes are correlated with the same symptoms or behaviors that ADHD medication targets. Many clinicians found similar deleterious restrictions imposed on their clients in the home environment as well.

Structure at Home. Participants perceived "structure" in the home environment an equally if not more important treatment strategy than advocacy on behalf of clients in their school. Those who embraced this view of structure often reported a correlation between its improvement and the parents' decreased desire to medicate their child, suggesting that, at certain times, medication is used to treat deficits in the environment rather than neurobiology of the child. Participant 2 described this perspective,

They don't necessarily need medication, they just need an environment—and all children, even the ones who medication would be beneficial for, all them, at the bottom line—that is structured, has clear boundaries, clear limits, that really teaches how to regulate their emotions and provides them with a sense of safety to be able to do that.

Many clinicians connected dysfunctional structure at home to a parent's lack of information or resources. To Participant 12 illustrated how issues of structure and resources are intricately

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connected and again, the importance of individualizing treatment approaches.

> I try to do a spectrum of an individualized approach, [first] going to a firm, and
> then going larger to NIH, and then going specific on a large scale to the issue, and
> I use CHAD.

In addition to websites and publications from National Institute of Health (NIH) and Child and Adults with ADHD (CHAD), clinicians reported recommending a range of resources including websites, books, support groups, referrals for the aforementioned alternative practitioners, and more. However, Participant 9 and others exercised caution when recommending resources that may lend, from her perspective, a one-sided perspective,

> I have a couple of little books for kids and parents that I sometimes give out.
> Sometimes I'm a little reluctant to give them out because…they almost always
> have a story about a child who is taking a pill, who's taking medication, and I
> don't want kids to think that they will necessarily be taking a pill or taking
> medication.

Here, she specifically objected to materials that failed to promote the child's ability to imagine overcoming or managing particular struggles with their own efforts as opposed to a "pill." The participants' selection of particular resources illustrated how a strengths-based perspective can influence the implementation of an intervention like structure over time. Bibliotherapy, the use of books or stories incorporated into the therapy either during or between sessions, was an alternative approach that clinicians used to help parents with structure. A few titles most commonly cited included *Driven to Distraction* (Halowell and Ratey), *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents* (Russell Barkley) and *The Mindful Child* (Susan Greenland).

Family therapy and parent counseling was a final key role participants like Participant 9 endeavored to help clients improve the structure in the home environment.

> If school is going really well and most of the distress is at home, then I'll focus pretty much exclusively on the child and family relationships, and also doing a lot of parent counseling to help. My goal really is to help parents help kids to—do a lot of work to help them parent differently so that their kids are more comfortable in their environment.

Similarly, Participant 6 reported working with parents separately from their children, offering classes, groups, and skill-building.

> We run parenting classes on skill levels [where we work on] what do you do, how do you talk to kids, and get them to listen. Then how [to] advocate for your child. Then we have parent support groups where they can use each other and get support within there to feel like they're not alone.

Clinicians shared a variety of empirically supported, traditional, nontraditional, as well as alternative or holistic interventions as part of their role in treatment with this population.

Summary

The four main themes that emerged from the qualitative data in this study exploring how social workers understand their role in treatment with children who take ADHD medication are *clinical setting, teasing out ADHD in assessment and diagnosis, roles regarding medication* and *various treatment approaches*. These themes and the supporting quotes suggest that social workers encompass a range of perspectives in relation to the ADHD diagnosis and their role when the child's treatment involves medication. Social workers' perspectives on their roles vastly differ depending upon the context of the client's history as well as the impact of agency

policies on the therapeutic relationship and potential for healing. While assessing children for

ADHD, social workers found it especially difficult to tease out from a history of trauma and their

experience of discomfort and ambiguity did not necessary subside in cases where the child was

already diagnosed.   The findings in this section also suggest that social workers may have

difficulty navigating their practice in relation to their clients' ADHD medication regardless of

whether they consider themselves formally accountable or whether there collaborate with

prescribers with explicit guidelines.   Finally, the findings in this section suggest social workers

frequently rely upon holistic interventions to reinforce the evidence-based or traditional

modalities they predominantly use. The following chapter addresses the implications of these

findings for social work practice, discussion of the interconnectivity of the four themes, and an

outline of the study bias and limitations.

CHAPTER V

Discussion

The purpose of this research study was to explore how clinical social workers understand their role with children who take medication to treat ADHD symptoms. The framework outlined in this discussion arose through analysis of qualitative data collected during semi-structured telephone interviews with 12 licensed clinical social workers who either currently work with at least 3 such children or have worked with 5 such children in the past 3 years.

The major findings of this research project are that social workers' roles in "teasing out" ADHD from comorbid diagnosis or issues are equally if not more complex than their roles in intervention and treatment and that their roles regarding medication and other aspects of treatment vary widely depending upon the clinical setting. While the literature generally supports the latter of these two main findings (Johnson et al. 1998; Bentley et al, 2005; Moses & Kirk, 2006), more recent medical understanding of how learning disabilities, sensory integration, and trauma manifest in children have not yet been captured in social work literature as it relates to diagnosing and treating ADHD.

This study contributes to the literature by fleshing out issues in diagnosis and treatment, by articulating the potential for symptoms of ADHD and trauma to overlap, and by clarifying social workers perceptions of their roles regarding medication, which previous research identified as "confusing" or poorly defined (Walsh et al., 2003; Bentley et al., 2005). The following sections highlight how the four themes from this study compare with the existing

literature on the connection between risk factors and issues in diagnosing ADHD, controversies regarding stimulants, and perspectives on non-pharmacological treatment approaches. *Clinical Setting* is considered first, followed by *Teasing out ADHD: Assessor and Diagnostic Role, then Roles related to medication*, and finally *Various Treatment Approaches*.

Following a comparison with the existing literature I will present a framework of intersecting themes that arose from the research as a guide for clinical social work practice with this population of children. In this chapter I will also discuss the study's strengths and limitations and offer recommendations for further research.

Clinical Setting

Examining factors within the clinical setting that might influence the quality of care is by no means new to social work literature. However the influence of social workers' clinical settings on the way they understand their roles have not yet been examined in an ADHD treatment context. Stark disparities between private practice and agency settings in how social workers interacted with their clients' medication (referrals, prescriber collaboration, etc.) raised implications about social work's perpetuation of structural inequality and racism. Racism as a source of health disparity in children and adults is well documented in the literature (Miller et al., 2009). African Americans are believed to be a group with unique health risk because health disparities between African Americans and Whites have been found across most major physical illnesses even when socioeconomic status (SES) is controlled (Miller et al., 2009). Despite this, ADHD research examining risk factors has tended to obscure the impact of racism, perhaps because due to evidence-based research standards that privileges certain types of data (Adams et al., 2009). One recent UK-based study offered an alternative explanation to the inheritability narrative, asserting social and economic disadvantage could also influence the etiology of

ADHD (Russell et al., 2013). Still, the range of indicators did not explicitly include racism but cited poverty, housing tenure, maternal education, income, lone parenthood and younger motherhood (Russell et. al, 2013), even though SES, race, and ethnicity are "intimately intertwined" due to discrimination on multiple levels of society (American Psychological Association, 2015).

Even though the DSM-5 does not incorporate this intersectional lens, some interviewees nonetheless grappled with ways that their clients' class or SES intersected with covert or structural racism. Study respondents, in particular those in settings that saw more low-income children of color, tended to reflect a social constructivist or post-modernist approach to treating ADHD. In this view, the question is not whether the problems associated with ADHD exist or a real but rather how they should be meaningfully interpreted. "For it is the interpretation and meaning one assigns an experience or behaviour that involves making all sorts of assumptions which are very often culturally specific" (Timimi, 2002, p. 17).

My findings contradicted the literature asserting that social workers across school social work and outpatient settings shared similar views toward medication (Johnson et al., 1998). While no inpatient social workers participated in this study, the findings suggested significant variation among social workers in various outpatient/school settings—all of which Johnson et al. associated with having a less "helpful" view of medication than inpatient social workers. Unlike the Johnson et al. study, what predicted participants' different views of medicating ADHD was not their relationship with the medical model did not but rather the sociocultural context of their clients as well as their own positionality in relation to race and class, which may have led to more or fewer reflections on the role of race and racism. In order to capture these nuances in social work practice, research should address the complexities that exist across outpatient

settings (including private practice) rather than categorizing them in the service of comparison to inpatient settings.

Teasing Out ADHD: Clinicians' Assessor and Diagnostic Roles

A key finding of this research study is the ubiquity of clinical social workers difficulties with the assessment and diagnosis of ADHD in their work with children. Almost all LCSWs who participated in this study identified some problematic issue in their experience assessing and diagnosing ADHD, though these issues varied in intensity and manifestation. The issues were identified as co-occuring disorders, sleep, and trauma.

The findings of this study align with existing research and highlight the challenges of making a clear diagnosis of ADHD when the symptoms of this syndrome overlap with many other disorders and illnesses listed in the DSM- 5 (American Psychological Assocation, 2013). This concern is echoed by client advocacy groups such as the National Alliance on Mental Illness (2015) who express specific concern about the overlap of ADHD in children with the diagnoses of Oppositional Defiant Disorder, anxiety disorders, depressive disorders and learning disabilities. The finding that almost participants identified learning disabilities either at some point during the interview or indicated it on the demographics form was consistent with research asserting that many children with ADHD also have a specific learning disorder (American Psychiatric Association, 2013), approximately 50% (CDC, 2014).

Overall, the way participants spoke about differential diagnosis (for example, as "issues") seemed to reflect a perspective that diagnoses in general were less important than the actual circumstances faced by the individual child and family. Participants most commonly referred to anxiety and depression in more general terms rather than the official diagnostic labels cited in the literature (Elia et al., 2008) but nonetheless echoed the challenges of differentiating ADHD from

many commonly diagnosed childhood mental health issues. Participants tended to regard the scientific basis for the ODD diagnosis with major skepticism and perhaps as a result did not represent findings from the literature on the co-occurrence of ADHD and ODD based on type or presentation. Interestingly however, some participants spoke to and affirmed differences between the "hyperactive" and "inattentive" ADHD presentations. A few participants even shared a belief, contradictory to the literature, that medication might be more appropriate for the hyperactive than the inattentive presentation primarily due to the harm it can cause to self (running out into the street) and others. Research should examine social workers' biases toward these different presentations and what they might mean.

Conduct disorder (CD), considered a less common but more severe and disruptive behavioral disorder than ODD (American Psychiatric Association 2013), was the only disorder co-occurring with ADHD found in research that was not reported either in the demographics form or in any interview in my study. This might be explained by the nature of the clinical setting in which participants saw clients, as CD is associated with major mental illness it is typically seen in more acute care settings that were not represented in this study. These and other limitations of will be discussed later in this chapter.

The existing literature supports the findings of my research that co-occurring sleep problems are difficult to tease out from ADHD in children (Owen, 2005; Owen, 2009).. An example of a clinical issue particularly relevant to my findings was that sleep disturbance could result from a side effect of psychotropic medications used to treat ADHD (Owen, 2009). Although research also supported this finding from a neurobiological perspective, the participants in my study neither referred to this as their basis for concern nor approached "treatment" in ways that conformed to standards such as screening for primary or co-occurring

sleep disorders such as sleep apnea (OSA) and restless legs syndrome (RLS) (Owen, 2009).

Participants' sleep related concerns seemed more related to external factors that could disturb

their clients' sleep—examples illustrated in the interviews included noise from television,

multiple people sharing one room, or fighting; lack of structure and consistency; hunger at

bedtime due to food insecurity; and anxiety and bedtime fears possibly related to a history of

trauma.

Few researchers have explored the overlap between ADHD symptoms and the effects of

chronic stress or experiencing or witnessing a trauma event (Ruiz, 2014). A recent study by

Fuller-Thompson et al. (2014), asserted that the odds of ADD/ADHD in children who had been

abused were 7 times higher than compared to those who were not abused. The aforementioned

Russell, et al. (2014) study, which asserted that external factors (such as poverty, homelessness,

single-parent households) also influenced the etiology of ADHD, could also be interpreted

through a trauma lens. Similar to issues to sleep described above, a previous edition of the DSM

urged clinicians to differentiate ADHD symptoms from "inadequate, disorganized or chaotic

environments" suggestive of trauma but removed that caveat from the latest version. Participants

frequently perceived the DSM-5 as failing to capture these profoundly traumatic circumstances and

events in the differential diagnostic criteria. In the absence of guidelines to assess for trauma in

children with ADHD, and that those parents may not disclose a history of trauma in their child's

initial intake evaluations, many participants in my research sensed that childhood trauma was

under-diagnosed and mistaken as ADHD. While the research lacks consensus, this finding

corroborates recent studies that suggest that ADHD is over-diagnosed in certain populations

(Elder, 2010). The paucity of research related to this finding may reflect the way trauma

disproportionately affects the lives of marginalized and oppressed populations, who are also not

the foci of study about ADHD and thus a failure to capture issues of intersectionality. Therefore,

the importance for future studies that focus specifically on examining the potential intersection

of trauma and ADHD diagnosis, perhaps particularly in racially and ethnically diverse

populations, cannot be underestimated.

Roles Regarding Medication

The literature supported the finding that clinicians identified at least some role regarding

medication although no studies have addressed ADHD specifically. The roles regarding

medication were identified as *referrals, managing parent expectations, collaboration with*

prescribers, monitoring side effects, and *psychoeducation*. These findings are especially

interesting when compared alongside the theme of Clinical Setting and to a lesser extent Teasing

Out ADHD that arose in my study. For example, my study found that the first and perhaps most

important of Bentley et al.'s (2005) referral guidelines, "establishing and maintaining

relationships with prescribers," came with barriers and challenges highly dependent upon to the

clinical setting. Some of the barriers my study found included the national shortage of child and

adolescent psychiatrists and the controversies particular to ADHD diagnosis. Although study

participants in settings where insurers (or lack thereof) limited referrals did not explicitly identify

a "role" in referrals, they nonetheless corroborated several of Bentley et al.'s (2005) best

practices. These included helping parents understand and manage expectations of medication,

anticipating issues that might emerge such as drug abuse, and following up on adverse effects.

Given the prevalence of ADHD and probability that social workers will work with children with

the diagnosis during their careers, social work education should integrate these best practices into

curricula.

Bentley et al. (2005) and LeFever et al. (2003) also raised ethical concerns regarding the

potential for medication to harm children and the perception that symptoms of the disorder are

inherently subjective. Although not specific to psychostimulants, Walsh et al. (2003) also found that more than 60% of social workers experience at least two types of ethical dilemmas about clients' drug treatment per month. My findings contradicted Bentley et. al (2005), Walsh et al. (2003), and LeFever et al. (2003) in that, even when directly asked, only a few participants identified experiencing "ethical" concerns or dilemmas regarding their medication-related treatment roles. Only a few participants identified ethical concerns, which appeared limited to disagreement between the child and parent or school about whether the child should take medication; perceiving a client or parent was abusing the prescription in some way; and confidentiality in the context of working with children and families. Only a small number of participants felt that the uncertain nature of the long-term safety of medication had ethical implications for them.

My findings reflect the assertion that social workers are perhaps increasingly skilled at embracing the tension that psychiatric medicine undoubtedly relieves the suffering of some while it overlooking its causes or even exacerbating the suffering of some patients (Moses & Kirk, 2006). However, there was still somewhat of a divide in that on the one hand some clinicians, irrespective of personal experiences, embodied a more cautious stance toward medicating children for ADHD than others. Generally, clinicians with more cautious or conservative views in my study conveyed more awareness of racism, patriarchy, and other dynamics of oppression operating in relation to their clients' lives. Thus their ethical dilemmas tended to center on whether they might have colluded with of these systems when social workers have an ethical mandate to dismantle them.

On the other hand participants who conveyed less critical consciousness regarding these structural or macro-level issues tended to experience fewer ethical dilemmas even if they

reported having worked with clients in cases where ADHD was overdiagnosed or overmedicated. It is possible some social workers are better positioned to compartmentalize ethics and roles and that this helps prevent burn out. In addition, although there are genuine risks associated with psychostimulants, they are generally far less severe than risks associated with other psychotropic medication. Social work guidelines for navigating and contextualizing ethical concerns regarding ADHD medication might be useful especially to new clinicians who have less experience to rely on.

However, the findings related to ethical dilemmas and participants' gender contradicted the literature. Although this reflected the broader gender demographics of the social work field as a whole (NASW, 2004), the literature suggests that the gender might influence social workers' attitudes toward this topic. Walsh et al (2003) asserted that female clinicians experienced ethical dilemmas with regard to drug treatment more frequently than did men and were much more bothered by "ethical struggles" than men. Walsh et al.'s (2003) study did not specifically examine attitudes toward medicating children, however Moses and Kirk (2006) found that male social workers were more likely to perceive benefits of medication to treat youth than their females counterparts. My findings contradicted these assertions about possible association between gender and medication bias because almost all of the females in my study spontaneously identified at least some benefit to ADHD drugs for children when appropriately used. Moreover, as described above, many participants denied experiencing any ethical dilemmas with regard to youth who take ADHD drugs even when they felt it might not be an appropriate treatment method. The contradictory findings may relate specifically to participants' perceptions about the relative safety of ADHD medication as opposed to "heavier" or "experimental" medication typically used to treat more severe or acute mental illness in children.

Literature also supported my study's finding that psychoeducation is part of social workers' evolving role in the field, particularly in medicalized settings (Bentley & Walsh, 2001). My study found that Bentley et al.'s (2005) recommendation for more clearly defined roles of social work in psychiatric medication has not been accomplished. Although participants were not directly asked to comment about if or how the field has addressed this initiative, the participants' average of 20 years in clinical practice might suggest that the sample does not have its finger on the pulse of social work education to be able to conclusively evaluate the status of desired educational changes over the past decade. However, on the contrary, several participants, two of whom had taught in graduate social work settings, commented that psychopharmacological trainings were sufficiently available (some of which qualify for CEUs) *should they elect to take them*. Nonetheless, without more clearly defined roles social workers in my study did not seem to know just how highly to prioritize psychopharmacological training opportunities (Bentley et al. 2005) when so many other salient emerging issues in the field important competing for social workers' time and attention as well.

Various Treatment Approaches

The findings in my study regarding treatment approaches reflected the conceptual divide that Adams et al. (2010) identified among social workers, some of whom believe they have an ethical imperative to offer clients treatments evidence-based practice (EBP) that are "known to work" while others believe this approach privileges certain knowledge and marginalizes other equally important ones. My study participants seemed to understand that "exclusive focus on the EBP aspect of social work service and intervention delivery may inadvertently deemphasize other important aspects of a holistic social work approach" (Adams et al., 2010, p. 170). Participants in this study voiced a desire to honor the uniqueness of each child by integrating

EBP with other techniques that address the child's unique needs and circumstances.

While my participants did not explicitly endorse behavioral therapy (the only effective non-pharmacological approach to treatment cited in the literature (APA Parent Guide, 2013)), their advocacy with parents and teachers reflected some similar principles. The findings around improving structure in the home environment are most closely linked with the literature on "parent training," which asserts that parents are an "essential" component of treating children of ADHD (APA Parent Guide 2013).

However, the wide variety of clinical interventions in my study's findings aligned with literature that has explained that social workers roles "do not fit neatly within the EBP model" (Adams et al., 2010).   Participants in the present study identified alternative approaches to treatment such as nutrition, exercise and electronics, which seemed to reflect common wisdom drawn from clinical practice rather than empirical research. During the first wave of speculation about ADHD overdiagnosis, some authors proposed "nutritional management" or diet modification as a treatment approach asserting that children with ADHD may be sensitive to one or more food component that can negatively impact their behavior (Schnoll, Burshteyn, and Cea-Aravena, 2003). However, these studies had problems with a heterogeneous picture in that they heavily relied on "individual responses" to determine the proper approach to treatment warranting larger controlled trials that have yet to occur (Ekhert, 2014). However, in spite of the absence of larger control trials, the most recent studies consistently find that nutrition should be noted as supportive rather then as alternative to pharmacological therapies of ADHD and that some nutritional supplements (Omega-3 fatty acids, etc.) are "worth a trial for most patients" (Ekhert, 2014). This open-minded and curious stance toward supportive measures like nutrition, exercise and electronics speak to the holistic nature of these treatment approaches and perhaps

capture the spirit of the second wave of concern my participants also shared.

Findings from this study align with the research that teachers' misperceptions can drive over-diagnosis. Participants' advocacy efforts targeting the child's classroom environment were specifically tied to a belief that teachers are ill-equipped to diagnose ADHD. Research is beginning to question the validity of teacher observation even in commonly used behavior rating scales. For example, Elder (2010) found that many ADHD diagnoses were driven by teachers' perceptions of poor behavior among the youngest children in a classroom. Elder (2010) asserted that a child's birth date relative to the eligibility cutoff "strongly influenced" teachers' assessments of whether the child exhibited ADHD symptoms but was only weakly associated with similarly measured parental assessments. Shockingly, the proportionately youngest children in school were shown to be twice as likely to use Ritalin as older children (Elder, 2010). Studies like Elder's (2010) may have led some participants to take more concern with psychostimulants for very young children where norms for assessment appear less accurate.

Other themes

Noteworthy but not at the level of a theme, this query led some participants to discuss issues of "status differential" in terms of social work's perceived value as a profession in the field. These findings aligned with well-documented issues of professionalization the field has debated for decades (Moses & Kirk, 2001). Contrary to the way those for and against professionalization have been positioned in relation to attitudes toward drug treatment in the literature, proponents in this study like Participant 11 did not necessarily correlate to whole-heartedly embracing to the medical model, and although there were no outspoken opponents to professionalization, they would not necessarily have perceived drug treatment as compromising social work values (Moses & Kirk, 2001). Although this theme does not necessarily tie back to

the phenomenon of how clinical social workers understand their role in treatment, it might offer insight into possible other queries about tensions in the field.

As important as themes with no connection to the query were themes that were surprisingly absent from participants' responses to the query. Many private practice clinicians felt this setting had protected them from "burnout" caused in part by "all of the paperwork" agencies demanded of clinicians. Agency clinicians voiced concerns about this too, however they did not tend to associate for example, lengthy documentation requirements and reporting, for example, about medication "compliance," as part of their role in a client's treatment vis-à-vis medication and thus it was not considered a theme. This may have been because they experienced it as perfunctory and not noteworthy.

The following section outlines a framework that describes how the four main themes found in this study interact to shape clinical social workers' roles in treatment with this population. This framework is a way of understanding the relationship between the four themes found in this study. It can also be used to guide social work practice with this population. Though every participant ultimately has her own set of roles and will experience them in a unique way, the framework described here presents psychotherapists with information that can help inform clinical decisions throughout that process.

Framework of Intersecting Themes

This study led to the generation of a framework encompassing the four main themes found in the data: *clinical setting, "teasing out" ADHD during assessment and diagnosis, roles regarding medication,* and *various treatment approaches*. This framework, explained pictorially below, captures the dynamic relationship between these four themes and proposes that they interact with and impact each other during clinical practice with children who take ADHD

medication. I will overview the dynamics of this framework here and then make suggestions for social work and mental health care practice.

Figure 5.1 Framework of intersecting themes.
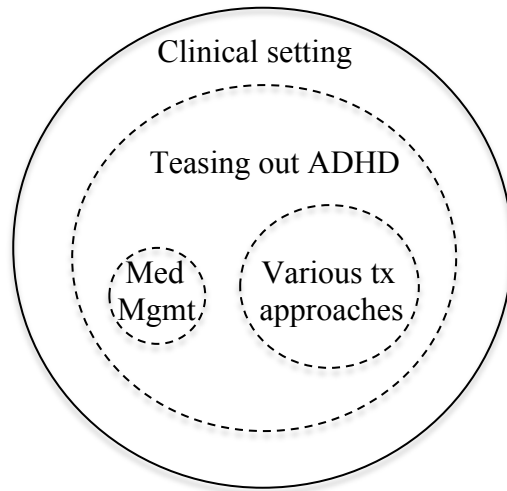
Almost all participants in this study in some way identified, directly or indirectly, that the clinical setting influenced how they understood their role in treatment. This theme is placed at the outermost concentric circle in order to indicate the effect of a metaphorical parameter—either obstructive or supportive—it bears on the rest of treatment. "Teasing out ADHD" is represented in the next circle because most participants conceptualized it as ongoing, requiring a stance of openness, curiosity and continual reassessment far into later phases of the treatment. Roles regarding medication ("med mgmt") are depicted as smaller than various treatment approaches ("Various tx") because, although the former is in certain ways more complex and time consuming than the latter, participants deemphasized the importance or meaningfulness their roles regarding medication in comparison to other treatment approaches. The dashed lines surrounding the three small circles indicate the ways they all get negotiated within a larger

context.

Access to this framework could help especially visual learners better understand the multi-directional relationships of these themes. In the following section I will describe how this framework can be used to inform social work education and practice.

Considerations for Practice

Without knowing the long-term impact of psychostimulants in which studies follow patients from early childhood to adulthood and without the scope of practice to make those decisions, social work education should help its students hold and manage these uncomfortable tensions, complexities, and ethical dilemmas pervading the field. The framework of intersecting themes described in this study can be a guide for clinicians for whom medication to treat ADHD has been formally or informally recommended or prescribed to clients. This framework can guide attention to the four themes, validating the tensions in diagnosis, clarifying clinicians' roles in treatment, and suggesting opportunities for advocacy both in the home, school, and doctor's office. This framework should be available to all clinicians, not just those working with children and families diagnosed with ADHD, because of its potential applicability to other diagnoses and issues, especially neurodevelopmental ones.

The finding that failure to attend to commonplace stressors in children's lives could result in misdiagnosis and overmedication of ADHD can also inform the field's approach to assessment and diagnostics. Agency protocol should advise therapists to attend to their clients' external factors (indicators of trauma such as abuse, poverty and homelessness, as well as symptoms of depression, anxiety, etc.) prior to attempting a medication approach. They could use this information to, for example, develop a more sensitive and comprehensive screening tool

than the current child PTSD scale. Educators and agencies could use these types of tools that measure to risk as part of orientation trainings.

Based on these findings, the academe or NASW should develop thoughtful yet explicit policy that clarifies social workers' roles regarding medication and expectations for collaboration between prescribers and social workers. Social workers should advocate that agencies reinforce these standards and define if applicable their own set of policies and procedures. Agencies should institutionalize weekly case conferences among in-house practitioners who share clients in order to facilitate interdisciplinary collaboration. Agencies and schools should institute monthly treatment team meetings to ensure that the individual work the various practitioners are doing with the child complements the rest and the wishes of the family. To that end, social work education should teach emerging therapists how to effectively facilitate those kinds of meetings.

In addition, findings related to disparities between private practice and agency settings in terms of standards of assessment and treatment of ADHD suggest that social workers should advocate for agencies to apply for funding for referrals and other approaches before going to medication. In addition, social workers should advocate for agencies to sponsor implicit bias training to help prescribers and therapists become more aware of when they are relying on stereotypes rather than deliberate, effortful processing while gathering client information and forming diagnoses (Bodenhausen, 1990). Social workers should advocate for smaller caseloads (again for therapists and prescribers) to allow practitioners more time with each client so that they are less rushed, stressed, and distracted and therefore less likely to apply implicit bias stereotypes when writing clinical formulations.

Agencies should prioritize hiring people of color especially in positions of leadership to increase the likelihood that practitioners will receive feedback when their caseload reveals

patterns of implicit bias and will be held accountable for their work. This might also encourage more dialogue and critical conversation among staff around issues of racism and discrimination playing out within and beyond the agency walls.

Findings related to disparities in the options for treatment of ADHD between private practice and agency settings suggest a need for greater funding and prevention programs in community-based mental health. While the field is aware of the importance of funding, often times one of the barriers is finding new, creative sources of funding. Agencies could apply for funding for research grant to empirically assess the perceived efficacy this study found related to collaboration between psychotherapists and prescribers (and other interdisciplinary practitioners).

Study Strengths and Limitations

The research question and study design were successful in collecting social workers' reflexive thoughts about their roles working with children who take medication to treat ADHD symptoms. This study stayed close to the participant's voices, an important part of the study design, and emphasized the meaning that participants made of their experiences.

The interview guide prompted responses that were tied to the research question, however the interview guide appeared to greatly impact the themes generated from the data analysis. The interview guide contained specific questions about how clinicians understood their role with regards to medication and about relationships with their clients' prescribers, which affected the generation of these themes as central to the data analysis. Also, participants were asked to reflect on "potentially challenging" dimensions of roles and aspects of the current treatment culture, which impacted the development of those themes as well. To avoid "leading questions," I refrained from using certain words like *managed care* and *welfare* that can take on meaning that

stir reactions in at least some people (Engel and Schutt, 2013).

The major limitations of this study relate to the sample bias, including a small sample size, snowball sampling, self-selection, and lack of sample diversity, which can indicate problems with validity and reliability. While the validity of the theory this inductive study generated was limited by the nature of the particular sample, the framework outlined above offered a suggestion for how to adapt this data to different or larger populations. Further study could discover whether this framework holds up in other study samples or in other contexts. However, given the practical nature of the findings and recommendations, they stand as good social work practice consistent with the current state of the field.

The recruitment methods may have increased the sample bias in two ways. First, study participants self-selecting for the interviews without monetary compensation may suggest they had an agenda or bias about ADHD and/or medicating children. Furthermore, people who self-selected for the study may have been more likely to have experienced a significant connection between these two phenomena. In addition, participants were accessed through one another, intensifying the possibility of like-mindedness in this sample. As Engel and Schutt (2013) state, "Researchers using snowball sampling normally cannot be confident that their sample represents the total population of interest."

The study was also regionally discrete with half of participants (n=6) practicing within a 10-mile radius of the same big city in the Mid-Atlantic with the remaining participants representing a relatively small span of the East Coast. Thus, reliability was especially challenged by the sample's inability to capture "wide regional variance" in the diagnosis and treatment of ADHD within the US (Polanczyk, 2007).

In spite of my attempt to recruit clinicians of color they ultimately represented only 17%

(n=2) of my study, creating a racial sample bias. While this figure was higher than the percentage of licensed social workers of color nationwide, it was lower than the general population of persons of color (NASW, 2004). Social justice, a core value of the field, requires social workers to represent diverse populations in their research, which is one of the unique challenges for social work research (Engel and Schutt, 2013). The participants' positionality in relation to race and class may have limited their consideration of how racism and dynamics of oppression might impact their roles in treatment with children medicated to treat ADHD, particularly children of color (Freire, 2000).

One potential strength in terms of sample diversity was that the white identified study participants (n=10) reported client demographics that were more racially diverse than might be expected. In addition to the 2 clinicians of color, 3 of the 10 White-identified clinicians reported that children of color, and specifically African American children, represented a significant proportion (30-75%) of their caseload. This caseload was associated with lower-incomes than their White counterparts and with a larger percentage of children in the foster care system. Meaning that closer to a third of all participant responses in the study concerned a very different demographic profile of medicated children than the other two-thirds. Thus, while in one sense the racial sample bias limited my study's applicability to other racial or ethnic populations, in another sense the two racially and socioeconomically discrete client populations found amongst participants highlighted the grave disparities that exist in the assessment, diagnostic, and treatment standards (between low-income children of color and middle to upper-income White children).

The overrepresentation of self-identified parents in the study (n=9) might have also biased the sample. Two of the 9 self-identified parents also disclosed having a child who

takes/took medication to treat ADHD. It is important to note especially with these participants an awareness that the experience of being a parent could influence their perspectives. Two reported that in certain circumstances they disclosed these positive or negative "disclaimers" to clients. While the seven other parent-identified participants did not report a history of ADHD in themselves or their children, personal parenting experiences may have nonetheless biased clinicians' professional views around medicating children. Many of these participants took the stance that psychotherapy should be tried "first" before medication, again indicating that cautious or conservative view discussed earlier and suggesting a potential bias or reluctance among social workers to embrace certain research findings.

The relative clinical seniority of participants was both a potential strength and limitation of the study. Previous literature neither confirms nor denies an association between clinical experience/expertise with perceptions about medication for ADHD, but suggests that more (6+ years) experience may be more positively correlated to knowledge about ADHD and openness to a range of interventions than less (5 or fewer years) experience (Pentecost & Wood, 2002). One study asserted that social workers with more direct clinical experience are more likely to perceive benefits to medication, but also found that the opposite was true of "older" social workers with less post-MSW experience who did not report consulting with MDs as a means of education in psychopharmacology, who had an existential-humanistic orientation, and a caseload with a lower proportion of medicated clients (Moses & Kirk, 206). On the one hand, most clinicians (n=10) estimated having worked with an average of hundreds of children who take/took medication to treat ADHD over the course of their careers. On the other hand, their seniority, especially among those in private practice, created the possibility losing touch with issues facing the field.

It is possible that conducting the study with a different population more diverse in terms of clinical setting, age, race and class would generate different themes, which raises issues regarding the study's reliability. Racial and regional sample bias is particularly concerning because the client population for whom this study concerns itself is more diverse than the study sample represents. As discussed above, further study should be done to examine whether study findings apply to other populations, contexts, and regions.

Areas for Further Research

The few peer-reviewed studies recently published concerning issues with trauma and ADHD have not been found in social work journals but in allied mental health fields (Fuller-Thomson et al., 2014). News media has recently disseminated important ideas from forthcoming publications regarding ADHD misdiagnosis in relation to issues of trauma, racism and poverty (Ruiz, 2014) that were not addressed in the first wave of dissent. Social work research should build upon these types of sources found outside the peer-review format because knowledge considered credible or evidentiary has historically overlooked marginalized and oppressed populations (Adams et al., 2010). Social work research should continue to examine the implications of implementing and embracing evidence-based practice as part of social work.

As mentioned previously there are many areas for further research that could enhance knowledge about the research question. Social workers should pursue research in areas that address structural forms of oppression, for example, by examining White privilege, class privilege and implicit bias within social work higher education and licensing procedures. Social work research should attempt to measure actual treatment outcomes of collaboration between therapists and prescribers in order to strengthen their argument that agencies should be accountable making sure practitioners have time for these endeavors (by reducing caseloads if

necessary). Social work research should take into account the voices of psychiatrists and other prescribes to determine how they see and value social workers' roles regarding medication. Finally, the National Association of Social Workers should update its review of social worker demographics and consider a study examining the barriers social workers of color face in acquiring agency leadership positions.   Further research should be conducted with different populations than the sample in this study and in different regions to determine the validity of the themes identified here.

Researcher Bias

The outcome of collection and analysis of this qualitative data may have resulted from the way I played my "role" as a researcher, not just from the interview itself (Engel and Schutt, 2013). As Engel and Schutt (2013) explain the importance of reflexivity in qualitative research, "By reporting how and why they think they did what they did, they can help other determine whether or how the researchers' perspectives influenced their conclusions." My social location and personal/professional values as a researcher have a bearing on the study biases. I am a female, white-identified researcher with wealth living in the Mid-Atlantic, all of which contributes to the homogeneity of the sample. Researcher bias shaped the research in several important ways. I would not have considered this research question if I did not first experience this topic as a potential problem. As described in the Methodology Chapter, while proposing and conducting this study, I interned at an outpatient clinic (located in one of the poorest congressional districts in the country) where I provided individual therapy for low-income children of color diagnosed with ADHD—and often wrestled with countertransference related to their assessment, diagnosis and medication interventions. While performing some of these roles I at times felt myself inadvertently colluding with forms of structural racism. From an ethical

standpoint, I felt committed to eliciting voices that by virtue of their experience or values might incorporate analysis of racism and oppression in connection with this topic. These feelings and convictions may have caused me, consciously or unconsciously, to look for other clinicians to validate my same experience.

To remain aware of potential researcher bias, I used a notebook for bracketing throughout the research process, including during and after every interview to examine my reactions and intuitions. I jotted down my emotional reactions to certain anecdotes or views that study participants shared. To attempt to address these potential biases, I employed specific strategies such as journaling and bracketing, but it is possible that my biases, nonetheless, impacted both the interviewees and the analysis process.

Conclusion

As discussed in the Literature Review, the late 1990s and early 2000s saw prolific writing and research questioning the validity of ADHD. These authors tended to critique the ADHD diagnosis itself on the basis of "medicalizing" ordinary problems that families face and weakens the vitality of a culture. Over the last ten plus years however, dissenting voices of authors like Tamimi (2003), Cohen (2002) seem to have since receded to the background. More than a decade later, findings from the present study call for "once again sounding a cautionary alarm" (LeFever, 2014) but with a new and different set of cautions than the first wave.

Asking social workers how they understood their role in treatment necessarily led many to share both positive and negative impressions of the ADHD diagnosis itself. This is in part due to issues of self-selection described earlier in this chapter and in part due to the contentiousness of this issue that may represent the revival or "second wave" of the debate. Nonetheless, this research question was aimed neither at demonizing child and adolescent psychiatry nor clinicians

who serve children with ADHD and their families. It did not seek to undermine the integrity of

children and families facing real problems that are diagnosed and treated as ADHD. If anything,

it was just the opposite. This query began as a new social worker's genuine curiosity and a

paucity of resources with which to explore it. Ultimately, it became a way to give voice and hold

space for uncertainty and discomfort around issues of diagnosing, treating, and medicating

youth.

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Appendix A: Recruitment text

Greetings!

I am a graduate student at Smith College School for Social Work. I am conducting a study as part of my Master's Thesis. Even if you do not meet the criteria to participate, YOU could make a vitally important contribution to the recruitment process. Read on to find out how.

First, here's a brief summary of my study: I will interview 12 clinical social workers people who currently work with children who are prescribed stimulant medication (e.g. Adderall, Ritalin, Concerta, etc.) for the treatment of ADHD. This study will focus on how social workers understand their role in the child's treatment in light of medication. Despite the prevalence of ADHD and drugs used to treat it, there has been very little research about how exactly social workers navigate their work with this population in the current treatment culture. Findings from this study may inform areas of social work practice, policy and education. Its implications may also help us imagine future research aimed at supporting children and families.

Second, the criteria to participate. You must:

• Hold either a MSW or PhD degree in social work with a valid license, or are currently working toward licensure as a clinical social worker

• Currently practice clinical social work in the continental United States

• Currently work with at least 1 child who takes medication to treat ADHD or have worked with at least 5 such children in the last 3 years.

• Finally, participation in this study will take only one hour! Interviews will be audio recorded (either in person or over the phone) but kept private. Participation is strictly confidential. There is no monetary compensation for participation. Fourth, the pitch: If you are interested in participating, please contact me at ▮▮▮▮▮▮▮▮▮▮▮ or ▮▮▮▮▮▮▮▮. I respectfully ask that you forward this email to those who either may be interested in participating themselves and/or have a relevant network *they* might forward this email to. With permission, I would be glad contact any potential participant. With gratitude, Rachel Reed

Appendix B: Informed Consent Form

Consent to Participate in a Research Study
Smith College School for Social Work

Title of Study: How Social Workers Understand their Role in the Treatment of Stimulant-Medicated Youth with ADHD

Investigator: Rachel Reed, Smith College School for Social Work MSW Program

Introduction
You are being asked to participate in a research study of how you understand your role in the treatment of youth who take medication to treat ADHD. You were selected as a possible participant because you:

- Hold either a MSW or PhD degree in social work with a valid license, or are currently working toward licensure as a clinical social worker
- Currently practice clinical social work in the continental United States
- Currently work with at least 1 child who takes medication to treat ADHD or have worked with at least 5 such children in the last 3 years.

Before you agree to participate in the study, please read this form and ask any questions you may have.

Purpose of Study
The purpose of the study is to learn about how social workers understand their role in the treatment of youth who take medication intended to treat ADHD. Results from this study will fulfill a thesis requirement for the researcher's Master's in Social Work (MSW) degree from Smith College School for Social Work. Ultimately, these results may be published or presented for professional purposes.

Description of the Study Procedures
If you agree to participate in this study, you will be asked to meet with the researcher to discuss your experiences working with children diagnosed and medicated for ADHD. If in-person, the interview will be held at a coffee shop or some other public setting that is both convenient for you and provide relative privacy while sharing your experiences. The interview will last approximately 1 hour and will be recorded for the researcher to review later. You will be asked a range of questions about your work (such topics include your view of ADHD, clinical interventions and techniques applied, and related challenges). You'll also be invited to share with the researcher any additional ideas about what is important to know about working with this population.

Risks/Discomforts of Being in this Study
This study has little foreseeable risk, but the researcher will ask you to discuss case material and issues of oppression, which may be difficult. However, you are encouraged not to share information that identifies clients, and no specific case will be published in this study.

Additionally, the demographics sheet, which asks you to reflect in very general terms upon personal experience(s) with ADHD and medication used to treat it, may feel vulnerable to share. This information will be kept confidential and combined with information from other participants in order to protect your identity. You may decline to answer any question or end the interview at any time. Upon request, I can provide a list of training resources on ADHD and psychopharmacology.

Benefits of Being in the Study
The anticipated benefit of participation is the opportunity to explore the complexities of your role in a confidential environment, and provide perspectives that could benefit research aimed at better supporting children and families. This study will benefit research insofar as it helps better locate the perspective of social workers about their work and their role with medicated youth. In turn, this will serve to more fully understand the current treatment culture, its strengths and weaknesses. Moreover, the information you provide will help fill a gap in the literature of qualitative research that addresses these questions with this population. Findings from this study may inform areas of social work practice, policy and education. Its implications may also help us imagine future research aimed at understanding more specifically if and how social workers' attitudes affect their clients' access/experience with drug treatment.

Confidentiality
Your participation and the information you provide are strictly confidential. The researcher will be the only person who will know about your participation. The researcher will have sole access to the audio recording of the interview, with the exception of a potential transcriber, who will sign a confidentiality agreement. Immediately following transcription, interviews will be permanently deleted from the recording device. Transcripts will be destroyed after three years, per federal mandate.

Data will remain confidential through the use of a key code. Once you sign the consent form, I will assign every individual a number (e.g. 01-12) and write their number on the printed demographics sheet. Therefore, any potentially sensitive information will remain confidential. Information collected from your interview will be analyzed for recurring themes and presented in the final write-up as aggregated with other interviewers' responses. In cases where a specific quote is used from an interview, it will be identified only as 'participant.'

All research materials including the demographics sheets, key code, consent forms, transcriptions, and written notes will be stored in a secure location for three years according to federal regulations. All electronically stored data will be password protected during the storage period. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. Finally, no identifying information will ever be published in any potential future report.

Payments/gift
You will not receive any financial payment for participating; however, the researcher may purchase coffee for example for the participant during the interview.

Right to Refuse or Withdraw
The decision to participate in this study is entirely up to you. You may refuse to take part in the study or ask to be removed from the study *at any time* up to April 1, 2015 without affecting your relationship with the researcher of this study or Smith College School for Social Work. Your decision to refuse will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any question, as well as to completely withdraw from the study: to do so, you must notify the researcher of your decision by email or phone by April 1, 2015. If you choose to withdraw, any information you provided for this study will not be used. After April 1, 2015, the research is entitled to use your information in the thesis and subsequent research.

Right to Ask Questions and Report Concerns
You have the right to ask questions about this research study before, during, and after the interview. Please address any study-related questions to Rachel Reed at rreed2@smith.edu. Upon request, a summary of results will be available once the study is completed. You are invited to contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974 regarding any other concerns about your rights as a research participant or problems as a result of your participation in this study.

Consent
Your signature below indicates that you consent to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You can obtain a list of training resources upon request.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix C: Demographic Form

1. What is your age? _____

2. How do you identify your gender? _____

3. How do you identify yourself racially and/or ethnically? _____

4. How do you define your class status? _____

5. What is your highest attained professional degree (i.e. MSW or PhD)? _____

6. Are you licensed as a clinical social worker?   Y/N

a. If not licensed, are you currently working toward licensure? _____

b. Anticipated date for licensure:_____

c. If licensed, how many years have you been practicing licensed clinical social work? _____

7. In what setting(s) do you currently practice? Check all that apply:

   ☐ Private practice   ☐   School   ☐   Outpatient ☐ Inpatient ☐   Other _____

8. Do you have a specialty/focus? Y/N.

a. If yes, please describe it: _____

9. What is your primary language? _____

a. Is this the language spoken in your work? Y/N

b. If no, please state that language(s) spoken at work: _____

10. Do you have children? Y/N

a. If yes, have any of your children been diagnosed with ADHD? Y/N

b. If yes, have they ever been prescribed or medication to treat ADHD?

11. Have you had an ADHD diagnoses and/or taken stimulant medication? Y/N

a. If yes, for how long (years) did you take stimulant medication? _____

    _____

12. For how many years (total) have you worked with children who take medication to treat ADHD?

   ☐ Less than 1 year   ☐ 1-3 years   ☐ 3-5 years   ☐ 5-10 years   ☐10+ years

a. Please estimate the *total* number of children from this population with whom you've worked in your social work career: _____

b. The number of children with whom you ***currently*** work: _____

13. Please describe the sociocultural variables reflected in your current work with this population

a. Race/ethnicity

    □ White: _____%
    □ Black or African American: _____%
    □ Latino:_____%
    □ Native American or Alaska Native: _____%
    □ Asian American: _____%
    □ Native Hawaiian or Pacific Islander:_____%
    □ Mixed-race: _____%
    □ _____: _____%
    □ _____: _____%
    □ _____: _____%

b. Religion

_____% Protestant   _____% Catholic   _____% Methodist

_____% Baptist   _____% Other Christian (please specify)

_____% Jewish   _____% Buddhist   _____% Muslim   _____% other (please specify)

c. Age

_____% Toddlers/Preschool (2-5)   _____% School-age children (6-12)

_____% Adolescents/Teens (13-18)   _____ other

d. Primary language

_____ English   _____Spanish   _____Other (please specify)

e. Please estimate the family's household income/SES

	10% or less	25%	50%	75%	100%
$Under 25k	□	□	□	□	□
$25-50k	□	□	□	□	□
$50k-100	□	□	□	□	□
$100k+	□	□	□	□	□

f. Please discuss any other sociocultural variables that describes this population:

14. Have some of the clients described above had a co-occuring disorder? Y/N

a. If so, what proportion?

   □ 10% or less   □ 25%   □ 50%   □ 75%   □   100%

Which primary diagnos(es)? _____

Appendix D: Semi-Structured Interview Guide

Note to the HSR Committee, questions 1-13 are primary questions, while the lettered and roman numeral questions beneath them are sub-questions reserved for participants who wish for further explanation.

Thank you for joining me today and so generously sharing your time to help me learn a bit more about your work with children diagnosed with ADHD. As a reminder, the interview will last approximately one hour. You have the choice not to answer any questions and I also invite you to add any information you think I should know, but don't feel is addressed in my questions. Please do not hesitate to interrupt me at any time during the interview. The audio recording for this interview will begin now.

Background, Experience, and Training

1. I'd like to start off by asking some questions that help paint a picture of the children you serve. Currently, about how many children diagnosed with ADHD do you serve?
   a. Of those children, about what proportion take stimulant medication?
   b. Are there any common co-occurring disorders? If so, which ones?
   c. Please briefly describe their sociocultural makeup
      i. *If the interviewer gets stuck or doesn't understand this phrase, I will suggest the following variables:* Race/ethnicity, age, gender, language, socioeconomic status, religion
2. You may have heard about a rise in ADHD diagnosis and medication to treat it in recent years. Can you tell me how you came to be involved in the treatment of children with ADHD?
   a. What factors have influenced your practice with this population?
      i. *If they get stuck* - Professional (e.g. training, orientation, treatment setting, years in practice) or personal experiences (family, etc.)

<u>Social Worker Views of ADHD: Causes and Appropriate Treatment Strategies</u>

3. What do you think causes ADHD or contributes to its diagnosis?

   a. How does this conceptualization compare to your understanding of the DSM-V definition of ADHD?

4. How do you know what you know about ADHD, its origins and treatments?

   a. How do you assess treatment options? (*If they get stuck*, through research?)

<u>How Social Workers Navigate the Current Treatment Culture</u>

5. How do you decide which interventions to reach for, when and with whom?

   a. How do you define cogent treatment goal(s)?

   b. How do you define successful treatment with this population?

6. What do you think influences your clients' decision to either take or not take medication to treat ADHD?

   a. Ideally, what should influence their decision?

   b. What, if anything, contributes to the gap between 'ideal' influences and 'actual' perceived influences?

   c. What protocol have you used or observed for when a client withdrawals from stimulant medication? ("Drug holiday")

7. In an ideal world, what would your relationship with your client's prescriber (psychiatrist, physician, etc.) look like?

   a. How have you experienced this relationship in the past?

   b. What, if anything, contributes to the gap between the ideal and actual experience of this relationship?

8. In an ideal world, what would your relationship with your client's parent/caregiver look like?

   a. How have you experienced this relationship in the past?

   b. What, if anything, contributes to the gap between the ideal and actual experience of this relationship?

9. If you could change one thing about your role in the current treatment culture, what would it be, and why?

Challenges to the Work

10. Social workers are increasingly called to interact with kids around medication and know what to do. As a social worker, what kinds of roles are you called to play in the treatment of youth who take ADHD medication?

    a. (*Possible topics*- Make referrals, monitor side effects, psychoeducation)

11. As a social worker, what do you think your role <u>should</u> be with regards to ADHD medication for youth?

    a. Have your clinical experiences diverged from the role you just discussed, if so, how? What are some of the challenges or barriers? (Managed care? pharmaceutical industry?)

12. Do you face ethical dilemmas in working with this population?

    a. If yes, what do you perceive them to be and how do you try to resolve them?

Closing Questions

13. I really appreciate your time and all the information you have shared. We are coming to the end of our time, but before you go, is there anything else that you think would be important for me to know about your role as a social worker working with this population?

Appendix E_HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

December 16, 2014

Rachel Reed

Dear Rachel,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Kristin Evans, Research Advisor

Appendix F: Transcriber Confidentiality Agreement

Confidentiality Agreement

Transcriptionist

I, _____ transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from Rachel Reed related to her research study on the researcher study titled Clinical Social Workers' Roles in Treatment with Children who take Medication to Treat ADHD (title subject to change).   Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher, Rachel Reed.
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.
4. To return all audiotapes and study-related materials to Rachel Reed in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.
6. I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed)

_____

Transcriber's signature _____

Date _____