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ABSTRACT

Much of the research indicates that diagnosing children with mental illness is a murky issue that has serious implications. Mostly absent in the literature regarding pediatric mental illness is the clinician's experience of diagnosing children. This study will help to address this gap by investigating clinicians' experience of diagnosing oppositional defiant disorder (ODD) and pediatric bipolar disorder (PBD) in children across treatment settings. Specifically, this study will investigate (1) how clinicians understand the etiological factors contributing to children's symptoms; (2) how clinicians are affected by mental health care policies and systems; (3) and lastly, how clinicians perceive both their personal and their clients' sociocultural identities impacting diagnosis and treatment. The latter was explored through semi-structured, open-ended interviews with eleven mental health practitioners. The findings from this study elucidate the points of ambiguity and tension in diagnosing a child with a psychiatric illness. The dissatisfaction with the current system of diagnosis potentially draws into question the validity and meaning of pediatric mental illness at all. Regardless, these findings suggest that more research is needed to examine clinician's perspectives, as there is significant literature exploring clinical treatment and practice, but little about how clinicians actually feel about the system, criteria, and practice of diagnosis.

**CLINICIANS' EXPERIENCE OF DIAGNOSING CHILDREN WITH OPPOSITIONAL
DEFIANT DISORDER (ODD) AND PEDIATRIC BIPOLAR DISORDER (PBD)**

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

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2016

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CHAPTER I

Introduction

Much of the research indicates that diagnosing children with mental illness is a murky issue that has serious implications. Mostly absent in the literature regarding pediatric mental illness is the clinician's experience of diagnosing children. This study will help to address this gap by investigating clinicians' experience of diagnosing oppositional defiant disorder (ODD) and pediatric bipolar disorder (PBD) in children across treatment settings. In particular, this study will investigate (1) how clinicians understand the etiological factors contributing to children's symptoms; (2) how clinicians are impacted by mental health care policies and systems; (3) and lastly, how clinicians perceive both their personal and their clients' sociocultural identities impacting diagnosis and treatment.

The present study is important to the field of social work by furthering understanding of how clinicians' interpret the impact of diagnosing, whether the diagnostic process aligns with their personal beliefs, and how systems and structures impact their diagnostic process. Understanding the latter can help determine how to improve the diagnostic process of pediatric psychiatric illness.

While the rate of diagnosis of pediatric mental illness is on the rise (Meagher et al., 2012; James et al., 2014), there is an unsettled feeling that permeates the mental healthcare system regarding the efficacy and ethics in diagnosing children (Stebbins & Corcoran, 2015). The burden of carrying certain diagnoses permeates all aspects of a child's life

(<http://bringchange2mind.org/learn/the-facts/>). Specifically, ODD and PBD seems to signal to teachers and caregivers that this child is inherently “bad” and fails to acknowledge the child as symptom barer for their environment (as cited by Atkins-Loria, Macdonald, & Mitterling, 2015).

Mental illness diagnoses can sometimes provide relief to the individual and their family by providing language that offers insight into their experience and thus help them seek proper treatment. Often, however, the diagnosis of mental illness can fail to acknowledge the environmental factors and systems causing stress to the individual. Community violence, family dysfunction and stress, and the experience of racism and discrimination have all been correlated with pediatric mental illness (Russell et al., 2015; Belardinelli, 2008; Coker et al., 2008). Thus, individuals bare the weight of these greater systems’ issues, often leading to their symptom presentation.

Mental health treatment providers do not have much control over these systems and are thus put in the position of pathologizing the individual. Yet, the degree of the latter can vary depending on the provider’s theoretical orientation and professional licensure. Psychiatrists are more likely than social workers to identify pathology in an individual (Pottick et al., 2007), which likely reflects the medical model’s tendency to seek illness.

Also significantly impacting a client’s diagnoses are the sociocultural identities of the clinicians and their clients. African American boys are far more likely to receive the ODD diagnosis than their white counterparts (as cited by Atkins-Loria, 2015; Heflinger & Humphreys, 2008; Russell et al., 2015), and it carries more risk in how the world perceives and interacts with them, as rates of ODD were up to 40% in the juvenile justice system (as cited by Atkins-Loria, 2015). Additionally, clinicians’ diagnostic decisions are impacted by their own identities, as male clinicians were more likely to judge a youth’s behavior as disorder, and minorities were

less likely to judge disorder present regardless of whether the behaviors suggested internal dysfunction (Pottick et al., 2007).

Research has shown that practitioners feel the burden of the insurance payment structure and its implications in their work with children (Stebbins & Corcoran, 2015). Specifically, they identify insurance impacting their decisions for course of treatment and the amount of time their clients can afford in treatment (Stebbins & Corcoran, 2015). The latter may directly impact diagnostic decision making by way of the practitioner feeling they do not have enough information to make an informed diagnosis or selecting a diagnosis that may offer the child more treatment.

The present study explored clinicians' experiences of diagnosis by interviewing eleven mental health practitioners who have had children diagnosed with ODD and PBD on their caseloads. They were recruited through purposive and snowball sampling, via social media and the researcher's professional network. The researcher interviewed each participant individually with a semi-structured, open-ended interview guide she created based on the existing literature and the research purpose and questions.

These findings elucidate the points of ambiguity and tension in diagnosing a child with a psychiatric illness. The dissatisfaction with the current system of diagnosis potentially draws into question the validity and meaning of pediatric mental illness at all. Regardless, these findings suggest that more research is needed to examine clinician's perspectives, as there is significant literature exploring clinical treatment and practice, but little about how clinicians actually feel about the system, criteria, and practice of diagnosis.

CHAPTER II

Literature Review

Mental health professionals and consumers, and those who observe from the outside, often debate the efficacy and ethics regarding the diagnosis and treatment process of children with mental illness. The empirical and theoretical literature on pediatric mental illness focuses on its possible impetuses, the pattern and effects of medicating children, diagnostic patterns amongst various demographic groups and the reasons for these differences. Inherent in much of the literature is examining the racial elements of pediatric mental illness and its diagnostic process. While researchers have superficially examined the diagnostic experience, there is little research regarding clinicians' experience of diagnosing bipolar disorder and oppositional defiant disorder in children.

Rate of diagnosis

Pediatric mental illness, in general, is continuously growing in the United States. According to Perou et al. (2013), in 2010, approximately thirteen to twenty percent of children experienced mental illness, and suicide was the second leading cause of death among children 12-17 years old. Behavioral disorders, like ODD, only accounted for 3.5% of the mental illness diagnosed amongst these children. Thus, the present study is only examining a small part of a much larger problem.

The rate of diagnosed pediatric bipolar disorder continues to increase annually. Blader & Carlson (2007) examined hospital discharges between 1996 and 2004 and found that rates of PBD as a primary diagnosis increased from 1.3 per 10,000 children in 1996 to 7.3 per 10,000

children in 2004. The authors make note of the fact that few black individuals were diagnosed with bipolar disorder in 1996, but this number had significantly increased by 2004. Pediatric bipolar disorder is also more likely to be diagnosed in the United States than in other countries. James et al. (2014) observed hospital discharge rates from 2000 to 2010 and found that PBD was significantly more likely to be diagnosed in the United States than in England, while all other mental illnesses were comparable.

Although a significant portion of the population is impacted by these diagnoses, the rates vary particularly across racial and ethnic groups. African American boys are disproportionately more likely to receive a conduct disorder diagnosis, which is the category in which ODD falls (as cited by Atkins-Loria, 2015; Heflinger & Humphreys, 2008; Russell et al., 2015). The latter is consistent with other research, including Russell et al.'s (2015) finding that minority youth are significantly more likely to receive a lifetime diagnosis of ODD. This pattern becomes further apparent when considered with the findings that boys were twice as likely to receive an antipsychotic prescription (NIH press release, 2015).

In an examination of Tennessee's public mental health care system, the average age at which a child received an ODD diagnosis was 11.7, and this age decreased if the child was a racial or ethnic minority and male (Heflinger & Humphreys, 2008). ODD was rarely the first diagnosis a child received, but rather came after a child had already had mental health services and a different primary diagnosis. This latter finding implies that the symptoms described by ODD may in fact be a behavioral manifestation of a different problem. While Tennessee is not necessarily representative of all states, these results may be indicative of patterns of usage across state lines.

Although much of the research indicates that racial and ethnic minority boys are more likely to receive a diagnosis within the conduct disorder category, further research indicates that black children are less likely to receive a psychiatric diagnosis (Pottick et al., 2007). In an examination of how clients' and clinicians' sociocultural factors impact the diagnostic process, Pottick et al. (2007) found that clinicians were more likely to identify a psychiatric illness in white children than in minority children. The researchers deduced from these results that minority youth may be more likely directed to the criminal justice system than to mental health care.

Buttressing the latter, rates of conduct disorder and ODD were up to 40% in the juvenile justice system (as cited by Atkins-Loria, 2015). The Department of Justice (2015) looked at data from the Northwestern Juvenile Project for the prevalence of pediatric mental illness among children 13 years of age and older transferred to adult criminal court versus juvenile court. While this study was examining where children were tried, their results are relevant to the present study. Specifically, 15% of participants had a diagnosis of ODD, 44% had any disruptive behavior disorder, and 38% had conduct disorder in the juvenile court. These findings coupled with Pottick et al.'s study suggest that those who are diagnosed with ODD often are directed to the criminal justice system and their mental health is overlooked.

Causes of ODD/PBD

The present study focused primarily on the research that explored the environmental factors that lead to ODD and PBD, but there is a dense body of literature examining biological and genetic etiologies.

In investigating the biological causes of oppositional defiant disorder, many researchers used twin studies as their means to possibly understand ODD (Dick et al., 2005; Martin et al.,

2006). Dick et al. (2005) and Martin et al. (2006) focused on the covariation of ODD, attention deficit hyperactivity disorder (ADHD), and conduct disorder (CD). Dick et al. (2005) found, amongst 600 14 year-old twins through face-to-face interviews, a high degree of genetic correlation amongst all of the disorders, including CD and ODD, and felt these genetic factors were stronger than the environmental ones. Martin et al. (2006) found a strong correlation between ODD and ADHD-HI (hyperactive/impulsive) with a shared genetic heritability of 42%.

While Dick et al. (2005) and Martin et al. (2006) focused on ODD in conjunction with other disorders, Zhu et al. (2014) investigated the brain mechanisms of pure ODD without a dual diagnosis. They found that the right inferior frontal gyrus in part, responsible for response inhibition-showed lower activity levels in those diagnosed with ODD, and as a result, the researchers deduced that those with ODD have attention problems.

Researchers (Zeni et al., 2016; Mwangi et al., 2014) have investigated parts of the brain that may impact pediatric bipolar disorder. Zeni et al. (2016) found smaller hippocampal volumes in children with PBD as a result of interaction between family dysfunction and a specific gene. Mwangi et al. (2014) focused on the amygdala's role in PBD by comparing neuroimaging scans of 16 unmedicated children with PBD and 16 children without. Their study confirmed previous literature that there are amygdala abnormalities in children diagnosed with PBD.

Much of the research on pediatric bipolar disorder (PBD) and oppositional defiant disorder (ODD) has explored the possible environmental factors that have led to the behaviors and symptoms of concern. Russell et al. (2015) investigated whether community and neighborhood safety and prenatal exposure to alcohol and drugs were possible causes of ODD through self-administered questionnaires to close to 6,000 parents of adolescents. They found a

high correlation between ODD in children and exposure to drug sales in their neighborhood and communities.

Others have wondered whether the functioning of the family of origin causes mental illness in children. Belardinelli (2008) compared the families of children with bipolar disorder to families with no reported psychiatrically ill child. They found that the former families reported more family disorder and conflict than those families with healthy children. While this research question seems important and worth investigating, the study design seemed limited in its inability to determine whether the family discord began before the child's mental illness or was in response to the stress it put on the family.

As previously described, racial and ethnic minority children are more likely to receive a diagnosis of ODD. Researchers have considered this latter finding and wondered how race and mental illness are correlated. Coker et al. (2009) examined whether perceived racial and ethnic discrimination led to mental health disorders amongst children. They reviewed data of 5,147 fifth grade students through data previously collected from parent and child interviews on behaviors and risk factors. They found that those children who reported perceiving or experiencing racial or ethnic discrimination were also more likely to experience symptoms of depression.

Rather than researching potential causes of ODD in children, Atkins-Loria, Macdonald, & Mitterling (2015) considered the validity of the diagnosis itself and the system from which it derived. The authors feel that psychiatric assessment and ODD as a diagnosis fail to acknowledge the history of the enslavement and oppression of black people. The authors endorse Dr. Joyce DeGruy's (2005) proposed diagnosis for Post Traumatic Slave Syndrome: "a multigenerational trauma together with continued oppression and absence of opportunity to

access the benefits available in the society [real or imagined],” in which “[a] syndrome is a pattern of behaviors that is brought about by specific circumstances” (p. 121). They feel that this diagnosis aptly acknowledges where behavior and mental health symptomology originate rather than labeling a child as inherently bad.

Treatment of ODD/BPD

Although the rate of diagnosis of PBD and ODD are on the rise, the treatment for these disorders is limited and seems to be primarily focused on psychiatric drugs. In 2006, in the United States, 1.6 million children were prescribed at least two psychiatric medications (Harris, 2006).

Psychiatric medications, specifically antipsychotic drugs, have been approved to treat children with illnesses such as bipolar disorder, schizophrenia, and autism. Despite this, researchers have found that antipsychotic medications are being prescribed and used for things other than their stated purposes, such as impulsivity and aggression (NIH Press release, 2015). Olfson, King, and Schoenbaum (2015) investigated filled prescriptions for all antipsychotics in 2006, 2008, and 2010 by looking at data through the IMS LifeLink LRx Longitudinal Prescription databases. They found that approximately 270,000 young children receive antipsychotic prescriptions. This study is consistent with other research that found that the use of antipsychotics for children doubled between 1996 and 2001, with an increased use of antipsychotics for conduct disorders despite no evidence supporting that this is safe (Cooper et al., 2004).

The authors also noted that the rate of conduct disorders decreases into adolescence, and they identified the neurobiological mechanisms that lead to a decrease in aggression and increased impulse control. It is important to consider these two findings together because one can

gather than many young children who are diagnosed with a conduct disorder are also receiving an antipsychotic medication. These same children's oppositional and defiant behaviors will eventually decrease on their own, yet they are still being medicated.

The number of children on antipsychotic medications is particularly troubling when considering the literature investigating its impact on children's overall health. Specifically, research has found that antipsychotic medications significantly negatively impact children's weight. Ratzoni et al. (2002) found that 90.5 percent of their adolescent participants on olanzapine and 42.9 percent of their adolescent participants on Risperidone gained a significant amount of weight in the 12 weeks of follow-up. In a review of the literature on second-generation antipsychotics, De Hert et al. (2011) found similar results in addition to other troubling health outcomes. They reported on one study, in which 28% of children on second-generation antipsychotics had very high prolactin levels; although none of these children had hyperprolactinaemia, there was no research to investigate the long-term effects of elevated prolactin levels.

Children diagnosed with bipolar disorder are also primarily utilizing medication to treat their symptoms (Voort et al., 2015). Voort and his colleagues (2015) conducted a study in which they appraised the medical records of 85 children with a PBD diagnosis who received psychiatric treatment from a specific facility from 2000 to 2011. They found that these clients were only coming in for medication management approximately once every two months and only half of the patients were utilizing some kind of psychotherapy with the same frequency.

While there is no evidence to support the use of these medications for young children, it is interesting to note that white children have more access to this treatment (Mendenhall et al., 2011). Cataife and Weinberg (2015) found that white children are statistically more significant to

receive an antipsychotic prescription than their ethnic and racial minority counterparts. Their participant pool was far reaching, as they looked at 5,843,711 children enrolled in Medicaid in Alabama, Colorado, Illinois, Iowa, Louisiana, New Hampshire, North Carolina, and Oklahoma from 2005-2009. Similarly, Mendenhall et al. (2011) found that children enrolled in Medicaid were more likely than children with private insurance to receive only therapy rather than multi-disciplinary treatment. This aligns with Pottick et al.'s (2007) findings that minority children are more likely to be directed to the juvenile justice system than mental health services, and white children are more likely to benefit from psychiatric treatment.

As the literature has suggested, psychopharmacological treatment seems to have replaced other forms of therapy (Voort, 2015), which is concerning considering medication's impact on children's health (Ratzoni et al., 2002; De Hert et al., 2011). Other researchers have investigated the efficacy of treatments without medication and have found promising results. Weinstein et al. (2015) examined the value of child- and family-focused cognitive-behavioral therapy (CFF-CBT) versus unstructured psychotherapy in the treatment of PBD. They defined CFF-CBT as treating the children's mood states, the parents' mental health, and teaching skills from CBT and mindfulness based practices. While there were nuances in their results, they found that CFF-CBT had a more positive impact in treating PBD than psychotherapy.

Like the treatment of PBD, the treatment of ODD without medication is limited. Laezer (2015) specifically investigated this query by comparing long-term psychoanalytic treatment with behavioral and medication treatment of ADHD and ODD. The child participants in the behavioral group were either assigned to an anti-aggression training group or an attention and concentration-training group, both of which included parent-training programs. Laezer (2015) found that both groups had a significant decrease in symptoms, and there were no significant

differences between the two. These results suggest that there are efficacious treatments that do not include medication, possibly sparing children the negative side effects of these medications.

Larson et al. (2009) also investigated treatment programs for ODD that included parent-training components. They found that the children's behavior improved in both the parent training and child therapy condition and in the parent training condition versus the placebo group. These treatment options and their outcomes emphasize the importance of including parents in the treatment of children, considering that children are spending a limited amount of time with their therapists.

Diagnostic experience for clinicians

Significant in the conversation on PBD and ODD are the individuals who do the diagnosing and treating, who are predominantly social workers and psychiatrists. As previously noted, black children are the largest population impacted by the ODD diagnosis and receiving the least amount of treatment, while the majority of the treatment providers are white-identified. While it has been a common theme throughout the articles cited, race in the clinical encounter is important to name. The white-identified clinician and the client of color is an overused trope in the field of social work that perpetuates white hegemony. With the latter in mind, it is also important to note that white-identified clinicians are often working with clients of color, and this racial contrast can magnify the potential racism and bias that occurs.

White clinicians report feeling less competent to work with their ethnic and racial minority clients (as cited by Iwamasa, 1997; Szigethy et al., 2012). This may in part, explain why white therapists underestimate the pathology in their clients of color and yet view them as more disturbed (as cited by Iwamasa, 1997; Szigethy et al., 2012).

The therapists' of color experience is very different from the white identified clinician's (Szigethy et al., 2012). Comas-Diaz and Jacobsen (1995) outlined common transference and countertransference themes in the relationship between white identified clients and their clinicians of color. The authors discuss the power reversal that occurs in this dyad, because the white individual is now in the position of seeking help from an individual that has historically been oppressed. This role reversal may lead the racial minority therapist to question their competence when issues arise in the relationship and thus cause them to seek approval from their client (as cited by Comas-Diaz & Jacobsen, 1995).

As previously stated by Pottick et al. (2007), black clients are more likely to be directed to the criminal justice system than to mental health services. Psychiatry has a history of cultural bias in which they view African Americans as “too jovial to be depressed or too impoverished to experience object losses” (Adebimpe 1981, p. 281, as cited by Atkins-Loria et al., 2015). With the latter in mind, it can possibly explain why black children are perceived as inherently bad rather than as experiencing symptoms that require mental health attention.

This pattern of directing black children to the juvenile justice system may be further exacerbated by the perception of black children as adult-like and responsible for their actions (Goff et al., 2014). Through a mixed-method design, Goff et al. (2014) had participants rate the innocence of children of different ethnic and racial backgrounds, and found that the adult participants rated black children as less innocent after they turned 10. In another part of their study, they had police officers rate the perceived age of child crime suspects from different racial and ethnic backgrounds and found that police consistently over-estimated the age of Black and Latino suspects. Goff et al.'s (2014) study is important in explaining why Black children may be over diagnosed with disorders of conduct or not diagnosed with mental illness at all.

As previously stated, environmental stressors greatly impact children's behavior (Russell et al., 2015; Belardinelli, 2008; Coker, 2009), and knowing a child's environmental context can influence how the psychiatrist or social worker chooses to diagnose. Pottick et al. (2007) found that clinicians were unsure about how to diagnose when they were only provided with behavioral symptoms when asked to judge a case vignette. This is consistent with Hsieh and Kirk's (2003) findings that clinicians were unsure and less likely to diagnose ODD if they did not know the child's environmental context.

Diagnosing and treating anyone of any age is significantly impacted by the therapist's various identities and how they intersect with their client's (Cardemil & Battle, 2003). The evidence on this, however, is not consistent. Pottick et al. (2007) found that clinicians' race and gender did not significantly predict whether they would judge disorder in their clients. Yet in an earlier study done by Pottick et al. (2003), they found that female clinicians were less likely than their male counterparts to judge a youth's behavior as disorder, and minorities were less likely to judge disorder present regardless of whether the behaviors suggested internal dysfunction. These mixed results might suggest that clinicians don't want to reveal their bias because of fear of judgment from the researcher.

The clinician's training can also be significant in the diagnostic process. Psychiatrists and social workers are the primary professional licensures diagnosing children, and it seems that their training significantly impacts their decision-making. Pottick et al. (2007) found that psychiatrists were more likely than social workers to judge disorder, which may reflect the medical model's need to identify pathology.

Stebbins and Corcoran (2015) specifically investigated psychiatrists' experience and perception of diagnosing children with bipolar disorder. Through exploratory, semi-structured

interviews, the researchers identified several themes that emerged from their ten participants. Most notably, many of the participants felt that PBD was over diagnosed and identified the environment as having a strong impact on children's behavior.

Important in the discussion of diagnosing and treating pediatric mental illness is the systemic influence. All participants in Stebbins and Corcoran's study (2015) felt that insurance created a barrier for their clients to access proper or sufficient treatment. Mental health care is often funded by government insurance payments, and managed care "control(s) the use of services" by doing such things as dictating the provider and the length of treatment (Glied & Neufeld, 2001, p.1130). Participants in Stebbins and Corcoran's study (2015) felt that the insurance payment structure was such that they didn't have enough time to evaluate their clients, which led to a potentially inaccurate diagnosis and treatment decisions. Similar feelings emerged in a qualitative study examining Marriage and Family Therapists' experience and perspective of managed care (Christensen & Miller, 2001). Amongst other themes that emerged, the participants noted struggling with the requirement to diagnose, as the process didn't align with their professional ethics and clinical understanding of their clients, especially when they felt that their clients' presenting problems resulted from a family systems issue (Christensen & Miller, 2001).

Considering how clinicians are impacted by managed care is important because approximately 16.7 million children are enrolled in a managed care plan (Glied & Neufeld, 2001). Glied & Neufeld (2001) explore several different aspects and requirements of funding streams, but one thing they noted was the use of utilization reviews. Utilization reviews require clinicians to review their clients with an insurance representative to request more days of treatment. Glied & Neufeld (2001) reported on a finding that utilization reviews didn't impact

adult clients seeking services but shortened their length-of-stay by 47%. They noted that this finding likely impacts children similarly “because authorization for mental health services often is based exclusively on preset guidelines for adults (American Academy of Pediatrics 2000)” (as cited by Glied & Neufeld, 2001, p. 1130). Further exploring how clinicians experience managed care can increase the understanding of how it impedes clinicians’ ability to deliver appropriate treatment to their pediatric clients.

The way clinicians are affected by macro systems can be mediated by their agency structure and culture. Researchers often consider how agencies impact clinicians by measuring their level of “burnout” (Rupert & Morgan, 2005; Stalker et al., 2007; Arches, 1991). Burnout has been operationalized and defined as “a cluster of physical, emotional, and interactional symptoms related to job stress and includes emotional exhaustion, a sense of lacking personal accomplishment, and depersonalization of clients” (Arches, 1991, p. 202). Arches (1991) focused on how the agency produces burnout, while they noted that other studies seemed to focus on the individual becomes burnt out or ways the individual can prevent it. They found, through use of mailed surveys, that the agency setting, as a result of bureaucracy, limits individuals’ autonomy and their professional creativity and style.

Similarly, through the use of a literature review, Stalker et al. (2007) found that emotional exhaustion and job satisfaction in clinicians who work in child welfare were largely impact by the workplace. They identified unsupportive management, lack of professional growth opportunities, and dissatisfaction with agency policy as leading to increased emotional exhaustion and lowered job satisfaction. Self-employed practitioners who work in independent settings were less likely to report symptoms of burnout (Rupert & Morgan, 2005). In fact, they seemed to have more job satisfaction and had less emotional exhaustion than those clinicians

who worked in agency settings. This seemed to be the result of having less paperwork and more hours with clients who were less acute.

These individual factors explored throughout this literature review interact and influence how or whether a child is diagnosed with a psychiatric disorder. The present study will attempt to investigate how clinicians observe biological, sociocultural, systemic, and interpersonal factors and how both they and their clients feel impacted by them in the treatment process.

CHAPTER III

Methodology

The purpose of the present qualitative study was to evaluate clinicians' experience of diagnosing and treating children with pediatric bipolar disorder (PBD) and oppositional defiant disorder (ODD). In doing so, this study addressed the following questions: (1) How do clinicians' perceive their clients' and their sociocultural identities impacting their diagnostic and treatment decisions? (2) How do their personal beliefs and values align with diagnosing and treating children with ODD and PBD? (3) How do systems, such as insurance reimbursement and agency structure, impact their diagnostic and treatment decision-making? Interviewing clinicians about their experience elucidated these interpersonal and systemic factors that influence the diagnostic and treatment process. Understanding these challenges can potentially help to improve systems, and thus allow practitioners to serve their clients to the best of their ability, unencumbered by bureaucracy and systemic obstacle and can potentially help improve children's mental health treatment.

The present study used semi-structured, open-ended interviews to collect data from child clinicians. There is a gap in the literature regarding clinicians' experience of diagnosing children with psychiatric disorders. Going directly to the source of the diagnosing can hopefully shed light on both the interpersonal and systemic factors that impact diagnosing and thus provide insight to improve them. Semi-structured, open-ended interviews provide the opportunity to explore this area where there is little to no framework.

An inductive approach was used in this study. Although theories of clinical practice/treatment abound, there do not seem any specific to the diagnostic process. For example, Cognitive Behavioral Theory explains why a person suffers from depression and how to treat that depression, but does not incorporate a rationale for why a clinician would diagnose a client with depression using the DSM criteria or what purpose this tool serves in treatment. Those theories that do exist are too generalized to seem applicable to this context. For example, a Fouccadian might examine power dynamics between the diagnosed and diagnostician, but that theory seems less applicable if the clinicians themselves are not in favor of- or feel forced to use the diagnostic system. A grounded theory approach requires that the researcher first collect their data and then create meaning and build theory from this data (Carey, 2012). Grounded theory is based on the assumption that ““patterns and theories are implicit in data, waiting to be discovered,”” rather than attempting to fit the data into an already existing theory (as cited by FTSYGM; Cohen et al., 2007, p. 491). Due to the time and resource constraints of this study, a formal grounded theory approach could not be used. Despite this, an inductive approach was comprehensive in identifying meaning in the raw data collected (Thomas, 2006; Carey, 2012).

Sample

Participants in this study were medical or mental health professionals who met the following criteria: (1) had worked with children for at least a year, (2) currently or previously had children on their caseload diagnosed with ODD or PBD, (3) were currently practicing [at the time of the study], (4) and held a medical degree, master’s or a doctorate in social work, psychology or marriage and family therapy. Participants who didn’t have a professional degree were excluded, because this would bar them from diagnosing a child with a mental illness. Of note however, participants who had worked with children diagnosed with ODD and PBD but had not

necessarily given these diagnoses themselves were included, given that some agencies divide these functions across departments or a child could be diagnosed by a psychiatrist, but seen by a social worker or psychologist. Also, most clinicians have the opportunity to modify their clients' diagnoses, thus interviewing these clinicians still provided insight into their feelings about pediatric psychiatric illnesses. Originally, only participants with an MSW were to be included in this study, but this limited the sample size too much. In addition, by including participants with various professional licensures, it illuminated how their training impacted their clinical formulation and reflection. Also of note, surveying a diversity of clinicians is isomorphic to typical agency structure, as most clinical teams are interdisciplinary. The participants worked in a variety of settings, which allowed for comparisons of how system structure and culture influences the diagnostic process.

All individuals who expressed interest in participation were interviewed. This was done in order to increase the number of referral sources to the present investigation; almost all interviewees were asked to pass along the information regarding the study to individuals they felt would be particularly interested. This researcher hoped to recruit participants with more diverse social identities, as the white, female identified clinician is a well-represented perspective in social work literature. Due to limited time and resources as well as the nature of snowball sampling, the participant pool was homogenous in racial, ethnic and gender identity, which is a limitation of this study.

People interested in participating in the study were asked to complete a demographics questionnaire (see Appendix A) and informed consent form (see Appendix B) and return them completed to the researcher prior to the scheduled interview.

In the present study, thirteen people were interviewed, but two were not analyzed as a result of lack of relevant experience or inability to answer the interview questions. The details of the demographics are outlined in Table 1.

Table 1.

Demographic Data

Participant #:	Q1: Degree	Q2: 1 year experience	Q3: US or Canada	Q4: children with ODD/PBD	Q5: Professional role/identity	Q6: Years of clinical work	Q7: Hispanic, Latino, or Spanish origin	Q8: Race	Q9: National identification	Q10: Gender identity	Q11: Age
11	Yes	No	Yes	Yes	Social worker	1-4 years	No	White	U.S.A. Identified	Female	25-34
4	Yes	Yes	Yes	Yes	Social worker	5-9 years	No	White	U.S.A. Identified	Female	N/A
2	Yes	Yes	Yes	Yes	Psychiatrist	20-30 years	No	White	U.S.A. Identified	Female	N/A
5	Yes	Yes	Yes	Yes	Social worker	Over 30 years	No	White	U.S.A. Identified	Female	55 and over
3	Yes	Yes	Yes	Yes	Social worker	1-4 years	No	White	U.S.A. Identified	Female	25-34
10	Yes	Yes	Yes	Yes	Social worker	1-4 years	Yes	Prefer not to answer	U.S.A. Identified	Female	25-34
6	Yes	Yes	Yes	Yes	Psychiatric nurse	Over 30 years	No	White	U.S.A. Identified	Female	55 and over
9	Yes	Yes	Yes	Yes	Social worker	20-30 years	No	White	U.S.A. Identified	Female	55 and over
8	Yes	Yes	Yes	Yes	Social worker	Over 30 years	No	White	U.S.A. Identified	Female	55 and over
1	Yes	Yes	Yes	Yes	Social worker	10-19 years	No	White	U.S.A. Identified	Female	35-44
12	Yes	Yes	Yes	Yes	Social worker	20-30 years	No	White	Internationally identified	Female	45-54
7	Yes	Yes	Yes	Yes	Social worker	1-4 years	No	White	U.S.A. Identified	Female	25-34

Recruitment

The Smith College School for Social Work HSR committee approved this study and all procedures used prior to recruitment.

A purposive and snowball sampling was used to recruit participants. Purposive sampling is appropriate when one needs their participants “to be biased in a certain direction-to have an expertise or reputable ‘judgment’ about your area of interest” (Steinberg, 2015; p. 102). Considering this study’s limited time and resources, purposive sampling also allows quick, and convenient sampling and helped make this study feasible (Steinberg, 2015).

Initially, participants were recruited from the current field placement of the researcher, but excluded any clinicians who worked directly in her department to avoid coercion and collusion. The researcher distributed a flyer via email to her supervisor and asked her to share it with individuals she felt would be particularly interested (see Appendix C). Due to the lack of interest from the professionals at the researcher’s agency, her supervisor provided her name and contact information to professionals in the field to pass onto those they felt would be interested.

The latter recruitment method was not fruitful, as this researcher received no inquiries for the first 3-5 weeks of recruitment. Due to the initial plan failing, this researcher changed her methods of recruitment. Facebook became the primary recruitment tool: the recruitment flyer was posted in interest groups related to the field of social work and child therapy (see Appendix D).

When individuals expressed interest, the researcher either reached out to them via phone or email or waited for their inquiries, depending on the preference stated by the referral source. Two to three emails were sent to those who initially offered to participate. After that amount of effort, if a person did not reply, a lack of interest was assumed and further attempts were ceased.

Once interest was established, a time was scheduled to conduct the interview. Regardless of interview format, the informed consent and demographics questionnaire was sent via email, with participants asked to complete them and return them prior to the scheduled interview. Participants were informed that they could refuse to answer any questions or ask clarifying questions regarding the interview questions.

Ethics and Safeguards

Protection of confidentiality. Participants were not anonymous due to the nature of conducting individual interviews. All efforts were made to keep their participation confidential. Interviews were conducted away from the participants' place of work. After the interviews, this researcher stripped the participants' names and any identifying information from the interview transcripts. All interview materials, including demographics questionnaire and informed consent forms, were stored in this researcher's personal files. Participants were assigned code numbers, which then indicated any information or documents pertaining to them. Identifying information was removed before this researcher discussed the interviews with her research advisor. When sharing private case information, this researcher removed any information that identified clients mentioned.

Risks and benefits of participation. The risks of participating in this study were low due to the nature of the topic. The present study focused on individual's thoughts and beliefs related to their professional identities. This reduced their vulnerability to risk associated with discussing delicate material. Despite this, discussing pediatric psychiatric health may elicit feelings of shame and guilt depending on an individual's personal beliefs. Additionally, participants may reveal aspects of their countertransference that increase the possibility of risk, as they may be unexpectedly triggered. Also, participants may reveal details about the

diagnostic process that are unethical which may cause negative feelings. Participants were reminded that their identifying information would be kept confidential and they had the right to refuse to answer any question. Similarly, participants might discuss aspects of the latter that are specific to their agency or clinical team. In such cases, this researcher determined that she would encourage participants to discuss their concerns with their supervisor as well as remind participants that their responses were confidential.

This study could benefit the participating individuals in several ways. As the study is voluntary, those who offered to participate likely feel passionate about the topic and therefore grateful for a confidential space to discuss an issue important to them. In effect, participants may feel they are giving voice to their clients' experiences. Additionally, discussing the issues surrounding pediatric diagnosing and treatment perhaps will lead to feelings of altruism, as participants could feel they are contributing to an important cause.

Data collection

Semi-structured, open-ended interviews were used to collect data from participants (see Appendix E). Thus, this researcher had twelve questions she intended to ask all participants, but skipped questions or jumped ahead in order if participants had already covered a topic or begun discussing a topic more related to a future question. This was done in order to reduce redundancy and thus prevent irritating participants or fatiguing them by making them repeat themselves.

The interview consisted of four specific sections: (1) an introductory section intended to create a level of comfort for the participant, by asking easy questions such as why the participant decided to become a clinician in the first place; (2) a section intended to gain understanding about how the participants' past clients informed their current clinical perspective and theories

on the diagnosis and treatment of children; (3) a section on the institutional influences on their perspective, such as how the agency or managed care provider may affect the diagnostic process; (4) and personal factors that influence clinician's experience and perspective.

Each interview lasted approximately 45 to 75 minutes. After scheduling an interview time, the researcher asked the participants to complete the demographics and informed consent form and return them to her prior to the interview. The demographic information included their degree, years of experience, country in which they practiced, number of years practicing with children, professional role or identity, whether they had children on their caseload diagnosed with ODD or PBD, gender, race/ethnicity, national identification, and age. No participant was excluded due to race, ethnicity or gender.

Each interview began by asking participants about their current work to make them feel comfortable and ease them into the interview. Any questions the participant might have about being in the study was then answered by the researcher. For instance, participants asked why the researcher chose to study both ODD and PBD or how the researcher came to the topic in general. In these moments, the researcher explained her reasoning and validated the participants' curiosity. If the demographics questionnaire and informed consent had not previously been completed, the participants completed them prior to the interview. Interviewees were told when the recording device was turned on. Interviews were recorded with typed notes and an audio recorder.

The researcher reminded the participants that they did not have to answer any question that made them feel uncomfortable. Throughout the interview, the researcher indicated to participants the need to keep moving due to limited time and not for lack of interest. She asked follow up questions or used case examples when necessary.

After each interview, the researcher wrote briefly about her initial reactions to the interviewee and any common emerging themes she noticed. For example, the researcher noted that several participants had focused on attachment disruptions as the underlying reason for their clients' behaviors. Additionally, the researcher transcribed major content from the interviews, barring unique syntax.

Data analysis

This study was attempting to fill a gap in the literature, thus there was little theory or previous research to use as a model for data analysis. As a result, this study used thematic analysis, which is well suited with an inductive methodology. The inductive approach focuses on developing theory and inferences from the raw data rather than attempting to make it fit with prior assumptions and hypotheses (Thomas, 2006). It also helps to condense extensive collected information into more succinct themes and data. Moreover, this approach best suits the present investigation as there is limited existing literature pertaining to the present study. Thematic analysis, in turn, identifies “themes and patterns regarding individual or, more often, group attitudes, behavior or values” (Carey, 2012, p. 222). Thus, the inductive and thematic approach will help to condense the large amount of raw data that the interviews produced.

The following is the detailed method used to analyze the collected data:

1. Interviews were transcribed to write down a significant portion of the content discussed.
2. Each transcript was read multiple times in order to identify common themes amongst them.
3. Categories were created when common themes emerged from the data. Initially, the researcher organized themes by each individual question. The latter plan was discarded after the researcher and her advisor separately analyzed and then discussed three

transcripts and then created a different list of categories to analyze emerging themes.

These categories are outlined in Table 2 below; they are separated by factors that impact the therapist and factors that impact the child:

Table 2

Categories for qualitative analysis

Therapist:	Child:
Self/Identity/Personal experiences/Age	Self/Identity/Personal experiences/Age/underlying factors that contribute
Professional identity (including balancing personal and professional life)	Relationship to parent/family/attachment figure (underlying factors)
Beliefs/Opinions about and comfort levels with diagnosis (e.g., does he/she see it as stigmatizing? Useful? Useless? Belief that the diagnosis is over diagnosed? Illness as metaphor...e.g., “ODD means criminal justice”)	Interaction with school system
Training	Socioeconomic/Sociocultural factors
Constraints or supports of agency	
Constraints or supports of health care systems	
Insurance/Managed Care/Provision of health care	

- The researcher then reread the interview transcripts and cut and copied quotations from the transcripts and placed them in a spreadsheet with its corresponding category. An example is illustrated in Table 3 below:

Table 3

Example of coding process

Themes:	Participant #3	Participant #6
Self/Identity/Personal experiences/Age		Grew up with an addict mother, in foster care, and shuttled around to families, finally back with her, and father died when I was young, and then ended up in a housing project...
Professional Identity	Noticed her own bias when she had a kid with certain diagnoses and how she has a reaction to the paper.	
Beliefs/Opinions about and comfort levels with diagnosis (e.g., does he/she see it as stigmatizing? Useful? Useless? Belief that the diagnosis is over diagnosed? Illness as metaphor...e.g., “ODD means criminal justice”)	I never look at a diagnosis and throw it away. I try and be pretty open about it...	When I was a visiting nurse, that was the first time they had mentioned the term “battered child.” I was one of the visiting nurses on what they thought was an abusive parent...

5. Categories were then refined to identify more pointed themes. The researcher reread the content organized in the spreadsheet and then color coded themes that overlapped amongst the participants.
6. The researcher then created larger themes that encompassed these categories and organized them from most to least significant. These larger themes are presented from most to least salient: (1) frustrations with mental health care macro systems, specifically the seeming stranglehold of insurance companies on the diagnostic process. These frustrations influenced participants on a micro level, and they discussed struggling with limited assessment time, needing to modify diagnoses for reimbursement, noting differences between agency and private practice settings, critiquing the DSM V manual in general and then specifically its depiction of ODD and PBD; (2) the need for a more intense focus on attachment history and trauma history, as an etiological bases for pediatric psychiatric disorders; (3) concern about the potential for stigma of children surrounding a diagnoses of ODD or PBD; (4) and the influence of clients' and clinicians' sociocultural identities on the diagnostic and treatment process.

CHAPTER IV

Findings

This chapter documents the findings from eleven semi-structured interviews with mental health clinicians who have treated children diagnosed with oppositional defiant disorder (ODD) and/or pediatric bipolar disorder (PBD). The present study intended to fill a gap the existing literature has failed to address: there is little documented on clinicians' perspective and experience of treating children diagnosed with pediatric mental illness. Clinicians are tasked with navigating systems (e.g., agency and government bureaucracy), understanding and treating a complex set of symptomology embedded within a family and community which may add further complexity to the diagnostic process, and simultaneously being aware of how their own experiences and identity may affect perceptions, interventions chosen, and treatment. Therefore, interviewing them can provide insight on how these multiple layers of intricacy are operating and affecting the treatment and mental health outcomes of the child.

The interview consisted of four specific sections: (1) an introductory section intended to create a level of comfort for the participant, by asking easy questions such as why the participant decided to become a clinician in the first place; (2) a section intended to gain understanding about how the participants' past clients informed their current clinical perspective and theories on the diagnosis and treatment of children; (3) a section on the institutional influences on their perspective, such as how the agency or managed care provider may affect the diagnostic process; (4) and personal factors that influence clinician's experience and perspective.

The present study used an inductive methodology, thus there was no theoretical body driving the research.

After careful deconstruction and coding of each participant's interview, the following four themes emerged: (1) frustrations with mental health care macro systems, specifically the seeming stranglehold of insurance companies on the diagnostic process. These frustrations influenced participants on a micro level, and they discussed struggling with limited assessment time, needing to modify diagnoses for reimbursement, noting differences between agency and private practice settings, critiquing the DSM V manual in general and then specifically its depiction of ODD and PBD; (2) the need for a more intense focus on attachment history and trauma history, as an etiological bases for pediatric psychiatric disorders; (3) concern about the potential for stigma of children surrounding a diagnoses of ODD or PBD; (4) and the influence of clients' and clinicians' sociocultural identities on the diagnostic and treatment process. The order in which they are presented is based on the frequency that the themes emerged amongst the interviewees, from most to least.

Demographic data about participants

All eleven clinicians interviewed were female identified. Four clinicians identified their age between 25-34, one between 35-44, one between 45-54, four over 55, and two did not answer the question. Ten of the participants identified their race as white, and one preferred not to answer. Ten of the participants were U.S.A. identified, and one was internationally identified. One participant was of Hispanic, Latino, or Spanish origin, while the rest were not. One participant had her degree in medicine, one as a clinical nurse specialist, and the rest had their degrees in Masters of Social Work (two had their PhD, one had a JD, as well). In terms of years of clinical work, four had 1-4 years, one had 5-9 years, one had 10-19 years, three had 20-30 years, and three had over 30 years of experience.

Feelings about mental health care macro systems

The major theme that emerged from the interviews was discussion of the frustration with managed care¹. The participants' feelings of discontent with the larger mental health care system revolved around their direct service work. They identified several different components that were extensions of managed care that incited these feelings, including limited assessment time, the need to modify diagnoses for their clients to receive services, differences between agency and private practice settings, the DSM V, and similarly, the DSM V's description of ODD and PBD.

Limited assessment time. Participants discussed the limited time they had to assess their clients in order to be remunerated by insurance companies. This limited evaluation time made it difficult to identify an appropriate diagnosis and course of treatment. The following outlines the difficulties in working within the confounds of time:

There are kids with ADHD combined type that actually look like they have bipolar disorder because their frustration tolerance is so low. You have to ask different questions and understand the child's experience and the parent's experience to really get a good diagnostic clue. And I have to say it's really hard, and when you work in a system that only gives you a fifteen minute appointment, you can do all kinds of stuff that's wrong.
(Participant #6, clinical nurse specialist)

I feel very rushed to making an evaluation very quickly before I actually know the family. And I think that is because we have to get authorization of benefits within 6 days. I have to get an initial treatment plan written within 7 days. Those things are dictated by the time frame of 'I need to get this done'... It felt very much more of, again, you have to

¹ "A system of health care (as by an HMO or PPO) that controls costs by placing limits on physicians' fees and by restricting the patient's choice of physicians." (Managed care)

have a diagnosis in order to get insurance to pay for things and have to have this treatment plan in order to be compliant, instead of let's actually take the time and energy to understand who this client and who their family before we decide how we're going to treat them... There's such a push to co-construct everything, but at the same time I feel when you're so pressured to get something done so quickly, you're spending that time to join, so I find myself diagnosing based on what other people will support and see rather than what I actually know. (Participant #11, LMSW)

I think it's unfortunate that I have to diagnose a kid often within 24 hours of meeting them. Often, I don't even meet the kid, I do the intake session with the parent, and then based on the information from the parent I have to make a diagnosis about what the kid might be going through. And that sucks. I don't feel comfortable with that. (Participant #3, LCSW)

As exemplified in the quotes above, the consequence of the limited time to diagnosis was clinicians feeling "rushed," "pressured," and not "comfortable" with the quick decision-making around a diagnosis. Some clinicians also were sensitive to how this rush provided little time for relationship building with the parent or, most central, the child.

Modify diagnosis to receive services. Additionally, participants felt they had to give certain diagnoses in order for their clients to receive services. Depending on the agency or system, participants explained that they sometimes had to give a diagnosis that didn't necessarily align with their clinical formulation in order to be remunerated or to ensure that their clients received treatment. This presented itself in several different ways. In private practice settings, clinicians could provide treatment regardless, but needed to give certain diagnoses in order to be paid, as one clinician said:

I see a lot of kids who are labeled as sex offenders, the insurance will not pay for sexual behaviors, so a lot of people will replace it with adjustment disorders, but I don't like doing that, so I just keep it, and insurance won't pay, so I just see them anyway.

(Participant #8, LCSW, PhD)

Similarly, another participant noted that she had to identify diagnoses that felt clinically appropriate as well as reimbursable.

They've impacted me in that there are certain diagnoses that I can't use because nobody's gonna reimburse me. I used to use adjustment disorders and V codes; nobody gives you money for a V code anymore, I don't even know what it's called anymore. Child problem, relational problem. When I was trained, we used to include those. There's no V axis anymore. I feel like insurance is telling me that I have to show 'medical necessity,' then it has to be either anxiety or depression, or something's that's measurably in those terms. So for the most part, those are the ones I use. I'm not making things up.

(Participant #12, LCSW)

These two participants chose to navigate the same problem differently. Participant #8 felt that she had enough financial and professional flexibility to maintain her clinical formulation and forego insurance reimbursement. Participant #12's approach seemed to reflect feelings other participants had suggested. Due to fiscal necessity, she needed to identify a DSM V diagnosis that most aligned with the client's presentation and her formulation, though these diagnoses are not how she necessarily conceptualizes her client's presentation.

While clinicians in private practice noted needing to tailor diagnoses, this seemed particularly relevant to those working in agency settings who seemed to feel more impacted by

systems, such as the Department of Mental Health (DMH), the Department of Developmental Services (DDS), and government insurance.

If you think a kid needs specific kinds of services, you almost have to tailor their diagnosis so that they can get those services. In the state of Massachusetts, if you want a kid to get services from the Department of Mental Health, they can only have one of like 6 diagnoses as their primary diagnosis. (Participant #3, LCSW)

DMH: They rely heavily on diagnoses. If you don't give a certain diagnosis, there's a very slim chance that they're going to get help. For our kids who are starting to age out, and they're gonna have to eventually leave us and we're trying to get them more services...ethically, it's a really difficult thing too, cause like what do we do? Do we give diagnoses that we have or do we change it a little bit so that they can get services?...PTSD would never work, Mood disorder NOS wouldn't work, adjustment disorder wouldn't work... (Participant #4, LCSW)

Both participants noted needing “to tailor” their clients’ diagnoses in order for them to receive services in particular settings. Thus, they have to work within the confounds of the DSM V and then are further limited by the diagnoses they can choose within it in order to ensure that they get services.

Differences between private practice and agency settings. There was a noted difference in responses from those who worked in agency settings and those who were self-employed or in grant-funded programs. Clinicians in the latter two settings seemed to feel a greater distance and less impact from mental health care systems, even if those macro systems were involved. Thus, even if they were paid by or had to show documentation to insurance, they

had more freedom and flexibility. One participant outlined the differences between expectations of insurance companies in private practice versus agency setting:

The only insurance that I'm on the panel is Anthem in CT, they're pretty lax with individual private practice. I don't have anybody that I need prior authorization for. When they need more intensive treatment, they need prior authorization. But nobody that I see needs it. They come, I bill the insurance company, I bill the insurance company twice a month, I do it online. Some have session limits, but I don't have anyone with such low limits, so I have to keep track, so once I get close to the session limit, I have to submit a form asking for more sessions. I haven't had a problem with that. There's a clinical review based on very little. You give a DSM diagnosis, say how much progress there's been, what current goals are, I haven't had a problem with that...SOAP (subjective, objective, assessment, and plan) note expectations, but nobody reviews them. In an agency, there's a structure for reviewing, but in a private practice, there's no structure for review. Periodically, insurance companies will say they're gonna do a review of this person, but that doesn't happen very often. Nobody reviews my notes. That's a big difference between agency practice and private practice. (Participant #9, LCSW, JD)

Participant #9 speaks to the autonomy she possesses in her private practice, despite insurance involvement. There are few expectations placed on her, and those that do exist are not closely monitored. There is an unbridled quality to this participant's current experience.

Furthermore, two participants discussed their experience of working in grant-funded programs, and both noted the freedom they had from diagnosing:

I work in a grant-funded program, so I don't have to worry about money. So if I ever work in the real world of social work and have to diagnose to reimburse, I'm going to be really sad. (Participant #7, LMSW)

Trauma response program-very lucky program, most of our work was grant funded. We didn't get paid session by session. Sometimes we did. Much of the work we did, we didn't need to give insurance diagnoses. It was very nice. (Participant #9, LCSW, JD)

Both participants seem to be speaking about their grant funded program with the managed care agency setting as an unspoken point of comparison in the background. Participant #7's comment that she'll "be really sad" if she had to "work in the real world of social work" suggested her awareness of the stress those feel who are more directly impacted by managed care.

Only one participant worked in a private practice setting in which she didn't take insurance and was strictly paid out-of-pocket. Her account of her experience is notably different from those in insurance funded programs:

In my case, not. I'm in this really wonderful position. I'm not delivering health care to a lot of needy people, unfortunately. When I was younger and more idealistic I thought I would be. I'm in a suburb and a pretty affluent area and I don't accept insurance...I don't have any insurance constraints at all. It's such a wonderful position to be in. (Participant #2, MD)

While most of those in agency settings felt the pressure from managed care in their diagnosis and treatment decisions, they noted feeling more supported by the agency itself to develop an appropriate clinical formulation. This support came through the agency developing creative ways internally to navigate these expectations and rules, as illustrated the following:

My agency is very supportive of asking question...The structure of the system I'm in

really supports reflection... The nice thing about this agency is, I have a practice, I can work around the insurance that they fully support that allows me to do hours on a psychiatric evaluation, and that means I spend the whole first hour meeting just with parent, or parents, or guardians, or whoever may be involved, and then a second appointment with the child and the parent, a little bit of time with the child, not much, I like to see the child and the parent in action... (Participant #6, clinical nurse specialist)

Most places are open to initially, especially initially, being more conservative diagnosis, so giving what used to be an NOS or what is now an unspecified in the DSM V, and then moving to refine more as you can. And always putting in the formulation or the biopsychosocial kind of all the other complicating pieces that the diagnostic code or label doesn't speak to in terms of issues with the parents or the family. (Participant #1, LCSW, PhD)

Both participants noted that while there were certain external realities as a result of managed care, their agencies helped them work around them, either by helping them increase their assessment period or encouraging them to refine the diagnosis over time.

Another participant spoke to the challenges of being in a community mental health agency. She felt that the pressures, such as caseload and billable hours, made it so that her agency became an environment that couldn't support her clinical work:

I see with our systems that put forth collaborate approach, but there's so much stress, not enough time to collaborate... The first thing for me to go at my agency is supervision. I've gone over a month without clinical supervision. What case management needs, or things with my partner, etc. I think that's a systemic issue of this agency that's growing so rapidly and supervisors who want to give you support but they're stretched so thin that

they can't give you what they want to. (Participant #11, LMSW)

A participant with over 25 years experience spoke of her concerns for those in community mental health agencies:

I think there are a lot of places where the pressure of funding and insurance and public resources and caseloads makes it really hard for younger clinicians to learn what I learned. If you have too many cases and not enough time and really high quality senior supervision, there's a lot of pressure to move really quickly. (Participant #9, LCSW, JD)

Participant #9 seems to be speaking to what participant #11 is directly and currently experiencing. Both are alluding to community mental health agencies' need to bill for a certain number of hours in order to make their programs financially viable. The pressures of the latter make it challenging for clinicians to sustain themselves and "learn" from "really high quality senior supervision" in the agency setting.

DSM V to get paid. While not always explicit, participants seemed to feel that the DSM V was a burdensome part of providing their clients care. This can be deduced based on participants needing to tailor their diagnoses or feeling that ODD and PBD fail to adequately describe their clients' experience. Specifically, as one individual put it, "the only reason for the DSM V is to get paid. That's how you get paid. You come up with a number and you get money." (Participant #6, clinical nurse specialist) Generally speaking, the clinicians felt that they assigned DSM V diagnoses to their clients because it was a required step in managed care. Few seemed to feel that it was a useful tool in treating children.

ODD and PBD in DSM V. In relation to the DSM V, there was a feeling amongst most participants that the description of ODD and PBD failed to address both the etiology and nature of the child's symptom presentation. Specifically in regards to ODD, clinicians felt that it was

purely a descriptive diagnosis. All, aside from one participant, seemed to feel that ODD, as it is described in the DSM V, was only a side effect of a different issue rather than innate pathology.

ODD is a construct that works. It doesn't necessarily link with a particular theoretical understanding, it's purely a description of the phenomenon that you see. (Participant #6, clinical nurse specialist)

Participant #6, as previously quoted, feels that the purpose of "the DSM V is to get paid." Thus, she continues to use the ODD diagnosis despite it not aligning with her clinical understanding of her clients.

I believe there are reasons for things, I don't believe that a behavior is just behavior. It may be the diagnosis that best fits the clinical presentation, but in terms of deciding what to do about it, I don't find it very helpful. We worked with kids who had been exposed to trauma for years, so their behaviors are identified so they're diagnosed with ADHD or ODD, so what's missed is the opportunity to identify what's causing their behaviors.

(Participant #9, LCSW, JD)

Participant #9 seems to agree with participant #6's feelings that ODD is "a description of the phenomenon that you see," yet seems to feel that assigning that diagnosis leads practitioners to fail to identify the underlying cause. She goes on to explain further:

I think because, if someone has conceptualized a child as acting out, they're oppositional, defiant, resistant, annoying, in a way, it's a leftover diagnosis. If you understand it as externalizing diagnosis as response to anxiety, you ought to be giving an anxiety disorder diagnosis. If you understand it as being driven by irritability as a result of depression, you should be giving a depression diagnosis. When just diagnosed based

on the basis of their behavior, they're treated based on the basis of their behavior.

(Participant #9, LCSW, JD)

Participant #9 feels that the ODD presentation signifies that there is something else going on for the child, and thus should be diagnosed in a way that indicates that.

The responses regarding clinicians' perspectives about PBD were more varied. A predominant feeling that arose was that it is not possible to identify and diagnose bipolar disorder in children due to the to their developing bodies. Many felt that emotion dysregulation and tumult was a normal part of development and thus discerning pathology was not possible.

I think personally for me based on the kids that I've work with, I think it's not necessarily right or fair to give a kid a bipolar diagnosis...I think maybe it's just cause, where I've worked, we would often say mood disorder NOS and really wait until they were 18 to say, cause, your body is still changing and brain is still developing a lot later than people initially thought. (Participant #4, LCSW)

Downright impossible with hormones, the changes, the family dynamics and the environment. It's not uncommon for a kid to be depressed some days, like what's their diet like, what's their sleep regimen like, like there are such untold variables. Like I wouldn't do it unless I was told by a psychiatrist, like you're a doctor and I'm not gonna argue with you. I wouldn't diagnose a kid with BD cause of all of those factors.

(Participant #7, LMSW)

Both participants are concerned that diagnosing bipolar disorder in children is irresponsible as their mood lability reflects their developmental changes.

I know clinicians, I've inherited patients from other clinicians who are treated like they have BD but it's not. I love neurobiology and human development. If you're thinking

about the trauma experience and attachment and how brain develops in the first 5 or 6 years of life, you have to think that the trauma that's done to children is also done to their attachment. It's only through attachment that your brain develops and that you develop the ability to manage disappointment and intense affect. There's something that happens from limbic system to limbic system, when child experiences emotion outside them to experience it inside. You have a really dysregulated kid and it doesn't make it BD.

(Participant #6, clinical nurse specialist)

While the other participants ruled out bipolar disorder as a result of normal development, participant #6 ruled out bipolar disorder because she felt that an emotionally dysregulated child reflected disrupted attachment and trauma.

Few participants seemed to conceptualize their clients as having the bipolar disorder diagnosis. Those who did consider it were very cautious in diagnosing it in children.

I took a few years off cause I had my third child and then my fourth child, so I took a little bit of time off. When I came back to work, I was looking for things to read, one of the first things I found was Demitri Papolos²' book. He wrote this whole book about PBD; when I trained we never called kids BD, but when I wasn't working I felt like I kept hearing news stories about kids being diagnosed with BD. When I read the Papolos stuff, it was a mass market kind of book, I did find some of his arguments convincing, I found that were kids who fit his description. It's come under fire of being too broad.

Some of the kids that I diagnosed during that time period, and some of them I still see

² Demitri Papolos is the director "of research of the Juvenile Bipolar Research Foundation (JBRF) where he established a consortium of clinical and basic researchers from medical centers across the country in order to focus on the root causes of childhood-onset bipolar disorder...He is one of a handful of psychiatrists in the world who began to see and to speak about the possible deleterious effects of antidepressants and stimulants in the population of children within the bipolar spectrum. His extensive work with youngsters with the condition and their families, led him to team with his author wife, Janice Papolos, to write the first book ever published on the subject of early-onset bipolar disorder, *The Bipolar Child*" (Papolos & Papolos, 2015).

and they're now college age. With some of them, some other symptoms have definitely emerged over time. I then did a shift and said it was just too broad and I wanted to narrow it down. Kids being diagnosed with BD as kids weren't looking bipolar, as they got older. I made the shift from being very broad and inclusive to narrowing it down. (Participant #2, MD)

Participant #2 was the only psychiatrist of those interviewed, and she seemed to be the most open, although discerning, to the possibility of bipolar disorder occurring in children.

What the DSM V does not consider

A topic that consistently emerged from participants was their feeling that the DSM V's description of ODD and PBD failed to include etiology, specifically trauma and attachment history. The terms trauma and attachment are used here broadly and without a specific definition in mind because neither the participants nor the researcher defined them specifically in the interview. This theme emerged mostly when participants were asked how they understood the underlying factors driving their clients' behaviors or about their professional opinion regarding the two diagnoses.

Participants talked about attachment in a couple of ways: (1) they discussed how caregivers' personal life experiences impacted the way they parented their children and thus their attachment to their child. (2) Similarly, when they identified these attachment relationships as being disrupted in some way, they labeled this as an "attachment trauma," which was a noted difference from the way they discussed other traumatic experiences for the child. This conceptualization is outlined by the responses below:

When I was a visiting nurse, that was the first time they had mentioned the term 'battered child.' I was one of the visiting nurses on what they thought was an abusive parent. It

occurred to me that I would be visiting two abused children, the child and the parents...Diagnosis goes haywire if you don't know what this child's experience has been in utero to present, and that involves a mother, and I have to be able to assure her, when she's been through some traumatic stuff, I'm not talking about blaming anybody, I just need to understand what they both have been through. (Participant #6, clinical nurse specialist)

I try to take a more careful early history and think about what that parent-child relationship was, what patterns the parent might have brought in, their own attachment history and patterns: how did they handle separation or reunion, were they feeling insecure about it or anxious about it? What did the parents do with feeling angry?
(Participant #12, LCSW)

Both participants appear to be as concerned about the experiences of the caregiver as the current presentation of the child. For them, there seems to be no separation between the two. These participants' conceptualization of their cases is well illustrated by the following case example another participant provided:

Mom presents with significant depression. She discloses past troubles as a teenager, she hasn't disclosed an actual diagnosis but enough background to lead me to think that she might have had struggles with oppositional defiance. Long family history of depression. Her mother recently committed suicide last year, so that was a huge stress and mom struggled with post partum and the loss of her mom. So mom has very significant stressors and the kids know about grandma, they know the nature in which grandma died, so that has been a huge factor. With him, it made sense that he's trying to find ways to connect with mom. Mom is also very flat. (Participant #11, LMSW)

In this case example, participant #11 spends a significant portion of time discussing the mother, suggesting that this is as important for her as the child's history and presentation. In this example, the mother's "very significant stressors" has impacted her ability to form a healthy attachment to her son, which then in turn has impacted the way he seeks attention.

Participants also understood their clients' behaviors and symptoms as reactions to their trauma experiences. The following is a conceptualization from one participant with over 25 years experience:

I think that part of what drives that is sort of a defense of putting, adopting a more controlling stance against the world when the world has been dangerous, unsupportive, anxiety provoking, rather than turning the anxiety inwards and doing things to oneself or being so afraid that one can't go out and engage in the world, trying to control something in your environment, and turning passive into active. One etiology of this behavior... The more trauma model, the anxiety, defense model. If I feel helpless and small, and the world feels overwhelming, one reaction is to be a bad ass. It's not conscious, they're not thinking that they want to identify with bad people, they feel helpless on their block or at home but not at school. Gets diagnosed as ODD, but its the kid's way of regaining power, regaining control. (Participant #9, LCSW, JD)

This participant conceptualized her clients' behavior as their attempt to have some sense of security and control when they otherwise "feel helpless on their block or at home." There appears to be no suggestion of innate pathology, but rather a response to their environment.

A couple of participants spoke about how a child's symptoms are the product of the entanglement between trauma and attachment:

If you're thinking about the trauma experience and attachment and how brain develops in the first 5 or 6 years of life, you have to think that the trauma that's done to children is also done to their attachment. It's only through attachment that your brain develops and that you develop the ability to manage disappointment and intense affect. There's something that happens from limbic system to limbic system, when child experiences emotion outside them to experience it inside. You have a really dysregulated kid and it doesn't make it BD. (Participant #6, clinical nurse specialist)

The BD is like the current ODD, it's just like saying there's mood swings and differences in regulation, to say that it's all biological...is probably true in that there isn't environment or biology anymore, they completely interact with each other from in utero; if you have trauma and attachment in the parents and then in the kids, then you're going to have dysregulation that's going to look like bipolar or oppositionality. (Participant #12, LCSW)

Both participants seem to feel that there is no separation between "environment or biology anymore, they completely interact." Thus, a child that is presenting as having symptoms of bipolar disorder, while valid, is reacting to trauma. Discerning a trauma response from emotion dysregulation is not possible because, according to these participants, "your brain develops" by responding to one's environment.

Stigma

A majority of the clinicians interviewed were concerned about the impact diagnoses would have on their clients in the future. Participants' worry about stigma led them to be more cautious and selective in the diagnosis they ultimately assigned their clients. The following response illustrate the participant's concern about how the rest of the mental health care field

perceived the ODD and PBD diagnoses and how she chose to navigate it:

I used to try to see if I could get away with an adjustment disorder with mixed emotions because I was always concerned about confidentiality and labeling with diagnoses and then getting away for them with other insurances, life insurance, disability (why she didn't want to take insurance). Certain diagnoses would prevent them from getting those things. (Participant #12, LCSW)

This participant was concerned about the way her clients would be stigmatized institutionally and prevented from attaining things in the future. Her concern went beyond other participants' worry that their clients would be perceived in a certain way. One participant spoke of her concern that the diagnosis of ODD "creates this preconceived notion about this child and places this child in a vacuum, and suggests that these other psychosocial barriers are not at play" (Participant #1, LCSW, PhD). Some participants even opened up about their own initial reactions to diagnoses:

ODD-I think that even as a clinician, when you see that as a diagnosis, I think that there is this gut reaction that they're going to be difficult. Even if they're not difficult, there's this immediate reaction that this child will be difficult, and I think that's going to be difficult in any setting for this child. I think we're setting them up for a different type of treatment. (Participant #7, LMSW)

Participant #7 was alluding to her own "gut reaction" she experiences when she sees ODD as a diagnosis, though she recognizes that a diagnosis doesn't necessarily represent a child's symptoms or behaviors.

Clinicians' and child's sociocultural identities

Trends in diagnoses. Participants were asked whether they observed demographic trends in who received what diagnoses. Related to stigma, some individuals noticed, or had this instinctive “feeling you get” as one participant put it, that ethnic and racial minority males were more likely to receive diagnoses that described their behaviors as delinquent or oppositional (Participant #9, LCSW, JD).

For our program, black males are diagnosed with ODD or CD, and white males are diagnosed with ADHD. (Participant #7, LMSW)

ODD default diagnosis for teenage boys with mental health issues and nobody knows what to do with them. We see ODD diagnosed in boys when we see the exact same symptoms in girls, and they get diagnosed with borderline personality disorder.

(Participant #3, LCSW)

In the school system, more black kids and Spanish speaking kids and Spanish immigrant population get diagnosed with ODD than white or Asian kids. (Participant #8, LCSW, PhD)

These participants mostly focused on trends they observed in ODD and made note of gender and racial and ethnic differences. They seemed to feel that white boys are given diagnoses that suggest their behavior is out of their control, whereas the diagnoses given to boys of color suggest they have volition.

Clinicians’ social identities. At the end of the interview, participants were asked what parts of their identity felt particularly salient or came into their awareness when working with children, especially in the context of ODD and PBD. Ten of the eleven participants were white females, and many of the white identified clinicians were initially confused by the question. When this happened, the researcher provided them with an example of being a liberal, Jewish

woman working with a family from a conservative Christian background or with a male-identified person made misogynistic comments. In these incidences of providing the latter example, several participants noted their religious and gender identities as feeling relevant to them in their work:

I did once have somebody come in who had been referred and had gone on and on about their Christianity, and they were saying how horrible it would be if they knew treater was atheist/Jewish. I do work with a lot of fundamentalist Christian people who will say, 'Have a blessed day,' but there was this one person who said it was really important to them that this person be religious. I ended up not working with that family...I can relate to the female thing you were saying-I had this one male client who said he wanted his wife to lose weight, and I was like, ugh I'd so much rather be working with your wife right now. Eventually he moved on, and I was so relieved, because it was really not a good match. (Participant #2, MD)

Because this participant and a couple others latched onto the examples the researcher provided, it seemed that they hadn't necessarily considered their social identities in their work before. There were other participants, unprompted by an example, who felt their gender identity and/or sexuality to be particularly relevant in their work.

While the question did not ask about personal histories, many participants discussed their memories and experiences of being children themselves coming into their awareness in their work.

My own early history of attachment disruptions and how that may have impacted behaviors that could've been seen as problematic, most of the time, they were more internalizing, so um, they may not have gotten as much attention, but isolating, or reading

a lot, or you know being super creative, or hyperactive...so I could see there could be a lot of diagnostic labels thrown around about me at the time...especially working with parents with personality issues, I grew up with a mom with a personality issue, and so I would find myself initially being immobilized in the work, like a deer in the headlights, and then I wasn't effective as a clinician. (Participant #1, LCSW, PhD)

My upbringing is so different than a lot of these children. I'm working primarily with Caucasian middle to higher class kids, and then the few kids in the system. So coming from a working family, a Latina family, immigrant parents, it's hard to really empathize with some of these kids... (Participant #10, LMSW)

While their responses focus on their childhood memories, their social identities are enmeshed in these experiences.

Several participants noted their maternal identities coming into their awareness, especially when working with caregivers who felt particularly punitive.

I think one of the parts of my identity that comes into my awareness when working with children is my maternal identity. I am the mother of a college aged daughter, and when I work with a lot of adolescents, I think about my daughter, and I think about how similar and different they are from my daughter and at various stages of her development, I've had particular reactions... I have a hard time working with parents who are rigid and punitive...When families are really rigid, punitive, authoritarian, I find that really a struggle to maintain the empathy. (Participant #9, LCSW, JD)

Struggling to "maintain the empathy" when working with authoritarian parents seemed to be a common theme for many participants, but especially for those who had children themselves.

Several individuals were especially aware of the privilege they possessed in relation to

their clients. This privilege was mostly discussed in terms of their racial and ethnic identity:

I'm Caucasian, and I think about, especially in the setting I'm in now...kids who are of a different race will say 'You know, you don't know what I've been through.' Regardless whether you're the same race as me, different race of me, you're right, I don't know what your experiences have been, like you're right...I try to be very aware of, I guess, white privilege. (Participant #4, LCSW)

Other participants provided case examples in which they wondered how their whiteness impacted how their clients experienced and reacted to them.

CHAPTER V

DISCUSSION

The present qualitative study explored clinicians' experience of diagnosing and treating children diagnosed with pediatric bipolar disorder (PBD) and oppositional defiant disorder (ODD). This study investigated (1) how clinicians understand the etiological factors contributing to children's symptoms; (2) how clinicians are impacted by mental health care policies and systems, both at the mezzo and macro level; (3) and lastly, how clinicians perceive both their personal and their clients' sociocultural identities impacting diagnosis and treatment.

Participants' responses filled a gap in the literature, as there appears to be a void in empirical and theoretical research on the experience of diagnosing. The diagnostic process taps into macro and micro level issues, as clinicians must navigate larger systems, like insurance reimbursement, within their unique agency setting. The latter must be done in conjunction with identifying a diagnosis that aligns with their clinical formulation and plans for treatment.

The following four categories were the major themes that emerged from the participants' responses: (1) frustrations with mental health care macro systems, specifically the seeming

stranglehold of insurance companies on the diagnostic process. These frustrations influenced participants on a micro level, and they discussed struggling with limited assessment time, needing to modify diagnoses for reimbursement, noting differences between agency and private practice settings, critiquing the DSM V manual in general and then specifically, its depiction of ODD and PBD; (2) the need for a more intense focus on attachment history and trauma history, as an etiological bases for pediatric psychiatric disorders; (3) concern about the potential for stigma of children surrounding a diagnoses of ODD or PBD; and (4) the influence of clients' and clinicians' sociocultural identities on the diagnostic and treatment process.

Critique of the diagnostic process and DSM V

As mentioned, a common theme that emerged from participants was their feeling that the DSM V and its clinical criteria for ODD and PBD was falling short. This feeling related to believing that the diagnoses were “purely a description of the phenomenon that you see” and that the DSM V failed to address etiology and other psychosocial factors (Participant #6).

In considering their responses, however, it seems trite to suggest that the DSM V should be thrown out all together. The present study respects the significance and importance of having some method of understanding, interpreting, and classifying symptoms of behaviors. While the participants felt that these diagnoses only described behavior, the process seemed to provide an entry point that led them to seek further meaning and underlying factors driving their clients' symptoms. The question of whether clinicians would seek out this information regardless of a diagnosis is beyond the scope of this study. Despite this, most of the participants had an internal working model for understanding ODD and PBD, thus suggesting that these labels provided them some type of schema.

While the diagnostic process serves some kind of pragmatic function, the present study's participants seemed to feel that the DSM V is inadequate in terms of understanding the complexity of a child's problems. This represents a larger conversation about the efficacy and utility of the DSM V that exists within the empirical and theoretical literature. Researchers are coming out with suggested alternative diagnostic manuals or diagnoses that better indicate their clients' experiences, including the Research Domain Criteria (RDoC) Model and Developmental Trauma Disorder (DTD) (Franklin et al., 2015; van der Kolk et al., 2009). Though these two models have different emphases, mainly one is biologically based while the other is socially based, they validate the present study's participants' observations that the way mental illness is defined needs to be expanded.

Much of the material discussed by the participants aligned with a newly proposed diagnostic system: Research Domain Criteria (RDoC) (Franklin et al., 2015). The RDoC model understands pathology from a neurobiological perspective. Its three major tenets are the following: "(a) mental illnesses are disorders of brain circuits; (b) neuroscientific methods can identify dysfunctions within brain circuits; and (c) knowledge about disorder circuits eventually will direct the classification, assessment, intervention, and management of mental illnesses" (Franklin et al., 2015, p. 281). With these assumptions in mind, the hope is to blur diagnostic categories and understand the etiology as coming from a variety of interplaying factors.

The RDoC model does not explicitly address how issues in development impact psychopathology, and the present study's participants emphasized the importance of attachment and developmental traumas in understanding their clients' behaviors. Franklin et al. (2015) proposes incorporating a developmental framework into the RDoC model that considers the interplay between one's unique biology and environments throughout one's lifetime. This

suggestion closely mirrors the present study's participants' understanding that "there isn't environment or biology anymore, they completely interact with each other from in utero" (Participant #12). Franklin et al. (2015) also recommends that the RDoC model expand its view of development beyond neurodevelopment. Inspired by the developmental psychopathology theory, they suggest giving "equal weight to different units of analysis and focus on the dynamic interplay of these units across development" (as cited by Franklin et al., 2015, p. 282). Other recommendations from Franklin et al. (2015) for the RDoC Model include expanding its conception of causes of mental disorders, which would directly mean no longer defining mental illness as a brain disorder; expanding its units of analysis; and adopting a constructionist model to reduce biological reductionism.

Similarly, van der Kolk and colleagues (2009) wanted to address the DSM's failure to include a diagnosis that adequately addressed developmental trauma. The current DSM V's diagnoses, including posttraumatic stress disorder (PTSD), fail to encapsulate the symptomology of those who have experienced "interpersonal violence in the context of inadequate caregiving systems" (van der Kolk et al., 2009, p. 2). Children are either receiving a different diagnosis or no diagnosis at all, such as 22% of children receiving the diagnosis of ODD despite having a history of abuse (as cited by van der Kolk et al., 2009). The latter aligns with the present study's participants' feeling that their pediatric clients' symptoms are a response to their trauma, rather than behaviors that are attributable to unique temperament or biology.

Van der Kolk et al. (2009) proposed the diagnosis Developmental Trauma Disorder (DTD) be added to the DSM V. The proposed criteria for DTD includes "exposure to multiple or prolonged adverse events of the period of at least 1 year" (van der Kolk et al., 2009, p. 5). These adverse events can include directly experiencing an adverse event or being subject to

repeated separations or attachment disruptions from one's caregiver. The diagnostic criteria also include a range of ways one might react to their trauma, including affective and physiological dysregulation, attentional and behavioral dysregulation, and self and relational dysregulation (van der Kolk et al., 2009). The latter criteria would address the way the present study's clinicians understand their clients' behaviors, especially in relation to PBD; as participant #6 said, "There's something that happens from limbic system to limbic system, when child experiences emotion outside them to experience it inside. You have a really dysregulated kid and it doesn't make it bipolar disorder." While the diagnostic process serves some kind of pragmatic function, the present study's participants seemed to feel that the DSM V is inadequate in terms of understanding the complexity of a child's problems. This represents a larger conversation about the efficacy and utility of the DSM V that exists within the empirical and theoretical literature. Researchers are coming out with suggested alternative diagnostic manuals or diagnoses that better indicate their clients' experiences, including the RDoC Model and developmental trauma disorder (Franklin et al., 2015; van der Kolk et al., 2009).

How present study relates to literature

Macro and mezzo systems. The present study's semi-structured interview asked clinicians to consider how mental health care policies impact their diagnostic decision-making. They identified the DSM V and its criteria for ODD and PBD, which were discussed above. Additionally, they named limited assessment time and the need to modify diagnoses in order for their clients to receive services as factors they felt were impacted by managed care. Some clinicians made note of how these factors varied depending on the treatment setting, and there seemed to be notable differences amongst those who worked in agency settings, grant funded programs, or private practice.

There were macro systemic factors that all of the participants experienced similarly, regardless of the setting they were in. There appeared to be no qualitative difference in assessment time amongst the participants. Although all noted the need to diagnose after the initial visit, they seemed to feel either supported by their agency or empowered to modify the diagnosis as they further developed their clinical understanding and formulation of their clients. Similarly, clinicians seemed to consider how diagnosis would impact their clients' ability to receive services and as a result, modified them appropriately.

While most of the participants were impacted by mental health care policies, those in private practice and grant-funded programs were more immune to the effects of those policies. In fact, some in the latter two settings noted differences amongst the three settings and expressed concern for those working in agencies. This concern revolved around the financial pressure that agencies experience that lead clinicians to have reduced supervision, high caseloads, and excessive paperwork. Other researchers have documented these differences, particularly as they relate to "burnout" and workplace satisfaction (Arches, 1991; Stalker et al., 2007; Rupert & Morgan, 2005). Arches (1991) focused on how the bureaucratic nature of agency settings produces burnout by limiting autonomy and professional creativity. Similarly, Rupert and Morgan (2005) identified unsupportive management, lack of professional growth opportunities, and dissatisfaction with agency policy as leading to increased emotional exhaustion and lowered job satisfaction, while those who were self-employed were less likely to report symptoms of burnout.

Stigma and trends. Consistent with the literature, the present study's participants were concerned about trends in diagnoses based on gender, race, and ethnicity. Specifically in regards to ODD, participants felt that racial and ethnic minority males were more likely to receive this

diagnosis or another that implied delinquency. Participants noted this as either an instinctive feeling or something they had observed in their clinical experience. This finding aligns with others that have found African American boys disproportionately more likely to receive a conduct disorder diagnosis, which is the category in which ODD falls (as cited by Atkins-Loria, 2015; Heflinger & Humphreys, 2008; Russell et al., 2015). While not noted by the participants, other research indicates that black children are less likely to receive a psychiatric diagnosis at all and are more likely to be directed to the criminal justice system (Pottick et al., 2007).

Returning to the idea of a different diagnostic system, the RDoC model and Franklin et al.'s (2015) proposed changes could possibly help to reduce these racist trends. If the RDoC model were to incorporate a developmental psychopathology lens, clinicians would have to evaluate how environmental factors and attachment relationships impact children. In doing so, practitioners may consider how factors, such as perceived discrimination or community violence, increase the likelihood of psychiatric symptoms (Coker et al., 2009; Russell et al., 2015).

Clinicians' social identities. The present study's participants had varying degrees of awareness of how their social identities impacted their treatment relationships and their clients. When asked what parts of their identity felt most salient in their clinical work, several of the white identified participants were confused about what the question was asking and needed the researcher to provide an example. While this didn't necessarily seem to predict whether or how they would judge disorder in their clients, it implied a lack of consideration of how the client and treatment relationship was impacted by their identities.

It is also interesting to consider the latter with participants exploring their experiences as children and parents when prompted by this question. The question intended to assess how certain aspects of one's social identity impacted clinicians in the diagnostic and treatment

process. Several participants immediately went on to consider such things as their gender identity or racial identity, but several bypassed this to discuss their life experiences. This interpretation of the question suggested a lack of evaluation of how one's social locations can intersect with one's clients in the treatment relationships.

That being said, working with children clearly pulls at people's heartstrings. Those participants who had children felt their roles as parents become activated. They discussed their struggle to maintain their empathy when working with parents they felt were particularly punitive. Relatedly, some parent clinicians felt that their own children were especially on their minds when working with their pediatric clients. Similarly, several of the participants noted that working with children ignited memories from their own upbringings. The participants showed tremendous vulnerability by examining how their own experiences impact them in their clinical work. The latter is important as one's own life experiences are constantly impacting the treatment relationship.

Limitations and Future Research

The present study was exploratory in nature, as there is limited existing theoretical or empirical literature documenting clinician's diagnostic experience. This study has limitations due to the uncharted nature of this topic, as the researcher had to, in part, intuit the areas and components impacting clinicians diagnosing or treating children with ODD and PBD. This section will outline these limitations and propose areas for future research.

There are several limitations to the present study's method and design and the findings gathered. To begin, the present findings are not generalizable as there were only eleven participants and no variability in gender identity and limited representation of racial or ethnic identities. Additionally, the sample was self-selecting, thus those who chose to participate in the

study were likely particularly interested in the topic and wanted to discuss it; their answers may be qualitatively different than other clinicians who work with children diagnosed with PBD and ODD. Because time and resources limited the present study, future research should attempt to recruit a more diverse sample of clinicians.

The reliability and validity of the interview measure used must also be questioned. The researcher drew the questions from previous studies as well as creating some with the research questions in mind. The questions may have been biased by the researcher's personal experience of working with children diagnosed with ODD and PBD in a managed care agency setting. Additionally, the participants could not remain anonymous due to the nature of in-person interviews. This form of data collection may have influenced their responses, as participants may have censored or embellished their responses in order to impress the researcher.

A significant limitation to the present study is the breadth of topics the researcher attempted to cover in relation to this topic. While all the areas addressed by the interview questions are important to the clinician's experience of the diagnostic process, it is difficult to synthesize all the data produced by these questions into a succinct theoretical understanding of diagnosing. Future research should further explore clinician's experience of diagnosis, but narrow their scope of areas of influence and impact on the clinician.

Future research. Similarly, future research should continue to explore ways to modify the diagnostic process that better aligns with practitioner's clinical understanding of their clients. The present study outlined the RDoC Model and developmental trauma disorder (DTD) as possible alternatives or additions to the DSM V. Finding ways to incorporate etiology into diagnosis should continue to be a focus of future research.

While the latter is important, it does not address the other macro systemic factors that the participants named as trickling down to impact their direct service work. These factors, such as limited assessment time and needing to modify diagnoses to insure further treatment, result from the health insurance companies' policies and regulations. While future research should continue to explore how mental health care policies and systems impact direct service work, this issue may be better handled by those seeking to impact policy.

On the other end of the spectrum, future research should focus on the clinician's sociocultural identities and experiences in the treatment relationship. While there seems to be a significant body of literature on how clinicians can be culturally competent, it was interesting to note the number of participants who needed clarification on how their identities get activated in their work. As previously noted, several, in fact, focused on their experiences as children and parents. Because the majority of the present study's participants were white, future research should attempt to explore the experience of clinicians with different racial and ethnic identities, as well as explore how personal experiences become activated in working with children.

Conclusion

The present study investigated clinicians' experience of diagnosing children with pediatric bipolar disorder (PBD) and oppositional defiant disorder (ODD). Through semi-structured, open-ended interviews with eleven mental health practitioners, it is clear that further research is needed to conceptualize the diagnostic process. Doing so can help to improve the systems impacting clinicians' work with children and their families, and thus help children receive the proper care and treatment they need.

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Appendix A: HSR Amendment Approval Letter



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

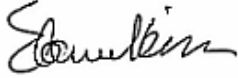
March 23, 2016

Lenni Marcus

Dear Lenni:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,



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

CC: Alisa Ainbinder, Research Advisor

Appendix B: HSR Informed Consent Form

2015-2016

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: Clinician’s experience of diagnosing oppositional defiant disorder and pediatric bipolar disorder in children

Investigator(s): Lenni Marcus, Smith College School for Social Work, xxx-xxx-xxxx

.....

Introduction

- You are being asked to be in a research study of on your experiences of diagnosing and treating children with certain types of diagnoses, like oppositional defiant disorder (ODD) and pediatric bipolar disorder (PBD).
- You were selected as a possible participant because you are a clinician who works with children with psychiatric illnesses.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn about the experience of diagnosing children with certain types of diagnoses, like ODD and PBD. Specifically, this study aims to investigate how sociocultural and systemic factors impact the diagnostic process.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: choose a location for an interview that will last approximately 45 minutes-hour. The interview will be audio recorded and this researcher will take hand written notes.

Risks/Discomforts of Being in this Study

- The study has the following risks but I will be asking you to discuss your experience of diagnosing children with ODD and PBD. Please feel free to decline any question that makes you feel uncomfortable or end the interview. I will strip out any identifying information about you or clients you discuss in the writing of this study.

Benefits of Being in the Study

- The benefits of participation are having an opportunity to talk about your experience and possibly gaining insights into your clinical work, and provide information that could be helpful for future research and better support therapists who work with children.
- The benefits to social work/society are: to provide information for future research and to identify areas of growth for practitioners working with children diagnosed with psychiatric illness.

Confidentiality

- Your participation will be kept confidential. Your identifying information and participation will be kept confidential and only known by this researcher. The interview will take place at your choice of place-the researcher's office, a quiet public place, or another place at your recommendation. In addition, the records of this study will be kept strictly confidential. I will be the only one who will have access to the video or audio recording. Recordings will be destroyed after the mandated three years by being permanently deleted from the recording device.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

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 *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. However, you must notify me of your decision to withdraw by email or phone by April 1, 2016. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Lenni Marcus at marcuslenni@gmail.com or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided 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.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix C: Demographics Questionnaire

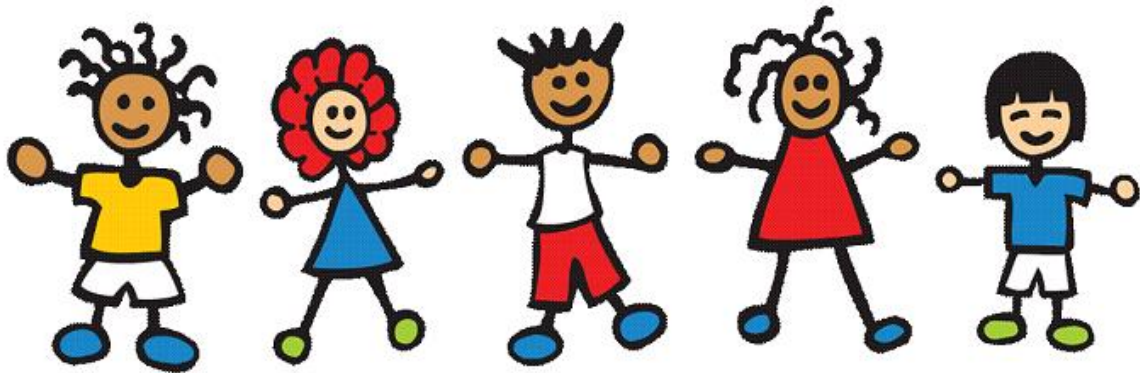
1. Do you hold a master's degree, doctorate or medical degree in one of the following disciplines: social work, psychology, psychiatry, psychiatric nursing, medicine, marriage and family therapy, or mental health counseling? (Yes/No)
2. Do you have at least one year's experience working with children diagnosed with psychiatric illness while under your professional degree? (Yes/No)
3. Are you currently practicing in the Canada or the United States? (Yes/No)
4. Have you had children diagnosed with ODD or PBD on your caseload? (Yes/No)
5. What do you consider your professional role/identity?
 - a. Counseling or clinical psychologist
 - b. Professional counselor
 - c. Social Worker
 - d. Psychiatrist
 - e. Other (please specify) _____
6. Approximately how many years of clinical experience do you have?
 - a. Less than 1 year
 - b. Between 1 and 4 years
 - c. Between 5 and 9 years
 - d. Between 10 and 19 years
 - e. Between 20 and 30 years
 - f. Over 30 years
7. Are you of Hispanic, Latino, or Spanish origin?
 - a. Yes
 - b. No
 - c. Prefer not to answer
8. What is your race? (Select one or more)
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Native Hawaiian or other Pacific Islander
 - e. White
 - f. Other
 - g. Prefer not to answer
9. How do you describe your country of national identification? (National identification is defined as the country with which you primarily associate)

- a. Internationally Identified
 - b. U.S.A. Identified
 - c. Prefer not to answer
10. What is your current gender identity?
- a. Female
 - b. Male
 - c. Another identity: _____
 - d. Prefer not to answer
11. Approximately how old are you?
- a. 25 to 34
 - b. 35 to 44
 - c. 45 to 54
 - d. 55 and over
 - e. I prefer not to report it

Appendix D: Recruitment Flyer

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Participants Needed



Do you work with children diagnosed with psychiatric illness? Want to discuss your thoughts about the ways diagnosis and treatment of children can be improved.

I am planning to interview 12-15 clinicians who work with children and have experience diagnosing or treating children with oppositional defiant disorder (ODD) and pediatric bipolar disorder (PBD). Even though the diagnosing of children with psychiatric disorders is an incredibly important issue, there is not much in the literature on clinicians' perspectives on it. This is an opportunity for

people who have had this experience to share their stories. Understanding clinicians' experience could help elucidate how to improve treatment both at the interpersonal and systemic level.

Participation includes one 60 minute interview with a student researcher from Smith College School for Social Work.

Contact Lenni Marcus
Smith College MSW Candidate 2016
lmarcus@smith.edu

Appendix E: Recruitment Flyer on Facebook

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Participants Needed

Do you work with children diagnosed with psychiatric illness? Want to discuss your thoughts about the ways diagnosis and treatment of children can be improved.

I am planning to interview 12-15 clinicians who work with children and have experience diagnosing or treating children with oppositional defiant disorder (ODD) and pediatric bipolar disorder (PBD). Even though the diagnosing of children with psychiatric disorders is an incredibly important issue, there is not much in the literature on clinicians' perspectives on it. This is an opportunity for people who have had this experience to share their stories. Understanding clinicians' experience could help elucidate how to improve treatment both at the interpersonal and systemic level.

Participation includes one 60 minute interview with a student researcher from Smith College School for Social Work.

Contact Lenni Marcus
Smith College MSW Candidate 2016
lmarcus@smith.edu

Lenni Marcus ▸ **Smith SSW Alums** ▾
March 23 near New Haven, CT · 🌐

Hi all! I'm looking to interview clinicians who work with children, particularly who have had children on their caseload with the diagnoses oppositional defiant disorder and pediatric bipolar disorder. If you, or anybody you know, is interested, please let me know!

🏷 Tag Photo 📍 Add Location ✎ Edit

👍 Like 💬 Comment ➦ Share

1 share

Write a comment... 📷 😊

People You May Know See All

Leah Au
36 mutual friends
➦ Add Friend

Appendix F: Interview Guide

Intro

“What made you decide to become a clinician?”

“What do you like most about working with children? What do you like least?”

First section

“Take a moment to think about your current or past client list. Think about anyone who really stood out to you as a challenge for example. Or maybe a child where the treatment was going very well, but had to be cut short for some reason. I’m particularly interested in children diagnosed with ODD and PBD, so if possible, please bring your attention to these children on your caseload.” [Allow them a few moments]

“What behaviors do you observe in children who come to see you?” (Stebbins & Corcoran, 2015)

“What is your understanding of the underlying factors that contribute to a child’s behavior?” (Stebbins & Corcoran, 2015)

Do your clients come to you already having been diagnosed? Do you usually keep their existing diagnoses or change them?

System influences

How does your agency’s policies and structure impact your diagnostic decision-making?

Have health insurance policies impacted your decision-making in diagnosing children [IF possible, provide an example from outside of the ODD/PBD context]?

“What mental health practices and policies impact your evaluation...practices with children?” (Stebbins & Corcoran, 2015) [I’ll provide examples if participant can’t answer the question]

Clinician Influences

What is your professional opinion about diagnosing children with PBD and ODD?

Once these children have received the PBD and/or ODD diagnosis, how do you see their treatment impacted?

Have you observed trends in who receives what diagnosis, in your own caseload or agency as a whole?

Are there aspects of your identity that feel activated or come into your awareness when diagnosing children? (Some question to ask about the clinician’s identity and how it impacts their diagnosis or their perception of their client) [For example, if I identify as a Jewish liberal, and I am seeing a teenager with a very religious, conservative Christian parent, I know I will be very careful in regards to...]

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix G: HSR Approval Letter



School for Social Work
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Northampton, Massachusetts 01063
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February 22, 2016

Lenni Marcus

Dear Lenni,

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,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

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

CC: Alisa Ainbinder, Research Advisor