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Ashley Petitt
The Experiences of Clinical Social
Workers in Diagnosing Bipolar
Disorder in Children and
Adolescents

ABSTRACT

Bipolar disorder (BD) is a diagnosis that an increasing number of individuals under the age of 18 are being given, despite the fact that the DSM-IV has no description or criteria of what BD in this age group looks like. The purpose of this exploratory study was to look at the experiences of clinical social workers who have diagnosed BD in children and adolescents. To do so, eleven social workers who have a Master's of Social Work were interviewed using a standardized open-ended interview guide.

The major findings of this study follow. Participants reported having diagnosed significantly more adolescents with BD than children. Participants looked for a wide range of different symptoms when making this diagnosis, such as: changes in sleep, changes in mood, agitation and irritability, risky behavior, and other symptoms of mania and depression. Participants found the following things helpful in making this diagnosis: collaborating with other providers and family members, observing the youth's behavior, and longitudinal information about the youth. Participants reported struggling with the following things while making this diagnosis: fear of labeling, access to services, and differentiating BD from other disorders. Most participants reported that after the diagnosis was made, it did have some positive influence on their understanding of and ability to appropriately treat these children and adolescents.

THE EXPERIENCES OF CLINICAL SOCIAL WORKERS IN DIAGNOSING BIPOLAR
DISORDER IN CHILDREN AND ADOLESCENTS

A project supported by an independent exploration,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

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2011

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Chapter I

Introduction

The purpose of this exploratory study is to look at the experiences of clinical social workers related to the process of diagnosing bipolar disorder (BD) in youth. To do so, eleven participants were interviewed, all of whom hold a Master of Social Work (MSW) degree and have experience diagnosing at least one child or adolescent with bipolar disorder. This study analyzes several different areas of these clinical social workers' diagnosing experiences, and has separated these experiences into those that are specific to diagnosing children and those that are specific to diagnosing adolescents. First, the number BD diagnoses each participant has made over the course of his or her career and in the past twelve months is summarized. Second, this study addresses how the participants reported deciding that a diagnosis of BD was warranted, in the cases where it was assigned, and what tools, skills, and methods they found helpful when making this diagnosis. Third, this study addresses the struggles that the participants reported having while making BD diagnoses in youth. Fourth, is a discussion of the specific symptoms that the participants looked for when making a diagnosis of BD in children and adolescents. Fifth, is a review of how making this diagnosis did or did not help participants further understand their child and adolescent clients, and how making this diagnosis did or did not affect the treatment that they provided or recommended for these youths. Lastly, this is an exploration of changes participants suggested should be made in order to improve the process of diagnosing this condition in youths.

The rationale for doing this study is that BD is a diagnosis that an increasing number of individuals under the age of 18 are being given, despite the fact that the DSM-IV has no description or criteria of what BD in this age group looks like. In 2007, it was reported that since the 1990s, there has been a “forty-fold increase in the number of office visits in which children had a diagnosis of bipolar disorder” (Parens & Johnston, 2010, p.1). Researchers are unsure whether this “upsurge... represent[s] a true increase in prevalence,” and each researcher presents his or her own theories about what factors could account for the increase in reported cases (Baroni, Lunsford, Luckenbaugh, Towbin, & Leibenluft, 2009, p. 203). Among them are: “Previous under-recognition,” previous lack of understanding about the differences between BD symptoms in children and adults, “inappropriate application of the diagnosis,” and increased publicity about BD which has created an outpouring of parents seeking this diagnosis for their troubled children (Youngstrom, Meyers, Youngstrom, Calabrese, & Findling, 2006, p. 990). This topic is also of timely interest given that the American Psychiatric Association is currently revising the DSM-IV.

For social workers who plan to do therapeutic work with children and adolescents, this is a diagnosis that they are likely to encounter. It is essential that more studies be conducted to further understand BD in children and adolescents so that a consensus can be reached about the appropriate way to diagnose and treat this disorder in this population (Baroni et al., 2009; Papolos & Papolos, 2006; Youngstrom et al., 2006).

There are several potential benefits of this study. The first is that, as opposed to many other studies regarding the diagnosis of youth that are quantitative, this study’s qualitative design gives readers a more in-depth and detailed understanding of how social work clinicians assign this diagnosis and how it affects their treatment with these youths. The findings of this study

cannot be generalized to the entire population of social workers who have diagnosed this disorder in youth. However, clinicians who assess for BD in youth may find this study's findings to be a helpful starting point, particularly the sections that address tools and skills the participants of this study found beneficial when making this diagnosis. This study also can be beneficial by continuing to spread awareness about the struggles that clinicians are facing while making this diagnosis, reinforcing the need for further guidance, clarity, and support.

Chapter II

Literature Review

The purpose of this chapter is to provide a succinct review of the literature that has been published on the topics of and related to the diagnostic phenomena surrounding Bipolar Disorder (BD) in children and adolescents. First, this investigator will provide a historical review, from the 1800s to present day of the evolution of the diagnosis of BD in children and adolescents. Second, the risk factors, symptoms, and course outcomes of BD in children and adolescents will be explored. Third, the role of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) in the diagnostic process, and the upcoming proposed changes for mood disorders in children and adolescents in the DSM-V will be discussed. Fourth will be an exploration of the proposed methods and tools, and costs and benefits of these, used in the assessment of BD in children and adolescents. Fifth, this investigator will explore the specific role and identity of social work clinicians who diagnose mental health disorders. Sixth, studies on the role of race, ethnicity, and culture in the diagnosis and treatment of mental health disorders will be reviewed. Lastly, the recommended treatment options for BD in children and adolescents will be discussed. Upon completing this chapter, readers will have a basis of knowledge to use in order to support their understanding of the chapters which follow.

History of Bipolar Disorder in Children and Adolescents

According to Greves (as cited in Youngstrom et al., 2006, p. 989) cases of “pediatric mania” have been recorded as far back as the 1800s. Following Kraepelin’s 1921 paper, which gave detailed descriptions of various forms of mania and depression, child psychiatrists began

looking for manic-depressive symptom presentations in their pediatric patients. Harms (as cited in Meyer & Carlson, 2010) speculated that perhaps this presentation had been missed previously because of symptom similarity to other childhood diagnoses.

In 1960, Anthony and Scott released an article that heavily influenced the child psychiatry community, stating that after reviewing the psychiatric literature from 1884 to 1954, they had concluded there had yet to be a demonstrated case of manic-depressive illness in a pediatric patient (Meyer & Carlson, 2010). This put a temporary halt to the research, but in 1976 Weinburg and Brumback began working on a symptom criteria for mania in childhood, based off of the newly standardized symptom criteria for mania in adults. In 1979, Davis was the first to solidify these criteria for what he referred to as “manic-depressive variant syndrome of childhood”. These children were characterized as “exhibiting heightened reactivity to seemingly minor events, hyperactivity, and disruptions in interpersonal relationships” (Meyer & Carlson, 2010, p. 37).

By 1980 manic-depressive illnesses began to be referred to as “bipolar disorder” (BD) in the DSM-III, and there was an increasing acceptance that this disorder presented in children and adolescents, as well as adults (Meyer & Carlson, 2010). Despite the lack of studies or longitudinal data on this topic, the American Psychiatric Association showed how they agreed in their 1980 release of the DSM-III, which states that criteria for mania in adults could be used to diagnose children (American Psychiatric Association, 1980; Meyer & Carlson, 2010). And according to Greves (as cited in Youngstrom et al., 2006), the 1990s marked the first time that clinicians began assigning the diagnosis of bipolar disorder to children and adolescents.

Most of the research conducted in the 1990s and early 2000s focused on identifying the clinical characteristics and the different phenotypes of BD in children and adolescents. Several

researchers concluded that youth could be categorized into a “narrow” or “broad” phenotype. The “narrow” phenotype identifies youth who had more classic symptoms of mania, such as elated mood and grandiosity, and depression, congruent with the DSM-IV criteria, but who cycle more rapidly, falling short of the four to seven day requirement (American Psychiatric Association, 1994; Findling et al., 2001; Geller et al., 2002). The “broad” phenotype identifies youth with nonepisodic symptoms of irritability, depression, anxiety, hyperarousal, poor concentration, impulsivity, and uncontrollable temper (Biederman, Faraone, & Mick, 1996; Leibenluft, Charney, Towbin, Bhangoo, & Pine, 2003).

Risk Factors, Symptoms and Course Outcome

There are no conclusive studies that say exactly what causes a youth to develop BD, but many probable risk factors have been proposed. Numerous studies in the United States suggest that genetics plays a role pediatric BD. Having a first-degree relative with BD, increases a child’s likelihood developing BD from 0-2% to 4-15% (Lapalme, Hodgins, & LaRoche, 1997). Youth who are at a higher risk of developing BD due to presence of BD in a parent, are also less likely to have supportive parenting due to the parent’s own mental illness. Other psychosocial risk factors include: Physical and sexual abuse (Leverich et al., 2002), poor social supports (Pellegrini et al., 1988; Petti et al., 2004), family conflict (Chang, Blasey, Ketter, & Steiner, 2001), exposure to low maternal warmth, and high negativity parenting (Meyer et al., 2006).

One of the primary debates surrounding BD in youth is ‘How is it defined?’ According to Papolos and Papolos (2006), BD is a diagnosis commonly assigned to children and adolescents who are described as being “extraordinarily irritable,” “inflexible and oppositional,” who exhibit rapid cycling and periods of “explosive rage” (p. 6). But Youngstrom, Freeman, and Jenkins (2009, p. 374) state that “irritable mood is diagnostically nonspecific”; and there are

“inconsistencies” in how clinicians define rapid cycling, which the DSM defines as “the occurrence of at least four or more distinct mood episodes (not changes in mood state within an episode)” (p. 357). Youngstrom, Birmaher, and Findling (2008) state that the following symptoms have shown to be more specific to BD in children and adolescents: Grandiosity, unstable self-esteem, decrease need for sleep, hypersexuality, racing thoughts, and psychotic symptoms.

Irritable mood is noted to be “one of the most distressing and impairing features” of BD in children and adolescents (Youngstrom et al., 2009, p. 378). However, there is yet to be a consensus regarding whether or not severe irritability and dysphoria are the hallmark symptoms of mania in children, as opposed to euphoria and elated mood, which is what the DSM-IV defines as the main characteristics of mania in adults (Baroni et al, 2009). While irritability is considered by some to be merely a sign that “something is wrong” (Kowatch et al., 2005), according to Youngstrom et al. (2008) if a youth is lacking these episodes of irritability, it should signal to clinicians that BD is not the correct diagnosis. Youngstrom et al. (2009, p. 357) also suggest that a better way of interpreting the “rapid changes in mood polarities, which [have] been well described in children, is...as a mixed episode rather than multiple episodes”. Also, similarly to adults, youth with BD appear to have a deficit in their ability to “experience and express basic dimensions of emotion” (Youngstrom, 2010, p. 72).

Few studies have measured the differences between childhood-onset BD and adolescent-onset BD, or between BD in males and BD in females, in a consistent and comparable manner. In a survey done by The Depression and Bipolar Support Alliance (as cited in Dunner, 2003), fifty-nine percent of adults with BD who completed this survey reported that they began first experiencing symptoms of BD during childhood or adolescents. According to Birmaher et al.

(2009b), depression is more common in adolescent-onset than in childhood-onset BD, and adolescents present with increased severity and more adult-like symptoms, such as grandiosity and elation. This is consistent with the findings of a study conducted by Olfson, Crystal, Gerhard, Huang, and Carlson (2009), which examined the BD insurance claims for privately insured individuals, ages seventeen and younger, between the years of 2003 to 2006. This study found that fifty-two percent of adolescents who received a diagnosis of BD during the examined period had received a diagnosis of depressive disorder in the previous year; and most of children had a preceding diagnosis of disruptive disorder (Olfson et al., 2009). Other studies have reported that it is also more common to see children diagnosed with ADHD in addition to BD, as opposed to adolescents (Biederman et al., 2005; Findling et al., 2001; Masi et al., 2006). While rates of BD diagnosis appear to increase with age, childhood-onset BD has been found to be significantly more common in males, and adolescent-onset BD significantly more common in females (Olfson et al., 2009). According to Daly (1997) and Achenbach and Rescorla (as cited in Diler, Birmaher, & Miklowitz, 2010) females experience more symptoms of depression, while males experience more symptoms of mania, hyperactivity, and impulsivity.

Researchers are now just beginning to follow children with early-onset BD into adulthood to see if the symptoms of BD persist. In 2009, Birmaher et al. (2009a) published a four-year study assessing the longitudinal course of children and adolescents, ages seven to eighteen years old, with BD spectrum disorders. The researchers in this study used the Longitudinal Interval Follow-Up Evaluation to seek information about the week-by-week symptomology of the participants and the rates of recovery and symptom recurrence. The study made the following findings. The participants as a whole spent 60%-80% of their time experiencing mood fluctuations. Of the time spent in a symptomatic period, more time was

spent in depressive or mixed episodes than in manic or hypomanic episodes. Approximately 80% of the youths in the study achieved full recovery, defined as eight consecutive weeks with minimal or no mood symptoms, roughly 2 ½ years after their first episode. However, 60% of the youths experienced a relapse in symptoms 1 ½ years after they were said to have fully recovered. Other studies have had similar findings that between 44% and 73.3% of youths relapse after a period of remission. Factors that are associated with poorer recovery outcome are earlier age of illness onset, longer duration of illness, rapid cycling, presence of mixed episodes, psychosis, a family history of mood disorders, presence of comorbid disorders, low maternal warmth, presence of family conflict, poor adherence to pharmacological treatment, low socioeconomic status, and non-Caucasian race (Birmaher et al., 2006; Birmaher et al., 2009a; Carlson, Bromet, Driessens, Mojtabai, & Schwartz, 2002; Geller, Tillman, Craney, & Bolhofner, 2004; Lewinsohn, Klein, & Seeley, 1995; Strober, Schmidt-Lackner, & Freeman, 1995).

DSM Criteria and Upcoming Changes

According to the DSM-IV TR, there are three categories of Bipolar Disorder: Bipolar I Disorder, Bipolar II Disorder, and Bipolar Disorder Not Otherwise Specified (American Psychiatric Association, 2000). Bipolar I Disorder is distinguished by the “occurrence of one or more Manic Episodes or Mixed Episodes” (p. 382). Bipolar II Disorder is distinguished by the “occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode” (p. 392). Bipolar Disorder Not Otherwise Specified “includes disorders with bipolar features that do not meet criteria for any specific Bipolar Disorder” (p. 400). “A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood” that “must last at least 1 week” (p. 357). A Hypomanic Episode shares the same definition of a Manic Episode, with the following exceptions: It must last at least

four days, it is “not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization, and there are no psychotic features” (p. 365). A Major Depressive Episode is defined by “a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities” (p. 349). A Mixed Episode is defined as a “period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day” (p. 362).

In 1999, the American Psychiatric Association began the initial planning for the creation of the DSM-V. To facilitate the changes being made, a Steering Committee was created, and thirteen DSM-V Work Groups were established, each co-chaired “by a leading U.S. expert in a given diagnostic area and a distinguished investigator in the same field from a country other than the U.S.” (American Psychiatric Association, 2010a, p. 1). A conference series, funded by the National Institutes of Health and the World Health Organization, were held regarding relevant research for changes to the DSM (American Psychiatric Association, 2010a).

One such conference called, “Externalizing Disorders of Childhood (Attention-deficit/Hyperactivity Disorder, Conduct Disorder, Oppositional-Defiant Disorder, Juvenile Bipolar Disorder)” was held on February 14-16, 2007 (First, 2010). Boris Birmaher, MD, Barbara Geller, MD, and Ellen Leibenluft, MD were three of the researchers in attendance, each of whom presented research relevant to the topic of “Juvenile Bipolar Disorder”. Each of these three researchers presented unique findings regarding this topic, but there was a general consensus between them that the same diagnostic criteria for BD should be used for children and adults and that no current evidence exists to “justify a BD diagnosis for children who do not meet adult criteria” (First, 2010, para. 30). However, they also agreed that although BD is not the correct diagnosis for many children, diagnostic options need to be created so that these “severely

impaired children” are not left behind (First, 2010, para. 30). To follow are the presentation specifics of each of the above researchers, along with their additional recommendations for diagnosing BD in children.

Boris Birmaher, MD presented findings of the Course and Outcome of Bipolar Youth (COBY) Study. Given these findings, Birmaher recommended that the following changes be made to the DSM criteria for pediatric BD: Symptoms should be interpreted using “developmental appropriate examples”; “symptoms should be present in more than one setting” and when coinciding with other disorders, symptoms should worsen in order to be counted. Birmaher also recommended “lowering the number of days required for a manic or hypomanic episode” (First, 2010, para. 4).

Barbara Geller, MD presented on how current diagnostic criteria allows for frequent overlap in criteria for BD and ADHD. Dr. Geller also cautioned against basing a diagnosis for mania in children specifically on the presence of “aggression/irritability”, stating that “95% of irritable children do not have a mood disorder” (First, 2010, para 13).

Ellen Leibenluft, MD presented research “on the clinical and pathophysiological differences between non-episodic irritability and childhood bipolar disorder”, by exploring “two possible clinical phenotypes of pediatric bipolar disorder” (First, 2010, para 14). The first is a “narrow phenotype” and the “broad phenotype”, as discussed earlier. Leibenluft called the “broad phenotype” “severe mood dysregulation” (SMD), and classified it as having “non-episodic symptoms, irritability...baseline anger or sadness, at least three ADHD-like symptoms...and an impairment in at least two settings” (First, 2010, para. 14). Dr. Leibenluft’s research shows that although these two phenotypes are “similarly impaired”, it is too early to

“assume that SMD is a phenotype of BD” because the age of onset, family history, and area of brain deficits are different (First, 2010, para 14).

Each of the thirteen DSM-V work groups created were also asked to submit “research base” to supported recommendations for changes in DSM-5, which were published on www.DSM5.org for “public review and comment” in 2010 (American Psychiatric Association, 2010a, para. 2). The two work groups relevant to this topic are the Childhood and Adolescent Disorders Work Group and the Mood Disorders Work Group. These two groups released a collaborative paper in 2010, *Issues Pertinent to a Developmental Approach to Bipolar Disorder in DSM-5*, which presented their recommendations for changes to the diagnostic criteria for BD and their rationales for these suggested changes (American Psychiatric Association, 2010b). This paper reflects that recommendations of the above scientists and “a major focus in the DSM [revision] process...to maintain continuity between adult and child” diagnostic criteria (American Psychiatric Association, 2010c, p. 1).

The first recommendation is to “revise the wording of the criteria for manic and hypomanic episodes in order to operationalize episodicity more clearly” (American Psychiatric Association, 2010b, p. 1). The work groups stated that much of the “confusion and controversy” regarding what counts as an episode, particularly when diagnosing children, is likely due to the “wording of the DSM-IV criteria” (American Psychiatric Association, 2010b, p. 1). The following changes in wording are meant to clarify areas of diagnostic uncertainty, specifically related to the frequency and duration of episodes and the overlapping of symptoms in different disorders. It is suggested that, similarly to how major depressive disorder is defined in the DSM-IV, “most of the day, nearly every day” be added to the “DSM-IV ‘A’ criterion for a manic or hypomanic episode” (American Psychiatric Association, 2010b, p. 1). It is also suggested that ‘B’ criteria for

(hypo)mania add language to clarify that the symptoms show a noticeable change from the person's baseline behavior.

The second recommendation is to “address the nosological status of hypomanic episodes shorter than 4 days” (American Psychiatric Association, 2010b, p. 8). While no specific proposal has been made as to how to change this, it is stated that a classification other than BD-NOS needs to be created for children and adults who have hypomanic episodes shorter than four days.

The third recommendation is the proposal of a new diagnosis in the Mood Disorder Section of DSM-V called “Temper Dysregulation Disorder with Dysphoria (TDD)” (American Psychiatric Association, 2010b). The rationale for this proposal is outlined in a paper released by the Childhood and Adolescent Disorders Work Group called *Justification for Temper Dysregulation Disorder with Dysphoria* (American Psychiatric Association, 2010c). The criteria for TDD is based primarily off of Dr. Leibenluft's research done on SMD. Advocates for the addition of TDD as a DSM diagnosis, state that opposed to applying the BD label “broadly” to children and adolescents when there is still uncertainty about “what is really wrong”, the “ TDD label more accurately describes these children's behaviors...and acknowledges what we do not know, including the outcome of their condition.” (Parens, Johnston, & Carlson, 2010, p. 1854).

The Childhood and Adolescent Work Group analyzed two options for creating a DSM home for children who present with severe, non-episodic irritability. The first was to create a specifier to oppositional defiant disorder (ODD), and the second was to create a new diagnostic category under DSM's Mood Disorders (American Psychiatric Association, 2010c). Despite the fact that “approximately 85% of SMD youth meet the criteria for ADHD and ODD”, the work group chose to propose TDD as a new diagnostic category for the following reasons (American Psychiatric Association, 2010c, p. 6). A TDD category would “focus attention on the need to

generate effective biological, psychological, and social treatments for a neglected, but important, clinical syndrome” (American Psychiatric Association, 2010c, p. 8). A specifier under ODD would not account for the “significant impairment of SMD youth”, or mood disturbances of these children, nor would it give these children “access to the intense level of services required” (American Psychiatric Association, 2010c, p. 4). The work group suspected that this would make it unlikely that providers would diagnose these children with an ODD specifier. The work group also looked at research that compared SMD and BD. Two post-hoc analyses showed that chronic irritability or SMD in childhood predicated increased risks for unipolar depressive disorders, major depression, generalized anxiety disorder, and dysthymia adulthood, but not BD or manic episodes (American Psychiatric Association, 2010c; Brotman et al., 2006; Leibenluft, Cohen, Gorrindo, Brook, & Pine, 2006). According to the American Psychiatric Association (2010c, Tier 2: Biological markers, para. 1), studies have also shown “difference in brain function between SMD and BD”, including differences in “amygdala activity” and “neural circuitry mediating...emotional reactivity” (Brotman et al., 2010; Guyer et al., 2007; Rich, Grimley, Schmajuk, Blair, Blair, & Leibenluft, 2008). While gender distributions of BD youth appear to be even, SMD is seen more frequently in boys than girls (American Psychiatric Association, 2010c; Brotman et al., 2006). The work group did acknowledge the faults and limitations of their research, including the fact that research regarding SMD has only been conducted by one research group, participants of the longitudinal studies were “drawn from the community, and few were treated in mental health clinics”, and research regarding biological markers is only in the preliminary stages (American Psychiatric Association, 2010c, p. 5). Currently, each work group is conducting field trials to test the suggested diagnostic criteria work in real-working settings (American Psychiatric Association, 2010a).

Making a Bipolar Disorder Diagnosis

According to the National Depressive Manic-Depressive Association (as cited in Singh & Rajput, 2006, p. 58), “69% of patients with bipolar disorder are misdiagnosed initially and more than one-third remained misdiagnosed for ten years or more.” Although these statistics are not specific to youth, they exhibit the difficulty that exists in assessing for BD. Bipolar Disorder is a particularly difficult diagnosis to make for the following reasons: Comorbidity of numerous disorders (i.e. ADHD, CD, ODD, and BD); younger people can struggle to accurately portray their symptoms to clinicians; it can be hard to differentiate between developmentally appropriate behavior and symptoms of BD; it is unclear what constitutes “mania” in children; the episodicity of BD in children appears to be much different than in adults; and the DSM-IV does not address BD in individuals under 18 years of age (Papolos & Papolos, 2006; Parens & Johnson, 2010).

Bipolar disorder in children and adolescents shows high comorbidity with several other psychiatric diagnoses, such as ADHD, conduct disorder, anxiety disorders, oppositional defiant, depressive disorder, and disruptive behavior disorder. Because the symptom presentations for many of these disorders are very similar, it increases the difficulty that many clinicians face in making this diagnosis. For example, “mood [dis]regulation, stress intolerance, and hyperactivity and impulsivity” are symptoms associated with both BD and ADHD (Atmaca, Ozler, Topuz & Goldstein, 2009, p. 197). In Biederman et al.’s 1996 study (as cited in McIntosh & Trotter, 2006, p. 453), they found that “96% of children who meet the criteria for [early onset bipolar spectrum disorder] also meet the criteria for ADHD.” According Olfson et al. (2009), most children and adolescents who are diagnosed with BD were previously diagnosed with a separate mental health disorder, most commonly depressive disorder and disruptive disorder. They also found that most

of these youth had filled prescriptions for psychotropic medications prior to receiving the BD diagnosis.

According to Baroni et al. (2009, p. 203), in keeping with the recommendations from the American Academy of Child and Adolescent Psychiatry, the BD diagnosis “should be reserved for youth who have a history of one or more distinct episodes of mania or hypomania meeting full DSM-IV duration criteria” and that BD NOS should not be assigned to youth who do not meet this duration criterion. Papolos and Papolos (2006, p. 32) agree that the BD NOS diagnosis is “not an accurate description of the condition as it presents in childhood”, but also acknowledge that this is the category that most children diagnosed with a type of BD fit into.

According to Galanter, Goyal, Jenna and Fisher (as cited in Meyer & Carlson, 2010, p. 39), in identifying these episodes “there should be a clear onset, offset, and return to premorbid level of functioning”. This means that symptoms, particularly those where there is comorbidity to another psychiatric illness, should not be counted as symptoms of mania unless they increase at the onset of an episode (Kaufman et al., 1997; Birmaher, et al., 2009b).

Baroni et al. (2009) note that what is important when diagnosing mania in children and adolescents is to distinguish whether there is a distinct change in behavior from a baseline behavior and whether the new-onset symptoms occur concurrently. To do so, collateral information, academic achievement, a longitudinal history of symptoms, and a physical examination should also be included in assessments (Singh & Rajput, 2006; Youngstrom, 2010). Clinicians must rule out the possibility that the symptom presentation is not due to other mental health disorders, general medical conditions, or substance induced. In making this diagnosis, Youngstrom et al. (2006) also encouraged the integration of family history into the child or adolescent’s assessment. Family history is helpful for establishing whether the youth has been

genetically predisposed to BD, understanding the youth's environment, and knowing how family members have responded to pharmacological interventions in the past (Youngstrom et al., 2006). And clinicians should rediagnose children with an early-onset BD as they continue to age to reassess the diagnosis in relation to developmental growth (Meyer & Carlson, 2010).

There are several tools that can be used in the process for assessing the presence of symptoms of BD in youth. Kiddie-Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS) is one of the most commonly used tools for assessing for pediatric bipolar disorder (Nottelmann et al. as cited in Youngstrom et al., 2004). The original K-SADS and the epidemiological version (K-SADS-E) have a validity rate between 95% and 97%, where the diagnosis was confirmed by expert clinical interviewers (Youngstrom et al., 2004; Wozniak, Biederman, Monuteaux, Richards, & Faraone, 2002).

Between 1997 and 2002, Youngstrom et al. (2004) compared the diagnostic efficiency of six index tests in their ability to recognize BD in children ages of five to ten years old and eleven to seventeen years old in two outpatient samples. For a baseline diagnosis, semistructured interviews were conducted using K-SADS. This study found that the two most efficient index tests were the Parent Young Mania Rating Scale (P-YMRS) (Gracious as cited in Youngstrom et al., 2004), an eleven-question survey which asks parents to rate their child's symptoms of the past week; and the Parent General Behavior Inventory (P-GBI) (Youngstrom as cited in Youngstrom et al., 2004), which asks parents to rate their child's depressive, hypomanic, manic, and biphasic symptoms. The tests that were least efficient, in order from best to worst, were the General Behavior Inventory (A-GBI), Child Behavior Checklist (CBCL), the Achenbach Teacher Report Form (TRF), and the Youth Self-Report Form (YSR). Volk and Todd (2007, p. 117-118), similarly found in their study of the CBCL that none of the subjects that met the

criteria for Juvenile Bipolar Disorder on the CBCL test “met the criteria for any DSM-IV bipolar disorder.” Youngstrom et al.’s (2004) results showed that parent reports provided very reliable and valid information for the assessment of BD. However, McDermott and Weiss (as cited in Youngstrom, 2010) argue that, as opposed to parents, clinicians and teachers who have seen a wide array of children at different developmental levels may be more skilled at distinguishing what is and is not developmentally appropriate behavior when assessing for BD.

According to the American Psychiatric Association (as cited in Youngstrom et al., 2004, p. 855) index tests “cannot substitute for a thorough evaluation by a trained professional familiar with the diagnostic criteria for bipolar disorder”. And Youngstrom et al. (2004, p. 854) cautioned that “these questionnaires were not originally intended to be diagnostic instruments”, but they can be used to differentiate BD from another diagnosis. Index tests have several other benefits over reliance on clinical interviews and judgment, such as being less expensive and time consuming, requiring less staff and training, and the omitting the subjectivity of clinical judgments which makes it easier to compare the diagnosis across different agencies.

Social Worker’s Role in and Thoughts About the Diagnostic Process

According to Corcoran & Walsh (2006, Chapter 2, Relationship Between Social Work and the DSM section, para. 5), “social workers are extensively employed in mental health settings, where clinical diagnosis is considered necessary prior to selecting appropriate intervention. In fact, social workers account for more than half of the mental health workforce in the United States (Gambrill, 2002; O’Neill, 1999)”.

As a social worker, an important part of the diagnostic process is knowing how to integrate knowledge of the DSM and biopsychosocial assessments with social work values and principles. Some of these values include “strength-based orientation, concern for the worth and

dignity of individuals, and an appreciation for the environmental context of individual behavior” (Corcoran & Walsh, 2006, Chapter 1, para. 1). Social workers commonly take a biopsychosocial framework approach to diagnosing. This framework integrates biological, social, and environmental factors, along with theories of human development, into the understanding of the person’s functioning (Corcoran & Walsh, 2006). All of these factors make up a system of “reciprocal impact of people and their environments...on human behavior” (Andreae as cited in Corcoran & Walsh, 2006, Chapter 2, Social Work Perspective: Social Functioning, para. 1). The social work approach also takes into account the risk and protective factors of a persons life and how these factors contribute to a person’s “resilience, or the ability to function adaptively despite stressful life events” (Corcoran & Walsh, 2006, Chapter 1, Risk and Resilience Biopsychosocial Framework, para. 1). Social workers are distinguishable from other mental health providers, in the fact that they view an assessment as an ongoing process that occurs throughout the course of treatment with a client, as opposed to a one time measurement (Corcoran & Walsh, 2006).

Similarly to other mental health fields, social work has become more focused on evidence-based practice over the past decade (Corcoran & Walsh, 2006). Evidence-based social workers incorporate treatment outcome studies and documentation of individual client progress into their practice in order to help inform them about what is the most appropriate and effective treatment to provide for a client (Corcoran & Walsh, 2006).

As stated above, DSM diagnoses are often required in mental health settings and the reason for their importance will be discussed here. The DSM used to be reserved for only psychiatrists, but now most mental health workers, including social workers, use DSM criteria to make diagnoses. The DSM gives providers a way to “consolidate [and] organize [a] description of client symptoms”; “classify or categorize mental disorders”; “communicate with other

professionals, insurance or managed care companies”; and “provide more appropriate and more effective treatments” (Sommers-Flanagan & Sommers-Flanagan, 2009, p. 283). Sommers-Flanagan and Sommers-Flanagan (2009) also argue that receiving a diagnosis is often a relief for clients and families. It allows them to put a name to their problems and gain reassurance that there are many other people who are suffering in a similar way. A diagnosis can also provide hope for recovery, which can encourage clients and families to become more engaged in the diagnostic and treatment process (Bucciarelli, 2005; Frank & Frank, 1991; Pierce, 2004; Sommers-Flanagan & Sommers-Flanagan, 2009). Lastly, DSM diagnoses are important because they are the means by which clients become eligible for mental health services and providers are reimbursed for the services provided.

Many social workers struggle with the diagnostic process and express resistance towards the use of the DSM. As opposed to social work’s biopsychosocial framework, the DSM is based on a medical model. The DSM perceives clients as isolated entities; and biological causation and interventions are “overemphasized”, giving little emphasis to possible environmental influences (Corcoran & Walsh, 2006; Kutchins & Kirk, 1997). The DSM also focuses mostly on the deficits of the individual, not taking into account the individual’s strengths.

Many social work clinicians struggle with this model because they do not want to put labels on clients. Although it was argued above that some clients feel relief from receiving a diagnosis, other clients feel stigmatized because of the mental illness labels given to them. Stigmas are often assigned to people who suffer from mental illness by members of society, including clinicians, as a way of “judg[ing] or label[ing] someone who is different or disfavored” (Overton & Medina, 2008, p. 143). Stigma can also be assigned by oneself, in a process where an individual internalizes the negative messages he or she receives from society. Stigma often

follows people for their entire lives, limiting their opportunities, decreasing self-esteem and self-efficacy, and affecting how people interact with them in their schools, communities, careers, and families.

Sommers-Flanagan & Sommers-Flanagan (2009, p. 286) noted that social work clinicians frequently struggle with diagnostic comorbidity, which occurs when clients' symptoms "qualify [them] for more than one DSM diagnosis...[and] with regards to children, diagnostic comorbidity occurs more often than not (Rounsaville, 2007; Wakefield, Schmitz, First, & Horwitz, 2007). Clinicians also struggle with the interplay of countertransference, which may cause them to lose "objectivity and/or distort information provided"; integrating cultural considerations; the accuracy of and discrepancy between client, family, school, and provider description of symptoms; and "client deceit". (Sommers-Flanagan & Sommers-Flanagan, 2009, p. 286). According to Bowden (as cited in Singh & Rajput, 2006, p. 59), clinical misdiagnosis of BD can result in "increase[d] risks of recurrence and chronicity of episodes" and inappropriate treatments, such as with antidepressants, which studies have suggested can trigger rapid cycling and manic episodes.

According to Garb (2005, p. 69), "little is known about the individual differences [in cognitive processes] among clinicians." But according to Youngstrom et al. (2009, p. 363), "emerging evidence indicates that clinical diagnoses often have low accuracy with regard to bipolar disorder". Studies suggest that one reason for this is that heuristics, or methods used to make judgments and decisions, play a significant role in the diagnostic process. Affect heuristics refer to when a clinicians' feelings or emotions affect their clinical judgment and decisions. These can play a positive role when they help clinicians to discriminate symptoms from developmentally appropriate behavior and gauge the responses of children and parents (Garb,

2005; Youngstrom et al., 2006). However, affect heuristics can also have a negative affect on clinicians' judgments. One example of this would be if a clinician's decision to label a patient with a diagnosis was based on his or her fear that not assigning a diagnosis to a patient "could result in [a patient's] death" (Youngstrom et al., 2009, p. 363). Availability heuristics can also negatively affect a clinician's judgment by increasing the likelihood that he or she will assign a BD diagnosis simply because of the increasing amount of times they have heard it mentioned in recent times (Youngstrom et al., 2009). For these reason, clinicians need to take notice of how heuristics can lead to possible biases that may affect their clinical judgment and decision making (Drive & Garb, 1997).

According to Garb (2005, p. 71), several studies have found that clinicians often do not hold fast to diagnostic criteria, but "frequently make diagnoses by comparing clients to prototypes...of a hypothetical client who best exemplifies a particular disorder". According to Kim and Ahn (as cited in Garb, 2005), when clinicians do use diagnostic criteria, they frequently weigh criteria that are congruent with their theories of a particular disorder more heavily than criteria that an incongruent with these theories. However, Youngstrom et al. (2009) argue that "not all symptoms carry equal weight toward making the diagnosis mania" (p. 374). According to the DSM-IV, when elated mood is present, only three additional symptoms need to be documented to make the diagnosis of mania, as opposed to four additional symptoms when irritable mood is present.

Several steps have been proposed to limit the possible affects of clinical bias. Some of these include sticking closely to diagnostic criteria (Drive & Garb, 1997), having clients use daily self-rating scales to measure symptoms and behavior, collecting information from multiple

sources and taking into perspective the nature by which each source knows the identified client, and using semi-structured interviews (Garb, 2005).

Race, Ethnicity, Culture, and Diagnosis and Bias

Many studies have found that a person's race, ethnicity, and culture affect the mental health diagnosis and treatment that a person receives. BD is one diagnosis that "has historically been underdiagnosed in minority groups in the United States" (Youngstrom et al., 2009, p. 358). The U.S. Census predicts that by 2020, fifty percent of all youth will be children of color; and the Surgeon General's Mental Health Report, released by the U.S. Department of Health and Human Services in 2001 (as cited in Muroff, Edelsohn, Joe, & Ford, 2008) stated that there is increasing concern that ethnic minority youth have unequal access to mental health services.

Muroff et al. (2008) conducted an investigation to look at the influence of race and ethnicity on diagnoses given to children and adolescents who presented in an urban psychiatric emergency services (PES). To do this, the medical records of 2991 African-American, Hispanic/Latino and white children and adolescents who presented to PES were reviewed. The sample population was 64.3% African American, 14.3% Hispanic/Latino, and 21.4% white. The diagnoses in this study were assigned by PES psychiatrists. The findings showed that "African-American and Hispanic/Latino youth in this sample were more likely to be diagnosed with psychotic disorders and behavioral problems, whereas white youth were more likely to be diagnosed with depressive disorders and bipolar disorders" (Muroff et al., 2008). Bipolar disorder was one of the diagnoses that had the largest rate of difference between racial groups, showing that white youth were almost three times more likely to be diagnosed with BD than African-American youth. The authors of this study suggest two reasons for the diagnostic discrepancies, but also stated that this study was limited due its retrospective nature and inability

to collect complete clinical information regarding the studied population, and the methods used to assign diagnoses. Muroff et al. (2008) stated that first possible reason for differences in diagnostic rates was that it reflected true prevalence rates between “African Americans, whites and Hispanics/Latinos who seek treatment [and]...those who are randomly included in epidemiological samples” (p. 8). It was further suggested that since ethnic minorities are less likely to seek “formal mental health services”, the delay in seeking treatment meant that when treatment was eventually sought, the diagnosis had become more severe (p. 8). The second suggested reason for these differences was “diagnostic errors, and misdiagnosis which may result from [such things as] clinician bias”, differences in cultural experience, and “mistrust” (p. 8)

Another study that explored the relationship between race and diagnosis was conducted at a state psychiatric facility in Detroit, Michigan (Neighbors, Trierweiler, Ford, & Muroff, 2003). In this study, third and fourth year psychiatric residents were asked to use DSM-III-R criteria to assign diagnoses. Similar to the previously mentioned study, this study also examined the difference in rates of diagnoses between races and found that white patients were much more likely to be diagnosed with BD than African-American patients. This study went more in-depth to try and uncover the “location of diagnostic divergence” and how clinicians’ uncertainty, judgment, and bias played a role (Neighbors et al., 2003, p. 239).

The study found that there were few differences in the symptom profiles between racial groups, but large differences in diagnoses given, leading the authors of this study to conclude that differences in diagnoses rates between racial groups could only be attributed to the clinicians’ influence. In examining clinicians’ biases, the study concluded that it was unlikely that the clinicians assigned diagnoses to patients of different races and ethnicities “with no conscious consideration of how the person’s race...might influence the clinician encounter”

(Neighbors et al., 2003, p. 248). In fact, Abreu (as cited in Neighbors et al., 2003, p. 249) found evidence that some clinicians make a conscious effort to resist “influence of racial stereotyping”.

This study also found that clinical judgment played a role in how clinicians perceived “subtleties of communication and cultural context” while making a diagnosis (Neighbors et al., 2003, p. 249). Specifically, the study cited concern about how accurate the psychiatric residents were in assessing patients “affective states and in judging its appropriateness”; and their ability to distinguish symptoms of poor reality testing from “culturally governed interpretations of subjective experiences” (Neighbors et al., 2003, p. 250). Neighbors et al. (2003) concluded that a DSM criterion does not “eliminate racial disparities in diagnostic outcomes” and that more research needs to be conducted to examine how clinical judgment affects the diagnostic process (p. 251). The study also made a call for clinicians to become better trained on how to make clinical interpretations through a more culturally sensitive lens. This study had limitations in the fact that they used outdated DSM criteria, had restrictions on time and resources, looked at only one clinical setting, used psychiatric residents as clinicians, and the data is only preliminary.

In regards to the role that race, ethnicity and culture play in the psychiatric treatment, the following findings have been made. African Americans psychiatric patients are more likely than Caucasian psychiatric patients to be forced to wear restraints, be placed in seclusion, and receive antipsychotic medications, at higher doses (Flaherty & Meagher, 1980; Strakowski, Shelton, & Kolbrener, 1993). According to a study done by DelBello, Soutullo, and Strawoksi (2000, p. 838), “African American adolescents with bipolar disorder were nearly twice as likely to receive treatment with an antipsychotic as were Caucasians”. Warren (2007, p. 33) highlights the important role that culture plays in the “development, expression, and treatment” of mental health patients and the importance of providers taking a more cultural competent approach to the

care given to these patients (Perlis, Vornik, & Hirschfeld, 2005; Warren as cited in Warren, 2007). Research shows that racially and ethnically diverse patients have worse treatment outcomes and higher mortality rates, especially when diagnosed with another physical illness, such as cancer or cardiovascular disease (Warren, 2007, p. 34). Warren (2007) offers suggestions for how to provide better treatment for racially and ethnically diverse populations, such as having providers examine their own cultural frameworks, as well as the cultural frameworks of their patients; being more attuned to differences in behavior and terminology when diagnosis and treating for mental illness; and being aware of the metabolic differences between patients when prescribing medications.

Treatment Options for Bipolar Disorder in Children and Adolescents

There are two different categories of treatment that will be discussed in this section: Pharmacotherapy and psychosocial. Some therapies for pediatric BD have been adapted from models used to treat BD in adults and others from models used to treat similar pediatric disorders. The research consistently states that youth treated two or more treatments have better recovery outcomes than youth treated with only one type of therapy. Specifically, the research shows that the use of “medications alone is seldom sufficient” and that “psychotherapeutic treatments should accompany medications for almost all children diagnosed with bipolar disorder” (Parens et al., 2010, p. 1855).

Pharmacological treatment can be difficult when working with children and adolescents with BD. Developmental changes in biological and psychological systems often complicates the ability to treat pediatric BD with psychotropic medications (Cicchetti & Rogosh, 2002; Spear, 2000 as cited in Kowatch, Strawn, & DelBello, 2010). Also, medications, such as antidepressants or psychostimulants, that are used to treat disorders with similar symptom presentations, such as

ADHD and depression, can exacerbate the symptoms of a youth with BD (Kowatch et al., 2010). However, findings in Olfson et al. (2009) showed that most children and adolescents who had previously been diagnosed with depressive and disruptive disorders and been receiving antidepressants, stimulants, or atomoxetine continued these medications even after the diagnosis of BD was added.

Studies have been conducted to examine the effectiveness of “traditional and novel mood stabilizers/antiepileptics” and found lithium to be the most effective, followed by valproate (Kowatch et al., 2010, p. 425). Studies testing lithium’s effectiveness in treating youth with BD date back to 1972. More recent studies suggest that 40-50 % of youth with BD will improve with lithium monotherapy (Findling et al., 2003; Kowatch et al., 2000; Youngerman & Canino, 1978). “Lithium is [also] the only mood stabilizer approved by the U.S. Food and Drug Administration (FDA) for the use in treatment of mania in adolescents (ages 12-18)” (Kowatch et al., 2010, p. 420). However, lithium has severe side effects, that are often more severe in youth, such as “nausea, polyuria, polydipsia, tremor, acne, weight gain”, “renal, hematological, thyroid, and other endocrine changes”, which must be all be closely monitored (Kowatch et al. 2010, p. 421). Atypical antipsychotics are also commonly prescribed to youth with BD, including risperidone, olanzapine, ziprasidone, quetiapine, and aripiprazole. The side effects of these medications include “extrapyramidal effects, tardive dyskinesia, obesity, hyperlipidemia, increased prolactin levels, and cardiac QTc changes” (Kowatch et al., 2010, p. 427).

Pediatric BD “can be extremely impairing for both the children and their families”, particularly since the children are still dependent on their families for their survival (Mendenhall & Fristad, 2010, p. 494). Likewise, family relationships and parenting styles can have significant effects on the course and outcome of BD. For these reason, it is important to have families

involved in the treatment. It is also critical for parents to understand the importance and possible side effects of the medications their children are being prescribed, since the parents are frequently the ones monitoring, reporting and in the best cases, encouraging their child's adherence (Miklowitz & Goldstein, 2010).

Many researchers prominently state the importance of psychoeducation as a part of treatment for children, adolescents, their families and teachers. Psychoeducation can help families better understand the biological nature of BD and the behaviors that accompanies it, which can lead to more empathic responses from family (McIntosh & Trotter, 2006). It can also help families to know how to monitor and address symptoms, regulate affect, and problem solve (McIntosh & Trotter, 2006).

Psychoeducational psychotherapy is one approach that is recommended for families, which involves "intensive, long-term treatment that combines education with individual, group, and/or family therapy" (Mendenhall & Fristad, 2010, p. 495). Two branches of this approach are family-focused treatment, child- and family-focused cognitive-behavioral therapy. Each vary in the way the material is presented, but in all of them both parents and children are educated about the specifics of BD; the importance of medication adherence; and skills for problem-solving, symptom management, and communication. In addition, children are taught "age-appropriate affect regulation" and social skills (Mendenhall & Fristad, 2010, p. 501). Another key component of these approaches is coming up with a plan to maintain or reestablish stability when youth's symptoms increase, their moods become unstable, or they become suicidal (Miklowitz & Goldstein, 2010).

A similar approach to the above mentioned, but aimed more toward adolescents is dialectic behavioral theory (DBT) (Miller, Rathus, & Linehan, 2006). DBT is instituted through

family skills training and individual therapy. DBT uses the following skill modules: Psychoeducation, mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and walking the middle path. Each of these modules is targeted to treat the following areas: Confusion about bipolar disorder, confusion about self, impulsivity, emotional instability, interpersonal problems, and teenager and family dialectical dilemmas. In a treatment trial by Goldstein, Axelson, Birmaher, and Brent (2007), adolescents who engaged in DBT and pharmacotherapy for one year exhibited “significant improvement from pre- to post treatment in suicidality, nonsuicidal self-injurious behavior, emotional dysregulation, and depressive symptoms” (Miklowitz & Goldstein, 2010). Although this trial only involved 10 adolescents, a similar larger scale trial is currently being completed.

The research presented in this chapter has demonstrated a number of things with regards to the diagnosis and treatment of children and adolescents with BD. It has provided a symptom picture of BD in youth, but also shown that there is still much controversy over how to define and assess for this disorder. Because of this there is a greater tendency for clinical bias to affect the diagnostic process. The varying roles that the DSM, diagnostic tools, and social work clinicians play in this process have also been explored. However, no literature was found discussing the specific experiences of social work clinicians in diagnosing BD in youth. For this reason, this study will seek to combine two of the areas in which researchers agree that more studies need to be conducted: The existence of BD in youth and the diagnostic practices of social work clinicians.

Chapter III

Methodology

This is an exploratory study that looked at the experiences of clinical social workers who have diagnosed bipolar disorder (BD) in children and adolescents. The research question being asked was: How is bipolar disorder in children and adolescent identified and diagnosed by clinical social workers and how does their own understanding of the disorder affect their treatment planning process? This included identifying what steps were taken to make this diagnosis, what specific symptoms were looked for, what things clinicians found helpful when making this diagnosis, what problems were encountered, how this diagnosis helped clinicians further understand the client, and how this diagnosis affected the treatment that was recommended for the client.

Research Design

A qualitative exploratory research design was used to for this study. An exploratory methodology is generally used when “a researcher is examining a new interest, when the subject of study is relatively new and unstudied...” (Rubbin & Babbie, 2007, p. 29). A review of the literature shows there have been many quantitative studies looking at BD in children and adolescents, including studies that have tested individual diagnostic tools against each other; however no literature was found containing narratives from social work clinicians describing their experiences or methods used when diagnosing BD in children and adolescents (Youngstrom et al., 2009). According to Moreno, Laje, Blanco, Jiang, Schmidt, and Olfson (2007, p. 1037):

As a separate line of research, it may be helpful to probe the diagnostic processes [for diagnosing youth with BD] used in routine clinical practice. For example, it might be informative to assess whether clinicians give more weight to particular clinical presentations, such as high levels of aggression, than to specific DSM-IV symptoms.

Sample

The sample size for this study was eleven participants. This investigator initially had the goal of interviewing twelve to fifteen participants. However, this was not achieved due to the difficulty this investigator encountered while trying to recruit willing participants. Participants for this study were recruited via word of mouth, in a snowball method, using social networking websites, e-mail requests, telephone calls, and face-to-face interactions. This investigator also contacted the clinical directors of a number of social service agencies and requested that they pass the recruitment information along to their colleagues and other social workers in the agencies. Most of the clinical directors were willing to do this, however only once did this result in a potential participant contacting this investigator. The feedback that this investigator received about why people were unwilling to participate was that people were either too busy or they had worked with children and adolescents with bipolar disorder, but not made the diagnosis.

The inclusion criterion for participants of this study follows. Each participant needed to have a Master's of Social Work (MSW) degree; must have worked in a clinical social work position for a minimum of one year following the acquisition of their MSW degree; must currently be working in a clinical social work position with clients ages nineteen and younger; and must have had experience diagnosing at least one child, twelve years old or younger, or adolescent, thirteen years old to nineteen years old, with BD. No clinician was excluded from

participating in this study due to his or her own or his or her clients' race, ethnicity, gender, age, or socioeconomic status.

In the initial part of each participant's interview, a series of demographic questions were asked of each participant (Appendix E). The data was obtained from these questions is located in Table 1 and a written description of the data follows.

Table 1

Description of Participants' Demographic Information: Age, Gender, Race, Socioeconomic Status, Total Years of Clinical Experience, and Agency Setting

Participant	Age Range	Gender	Race	Socioeconomic Status	Total Years of Clinical Experience
1	41-50	Female	Caucasian	Middle	16
2	41-50	Male	Caucasian	Middle	17
3	41-50	Female	Caucasian	Middle	23
4	51-60	Female	Caucasian	Middle	24
5	51-60	Female	Caucasian	Middle	30
6	20-30	Female	Caucasian	Middle	8
7	20-30	Female	Caucasian	Middle	9
8	41-50	Female	Caucasian	N/A	20
9	41-50	Female	African American	N/A	20
10	51-60	Female	Caucasian	Upper-Middle	31
11	20-30	Female	Caucasian	Middle	2

Ten of the participants are female and one is male. Three of the participants are between the ages of twenty and thirty years old, five of the participants are between the ages of forty-one and fifty years old, and three of the participants are between the ages of fifty-one and sixty years old. When asked about race and ethnicity, ten of the participants identified themselves as Caucasian, including one who identified as Caucasian and Jewish, and one participant identified as African American. Regarding socioeconomic status, eight participants identified themselves

as middle class, one participant identified his or herself as upper-middle class, and the remaining chose to abstain from answering. Participants reported having a total of two to thirty-one years of clinician experience, including zero to seven years of social work experience prior to obtaining their MSW degrees, and one to thirty years of social work experience since obtaining their MSW degrees. Seven of the eleven participants also reported having other degrees or certificates above the bachelors and associates level. These included:

- Certificate of Psychoanalytically Oriented Treatment of Children, Adolescents, and Families;
- Master in Speech Pathology;
- Master in Clinical Psychology;
- Master in Counseling;
- Licensed Independent Chemical Dependency Counselor;
- In the process of obtaining Ph.D.

Recruitment and Interview Procedures

Prior to individuals being recruited for this study, an application for approval of this study was submitted to The Smith College School for Social Work Human Subjects Review Committee. Once this investigator was given a letter of approval (Appendix A), the recruitment process was able to begin. Participants for this study were recruited in a snowball method, via word of mouth, social networking websites, e-mail requests, telephone calls, and face-to-face interactions. Efforts were made to recruit participants working in diverse settings, including: Community mental health agencies, public and private schools, therapeutic schools, hospitals, medical settings, and private practice. This was done by contacting employees and program directors of a wide variety of these agencies. Letters of recruitment (Appendix B) were also sent

to known contacts who were suspected of meeting the inclusion criteria for this study. In the letter of recruitment, individuals who wished to participate in this study were asked to contact this investigator using the contact information provided and were asked to forward the letter of recruitment to any colleagues they thought may be interested in participating.

Once an individual made contact with this investigator, stating that he or she would like to participate in this study, a preliminary screening was done to ensure that the volunteer met all of the inclusion criteria (Appendix C). The preliminary screenings were done via phone and e-mail. If the volunteer did not meet the criteria, they were informed of such and thanked for their time. If the volunteer did meet the criteria, they were informed and sent the Informed Consent form for this study (Appendix D). Each participant was either e-mailed one copy or mailed two copies of the Informed Consent with a self addressed, stamped envelope. Participants were asked to sign one copy of the Informed Consent and either send it back to this investigator using the self-addressed envelope provided to them, e-mail, or fax it back to this clinician. Once this investigator had received a signed copy of the consent form, contact was made with the participant to schedule an interview time.

All of the interviews for this study were completed over the telephone and recorded using Audio Acrobat. This interviewer facilitated each interview on a one-on-one basis. Participants were informed that if they felt uncomfortable with any of the questions, they would not be required to answer them and were asked to say 'pass'. Participants were also informed that if they had any questions during the course of the interview that they should not hesitate to ask them. During the initial part of the interview, participants were asked a series of demographic questions, identifying information, and agency information questions (Appendix E). The interview followed using a standardized open-ended interview guide, which is included in

Appendix F. There were two sets in interview questions – one set for clinicians who worked with children, twelve years old or younger, and the second for clinicians who worked with adolescents, ages thirteen to nineteen years old. If participants only had experience diagnosing BD in one of these age groups, they were only asked the questions from that age group. The questions asked required each participant to answer subjectively, depending on the basis of her or his own experiences. The questions addressed the diagnostic experiences, processes, tools, and obstacles that each clinician has faced when diagnosing a youth with BD. The questions also addressed how the diagnosis made affected the treatment that was recommended for the client. Each interview lasted between twenty to thirty-five minutes, depending on the depth of each participant's answers to the questions. This investigator transcribed all of the interviews from their audio recordings at a later date.

Although participation in this study was not anonymous, several steps were taken to ensure the confidentiality of each participant in this study. All participant responses were coded and each participant was given a subject number identifier so that identifiable information could be kept separate from participants' responses. When direct quotations were used, they were carefully disguised to remove any identifying information prior to publication. The audio files of the interviews and the corresponding transcriptions were stored on this investigator's computer, under password protection. All signed consent forms and other correspondence from participants were kept in a separate and secure location. All data collected, including audiotapes, notes, and transcripts will be kept in a secure location for a period of three years, as required by Federal regulations and data stored electronically will be protected. All data and materials will be destroyed after three years or, if kept beyond three years, will be destroyed when they are no longer needed.

Data Analysis Procedures

All of the data used for this study was taken from the interviews that this investigator conducted and then transcribed. Using the transcribed interviews, the data was entered into an Excel spreadsheet. The spreadsheet organized the data by participant and interview question, and also included all of the demographic information that was obtained in the first part of the interviews. Participant's assigned number served as the primary identifier for each participant and their corresponding interview for the entire analysis process. The demographic data could be entered into the spreadsheet verbatim because of the short and direct nature of participants' responses. However, due to the length of participants' responses, the narrative answers were shortened and coded in order to make them more viewable in the spreadsheet. Using the spreadsheet, this investigator was able to easily see patterns and potential themes that arose in the responses to each question, as well as across questions based on participants' agency settings, years of experiences, and client population. An outline was then created, further sorting the patterns and potential themes that arose in response to each question. Significant and telling quotations were then pulled from the interviews to enhance the depth of the revealed data.

Reliability and Validity

Reliability and validity are two areas that are not easily assessed in qualitative studies. According to Lincoln and Guba (as cited in Padgett, 2009) a qualitative study can be assessed for reliability by how trustworthy it is. "A *trustworthy* study is one that is carried out ethically and whose findings represent as closely as possible the experiences of participants" (Padgett, 2009, p. 102). This study was created to gather up and report on those very experiences that Padgett mentions. To the best of her ability, this investigator has tried to relay the information as accurately as possible, based on how each participant presented it to this investigator. To help

with this, interviews were transcribed word-for-word and direct quotations have been inserted into the data analysis frequently.

Bias and Limitations of Study

There are some limitations to this study. Two of the most significant are the small sample size and lack of diversity among participants. Due to the small sample size of this study, this investigator does not feel that it would be correct to say that the results of this study can be generalized to all social worker clinicians. As you will read in the findings and discussion sections, although there were themes that arose, the experiences of each participant varied greatly. And while the findings of this study will likely not affect the clinical social work population as a whole, this researcher does hope that it incites critical thinking and curiosity in the people who read this study.

Participants for this study were also recruited using snowballing methods, so it is likely that some of the participants of this study know each other and/or have worked together. Therefore, it is possible that a participant may have discussed his or her answers to the questions in the interview for this study with other participants prior to them being interviewed. It is also possible that participants referred colleagues who have similar assessment and practice styles as their own. And if there are participants who previously or currently work in the same agency, it is possible that they could have similar answers due to agency guidelines and trainings.

There are also a few possible sources of investigator bias in this study. This investigator has previous experience working with youth who have received the diagnosis of BD. Part of the reason that this investigator was initially interested in conducting this study was because of this previous work and her concern that many of her clients who were given the diagnosis of BD were possibly misdiagnosed. The second motivating factor behind this investigator's desire to

study this topic was that an adolescent member of her family was recently diagnosed with bipolar disorder, so there is a fair amount emotion tied to this topic.

Knowing both of these things, this investigator attempted to be as objective as possible and not let her own biases become known or affect any of the participants or interviews. One way this investigator did this was by creating a structured interview guide for the interviews. However, during the interviews, this investigator occasionally asked the participants follow-up questions. This investigator only did so when she felt unsure of what a participant meant by their response. When this investigator began analyzing each participant's response, it became apparent that this clinician's own knowledge or lack there of had affected what follow-up questions were or were not asked to each participant. Other ways this investigator tried to limit bias was by recruiting from a wide array of agencies, familiar and unfamiliar to this investigator and responding to participant's answers as little as possible, with as much neutrality as possible. This investigator also reviewed her findings with her research advisor, so as to have a second perspective.

Due to various limitations of this study, such as small sample size and lack of diversity among the sample population, this research would like to reinforce that the findings of this study cannot be generalized to all social work clinicians. However, the qualitative nature of this study is meant to add depth and understanding, where there may have been none before, through narrations of individual clinical experiences.

Chapter IV

Findings

This qualitative study sought to answer the question: How is Bipolar Disorder in children and adolescent identified and diagnosed by clinical social workers and how does their own understanding of the disorder affect their treatment planning process? This chapter summarizes the findings obtained from interviews with eleven clinical social workers who had had experience diagnosing bipolar disorder (BD) in children, ages twelve or younger, and adolescent, ages thirteen to nineteen. A summary of the responses to each topic will be subdivided into responses that were specific to children, responses that were specific adolescents, and those that were common to both groups.

Demographic Description of the Study Sample Population -

The demographic description of the participants, the agencies they work in can be found in Table 1. Table 1 shows that the majority of the participants are employed doing private practice. It is also apparent that the participants who are employed in medical settings and residential treatment facilities have the fewest years of clinical experiences, as opposed to those employed in private practice and community mental health agencies, who have the most years of clinician experiences. Participants reported performing the following duties at the agencies they are currently employed:

- therapy with children and/or adolescents;
- completing diagnostic assessments;
- working with and providing support to parents;

- making referral and discharge recommendations;
- crisis management;
- case management;
- serving as a supervisor to other clinicians;
- serving as a faculty member;
- running therapy groups;
- conducting research.

Participants were also asked to estimate the age, gender, socioeconomic status, race and ethnic distribution of their client population at their respective places of employment. These findings are displayed in Table 2.

Table 2

Description of the Composition of Participants' Client Populations: Gender, Age, Socioeconomic Status, and Race/Ethnicity

Participant	Agency Setting	Distribution of Genders in Participants' Total Client Population	Distribution of Ages of Participants' Total Client Population	Distribution of Socioeconomic Status in Participants' Total Client Population	Distribution of Race/Ethnicity in Participants' Total Client Population
1	Private Practice	Mostly Female	½ younger than 20 years old; ½ older than 20 years old	Mostly Low-Middle SES	Mostly Caucasian
2	Private Practice	Equally split between males and females	Mostly 20 year olds or older; Some 13-19 year olds	Mostly Low SES	Mostly Latino; or Native Hawaiian or Other Pacific Islander
3	Private Practice	Equally split between males and females	Mostly 5-17 year olds	Mostly Low SES or Middle SES	African American or Black; Caucasian; Latino
4	Private Practice	Mostly Females	Mostly 20 year olds or older; 13-19 year olds	½ Low SES; ½ Middle SES	Mostly Caucasian
5	Private Practice	Mostly Females	13-19 year olds; 20 year olds or older	Mostly Middle SES	75% Caucasian; 15% African American or Black; 5% Latino
6	Medical	Mostly Males	Mostly 20 year olds or older	Mostly Middle SES	Mostly Russian Immigrant; Caucasian
7	Medical	Equally split between males and females	All 13-19 years olds	Mostly Low SES	33% Caucasian; 33% Latino; 33% African American or Black
8	Medical	Equally split between males and females	½ 6-12 year olds; ½ 13-19 year olds	Mostly Low SES	Mostly African American or Black
9	Community Mental Health	Mostly Males	Mostly 5-19 year olds	Mostly Low SES; Some Middle SES; Very Few High SES	Mostly African American or Black
10	Community Mental Health	Mostly Females	Mostly 6-12 year olds	Mostly Low SES	African American or Black; Caucasian; Native Hawaiian or Other Pacific Islander
11	Residential Treatment	All Females	All 13-19 year olds	Mostly Middle SES	Very diverse

The majority of participants reported that adolescents, ages thirteen to nineteen years old, make up the majority of their clients, followed by an equal amount of participants reporting that either children, ages six to twelve years old, or adults, ages twenty years old or older, make up the majority of their clients. Regarding gender, five participants reported that the majority of their clients identify as female, two participants reported that the majority of their clients identify as male, and four participants reported that their client population is equally split between males and females. There was equal distribution between participants who reported that the majority of their client population identifies as lower class, participants who reported that the majority of their client population identifies as lower-middle class, and participants who reported that the majority of their client population identifies as middle class. There also appeared to be a correlation between some agency settings and the reported socioeconomic status of the clients served. Both participants employed in community mental health centers reported that the majority of their client population identifies as lower-middle class. Two of three participants employed in medical settings reported that the majority of their client population identifies as lower class, the third reported that the majority of their client population identifies as lower-middle class. Although not all participants employed in private practice reported this, most of the participants employed in private practice, along with the one person employed in a residential treatment facility, were the only participants who reported that the majority of their client population identifies as middle class. The majority of participants reported that the majority of their client population identifies as Caucasian, which is also the race that ten out of the eleven participants identify with. Two participants, one of whom is employed in a medical setting and the other whom is employed in a community mental health agency, reported that the majority of

their client population identifies as African American, and most other participants stated that people who identify as African American make up at least some part of their client population. One participant, who works in private practice, stated the majority of their clients identify as either Latino or Puerto Rican and three other people, two of whom also work in private practice and one is works in a medical setting, stated that people who identify as Latino or Hispanic make up some portion of their client population. Lastly, one participant employed in a medical setting stated the majority of their clients identify as Russian and another participant who is employed in a community mental health agency reported that people who identify as Pacific Islander make up an unspecified percentage of the clients worked with.

Description of Participants' Agency Settings and Diagnoses Made Over Time

Of the eleven participants interviewed, six of them reported having diagnosed BD in at least one child, age twelve years old or younger. These participants represented three of the four agency settings, three work in private practice, two work in a medical agency, and one works in a community mental health agency. Their total years of clinical social work experience ranged from nine to thirty-one years. When each participant was asked how many children he or she had diagnosed with BD, the responses varied from one child to ten children. When asked how many children each participant had diagnosed with BD in the past twelve months, the responses ranged from zero to five. See Table 3 for participant's specific response.

A total of ten participants reported having experience diagnosing BD in adolescents. Of these, five participants also had experience diagnosing children with BD, and five of the participants only had experience diagnosing adolescents with BD. The agency locations of these ten participants varied, four in private practice, three in medical settings, two in community mental health agencies, and one in a residential treatment facility. The responses of these ten

participants varied greatly when asked how many adolescents each of them had diagnosed with BD, ranging from four adolescents to several hundred. And when asked how many adolescents each participant had diagnosed with BD in the past twelve months, the responses again varied greatly from zero to “between forty and one-hundred”.

Table 3

Participants’ Agency Settings and Number of Child and Adolescent BD Diagnoses Made

Participant	Agency Setting	Number of Children Diagnosed with BD	Number of Children Diagnosed with BD: In Past 12 months	Number of Adolescents Diagnosed with BD	Number of Adolescents Diagnosed with BD: In Past 12 months
1	Private Practice	1	0	N/A	N/A
2	Private Practice	N/A	N/A	“A lot”	1 or 2
3	Private Practice	10	5	20	2 or 3
4	Private Practice	N/A	N/A	3 or 4	2 or 3
5	Private Practice	5 or 6	1	30-40	6
6	Medical	4 or 5	3	4 or 5	4
7	Medical	6	1	“Several hundred”	40-100, “at least 1 per week”
8	Medical	N/A	N/A	“Unsure”	1
9	Community Mental Health	N/A	N/A	4 or 5	0
10	Community Mental Health	2	0	5	0
11	Other: Residential	N/A	N/A	12	1

It is clear that in this sample that participants have more experience diagnosing adolescents with BD than children. Of the six participants who had diagnosed both children and adolescents, five of them reported that the number of adolescents they had diagnosed with BD were at least one hundred percent higher than the number of children they had diagnosed with BD. Regarding the agency setting, four of the six participants who reported having diagnosed children with BD work in private practice. This is a strong majority and much different from the variety of treatment settings where adolescents were being diagnosed.

Two participants, both of whom work in private practice, also remarked that they have worked with youth who had already “carried the diagnosis of bipolar disorder” when they began working with them. Another participant, who works in a residential treatment facility, stated that, “many of the [adolescents] come to the agency with a bipolar diagnosis, but then we also make our own diagnosis after a [period] of assessment.” This participant then went on to respond to another question by stating:

[I find it difficult] how frequently the diagnosis is used inaccurately because then if a child actually does have bipolar disorder it’s harder to necessarily tell, at first, because I wouldn’t necessarily look at the diagnosis and think that it’s accurate.

Description of Elements Participants’ Found Helpful in Arriving at a Diagnosis of BD

Participant’s responses about what they found helpful when deciding that a diagnosis of BD was warranted were generally the same when working with children and adolescents. However, one participants who had diagnosed both children and adolescents reported that, “it’s easier to diagnose [BD] in adolescents because the symptoms are clearer and more apparent”. Another participant who had also diagnosed both children and adolescents stated that,

“adolescents are often able to self-observe better than children, so often I get very helpful information about what their subjective experience is and that helps me makes a diagnosis.”

Most participants reported that consulting with collaterals, such as other providers, psychiatrists, pediatricians, therapists, school counselors, and teachers was something they found useful when making this diagnosis. Three of six the participants who had diagnosed children, all of whom work in private practice, and nine of ten participants who had diagnosed adolescents reported finding consultation with others to be helpful. Two of the participants who have diagnosed both children and adolescents listed collateral consultation as something they found helpful when diagnosing adolescents, but they did not list this as something they found helpful when diagnosing children.

Several participants stated that they find collaboration with a psychiatrist to be particularly helpful and that they often refer their clients for a “psychiatric consult [to] see what the doctor thinks”. One participant remarked that this is because, “ I don’t really like diagnosing that disorder by myself because it’s such a serious diagnosis”.

One participant who cited consultation with the youth’s school as something that was helpful stated that they often found collaterals, such as teachers, to be “less-biased reporters”. Another participant said that they broaden who they speak to when diagnosing an adolescent as opposed to a child, for example by speaking to an adolescent’s school counselor. Another participant reported:

Talk[ing] to high school counselors and finding out how [the adolescent] is functioning at school, [helps me] tease out, ‘Is this an adolescent acting out or this more intense than normal adolescent behavior?’

Two participants who work with children and four participants who work with adolescents noted collaboration with youths' families and "people who have known the child over time" to be something that is helpful. According to one participant:

Also talking to parents and hearing about the history of the child and how they've seen the mood develop over time and hearing from other providers that the child has worked with [is helpful].

Another common response for things that participants found helpful was use of the DSM-IV, which one participant stated, "is like [my] bible". More participants reported using the DSM-IV while diagnosing adolescents than while diagnosing children. Similarly, a few participants in each category found psychological tests and/or mood rating scales or charts to be helpful. Three participants who diagnose adolescents, but only one participant who diagnoses children responded that client "self-report measures such as mood charts that I had created and taught parents and kids to use" were helpful. Most of these had at least twenty years of clinical experience. Another one of these participants reported:

I [do] interviews with the mothers and children using K-SADS, as well as self-scoring tests, such as Young Mania Rating Scale, Child Behavior Checklist, Family Environment Scale, General Behavior Inventory, that both the mother and child completed.

Gathering longitudinal information or looking at a client's history at their agency was mentioned as something that could provide participants with some clues, and the participants who reported using this while working with adolescents were also the participants with the fewest number of diagnoses made. One participant stated, "I also look at [the adolescents] previous track record in the hospital to see if there's any kind of pattern with what they're saying

and how they're presenting." Observing a client's behavior was cited as being helpful when working with both age groups. Half of the participants diagnosing children cited this. And only three participants diagnosing adolescents mentioned this, but those three also reported the lowest number of BD diagnoses made.

There were other participants who cited things that were unique to just them. One participant went into detail about a standardized form the social workers in his or her agency have created:

We don't have any kind of specific assessment forms at the hospital, so it's kind of just doing our own assessments. So the social workers in the ER actually came up with a generalized form of things that we look for to determine whether it's more depression or manic or what other features are present. It's split up into categories, so one section will say 'Mood' and then it will ask 'Were they exhibiting depressive features?', 'Were they exhibiting manic features?', 'Was there suicidal ideation?', 'What kind of eye contact were they making?', 'Are they having tremors?', that sort of stuff. But no one else in the hospital uses it, just the social workers in the ER.

Another participant, the same one who talked about using psychological tests above, stated that:

Training on how to look at test items and interviews and integrate them into the diagnosis process [has been helpful]. On-site trainings have been particularly helpful. These gave me a more logical way to figure out whether a child really fits into this category and they help me feel comfortable diagnosing the child, even if they didn't show all of the characteristics.

Some other responses that came up in reference to both age groups, but were mentioned by only one or two participants, were “past experience...because you know it’s easier to diagnose something once you’ve seen it”, family history, making the diagnosis over an extended period of time, and doing research.

The one response that only occurred in the adolescents group, but was reported by three participants in this group, was the use of a client’s previous diagnosis as a tool. For one participant:

Basically all of the kids I diagnose with bipolar disorder had a previous diagnosis of ADHD and had been diagnosed with ADHD around age five or six, when they started school. Then they went on medications for ADHD and what I noticed in some of the clients that I had for a couple years, was that when they hit pre-adolescents, beyond twelve or thirteen years old, their medications didn’t seem to be working as well. And I began to notice some of the key features of a mood disorder, which made me very concerned.

The two participants who did cite collaboration with family to be something they found helpful when diagnosing children were the two participants with the most years of clinical experience, one with thirty years and the other with thirty-one years. And the only participant who did not cite collaboration as something that was helpful while diagnosing adolescents was the participant who reported making the most BD diagnoses of the whole participant sample. Despite whether participants found collaboration helpful, these findings signal that for participants who diagnose adolescents there is a relationship between the use of collaboration and number of diagnoses made.

While the use of the DSM-IV was commonly mentioned as a helpful tool, only half of the participants who work with adolescents, and only two of the participants who worked with children, reported this. There did not appear to be any relationship between participant's finding the DSM-IV helpful and their agency setting, number of diagnoses made, or years of experience. Participants with the lowest number of adolescent diagnoses did, however, cited observing the adolescent's behavior and looking at longitudinal information as two things that were helpful. And using a youth's previously assigned DSM-IV diagnosis was said to be helpful by several clinicians when working with adolescents. It was also apparent in this sample that participants with a higher number of years of clinical experience were the only ones to report using psychological tests, mood charts, and rating scales.

Description of Issues Participants Struggled with While Diagnosing BD in Youth

Participants were asked whether or not there was anything they struggled with when making this diagnosis. In the words of one participant, "Yeah! I think it's an incredibly complex diagnosis." Participants were also asked about any implications they thought were attached to making or not making this diagnosis. Many of the answers to that question have been tied into this section because of the commonality in responses that arose. Although there was some overlap in the struggles that participants spoke about in both age groups this investigator has chosen to discuss each struggle under the age group where people raised the concern the most.

Issues specific to diagnosing children.

All but one of the participants who have diagnosed children with BD stated that one of the things they struggle with is labeling such young children with such a severe diagnosis. One participant stated:

My biggest struggle, particularly with children, is just that I have a hard time diagnosing children with such a severe disorder because I don't think children manifest certain types of symptoms or features at that age. I think sometimes it could be attributed to other things, so I really don't like diagnosing it.

Many participants reported struggling with differentiating BD from other disorders and behaviors that may have been triggered by a child's external environment.

For a lot of my clients, I would say about eighty percent, there is a trauma history, so it can be difficult teasing out what are the symptoms of trauma [versus BP], especially symptoms like anger, lashing out, and depression.

Half of the participants reported that ADHD was one of the disorders that they had a particularly hard time differentiating BD from.

Sometimes, at first glance, some of the symptoms can be hard to distinguish from ADHD. The impulsivity and hyperactivity can be difficult to tease out between ADHD and bipolar. And some kids I've worked with have both bipolar and ADHD, so it's a matter of figuring out which symptoms are from which disorder.

Other participants expressed concerns about the possible negative effects for children if given such a strong diagnosis, including facing stigma and implications for the future. One participant reminisced about a recent diagnosis she had made, where she questioned, "Am I just putting another label on this child?"

Another participant stated, "Sometimes I don't want to label a child too early, but then sometimes they need to have the label to be eligible for services." And another:

Sometimes, yeah I would say [the diagnosis of BD is made] to get them admitted [to the hospital] under their insurance, to get them the help they need, if they can't necessarily afford it or have access to services otherwise, or if it's a really severe case that needs to be dealt with. Particularly for us, because we're in the ER and we don't have a psychiatric unit at our hospital. And there are very few pediatric [psychiatric] facilities in the area, so in order to get them admitted, they need to have a serious diagnosis. So, we either have to get them help or they go home.

The concern that accessibility to treatment funding and services increased more when children were given a more severe diagnosis, like BD, was raised by many participants. And so was the desire to do early interventions, such as with this participant:

I don't want to give a child a label that will interfere with his or her normal development, but I also want to do early intervention because that is what does the most good, being proactive. I look at some of my adult clients with bipolar disorder, who began showing symptoms in their childhood and I think if something had been earlier, they wouldn't be in such bad shape now.

Lastly, a few participants discussed how difficult they found it when "the parents seemed very invested in having their child be given a bipolar diagnosis". One participant explained the reason for this being:

There was a way in which the family took this [diagnosis] as relieving and said, 'Okay, [the child] has a severe disorder, kind of nothing we can really do and we can't be held accountable for his behavior.'

A second participant had an even more alarming reason. “Some of our parents have motives when they come in and some parents believe that if their child has a certain diagnosis, they may be eligible for some type of financial assistance.” While alarming, according to other participants these parent’s impressions are completely wrong. It appears that their children and families are more likely to receive financial assistance if given a more severe diagnosis.

These findings speak to the number of external factors that play a role in how the social workers in this study made a diagnosis of BD. Specifically, it spoke to the dilemma that many of the participants of this study reported facing regarding the severity of this diagnosis. If they did label a child with this severe diagnosis, they risked interfering with the child’s normal development and possibly exposing the child to a lifetime of stigma. But if they did not assign a severe diagnosis to a child, it often meant that they could not obtain access to the services that they needed and early interventions could not take place.

Issues specific to diagnosing adolescents.

Although there were some commonalities, there was also a greater variety of response by participants when discussing the struggles that they had diagnosing adolescents, as opposed to while diagnosing children. One area of struggle that participants reported while diagnosing adolescents was distinguishing BD from other possible disorders and external factors. This was also mentioned in the child section, however there were two additional things that participants working with adolescents reported having to differentiate from: Substance induced behavior and normal “moody” adolescent behavior. One participant stated:

Environmental issues [make it difficult] because so many of the clients we see come from families that are pretty chaotic, that have lots of environmental stressors. Families that have histories of trauma, a lot of our clients have histories of trauma. I wanted to make

sure this wasn't an issue related to environment, an issue that could have been related to possible PTSD. So just making sure that I'm ruling out other factors that could play a role in this behavior. And also ruling out drugs and alcohol...in addition to developmentally, teenagers are moody, not all but, generally teenagers can be moody and have mood swings, which doesn't necessarily make them bipolar. So just making sure that I'm ruling out other developmental issues and external factors is a challenge.

Another area of concern that participants shared was about "medications that could affect [the adolescent] severely if the diagnosis [given] is wrong." Both participants who mentioned this work in community mental health settings.

Although parent investment was raised as a concern when working with children, the concern raised by two people when discussing adolescents was the use of manipulation by the adolescents themselves in order to get a diagnosis of BD. One participant stated that, "With adolescents, bipolar can be sort of a cool diagnosis...so I want to make sure there is not some sort of social component to [the symptoms they present with]." Another participant described the "manipulation" and "attention seeking" behaviors of adolescents who "present with specific symptoms to get a certain diagnosis" as a way to "get out of school, or to get out trouble if they're coming in...with legal problems. They have been through the ringer so many times that they know what gets them what they want."

The final concern mentioned was about over diagnosis, under diagnosis, and misdiagnosis of BD. This topic will continue to be discussed in *Description of Participants' Suggestions for Changes for Diagnosing Youth with BD*.

After reviewing the struggles that participants reported having while diagnosing children and adolescents, one particular pattern arose. This was that, with the exception of differentiating BD from other disorders and external factors, the things that participants struggled with the most were not necessarily related to the actual process of diagnosing BD. Instead, they were concerns about the effects that may or may not occur as a result of the diagnoses being made, like access to care, stigma, and the effects of medication.

Description of Symptoms Participants Looked for While Diagnosing BD

When participants were asked for the specific symptoms that each of them look for when making the diagnosis of BD in children and adolescents, they responded with a greater variety of responses than to any of the other questions asked. Not only was there a range in responses in what is looked for in children versus adolescents, but there was also a huge range of symptoms mentioned within each of these age groups, with varied in levels of descriptiveness. For example, some participants gave very little detail about the symptoms they reported looking for, like one participant who stated, “For bipolar I’s, [I look for] more manicky symptoms, like more acting out and you could tell it was not psychosis or any kind of psychotic disorder.”; and another participant who responded that they look for “classic hallmark symptoms”. Other participants provided a fuller list of symptoms, like this one who said they used DSM to diagnose youth:

[I look for] mood and emotional dysregulation; irritability and dysphoria; vegetative changes in sleep, appetite, and circadian rhythm; changes in thought process and content; paranoia; and agitation.

Symptoms that were mentioned most often in both children and adolescent categories will be discussed first. The first of these was changes in sleep. “If a [child or adolescent] tells me

they've gone two or three days without sleeping and still feel revved up...that's the easiest key for me to know they're bipolar." When making reference to changes in sleep, two participants made reference to the importance of looking for changes in circadian rhythms.

The second most common symptom was changes in mood. These included mood swings, erratic moods, instability, severity and lability of moods, and mood dysregulation. The third most common thing that participants reported looking for was "manic" symptoms or symptoms of "mania". However, most participants did not expand on the specifics of what they referred to as "manicky symptoms" or "classic symptoms of mania".

There were also a series of symptoms that were mentioned for both children and adolescents, but with much less infrequency. The following symptoms were only mentioned by one or two participants in both child and adolescent symptom profiles, and often they were the same two participants in both categories. These symptoms were:

- Aggression;
- risky or reckless behavior;
- difficulty slowing down or self-soothing;
- changes in thought process or content;
- lack of insight;
- grandiosity;
- outbursts of anger;
- impulsivity;
- lack of psychosis;
- changes in appetite;
- paranoia;

- acting out;
- symptoms similar to ADHD and responses to trauma;
- difficulty functioning in their environment.

Symptoms specific to children.

There were two symptoms that were mentioned frequently in both age groups, but more so in children than in adolescents. The first was the presence of depression, which was in fact the most commonly mentioned symptom in the children's category. One participant stated, "in children and teenagers, often there is a dysphoric presentation." However, other participants stated that they generally do not see any symptoms of depression. Irritability and agitation were the other commonly mentioned symptoms in both categories, but more so in reference to children. Both of these terms describe unpleasant feelings of arousal or over arousal, possibly in responses to stimuli. Although these words mean very similar things, interestingly, participants used agitation more commonly to describe this symptom in children and irritability to describe this symptom when referring to adolescents.

The one participant who had diagnosed only children, responded that he or she looks for many of the above mentioned symptoms, including: Mood lability, depression, agitation, and "seemingly manic states". When this participant was asked to expand on what they meant by "seemingly manic", they responded with the following, "Yeah, impulsive, silly, laughing inappropriately, anxious, a lot of difficulty slowing down". None of these are listed in the DSM-IV criteria for a manic episode, although "difficulty slowing down" could arguably be the same as a few of the DSM-IV listed symptoms. Also, with the exception of impulsivity, these symptoms were unique to this participant's response.

Symptoms specific to adolescents.

Participants listed many common symptoms that were specific to adolescents. One commonality that arose repeatedly was how participants looked for behavior that was “over the top compared to other adolescents”, “extreme diversions from baseline behavior”, or “above and beyond the normal realm”. Many participants made reference to having to distinguish this behavior from normal adolescent behavior, particularly when looking at things like acting out, irritability, and moodiness. Some participants helped distinguish the two by looking at the intensity and duration of the behavior and symptoms. For example, several participants made reference to life threatening behavior, such as suicidal ideation, as a symptom they look for.

Risky behavior was made reference to in both age groups, but participants who had diagnosed adolescents went more in depth into what this behavior may look like. Some of these descriptions included hypersexuality and promiscuity, which was mentioned by half of the participants, overspending, and shoplifting. Another symptom noted only in reference to adolescents was pressured speech.

Although perhaps not a symptom, family history of mental illness, in particular the presence of a first-degree relative with BD was also commonly noted. However, as one participant described how:

Even with family history, I think some of the young people that we see come in with the belief that they are destined to be bipolar. And I think what we try to do is let them know that it does increase their chances, but does not necessarily mean that they will have bipolar.

In children, the wide range of symptoms was demonstrated, but in adolescents, some responses given by participants were opposing. Three examples of this follow: One participant stated that moods must occur in “definitive cycles” and another listed “continuous agitation” as a symptom; one participant stated that “really bipolar people have a psychotic component”, but another participant listed “the absence of psychosis” as a symptom; and one participant listed “drug and alcohol use” as a symptom, while another reported “ruling out drug and alcohol use [as a factor]”.

Description of How Participants Found this Diagnosis to be Helpful in Understanding Their Clients

Despite the level of concerns and struggles that participants reported about making this diagnosis, an overwhelming number reported that after the diagnosis was made, it did in fact either help them understand the client, or helped them help others understand the client. A majority of the participants answered that the diagnosis of BD helped them either help the child or adolescent help themselves or helped them help the family understand the child or adolescent better. Several participants made comments similar to this participant’s response about how it was helpful for the youth’s family. “It helped me to explain to families and other people that it’s a chemical imbalance and it’s not just [the youth] being mean or lazy.” Another participant stated:

It’s helpful for the family to understand the behavior better and why these kids might be having anger outbursts or mania symptoms. Once we get a firm diagnosis of bipolar, we can demonstrate to the family that this is cyclical. If they write down some data on the mood, that can also be helpful...for predicting later periods of mania and depression.

Similarly to how the above participant made reference to how having the diagnosis can help families in the future, several other participants made reference to how having the diagnosis helped them facilitate conversations with children, adolescents, and their families about how to be “attuned to what symptoms can precede a manic episode” and “learn ways to deal with those behaviors”.

Some participants discussed specifically how having this diagnosis was helpful to the client themselves. Like this participant, who stated:

I don't think the diagnosis per say helped me understand the child, but I think understanding the spectrum of dysregulation that can occur helped me help the child understand themselves better.

And another participant who stated:

When properly diagnosed, I've also found it to be tremendously liberating to kids, to have a name and vocabulary for their experiences and understand that they're not alone. I think also for families, it can be a great relief just to have some rubric of understanding.

The next highest percentage of participants responded that assigning this diagnoses was particularly helpful for them in understanding the child or adolescent they were working with. Participants who had diagnosed adolescents gave this response more often than those who had diagnosed children. The most commonly mentioned reason was that it was helpful in conceptualizing the client's behavior and being able to distinguish between what was BD and what was adolescent behavior. One participant also commented that, “Having the diagnosis opened a door to thinking about treatment in a different way.”

Two participants responded that they found assigning this diagnosis to only occasionally be helpful in understanding the client. The main reason was that, “Sometimes this can become an identity...and this would give them the freedom to act out.”

Description of How the BD Diagnosis Affected the Treatment Participants Recommended or Provided

Participants working with children were evenly split between those who responded that making the BD diagnosis did affect their treatment and those who responded that their treatment stayed the same. Of those working with adolescents, eight out of ten participants responded with something similar to, “How could [my treatment] not be influenced by that?” versus only two participants who reported that the treatment would stay the same. For those who responded that their treatment methods would not change, most reported that it was because they were “trying to work with the symptoms, not the diagnostic label.” However, of the five participants who reported that their treatment would not be affected by the diagnosis, three of them continued on to comment on changes that they would make to the treatment.

In general, the treatment changes that participants made for children and adolescents following assigning the BD diagnosis were primarily the same in both age groups. Participants spoke about the importance of psychoeducation for both the client, family, and school. This included teaching them how to chart behaviors to find patterns and anticipate future symptoms. One participant stated the following about her treatment with children:

A major factor was more parent education and trying to get the school in on the picture and getting the school’s point of view. Sometimes I have contacted the school to have them rate the child’s behavior every so often in order to get more feedback about how the child was doing. I also do a lot of educating the child himself about his behaviors so he

could begin to understand how things that he sees as positive, at times might have a negative outcome.

Another participant stated that:

Part of my recommendation is always talking with teens about how they will need to stay on medications for the rest of their lives. I explain how the medications work and that it's not like antibiotics or antidepressants, where you take them for a period of time and the symptoms go away.

Several other participants stated that with this diagnosis, they make sure to refer the youth to a psychiatrist and medications are added as another line of treatment, if these are not already part of the treatment the youth was receiving.

There were three areas of treatment that were only brought up by participants when speaking about their work with adolescents. The first was the use of evidence-based practice, such as dialectical behavior therapy (DBT) and cognitive behavior therapy (CBT). One participant stated that their treatment was affected:

Tremendously because I knew the importance of using some sort of evidence based practice. I wanted to make sure, if the client was able to do it, that I used manualized treatment that our agency came up with as part of a study we participated in regarding youth with bipolar disorder. So our manualized treatment is a CBT protocol that we have it laid out for each session, such as psychoeducation of the disorder, goal setting, anticipating stressors, problem solving. So it made me know that I had to be very specific and target certain behaviors and cover certain areas in treatment.

The second area of treatment that was mentioned only when speaking about adolescents was the importance of avoiding alcohol and substance use. The third was focusing on identity development. One participant stated:

I think with adolescents one of the crucial issues is that because of normal development they are developing their identity, it's really key to help them, if they are truly bipolar, to sort out what is who they are versus what is an illness that they have. It's so easy for them to being to define themselves in terms of their symptomology, as opposed to who they are separate from these fluctuating, intense, overwhelming moods. I think that it is the greatest challenge, but also the most important piece as a therapist, to at least help them to begin to sort that out and have language for that.

Description of Participants' Suggestions for Changes for Diagnosing Youth with BD

At the conclusion of each interview, participants were asked if there were any changes they felt that should be considered in making the diagnoses of BD in children and adolescents. This question was different from all the questions previously asked because it was not just reflecting on their past experiences, but it was asking for each of their opinions about future practice. The major theme of these findings was that participants want to see some changes made.

Although this is not necessarily a suggested change, the most common responses that participants, three of whom work in outpatient settings and one in a residential treatment facility, started out with was their concern that BD was either being over diagnosed or misdiagnosed in children and adolescents. One participant stated, "I think people should use [BD] less as a diagnosis if it's not indicated." And another reported:

My concern, just in the past several years, is that more children and adolescents are being over diagnosed with bipolar disorder. I think that it's more well-known in the community and I just don't want to misdiagnose someone without being careful and cautious.

There was also one participant, who works in a medical setting and reported the highest number of BD diagnoses made, who expressed concern about under diagnosis.

I think psychiatrist don't diagnose with bipolar disorder in cases where they should because they don't spend enough time with patients, they don't ask all the questions about symptomology, and they think that just because the kid doesn't look manic or depressed at the time they see them means that they are fine, but they don't take into account that there is a baseline period. I see a lot of kids who are diagnosed with ADHD and depression instead and given medications that end up making it worse.

Several participants also made comments about how they would like to see this diagnosis be made with less haste and more caution, prudence, and discretion.

Overall, I think what would minimize children being misdiagnosed, is that I think the protocol really should be that if a clinician has concerns about bipolar disorder, that before they make that formal diagnosis, they should more so have it as just a rule out and then order further testing, such as psychological testing and a psychiatric evaluation.

Three participants discussed how they would like to see the symptoms of BD in children and adolescents be clarified. Many of these same participants want to see better diagnostic instruments introduced, like this one:

I would like to see more clarification around the distinctions between a moody or difficult kid with strong mood swings and bipolar disorder; and I'm concerned about over

diagnosis of bipolar disorder in children. It's actually, as you know now, a very rare diagnosis in childhood and yet kids can be really tough and really really moody, and I think there needs to be perhaps better instruments to be used to distinguish between a really tough kid, a really fussy kid and a kid with bipolar disorder, that kind of thing.

Two participants said they would like to see clinicians receive more education around how to diagnosis BD in children and adolescents. And the following participant even asked this investigator to send some instruments along if any other participants mentioned ones that they found useful.

I think there has to be better clarification about the difference between symptom presentation with adults versus kids, particularly little kids. I think the DSM-IV bases most diagnoses on adults and I almost wish there was a separate section for children that outlined specific symptoms as they present in adolescents and children. It would be great to have a section in the DSM that just focusing on how these disorders presents in little kids, that would be helpful. I have seen, particularly with the cycling stuff, adults that have more discrete periods of cycling through mania and depression; and I wonder if kids can cycle through those same moods in a day.

Like the participant above, a few participants make reference to things they would specifically like to see changed in the DSM, such as having a “diagnosis of mood instability” or having a “category be created that is similar to bipolar in its symptoms, but can be used if the kid does not necessarily meet all the criteria”.

The following is a list of other suggested changes participants thought should be considered in making the diagnosis of BD:

- “[Increased] consultation with a large range of people who interact with the kid, taking one’s time, consulting with other professionals, [and] supervision.”
- “If we can do early interventions, it is more helpful.”
- “I don’t always want to have to diagnose a child or adolescent [in order to] get them access to services.”

And finally, there was one participant who responded to this question with, “Oh I think we pretty much need to scrap the whole thing.” When this investigator asked this participant if he or she could expand on this, the participant asked for a few moments to gather their thoughts and responded with this:

I think it’s really important to not only look at mood aspect of bipolar diagnosis in children and adolescents, but also to really frame it in terms of stimulation and responses to stimulation, so that kids begin to understand that there’s a dimension of sensitivity to all kinds of things. And my experience in beginning to frame it that way, not only can they begin to identify what over stimulates them or is likely to make them become more dysregulated, but also its less stigmatizing. So I think that a lot of the language that we use is really important and has real consequences that often are negative. For example, moody is something inherently nobody wants to be and is pejorative in some ways, but if you talk to kids about how some people are more permeable, and they respond and do things in a much more sensitive way this may not have such a negative effect on the kid. So I think we need to rethink our language and really talk about this in terms of a spectrum disorder, in which we need to include mood, but also really look at the circadian rhythms that are involved to really broaden it.

In summary these findings provide a first hand perspective regarding provide a first hand perspective regarding the experiences of this sample of social workers who have diagnosed BD in children and adolescents. The findings demonstrate that there were things that there are things that participants have found helpful in making this diagnosis, like collaborating with other providers and family, looking at longitudinal information about the youth, and observing the youth's behavior. There are also an equal number if not more things that participants reported struggling with while making this diagnosis, like the fear of labeling, access to services, and differentiating BD from other disorders. With this being said, most participants reported that after the diagnosis was made, it did have some positive influence on their understanding and treatment of these children and adolescents.

Chapter V

Discussion

The previous chapter presented the findings of this study. This chapter will now compare these findings to previously published literature on this topic. The implications of these findings in relation to clinical social work practice will be discussed. The limitations of this study will be addressed, and the questions and possible areas of further research that were derived from these limitations will be proposed.

Comparison of Study's Findings With Existing Literature

This investigator has identified several different patterns that emerged in the findings of this study that can be compared to previously published literature. The following are topics that will be addressed in this section. First, this section will address the concerns with the appropriate diagnosing of BD and the symptoms that are looked for when making a BD diagnosis in youth. The difference in number of children versus adolescent diagnoses made by the participants in this study, and possible reasons for this will be explored. This section will then compare some of the struggles of making this diagnosis with some things that might be helpful. The role of bias in the diagnostic process will be discussed. This will be followed by a discussion of how this diagnosis can be helpful and treatment options that are available to youth who have been diagnosed with BD. Finally, possible changes for this diagnosis and the process of making this diagnosis will be addressed.

Concerns with over diagnosis, under diagnosis, and misdiagnosis were raised frequently by this sample population. These concerns appear to be valid, since the literature reports that

“clinical diagnoses often have low accuracy with regard to bipolar disorder” (Youngstrom et al., 2009, p. 363). And according to Singh and Rajput (2006), sixty-nine percent of patients with BD are initially misdiagnosed. Fear of misdiagnosing, which could result in inappropriate and possibly harmful treatment was a concern raised by two participants who have diagnosed adolescents, both of whom work in community mental health settings. Although this sample is very small, it is fair to question whether either it is common for adolescents to be misdiagnosed and given medications that negatively affect the client when seen in community mental health agencies, or whether adolescents come to community mental health agencies as a result of having received a misdiagnosis and treatment from another setting. Regardless, the literature supports this concern, stating that misdiagnosis can lead to inappropriate treatment with antidepressants and psychostimulants, which can exacerbate symptoms (Kowatch et al, 2010; Singh & Rajput, 2006).

The wide range of symptoms listed by participants is a clear demonstration of the controversy that exists between social workers around what are and are not considered symptoms of BD in youth. According to First (2010), a BD diagnosis should not be assigned to a youth unless they meet the DSM criteria for adults. However, most of the symptoms listed by participants either did not fit into this category or participants did not list enough symptoms to meet the full criteria. The following were the most frequently mentioned symptoms when diagnosing either children or adolescents: Changes in sleep, changes in mood, mania, depression, risky behavior, and agitation or irritability. Each of these symptoms were independently mentioned by previous researchers as a criterion for BD in youth, but these symptoms as a whole did not reflect an one study or researcher’s suggested symptom criteria for BD with youth.

Only five participants listed irritability or agitation as a symptom they look for, but according to Youngstrom et al. (2008), if irritability is not a presenting symptoms, then BD is not the correct diagnoses. Depression was the most commonly mentioned symptom when speaking about children, and only three participants listed this as a symptom when discussing adolescents. This was incongruent with the literature (Baroni et al., 2009), which stated that depression is more common in adolescent-onset BD than in childhood-onset BD, and that adolescents diagnosed with BD spend most of their time in depressed or mixed episodes. More participants listed mania when describing adolescent symptoms. Some literature (Baroni et al., 2009) suggested that an important part of looking at symptoms of mania is looking for “distinct episodes” that meet “full DSM-IV duration criteria”, but only four participants in this study mentioned looking at frequency or duration of symptoms (p. 203). Other literature (Baroni et al., 2009; First, 2010) suggested that what is important is distinguishing symptoms from baseline and developmentally appropriate behavior, which some participants reported doing, but found difficult. These findings suggested that perhaps BD is not the correct diagnosis for many children and adolescents, and that changes need to be made to the DSM so that these youth can have a diagnostic home (First, 2010).

Another definitive finding of this study was that the number of adolescents diagnosed with BD by participants in this sample was much higher than the number of children diagnosed with BD. This was consistent with Olfson et al. (2009), who reported that BD diagnoses increase with age. The findings of this study suggested that a possible reason for this is that adolescents are easier to diagnose with BD than children. Participants’ reasons for this were similar to Parens and Johnston’s (2010) report that, “Younger persons can have difficulty noticing and describing symptoms and providing accurate accounts of time of onset and duration of symptoms” (p. 5).

Given that several participants commented on the increased difficulty of diagnosing children, as opposed to adolescents, one might hypothesize that participants would report utilizing family reports and consultation with collaterals who have known the child over time and in other contexts more when diagnosing children as opposed to adolescents. While this study found that collaboration with other providers and family members was one of the most commonly mentioned helpful elements, and appeared to correlate with fewer number of diagnoses made, more participants reported using this when diagnosing adolescents, not children. Participants who more commonly mentioned using collaboration were also the participants who reported having more years of clinical experience, suggesting that perhaps this is a skill that is learned with experience.

Participants in the study frequently mentioned struggling with being able to differentiate BD symptoms from behavior that could be caused by environmental factors or symptoms of other disorders, particularly ADHD. According to Sommers-Flanagan and Sommers-Flanagan (2009), diagnostic comorbidity is something that social work clinicians struggle with frequently. And to add to this struggle, the current DSM-IV TR criteria of BD and ADHD have many overlapping symptoms (First, 2010) and it is common for children to be diagnosed with ADHD and BD (Biederman et al., 2005; Findling et al., 2001; Masi et al, 2006).

The literature makes two suggestions for easing this struggle. Birmaher (as cited in First, 2010) stated that when making the diagnosis of BD in youth who already have another diagnosis with similar criteria, like ADHD, clinicians should not count symptoms as criteria for BD unless there is evidence that they have worsened since the initial diagnosis. Youngstrom et al. (2004) stated that diagnostic questionnaires, such as K-SADS, can also be particularly helpful in ruling out other diagnoses. However, only one participant reported using K-SADS and two other

participants cited other types of diagnostic questionnaires to be helpful in making this diagnosis. All of the participants who mentioned using these tools practice in outpatient settings, such as private practice and community mental health agencies. It is possible that so few participants reported using these tools because of the amount of time that a clinician must put into learning how to use these tests.

Participants appear to have had a variety of different experiences with and reactions about the helpfulness of using the DSM-IV TR in making a diagnosis of BD. The purpose of the DSM-IV TR is to help clinicians “consolidate”, “classify”, and “communicate” symptoms, creating a universal language and coding system for clinicians between agencies (Sommers-Flanagan & Sommers-Flanagan, 2009, p. 283). However, only half of the participants who work with adolescents, and only two of the participants who have diagnosed children, reported finding the DSM-IV TR to be a helpful tool. Given that the DSM-IV TR is supposed to be the guide that social work clinicians use to diagnose mental health disorders, these numbers seem low. This is consistent with the literature, which states that social workers are often resistant to using the DSM because it is based on a medical model, gives little emphasis to possible environmental factors, and focuses more on client’s deficits than their strengths (Corcoran & Walsh, 2006; Kutchins & Kirk, 1997).

Another struggle of participants was parent and client investment or interest in having this diagnosis be assigned to the client. This included participants’ reference to possible manipulation from adolescents and families in order to get a diagnosis and how some families used the diagnosis as a way of shifting accountability from themselves to the disorder with. According to Parens and Johnson (2010), this has been a common trend since the publication of *The Bipolar Child* (Papolos & Papolos, 2006) and the *Time* magazine’s cover story about bipolar

disorder in youth in 2002. The participants of this study suggested that parent and self-interest in having this diagnosis be assigned is often driven by the desire to receive financial assistance or funding for treatment, or to have an excuse for behavior. But Parens and Johnson (2010) also argue that “an ill-fitting diagnosis can sometimes be more helpful to children, families, and researchers than no diagnosis at all” (p. 11). This finding also demonstrates the power of availability heuristics, in that with increasing media exposure about BD in youth comes increasing parent and self-interest in having this diagnosis be assigned to clients (Youngstrom et al., 2009).

Of the participants who have diagnosed children with BD, one theme that arose in their stated struggles was around the positive and negative implications of assigning such a severe diagnosis to such a young child. Their concerns were consistent with the literature, which stated that assigning this diagnosis could result in a lifetime of stigma (Overton & Medina, 2008), but not assigning it could mean that the child does not get access to the services that they need (American Psychiatric Association, 2010c).

These findings suggested that personal bias played a significant role in the diagnostic process. Not only were client and family biases pushing participants to make this diagnosis, but participant bias also appeared to be having an effect on the diagnostic process, by showing great concern for the implications of making or not making a BD diagnosis. In this way, the possible implications of having a BD diagnosis were actually affecting whether or not a BD diagnosis was being assigned. But this incorporation of a client’s biological, social, environment, risk and protective factors also demonstrates these participants’ tendencies to incorporate a biopsychosocial framework. These findings were congruent with previous studies (Garb, 2005; Neighbors et al., 2003), which have shown that clinicians often do not hold fast to diagnostic

criteria, and instead “frequently make diagnoses by comparing clients to prototypes...of a hypothetical client who best exemplifies a particular disorder” (p. 71).

Drive and Garb (1997) suggested that one way to limit this bias is by sticking closely to the diagnostic criteria. However, given the wide range of symptoms that participants reported looking for when making this diagnosis, it is clear that there is a lack of clarity and consensus about what the diagnostic criteria actually are, leaving even more room for participants’ own biases to affect the diagnoses made.

Most of the participants in this study reported that making this diagnosis either helped their own understanding or helped the client and families’ understanding. This was consistent with Sommers-Flanagan and Sommers-Flanagan’s (2009) literature, which stated that receiving a diagnosis can often be a relief for clients and families because it allows them to name what they have been struggling with and lets them know that they are not alone in this struggle.

Given that so many participants responded that the diagnosis was helpful in some way, it is logical to assume that the diagnosis would then have some affect on the treatment provided. Although participants were initially split between saying their treatment changed and saying their treatment did not change, most did say something about the treatment they provided. Their reports of using psychoeducation with clients and families, as well as making referrals to psychiatry for medication, were consistent with the literature (McIntosh & Trotter, 2006). However, the literature (Corcoran & Walsh, 2006; Miklowitz & Goldstein, 2010) also stated that social workers are becoming increasingly focused on using evidenced-based therapy, particularly as a line of treatment for BD, but only two participants mentioned evidenced-based treatment as something they use with these youths.

There were several things that stood out about participants' responses to things they would like to see changed. The first was that these responses were fairly evenly divided between things participants wanted others to change when making this diagnosis, like using more caution, and things they would like to see changed that would assist them in making the diagnosis, like clarifying symptoms. For the number of things and depth that participants went into about struggles they faced when making this diagnosis, it was surprising to see there were not more responses focused on how they would like to see these struggles resolved. For example, many participants discussed earlier how they struggled with labeling a youth with a severe diagnosis, but not one participant discussed this when answering this last question. Many participants also made earlier reference to their struggle with the fact that access to mental health services was dependent upon them diagnosing youth with a more severe mental illness, like BD; however, only one participant mentioned this as a change they would like to see occur.

Access to services was something that the American Psychiatric Association (APA) (2010c) appeared to be concerned about when considering how to revise the DSM. Participants and the APA also appeared to agree that they both want to have more clarification about the symptoms of BD in youth. One participant stated that they would also like to see the DSM have a different diagnostic section for children and adolescents, but this was not congruent with the APA's (2010c) focus of "maintain[ing] continuity between adult and child" diagnostic criteria.

Implication of Findings for Social Work Practice

Given that social workers hold a large percentage of mental health positions where making clinical diagnoses is an important part of the work, this study holds many implications for social workers (Corcoran & Walsh, 2006). Social workers who work with children or adolescents will likely come in contact with someone who has been diagnosed with BD. For

social workers who have no experience working with this population, these findings can be helpful for obtaining a basic understanding of how to diagnosis and treat children and adolescents with BD. These findings can provide social workers with a range of symptoms to look for, a projection of possible struggles they may encounter, and tools they might find useful when making this diagnosis. These findings also suggested that for the participants of this study, personal bias about the implications of making a BD diagnosis played an important role in their actual decisions to make or not make a BD diagnosis. Social workers need to be aware of this and always keep in mind how their personal biases may be affecting the diagnoses they make. For social workers who have struggled to make this diagnosis before, they may feel that these findings normalize this experience for them and help them to see that they are not alone in this struggle.

Limitations and Questions for Future Research

After reviewing the findings of this study, this investigator realized that this study had many more limitations than initially thought. However, many of these limitations posed questions for future research and these will be discussed here. One of the most apparent limitations was the small and non-diverse sample of participants. Future studies may want to expand the sample population to incorporate greater diversity in the areas of gender, ethnicity, race, socioeconomic status, and agency setting.

Although this investigator initially asked participants about the demographics of their client population, this investigator was unable to integrate most of this demographic information for a number of reasons. This study did not differentiate between the general population of clients that participants serve and the population participants serve that have been diagnosed with BD. This study asked for participants to give rough estimates of their clients' demographic

information. And the questions asked were not separated out depending on specific populations of clients with BD. Future studies may want to look for differences in how social work clinicians diagnose BD in clients based on characteristics such as genders, races, ethnicities, and socioeconomic statuses.

This study also did not distinguish between BD I, BD II, or BD NOS. This may be useful to do in future studies. Future studies could also give clinicians a list of criteria to use for making this diagnosis and measure how this affects the number of diagnoses they make over time. When asking about treatment, this investigator did not thoroughly distinguish between treatment that may have already been provided versus treatment that was initiated following the diagnosis of BD. Future research should consider distinguishing between treatment being provided before the diagnosis was made and treatment that was provided after.

It is possible that this investigator's own biases had some effect on the findings. While this is always something that must be managed when doing qualitative interviews, some things that may help decrease this in the future are: Having pre-planned follow-up questions; always asking participants to clarify ideas that they have relayed that could be seen multiple ways; having more than one investigator conduct each interview; and using interviewers who have no personal attachment to this topic.

This study's findings also raised a number of questions for this investigator which include the following:

- Given the wide range of symptoms that participants reported looking for, this investigator found it difficult to believe that all of the children and adolescents who had been diagnosed with BD by these participants actually had the same disorder. If this is in fact the case, what would have been the correct diagnosis for these children, if there is one?

- Were the participants of this study aware of how much their expressed concerns for future implications appeared to play a role in making this diagnosis?
- If social work clinicians felt more clear about what the symptom criteria are for diagnosing BD in youth, would these concerns about treatment and stigma play such an apparent role in the diagnostic process?
- Do social work clinicians consider future implications when making all DSM diagnoses? If not, which ones does this occur with?
- Is the suspected rate of high misdiagnosis of BD in youth due more to lack of clarity about the symptoms or clinical error?

Summary

This qualitative study sought to answer the question: How is Bipolar Disorder in children and adolescent identified and diagnosed by clinical social workers and how does their own understanding of the disorder affect their treatment planning process? The findings of this study revealed a number of things about this sample of social work clinicians. The findings showed that there was a wide range of different symptoms that participants looked for when making this diagnosis, including changes in sleep, changes in mood, agitation and irritability, risky behavior, and other symptoms of mania and depression. Many of these symptoms were mentioned individually in the literature, but the total array of reported symptoms did not parallel any one researcher's findings about what the symptom criteria for BD in youth is or should be. Also, the array of symptoms reported by participants were not consistent with the symptom criteria according to the DSM-IV TR. These findings also showed that participants found one or more of the following to be helpful in making a diagnosis of BD in children and adolescents:

Consultation with collaterals and family members, the DSM-IV TR, observation of behavior,

longitudinal information about the client's history, a previous diagnosis, and psychological tests and mood rating scales to be particularly helpful while making the diagnosis of BD in children and adolescents. Most of these diagnostic related activities were congruent with the literature, although questions were raised about why some of these were more helpful with one age population than another. Some of the things that participants reported struggling with while making this diagnosis were: Differentiating symptoms of BD from symptoms of other disorders, the possible implications of labeling a child such a severe diagnosis, and parent or client investment in the BD diagnosis. These struggles showed that participants pay attention to a number of external factors when making a BD diagnosis in a child or adolescent. Most participants reported that making this diagnosis either helped them or helped the client or family better understand some element of the client's illness. Participants reported that this diagnosis increased their use of psychiatry, medications, and psychoeducation with the client, family, and other involved parties; all of which are described as effective means of treatment by the literature.

The findings of this study did suggest some answers to the question of how social work clinician's come to decide that a BD diagnosis is the appropriate diagnosis for a child or adolescent. Some of these, such as symptoms looked for and things found to be helpful, were consistent with the literature. However, these findings also illustrated the amount of difficulty the participants of this study encountered while making this diagnosis, and the amount of clarification that still needs to be made around what to look for when making a BD diagnosis in youth. It is the hope of this investigator that this study will encourage others to continue to do research and seek clarification around what BD looks like in children and adolescents and how social work clinicians should diagnosis and treat this condition in children and adolescents.

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Appendix A

Approval Letter from the Human Subject Review Board



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

January 28, 2011

Ashley Petitt

Dear Ashley,

Your revised materials have been reviewed and they are fine. Everything is now in order and we are happy to give final approval to your interesting study.

Please note the following requirements:

Consent 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.

Good luck with your project.

Sincerely,

A handwritten signature in black ink that reads 'Ann Hartman D.S.W.' with a long horizontal flourish extending to the right.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Victoria Winbush, Research Advisor

Appendix B

Recruitment E-mail

Subject: Social Workers who have diagnosed children/adolescents with bipolar disorder

Body:

Calling all
Social Workers
who have diagnosed
Children/Adolescents
with
Bipolar Disorder

Hi Everyone,

My name is Ashley Petitt and I am a social work student at Smith College School for Social Work. For my master's thesis I will be researching the experiences of social workers who have diagnosed children and/or adolescents with Bipolar Disorder and I am asking for your help to find people to participate in my study. If you are a social worker who has diagnosed a child or adolescent with bipolar disorder, you are eligible to participate in this study.

Participation in this study will involve a one hour interview, which includes a short series of demographic and agency profile questions, followed by series of questions regarding the participant's experiences diagnosing and treating children and/or adolescents with Bipolar Disorder. These interviews will be conducted by me and can be done in person, over the phone, or via video conferencing.

If you, or anyone you know may be interested in participating, please call me [REDACTED] or send an e-mail to [REDACTED]. In your phone message or e-mail include the following information: your name, a good phone number to reach you at, and a couple of times you can be reached in the next few days. If you would like to participate, please contact me by February 31, 2010.

If you have any questions about the study or are not sure if you qualify for participation, please call me at [REDACTED] or e-mail me at [REDACTED]

If you know of anyone who may be interested in participating in this study, please forward this e-mail on to them.

Thanks in advance for your help!

Sincerely,

Ashley Petitt

Appendix C

Preliminary Screening Form

Please complete the following questions, to determine if you meet the criteria to participate in this study.

1. Do you have a Master of Social Work Degree?

Yes No

2. Have you been have worked in a clinical social work position for a minimum of one year, since the acquisition of your MSW degree?

Yes No

3. Are you currently working in a clinical social work position?

Yes No

4. Do you currently work with clients age nineteen or younger or have worked with this population of clients within the past year?

Yes No

5. Do you have experience diagnosing at least one client age nineteen or younger with Bipolar Disorder?

Yes No

Appendix D

Informed Consent Form

Dear Participant,

My name is Ashley Petitt, and I am a graduate student in clinical social work at Smith College School for Social Work. I am conducting a research study regarding the experiences social work clinicians have diagnosing children and adolescents with Bipolar Disorder and the treatments they recommend for these children and adolescents. This data collected from the study will be used in my MSW thesis and possibly future presentations or publications.

You have been screened and met the inclusion criteria for participation in this study. If you agree to participate in this study, you will be asked to complete a one hour interview, which includes a short series of demographic and agency profile questions, followed by series of questions regarding your experiences diagnosing and treating children and/or adolescents with Bipolar Disorder. These interviews can be conducted in person, over the phone, or via video conferencing. The interviews will be audiotape recorded and I will be transcribing them at a later date.

I hope the results from this study will help broaden the field of knowledge regarding how clinicians diagnose and treat children and adolescents with Bipolar Disorder. The benefits that you may experience are: enjoyment of the opportunity to share your clinical experiences; an increased desire to do further research of your own about this topic; increase in critical thinking about diagnoses that you make in the future; and the value of knowing your participation in this study will help increase the amount of available knowledge about this topic, and could be used as a resource for social workers in the future. There will be no compensation for your participation in this study.

Your confidentiality is extremely important and will be conscientiously maintained. All identifying information about you will be removed before any interview data is shared with my research advisor. In the publication and presentation of this study, all data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised to remove any identifying information. I plan to transcribed all of the audio recordings myself; however, should an additional transcriber be used, they will sign a confidentiality pledge. All data collected, including audiotapes, notes, and transcripts, will be kept in a secure location for a period of three years and data stored electronically will be protected, as required by Federal guidelines. All data and materials will be destroyed after three years or, if kept beyond three years, when they are no longer needed.

Your participation in this study is voluntary. You may withdraw from the study at any time during the data collection and you may refuse to answer any question by simply informing the interviewer. If you decide to withdraw after your data has been collected, you must notify me

within twenty-four hours of data collection. If you decide to withdraw at any point, all materials pertaining to you will be immediately destroyed. Should you need to contact me regarding your desire to withdraw from the study, further questions regarding your rights or other aspects of the study, you are encouraged to email me at [REDACTED] or call me at [REDACTED], or you can call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. After you have signed this Consent Form, please use the self addressed envelope you have been given to return it to me.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant

Date

Signature of the Researcher

Date

Please keep a copy of this form for your records.

Thank you for your participation in this study!

Appendix E

Background Information Questions

Please provide the following demographic information which will assist me in the analysis of the data. If you feel uncomfortable answering any of the below questions, please omit the question. You will not be penalized for omitting any of the below questions.

1. Which age group do you fall into?

20-30 31-40 41-50 51-60 61-70 71-80 81-90

2. What gender do you identify with?

3. What race and/or ethnicity do you identify with?

4. What socioeconomic status do you identify with?

5. How many years of clinical social work experience did you have prior to obtaining your Master of Social Work degree?

6. How many years of clinical social work experience have you had since obtaining your Master of Social Work degree?

7. In addition to a Master of Social Work degree, do you have any other degrees or certifications above the Bachelor or Associate level?

8. If you answered 'Yes' to the previous question, please stated what other degrees you have obtained.

9. Please circle the option that best describes the agency setting you work in.

Public or Private School

Therapeutic School

Medical Setting

Private Practice

Community Mental Health Agency

Other:_____

10. List the specific duties you perform in your position

11. Identify by estimated proportion the following demographics of the client population you work with.

Gender: Male: _____ Female: _____ Other: _____

Age: 0 – 5 years old: _____ 6 – 12 years old: _____

13 – 19 years old: _____ 20 years old and older: _____

Socioeconomic Status: Low Socioeconomic Status: _____

Middle Socioeconomic Status: _____ High Socioeconomic Status: _____

Race/Ethnicity : American Indian or Alaska Native: _____ Asian: _____

Black or African American: _____ White: _____

Native Hawaiian or Other Pacific Islander: _____

Hispanic or Latino: _____ Other: _____

Appendix F

Interview Questions

In the following questions, a child refers to someone who is twelve years old or younger.

- 1) Have you ever diagnosed a child with Bipolar Disorder? (If yes, continue onto the next question. If no, skip to question 11).
- 2) Please estimate how many children you have diagnosed with Bipolar Disorder?
- 3) How many children have you diagnosed with Bipolar Disorder in the past 12 months?
- 4) How did you determine that the diagnosis of BP was warranted?
- 5) Were there specific symptoms that you looked for in children when making this diagnosis? If so, what were they?
- 6) What, if anything, did you find helpful in arriving at this diagnosis?
- 7) What, if anything, did you not find helpful or struggle with in arriving at this diagnosis?
- 8) What, if any implications were attached to making or not making this diagnosis?
- 9) How did this diagnosis help you further understand these children?
- 10) How did this diagnosis influence the treatment that you recommended and may have been involved in providing?

In the following questions, an adolescent refers to someone who is between the ages of thirteen and nineteen.

- 11) Have you ever diagnosed an adolescent with Bipolar Disorder? (If yes, continue onto the next question. If no, skip to question 21).
- 12) Please estimate how many adolescents you have diagnosed with Bipolar Disorder.
- 13) How many adolescents have you diagnosed with Bipolar Disorder in the past 12 months?
- 14) How did you determine that the diagnosis of BP was warranted?
- 15) Were there specific symptoms that you looked for in adolescents when making this diagnosis? If so, what were they?
- 16) What, if anything, did you find helpful in arriving at this diagnosis?
- 17) What, if anything, did you not find helpful or struggle with in arriving at this diagnosis?
- 18) What, if any implications were attached to making or not making this diagnosis?
- 19) How did this diagnosis help you further understand these adolescents?
- 20) How did this diagnosis influence the treatment that you recommended and may have been involved in providing?

Concluding question:

- 21) What changes, if any, do you think should be considered in making the process of diagnosing Bipolar Disorder in children and adolescents more effective?