SCHOOL PROFESSIONALS' ROLE IN DIAGNOSING CHILDREN

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Abstract

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The scientific society continues to study individuals affected by bipolar disorder. The prior scientific community's belief was that bipolar disorder only affected individuals older than 21-years of age (Papolos & Papolos, 2002). Today this belief has changed. As early as infancy children can experience mood, cognition, behavior, and biological functions congruent with a bipolar diagnosis. It is the objective of this study to determine school professionals' perceptions of diagnosing children with bipolar disorder and common practices of this process in schools, primarily elementary schools. Many times, school professionals complete checklists used to diagnosed children with a variety of disorders in order to help the child receive a better education. However, it is the position of this paper that if school professionals have a predetermined opinion of the diagnoses available to physicians and/or child psychiatrists that this will not only

have an impact on the data received through these checklists, but a bias towards those diagnosis school professionals prefer.

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To all who have encouraged me throughout this experience.

Treasures In You

There are treasures in life,
but owners are few
Of money and power
to buy things brand new.

Yet you can be wealthy
and feel regal too,
If will you just look
and find the treasures in you.

These treasures in life
are not hard to find
When you look in your heart,
your soul, and your mind.

For when you are willing
to share what's within,
Your fervent search
for riches will end.

The joy and the laughter,
the smile that you bring;
The heart unafraid
to love and to sing;

The hand always willing
to help those in need;
The ones quick to reach out.
to labor and feed.

So thank you for sharing
these great gifts inside;
The caring, the cheering,
the hug when one cried.

Thanks for the energy,
encouragement too,
And thank you for sharing
the treasures in you.

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Chapter I

Introduction

The scientific society continues to study individuals affected by bipolar disorder. Prevalence rates in community samples taken range from 0.4% to 1.6% (American Psychiatric Association, 2000). While the American Psychiatric Association's Diagnostic Manual of Mental Disorders Fourth Edition Text Revision (*DSM-IV TR*) has defined how this condition affects the adult population, yet it presently overlooks children (Waltz, 2000). Reference to children concerning the diagnostic criteria for bipolar disorder has been published in the *DSM-IV TR*. However, for a proper diagnosis of children adult diagnostic standards must be adhered to (Papolos & Papolos, 2002). Such practice is, however, problematic because the mental health community's belief has previously believed that bipolar disorder only affected adults. Recently this belief has changed. As early as infancy children can experience mood, cognition, behavior, and biological functions congruent with a bipolar diagnosis (Papolos & Papolos, 2002).

Numerous researchers have hypothesized that some children diagnosed with various disorders, such as depression and attention-deficit disorder with hyperactivity (ADHD), are actually suffering from bipolar disorder (Waltz, 2000). Of 3.4 million children diagnosed with depression, researchers have estimated that one-third to one-half will have a future diagnosis of bipolar disorder. Children who have been diagnosed with ADHD also have a high correlation with a future diagnosis of bipolar disorder. One-third of the four million children diagnosed with ADHD have later been diagnosed with bipolar disorder (Waltz, 2000). Recently, efforts have been made to create diagnostic materials to enable an accurate bipolar disorder diagnosis in children. Research continues

to explore bipolar disorder's developmental course in children in order to create this new diagnostic process (Waltz, 2000).

Papolos & Papolos (2002) found that habitually, there has been a "ten-year gap between the onset of symptoms and intervention" (p. 54). The biological and psychological effects from an untreated medical issue have a vast negative effect on the child. If diagnosed earlier the prognosis could be entirely different.

When bipolar disorder symptomology is apparent, it is imperative that health care professionals make an accurate bipolar diagnosis. When in a depressive state the child's mood swings low and continues to drop until the child feels desperate, hopeless, and miserable (Birmaher, 2004). Then when the child swings into a manic or hypomanic state, he or she loses contact with reality. The child makes reckless and impulsive decisions. These symptoms occur during all of the formative years of childhood.

If the child is undiagnosed or misdiagnosed, the effects from the bipolar disorder will affect the child's ability to develop in a healthy manner, creating additional problems for this child. This could lead to unnecessary suffering and future developmental, academic, emotional, and social problems. Some of these problems include; suicidal ideations, attempts, or at worst, completion of suicides (Birmaher, 2004; Waltz, 2000; Papolos & Papolos, 2002). Furthermore, there is a heightened risk for involvement with tobacco, illicit drugs, alcohol, hypersexuality, and other legal problems, such as stealing, damaging property, and causing injury to others. Experimentation with illegal drugs is dangerous for anyone. Moreover, it is especially risky for children with bipolar disorder due to the already previously prescribed medications the child is taking. There are possible serious negative chemical interactions that can be produced if the child mixes

street drugs with his or her prescription drugs. Lastly, using illicit drugs and alcohol increases the chances of psychotropic medication noncompliance (Birmaher, 2004).

Children taking psychiatric medications for an incorrect diagnosis, severe and, enduring cognition impairment may result. The child could possibly experience difficulties with critical thinking ability, memory, and comprehension (Birmaher, 2004). Moreover, when a child with bipolar disorder ingests some types of prescribed medications, namely antidepressants, it is possible to induce various stages of mania or even depression. Severe aggression and violent behaviors, putting the child and others at physical, emotional, and social risk, often accompany these states.

The symptoms of untreated bipolar children face continue to affect every area of the child's life (Birmaher, 2004). Due to these adverse social situations, children with bipolar often isolate themselves from social interactions because others fail to acknowledge them or pick on them. Also, if the child's life is compounded by the addition of psychotic symptoms, including delusions, which are very often apart of the bipolar disorder diagnosis, the child often behaves abnormally, running into traffic, talking to him or herself, or touching people without reason. This often leads to the rejection from the child's peers and leaves the child having doubts about his or her worth. Furthermore, all of these scenarios combined, can create low self-esteem. There are also negative effects on a child's academic career. School professionals and faculty often see behavioral problems, homework incompletion, and poor grades.

In addition, families and patients are not the only people to endure the negative effects of an undiagnosed or misdiagnosed bipolar patient. The community also pays; "school failures, limited job prospects, dependence on public assistance, legal difficulties,

and expensive hospitalizations" (Waltz, 2000, p. 3) are just a few of the overall harmful effects. Moreover, with a correct diagnosis there is an appropriate treatment regimen, without treating the condition with medications that could potentially worsen the patient. Furthermore, family and schools can provide appropriate interventions and services for the child. An accurate diagnosis allows the child and family to lead more stable lives.

Diagnostic criteria for bipolar disorder are clearly defined in the American Psychiatric Association's *DSM-IV TR*. Bipolar I disorder, historically labeled Manic Depression, is defined as episodes of mania and major depression (Birmaher, 2004), is considered the most challenging form of bipolar disorder (Waltz, 2000). Bipolar II disorder patients suffer from recurrent states of depression and hypomania. However, those with mania and mixed states do not qualify for a Bipolar II diagnosis. Due to the rapid changes between the patient's depressed and hypomanic periods Bipolar II is also very difficult to treat. Cyclothymic disorder affects patients through experiences of less severe depressed and hypomanic mood states without entering into a major depressive, mixed, or manic episode for at least a year. Additionally, the patient will not experience a normal mood state for longer than two months during this year. If an individual has characteristics of this diagnostic criterion, but does not quite meet the standards set a bipolar disorder NOS diagnosis may be given.

Bipolar Mixed includes episodes of both mania and depression. Furthermore, the individual may vacillate between the three states of, depression, mania, and hypomania, over a period of days (also called ultra-rapid cycling) (Waltz, 2000). People experiencing four or more mood shifts in a year's time receive a diagnosis of bipolar disorder with rapid cycling features. A diagnosis of bipolar with psychotic features has an added state

including, hallucinations or delusions in addition, to the several mood states already discussed (hypomania, mania, and depression) (Birmaher, 2004).

Symptoms of childhood-onset bipolar disorder can manifest itself in children very differently (Birmaher, 2004). Children infrequently display the symptoms found to meet the criteria required for an adult bipolar diagnosis (Papolos & Papolos, 2002). While some children's symptoms are identical or very similar to adult symptoms, some children can have fewer periods of normal moods in between cycles and still other children can suffer with intense mood lability (Birmaher, 2004). This includes extensive irritability, rapid mood swings, temper-tantrums, being hyperactive, and impulsive.

Research that has included parent reports of child behavior reveals that parents observe bipolar disordered child behavior as markedly different compared with other children, and that these children are more difficult to care for and more unpredictable (Waltz, 2000; Papolos & Papolos, 2002). Parents of children diagnosed with bipolar disorder report difficulty with developing routine sleep schedules, breast-feeding and solid food introductions, acceptance of new situations, and transitioning (Waltz, 2000). Parents also reported that crying was more intense, temper-tantrums more often, and persisted later in life. The children progress rapidly through the developmental stages early in life (Papolos & Papolos, 2002). Often these children are exceptionally intelligent, learning tasks and skills quickly. Also, these children display an increased creative ability than other children.

Papolos & Papolos (2002) argued that, health professionals often mistake the symptoms of bipolar condition of that of, Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Schizophrenia, Anxiety disorders, Asperger's disorder, Borderline

Personality disorder, Substance abuse disorders, or ADHD. One of the most common mistaken conditions for bipolar disorder is ADHD (Birmaher, 2004). It is very common when observing children who are inattentive, impulsive, easily distracted, and over emotional to conclude that the child meets the diagnostic criteria for ADHD. This is also a more common diagnosis given the symptoms presented (Papolos & Papolos, 2002). In the United States, the estimate is that three to five percent of children have symptoms congruent with an ADHD diagnosis. In *The Journal of American Academy of Children and Adolescent Psychiatry (JAACAP),* a current article estimated that 23 percent of children currently diagnosed with ADHD would later have the diagnosis of bipolar disorder (Waltz, 2000); therefore, affecting one million of America's children. This is because the characteristics for each disorder are very similar. Mood disorder symptoms are similar, if not the same as the symptoms, which help diagnose children with ADHD (Papolos & Papolos, 2002). Birmaher (2004) found that 50 to 80 percent of children and teenagers diagnosed with bipolar disorder also have also been diagnosed with ADHD.

Diagnosing children with early-onset bipolar disorder is easier if there is evidence of bipolar disorder in other first generation family members, e.g. biological mother, father, sister, brother, or grandparents (Waltz, 2000). In fact, Dr. Gerald Klerman and Dr. Elliot Gershon et al. found that with each generation the children have an increased chance of having the disorder (Papolos & Papolos, 2002). When conducting an initial family history report a professional should take note of any record of bipolar disorder or other mood disorders (Waltz, 2000). This could indicate a possible diagnosis for the childhood-onset bipolar disorder. Some hypothesize that ADHD and bipolar disorder co-exist in children; you cannot have one without the other.

Nevertheless, a controversy lies in diagnosing children with bipolar disorder. Until recent years, children were not able to receive a diagnosis of bipolar disorder (Waltz, 2000). In fact, even diagnosing adolescents was irregular. This is particularly surprising because studies have shown that 20 to 40 percent of adults displayed symptoms of bipolar disorder in childhood and adolescents. Furthermore, in a study conducted 60 percent of adults from the National Depressive and Manic Depressive Association members with bipolar disorder think that a bipolar diagnosis should be available for those under the age of 19-years-old. Yet it is still very difficult to find doctors who are even willing to make a bipolar diagnosis in children when they recognize the symptoms (Papolos & Papolos, 2002). There are a number of reasons for the hesitation in diagnosing children. The medical community believes that the length of time in a child's life is too short to determine the course of illness. Furthermore, children are in the midst of developing socially, physically, and mentally. Therefore, the child has not fully developed his or her personality and can often change their behavior on their own through the maturation process (Birmaher, 2002). Additionally, children can often manifest similar characteristics found in a bipolar diagnosis when suffering from other illnesses. For example, children suffering from a viral infection can display symptoms similar to depression. Yet, children with medical illnesses symptoms will dissipate in a relatively short period whereas, children who have bipolar disorder symptoms will continue over a long duration of time. Because symptoms in children and adolescents are very different than those identified and accepted by the DSM-IV TR future diagnosis in children are at jeopardy.

Statement of the Problem

The purpose of this study was to determine elementary school professionals' perceptions of diagnosing children with bipolar disorder and common practices in this process in schools (K-12). Using surveys sent via mail to a randomly selected group of School Counselors and School Psychologists in the spring of 2005. The objective of the researcher is that school counselors, school psychologists, and other professionals' better serve children by utilizing this study.

Research Objectives

This research intends to address five main objectives. They are:

1) Why is misdiagnosing children with bipolar disorder and attention-deficit hyperactivity disorder such a significant and prevalent problem?
2) What are the similarities and differences in prevalence, etiology, and symptoms between pediatric bipolar disorder and attention-deficit hyperactivity disorder?
3) What is the controversy surrounding making a bipolar diagnosis in children?
4) What are the best practices identified in diagnosing children?
5) What is the role of school professionals in diagnosing children?

Definition of Terms

To understand clearly the following text the following terms need to be defined.

Children – Defined as three through twelve years old for the purpose of this paper.

Pediatric bipolar disorder – Children diagnosed with bipolar disorder prior to the age of puberty, usually before thirteen years old.

Chapter II

Literature Review

Children suffering from bipolar that go undiagnosed have numerous negative effects. When a child goes through an untreated period of mania or depression, he or she must possibly deal with negative social effects, such as losing friends, recurrent arguments, and explaining strange behavior to friends, family members, teachers, and others (Birmaher, 2004). Diagnostic criteria for bipolar disorder are clearly defined in the American Psychiatric Association's *DSM-IV TR*. Individuals who suffer from one or more Manic or Mixed Episodes and Major Depressive Episodes without being due to uncontrolled substances or other mood disorders have standards congruent with a bipolar diagnosis. Additionally, these symptoms do not account for another possible diagnosis of another disorder, namely Schizophrenia, Delusional disorder, or Psychotic disorders Not Otherwise Specified (NOS).

As previously stated the American Psychiatric Association's *DSM-IV TR* recognizes bipolar disorder in children, but the individual must meet the adult criteria provided by this publication. These diagnoses are based on cycling mood states of depression, hypomania, and mania.

A depressed state, for the purposes of diagnosis, must last for approximately two weeks, or past a normal period of grieving, which typically has been defined as two months, but varies depending on cultural circumstances (Waltz, 2000). Symptoms that have been recognized as depicting clinical depression include: continuing sadness, uncontrollable crying (often without reason), extreme eating behaviors (either colossal or diminutive meal sizes), negative outlook on life, excessive tiredness, rage or anger, short-

tempered or easily agitated, relentless stressing, inadequateness, insignificance, hopelessness, unable to make decisions, lack of concentration, loses interest in activities that once brought pleasure, psychosomatic complaints, isolating from friends and family, problems or drastic changes in sleep patterns, and suicidal ideations or glorifying death in general. Children frequently display depression in atypical behaviors, temper-tantrums, defiance, extreme irritability and rage, severe overreactions to minor situations, and many others.

A hypomanic state is a less severe version of a manic state. Like in a manic state, hypomania is often associated with creativeness and/or motivation (Waltz, 2000). Unfortunately, hypomanic states untreated often lead to a full-scale manic attack. These children acquire or have strong characteristics or symptoms related to separation anxiety disorder, clinging to their parent(s), screaming when left, or refusing separation (Waltz, 2000; Papolos & Papolos, 2002). Unlike the *DSM-IV TR* diagnostic criterion, children have very rapid shifts in mood states for all bipolar diagnoses. These children exhibit worsening disruptive, troublesome behavior, intense moodiness, constant irritability, hypersomnia or insomnia, rage, hostility, and extreme remorse or guilt for mistakes. Furthermore, deteriorated academic performance, impulsivity, hyperactivity, lack of concentration, and lack of ability to handle anger appropriately, and being short tempered are also characteristic of a child with bipolar disorder. The temperament of a child with bipolar disorder is a distinguishing feature of the disorder. These children often are happy one minute and then without reason, and lingering beyond expected, or out of proportion to the situation, the child shifts mood to an uninhibited fit of rage (Waltz, 2000; Papolos & Papolos, 2002). Their thinking patterns are extremely slow and they are noticeably

lethargic one day and the next, they have an increased, excessive energy supply and do not need to sleep at all. Additionally, a disturbance in body functioning can be noticed, e.g., bedwetting. Bedwetting in children with bipolar disorder is common. Furthermore, soiling, wiping feces on walls or other objects, is frequently found. Children with bipolar disorder regularly suffer from night terrors (Papolos & Papolos, 2002). During these "dreams," children have horrific visions of bodily harm occurring to him- or her-self, blood, and gore. Due to these night terrors, the child acquires a fear of death and annihilation. Sensitivity to stimuli, visual, audible, or tactile, is also found consistently with children diagnosed with bipolar disorder. This can include the temperature of the child's body. A child may exhibit sensitivity to soups that are too hot or have to be completely naked in a room that is extremely cold to everyone else. Lastly, children with bipolar disorder crave carbohydrates and sweets regularly, consuming excessive amounts of pasta, bread, and candy.

Mania episodes have more unstructured diagnostic criteria. An important part of the diagnosis is that the individual's life is impaired in all areas of life; social, occupational, and educational (Waltz, 2000; Birmaher, 2004), but the duration of time is specified. Everyday functioning cannot occur. Common characteristics include: euphoria, extreme optimism/creativity/motivation, lack of need for sleep/insomnia, extreme irritability, rage, hyperactivity (both mental and physical), relentless loud, hurried, pressured speech, talkativeness, mind races and jumps from subject to subject (flight of ideas), bad judgment, impulsivity, distractibility, unrealistic sense of self importance and authority over others (grandiosity), obsessive compulsive-like behaviors (e.g., cleaning into the early morning hours), irresponsible, risky behavior (e.g., gambling, substance

abuse, promiscuity, audacious behaviors), arrogance, bizarre, extreme changes in clothing worn, and in some instances hallucinations.

Moreover, mania in children can often be recognized in children through bossiness, extreme goofiness, labeled as the class clown, continuous laughter and talking during times of seriousness, and mischievous (Birmaher, 2004). These children's peers/friends tend to make comments to him or her regarding their euphoric mood state, often questioning the child about possible drug use. The vital piece to observing manic episodes is to note the abnormality of the mood or enthusiasm expected for the child's age and developmental level. Controversially, Carlson (1983, 1984) notes that euphoric mood is not a common symptom of mania found in children, but rather hostile temper tantrums (Biederman et al, 2000). Wozniak et al (1995) also made note of this phenomenon stating that children with bipolar disorder often have serious, continuing, and destructive temper tantrums.

In addition, the impulsivity matched with the lack of reasoning displayed by bipolar children creates a hazardous situation frequently resulting in breaking the law (Birmaher, 2004). While these states are very dangerous for adults because of the impairment done to a person's ability to judge the safety of situations, children who enter into a manic state often suffer much greater consequences for their actions. This is because, generally speaking, children tend to take more risks. Adults usually are able to help children learn when a situation has become too dangerous. In the case of a child with bipolar disorder, there is an inability to recognize when something has become too hazardous. Children with bipolar disorder often display impulsivity and recklessness during a manic state creating a very scary situation. Stealing, vandalism, and

irresponsible money decisions are common among childhood-onset bipolar disorder. Children, during a manic episode, regularly become easily frustrated and therefore, can become verbally and physically aggressive.

Children become further frustrated because he or she has increased, rapid thought processes (Birmaher, 2004). He or she is unable to communicate with words his or her thoughts. The child attempts to communicate his or her thoughts, but the conversation is delayed by a failure to disclose vital information to others. When the participant does not understand what the child is talking about, the child becomes aggressive. Further related to communication, children with bipolar disorder continuously talk during situations or environments that society expects quiet, i.e. school, places of worship, etc. Often this leads to them getting in trouble, but the child is unable to quit talking, leading to frustration and anger. Additionally, the child may not be able to continue to think about a specific subject due to environmental distractions; he or she becomes extremely distracted by what is taking place around him or herself. Additional negative affects include the child's unrealistic or impracticable thoughts, which further confuse others around him or her.

These thoughts produce a bigger problem for the child. Such thoughts as those detailed previous can induce feelings of invincibility (Birmaher, 2004). Children often act on this invincibility by behaving in dangerous ways, e.g. standing in front of vehicles, jumping off the roofs of houses, and/or participating in risky stunts on their bikes, roller blades, or skateboards. Some children have accompanied delusions, hallucinations, and/or paranoid ideations. Children may believe that he or she has special powers, is very important, or that others are out to hurt them physically. This can add to the serious

indecisions that these children make. Nevertheless, it is essential to differentiate between normal fears and fantasies in young children.

During a manic period, a child often becomes creative, painting, writing poetry and/or songs (Birmaher, 2004). A child's manic behavior manifests itself in his or her inability to sit still. He or she is constantly disrupting others, touching everything around him or herself, and seems extremely agitated.

Due to disruptive behaviors at school and home, children are often directed to seek professional help (Kowatch & DelBello, 2003). Children often demonstrate poor performance academically, social concerns, and many other disenabling characteristics. Furthermore, these children often have comorbid diagnoses, i.e. Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Schizophrenia, Obsessive-Compulsive Disorder (OCD), Asperger's, Borderline Personality Disorder, Substance Abuse Disorder, Separation Anxiety Disorder, or ADHD, making these children hard to treat. The primary reason for diagnostic uncertainty is the lack of education regarding symptoms overlapping between childhood mania and ADHD (Biederman et al, 2000; Weller et al, 2004). It has been estimated that approximately 90% of children with bipolar disorder also have a comorbid ADHD diagnosis. Dr. Charles Popper, who has researched childhood-onset bipolar disorder and ADHD extensively, found that due to regular misdiagnoses it is imperative that a mood disorder diagnosis is ruled out first before diagnosing ADHD (Papolos & Papolos, 2002).

When comparing children with ADHD and bipolar disorder differences in judgment ability, irritability, inattention, and energy levels are not notable (Birmaher, 2004). Lynn (2001) noted that although ADHD and bipolar disorder are two considerably

different disorders, hyperactivity, impulsivity, and inattention are symptoms primary in each. Feinstein (1982) noted that both children with ADHD and bipolar disorder had symptoms including hyperactivity, impulsivity, and harsh reactions (Kaplan & Shachter, 1993). Geller et al (2002) concurred that irritability, hyperactivity, distractibility, and accelerated/pressured speech are very common, distinctive, and visible symptoms of both ADHD and bipolar disorder (Weller et al, 2004). Furthermore, distractibility, talkativeness, and hyperactivity were all noted again as being significant signs of children with bipolar disorder or ADHD (Moyer, 2002). While there are virtually no significant, observable differences between ADHD and bipolar disorder concerning inattention and hyperactivity some key characteristics can hint to bipolar disorder over ADHD. Due to the presence of hyperactivity, inattention, and impulsivity Biederman et al (2000) found that 98% of children diagnosed with bipolar disorder would also qualify for an ADHD diagnosis.

Fristad et al. (2003) found that children with bipolar disorder often display increased energy, recurrent elevated mood states, irritability, flight of ideas, hurried speech patterns, and thought processing problems more noticeably than children with ADHD. Children with bipolar disorder display pressured speech in more of a continuous expression of random thoughts (Lynn, 2001). What the child is attempting to communicate is often ineffective due to the lack of accuracy. This type of speech pattern is known as a flight of ideas. On the other hand, children with ADHD exhibit pressure speech patterns in a very different manner. These children often will go on and on about whatever it is that comes into his or her head until asked to slow down. When interrupted bipolar children and children with ADHD will respond in much different ways. The

children with bipolar will often look confused by the interruption and continue when there is a break again in conversation. The child with ADHD will often become refocused on the conversation and explains him or herself much more clearly.

In addition to these symptoms, Biederman et al. (2000) found indicators of depression, aggression, delinquent behaviors, anxiety, social problems and withdrawal, and somatic complaints. Moreover, a study conducted by Geller et al. (2002) found that children with bipolar disorder had increased euphoria and grandiose ideations as compared with children with ADHD. Lastly, Birmaher (2004) found when comparing bipolar children with children to depression, ADHD, anxiety, and behavioral disorders that children with bipolar disorder displayed an increase in suicidal thoughts and attempts and psychotic symptoms.

The most prominent red flag for bipolar disorder is the observation of mood swings, the shifts in mood states from one minute or day to the next (Birmaher, 2004; Waltz, 2002). Children with bipolar disorder display episodic periods of hyperactivity (Weller et al, 2004). Whereas, in the case of ADHD, the children are consistently hyperactive, in school, at home, in the community, and during any of the seasons, there are not any severe mood shifts (Birmaher, 2004; Weller et al, 2004). The shifts seen in behavior are a result from structured environments and/or the motivation behind completing a particular task (Birmaher, 2004).

Children with ADHD do not demonstrate psychotic tendencies (Waltz, 2002). Children with bipolar disorder, however, show a distinct distortion in reality. Additionally, depression, an essential condition in bipolar diagnosis, is not commonly the foremost symptom found in ADHD. Along with this diagnosis, somatic complaints,

dysphoria, irritability, and unclear thinking are common with children with bipolar disorder, but not ADHD. Destructiveness is a characteristic found in ADHD and bipolar disorder. Children with ADHD often break things by accident due to an overwhelming amount of energy (Papolos & Papolos, 2002). Children with bipolar disorder display excessive destructiveness. These children break things while angry, and on purpose as a part of a temper tantrum. These anger outbursts sometime include violence and destruction of property. Furthermore, children with bipolar misbehave intentionally (Papolos & Papolos, 2002). These boys and girls are usually the bullies on the playground and mean to others to make them feel bad. On the opposite end, children with ADHD often misbehave unintentionally and without an agenda. Occasionally, these outbursts may include sadistic drives. In addition, the duration of these outbursts vary. Children with ADHD often calm down within 20 to 30 minutes (Papolos & Papolos, 2002; Lynn, 2001). Whereas, children with bipolar disorder remain angry or have anger outbursts spontaneously that can occur up to four hours. These children also display confused thinking, body position, and language (Papolos & Papolos, 2002). Furthermore, Papolos & Papolos (2002) documented that children with bipolar disorder often lose memory of their temper tantrums. Children with ADHD and bipolar disorder often differ in what triggers their temper tantrums (Papolos & Papolos, 2002). Lynn (2001), Papolos & Papolos (2002), and Weller et al (2004) agree that children with ADHD have temper tantrums due to sensory and emotional overstimulation. Usually children with bipolar disorder have temper tantrums triggered by authority figures taking a stand, setting limits; someone in authority not giving him or her they want.

While both children with bipolar disorder and ADHD have a decreased need for sleep their sleeping patterns are quite dissimilar (Weller, 2004). Children with bipolar disorder often have disturbed sleep. Nightmares and night terror, including mutilated bodies and gore, disturb the bipolar child's sleep.

Children with bipolar disorder often seek out risky situations (Papolos & Papolos, 2002). Children with ADHD act without realizing the risks of their behaviors. In reference to risky behavior, children with bipolar disorder often display a strong sexual behavior and interest. Dysinhibition for both children with bipolar disorder and ADHD are caused by an inner search or need for stimulation (Lynn, 2001). The dissimilarity between these cases is first, in the case of the child with ADHD, the need or craving for stimulation can be satisfied. In contrast, the child with bipolar disorder, this craving consumes his or her identity. Their personality is completely overtaken by the stimulation addiction.

Birmaher (2004) notes the following as "Tips for Distinguishing between Bipolar Disorder and ADHD": If the presence of the following symptoms is found, a bipolar diagnosis should be considered instead of that of ADHD.

The "ADHD" symptoms appeared later in life (e.g., at age 10 years or older).

The symptoms of "ADHD" appeared abruptly in an otherwise healthy child.

The "ADHD" symptoms were responding to stimulants and now are not.

The "ADHD" symptoms come and go and tend to occur with mood changes.

> A child with "ADHD" begins to have periods of exaggerate elation, depression, no need for sleep (particularly if the next day she or he is not tired), and inappropriate sexual behaviors.
>
> A child with "ADHD" has severe mood swings, temper outbursts, or rages.
>
> A child with "ADHD" has hallucinations or delusions.
>
> A child with "ADHD" has a strong family history of bipolar disorder in his or her family, particularly if the child is not responding to appropriate treatments. (p. 48 -49)

An additional assessment needs to be made for children who exhibit the following: persistent behavioral, social, academic, emotional, or family relations troubles, suicidal ideations and/or attempts, discusses thoughts of hurting or killing others, having delusions or hearing voices, responds disproportionately to others when agitated, has a bizarre belief system, and uses drugs and/or alcohol (Birmaher, 2004).

One of the largest arguments surrounding this controversy has been that childhood-onset bipolar disorder is unlikely and therefore is an atypical diagnosis prior to puberty (Geller et al, 1995). This misconception is observable in numbers throughout many studies. Greater than one-half of approximately 500 Depression and Bipolar Support Alliance members reported symptoms of bipolar disorder prior to 19-years-old (Kowatch and DelBello, 2003). In another self-report study, the average onset of bipolar symptoms was nine to twelve years old. Lynn (2001) referenced eight to nine years old being the magically number to conclusively detect the mood swings used to define bipolar disorder. Sachs (2000) recorded prior to 19-years-old high comorbidity is found (Biederman et al, 2000). Faraone et al (1997) found evidence that an ADHD/bipolar

comorbid diagnosis decreases significantly from 90% during childhood to 60% during adolescents (Biederman et al, 2000). Schmidt and Friedson (1990) suggested that ADHD might be a precursor for a latter bipolar diagnosis (Kaplan and Shachter, 1993). Moyer (2002) suggested that an ADHD diagnosis is universally recognized. Therefore, a bipolar diagnosis is overlooked initially. It is however, very clear that diagnosing children with bipolar still seems extremely unclear. Still, many parents and medical professionals are pressured to diagnose and treat these children (Kaplan and Shachter, 1993).

Due to the pressure to diagnose, it is imperative to consider the current research presenting ways to ensure the best diagnosis process available. Birmaher (2004) noted that the only way of making an accurate diagnosis is by getting constant, up-to-date information about the child from the child, parents, teachers, and others well known by the child. Sheridan et al (1998) noted the importance of school professionals and faculty in the diagnostic process. It is impossible for either the schools or the community-health facilities to meet the needs of children alone. Sheridan et al (1998) discussed the school-community relationship as enabling "an exchange of ideas, resources, services, and expertise between educational and non-educational agencies in a variety of settings that mutually address the needs of students and the community as a whole" (Welch & Sheridan, 1995, p. 353). Within this relationship, it is essential that both the schools and community-health facilities are equally helpful in providing information about identifying, addressing, and resolving the issue(s) Sheridan et al (1998). The accuracy of the health-care professional's diagnosis is determined by how well the child, parents, and others communicate the child's symptoms (Birmaher, 2004). Most families start at the pediatrician's office (Waltz, 2000). While this is a good starting point, Waltz (2000)

noted that pediatricians have little training in psychiatry or neurology. Psychiatrists, psychologists, and other mental health-care professionals are all places Birmaher (2004) notes to seek care for your children.

At the initial appointment with a health-care professional, it is important that parents bring some baseline information regarding their child's medical and psychiatric symptoms (Birmaher, 2004). This information should include current psychiatric problems, past psychiatric history, developmental and medical history, school history, psychosocial history, information about the family and environment, and contact information of professionals working with the child. It is also important during this appointment to have listed the child's issues organized by severity to aid in not only diagnosing, but also treatment and response to treatment.

In addition to the initial appointment the following is recommended: controlled interviews with the child and/or parent(s), therapy sessions, direction observation of the child in a medical setting and natural setting (home or school), and standardized assessments (Waltz, 2000). These are considered the chief tools in diagnosing children. Schedule for Affective Disorders and Schizophrenia in School-Ages Children – Present and Lifetime Versions (K-SADS-PL) and the Diagnostic Interview Schedule (DISC) are two of the many psychiatric interviews that may be used. To administer these structured interviews, special training is needed. These interviews are often not administered due to lengthiness, and are unneeded for a psychiatric diagnosis. Furthermore, a health-care professional with an adequate knowledge of psychiatric symptoms and childhood development can provide your child with an exceptional evaluation without utilizing these interviews.

During therapy session and/or discussions with parents, it is crucial that the health-care or school professional does not imply the answers to meet a specific diagnosis (Birmaher, 2004). For instance, a teacher when talking to a parent states, "At home, I am sure that you've noticed his/her inability to sit still or pay attention, right?" This creates a biased answer. Even if the parent did not see these behaviors at home, he/she would generally not feel comfortable admitting this to a teacher. Furthermore, if the parent is frustrated at home with the child's behavior and is looking for a diagnosis to "cure" his/her child this again will lead the parent to a conclusion about his/her child's behavior. By asking open-ended questions, parents are able to answer more honestly. This leads to a better diagnosis.

Another imperative part of the making an accurate diagnosis is through direct observation by the parents and other people close to the child (Waltz, 2000). Children do not have the vocabulary when young to express their feelings and/or thoughts associated with his/her behaviors. Furthermore, due to bashfulness, nervousness, or fear the child will not be able to answer questions to help the health-care professional make an accurate diagnosis; making it essential that the people close to the child aid in the diagnostic process. Birmaher (2004) suggests in addition to supplying the health-care professional with direct information via a conversation that a mood diary be utilized. The child's behaviors/symptoms that occur on a daily basis are tracked in a more precise way. This allows for even a better view of the child for the health-care professional and a more accurate diagnosis can be made.

Questionnaires are employed to allow parents the opportunity to express their views regarding the child's behavior: Mood and Feelings Questionnaires (MFQ), Screen

for Child Anxiety Related Disorders (SCREEN), Disruptive Behavior Disorder (DBD), Child Global Assessment Scale (CGAS), and Child Mania Rating Scale, Parent Version (CMRS- P) are some example of questionnaires used (Birmaher, 2004). These questionnaires are also utilized to assess the severity of the child's symptoms and the response to treatment. Most questionnaires focus on the child's behavior, however, some questionnaires ask about the parents' behavior.

There is a wide variety of tests used to assess the child's symptomology, current level of functioning ability in their natural environment, state of family relations, treatment response, medication side effects, and other external factors (Birmaher, 2004). Primarily psychological tests are helpful to recognize language and learning issues, cognitive insufficiencies, and attention difficulties. The Achenbach Child Behavior Checklist (CBC), Behavior Assessment System for Children (BASC), Connors Rating Scale (CRS), Halstead-Reitan Neuropsychologist Test Battery for Children, Kiddie-SADS-Present and Lifetime Version (K-SADS-PL), Luria-Neraska neuropsychological Battery, Children's Revision (LNNB-CR), Pediatric Symptom Checklist (PSC), Vineland Adaptive Behavior Scales, Kinetic Family Drawing System for Family and School, House-Tree-Person Projective Drawing Technique, and Draw-a-Person are a variety of assessment that may be required to make a diagnosis (Waltz, 2000). Often teachers or school professionals are asked to complete these assessments regarding a child. This is an imperative role for these individuals to aid in the diagnostic process. These assessments are far more subjective than direct observation, interviews, therapy sessions, or standardized assessments. Nevertheless, it is important to remember that assessments are utilized to ascertain information related to symptomology, not to make a diagnosis

(Birmaher, 2004). Nevertheless, several individuals believe that these tests will provide a diagnosis of psychiatric disorders.

It has been suggested that when considering the diagnosis health-care professionals need to observe symptomology in a different manner due to the overlap of symptoms for various diagnoses (Weller et al, 2004). The subtraction and proportion methods are suggested for aiding in the diagnostic process. When using the subtraction method, a health-care professional views all of the symptoms initially. Then he/she eliminates those symptoms that overlap with many other diagnoses. Lastly, he/she views the remaining symptoms to make the appropriate, more accurate diagnosis. If the health-care professional utilizes the proportion method he/she would again initially views all of the symptoms. Then he/she compares the symptoms to other symptomology for a variety of diagnoses. The chosen diagnosis is based on where the majority of the symptoms are represented in the diagnosis.

If the previously discussed diagnostic regimen is not followed, serious negative impacts can occur for the child, especially in the case of a mis-diagnosis for children with bipolar disorder. School professionals need to acknowledge their importance in this diagnostic process through counseling sessions and/or discussions with parent(s), students, and teachers and the effect of personal biases towards specific diagnoses when completing behavioral checklists for medical personnel, psychologists, and/or psychiatrists. If a school professional goes into a discussion biased about the diagnoses available and predominant in childhood this may alter the diagnosis of that child significantly. Furthermore, if this occurs the child would be negatively affected physically, mentally, and/or emotionally by the improper diagnosis.

It is important to not, however that symptom overlap in children is a huge problem. Because a wide variety of diagnoses have "similar" symptomology and an enormous variance in medical treatment, namely medications administered, careful consideration should be given to re-examining diagnosing children affect with overlapping symptomology. The validity of making such a diagnosis is questionable because of this overlap. Furthermore, there is not an agreement among professionals with regards to how to make an accurate diagnosis. Many practitioners or primary diagnosticians do not think children should be diagnosed with mood disorders at this age level due to the following: social, physical, and mental development is not complete, personality changes during maturation, short life-span to note course of illness, and symptomology is congruent with other illnesses. Additionally, there has not been empirical research identifying an acceptable way to identify pediatric bipolar disorder, also providing evidence of lack of accountability.

As previously discussed, the pressure for a diagnosis to be made for all involved is extremely high, but again it is extremely important that an accurate diagnosis is made. If a child is diagnosed with a disorder that he/she does not truly have similar serous negative side effects are endured, i.e. negative social relationships, harmful pharmaceutical effects, and developmental delays (mental and physical).

Chapter III

Methodology

Within this chapter research questions and the subject selection process is described. Additionally, information regarding the instrument used to collect data is given. Next, the procedure for collection and analysis of data is presented. Lastly, methodological limitations are discussed.

Research Questions

This study had five research questions. They were:

1) Do school professionals who have worked with children affected by specific diagnoses have a different view of children's' ability to be diagnosed with these disorders?
2) How do school psychologists and/or school counselors perceive their role in diagnosing children?
3) Were there any patterns in how school psychologists and/or school counselors viewed diagnosing children with mental health conditions?
4) Were there any patterns in how school psychologists and/or school counselors viewed medicating children with mental health conditions?
5) Are there specific patterns in answering questions related to diagnosing and/or medicating children for school psychologists and/or school counselors?

Subject Selection and Description

Subjects requested to participate in this study were a random selection of employed elementary school counselors and school psychologists from the state of Wisconsin. One hundred school counselors and 100 school psychologists were asked to

complete and return a survey about their views related to pediatric diagnostic procedures. Two hundred surveys were mailed. Participants were allotted approximately two weeks to return the completed surveys. One hundred and eight surveys were returned, which lead to a response rate of fifty-four percent. However due to the write in responses of four participants having dual-certifications and roles these responses were deleted. Therefore one hundred and four surveys were compared, 52% School Psychologists and 46.3% School Counselors.

Instrumentation

One 12-item questionnaire was developed by the researcher to determine school professionals' views on current pediatric diagnostic procedures (see Appendix A). The questions concerning the school professionals' views on their current practices requested the subjects to respond by checking the box that best fit their situation. Subjects were allowed the opportunity to include personal answers by checking the box label "other" and recording a personal response. A nine-point Likert scale was used to determine the subjects' perceptions on their role in aiding the diagnosis of children: 1= "I do not believe I should ever contribute to the diagnosing of children"; 5= "I believe it is somewhat important I give feedback regarding a child's behavior when asked"; 9= "I believe it is extremely important school professionals be involved in diagnosing children".

Data Collection Procedure

Permission was granted by the Department of Protection of Human Subjects at the University of Wisconsin–Stout to proceed with this study utilizing the participant consent form (see Appendix B) and questionnaire. Addresses were accessed through the Department of Public Instruction of Wisconsin. Through random selection, a sample of

subjects was determined. Two hundred questionnaires, consent forms, and self-addressed stamped envelopes were mailed to selected school counselors and school psychologists throughout the state of Wisconsin.

Data Analysis

The Statistical Program for Social Sciences, SPSS, was used in this study to analyze data. Frequency and percentage data was computed for the entire survey. Crosstab calculations were also run comparing data reported from School Counselors and School Psychologists to identify any variances in answers. Another independent group T-Test analysis was completed on the results reported from question 7, "On a scale from 1 to 9 (9 being the highest), how important do you see your role in **aiding** the diagnosing children?"

Limitations

There was one notable limitation apparent in this research.

1) The sample was drawn from an upper Mid-western state. The demographics of this state are much different from others, ethnically, socioeconomically, etc. Therefore, caution should be applied to the findings of this research based on these facts.

Chapter IV

Results

The purpose of this study was to determine school professionals' perceptions of diagnosing children with bipolar disorder and common practices in this process in schools (K-12). The results of the surveys given to School Counselors and School Psychologists will be provided within this section. The research questions previously addressed will be restated and addressed concerning the findings. To conclude, other significant findings will be addressed.

Item Analysis

As previously discussed, 108 subjects voluntarily participated in this study. However, due to the write in response from four participants of having dual-professional duties, 104 surveys were analyzed. Fifty-four of the subjects were School Psychologists and fifty of the subjects were School Counselors. The most common response to question two (Appendix A) was "10 or more years" (64.8%), meaning that the vase majority of school professionals have worked in their profession for ten or more years. However, on closer inspection, Pearson Chi-Square data analysis was run and it was found that School Counselors and School Psychologists answered significantly different. Utilizing this procedure data resulting close to .05 shows significance; in this case, .076 resulted, confirming a difference in the answers. The majority of School Counselors and School Psychologists have "10 or more years" experience. The difference lies in the percentages. Seventy percent of School Psychologists have "10 or more years" experiences, while only 58% percent of School Counselors answered in this manner. There was a significantly larger number of School Counselors reported having "0-3 years" experience,

20%. Whereas, 3.7% of School Psychologists reported have "0-3 years" experience. Calculations regarding the background education of the school professionals who participated in this study showed 41% of school professionals completed their undergraduate studies in the "Psychology" major. The second most represented major among subjects with "Education" (27.8%). When further analysis was completed comparing School Counselors and School Psychologists it was found that School Counselors made up the majority of the "Education" majors, 44% of School Counselors majored in "Education" while 18% of School Counselors majored in "Psychology." Much different results were found when analyzing the data answered be School Psychologists. Sixty-one percent of subjects responded that they had majored in "Psychology" with only 14.8% majored in "Education." Some of the write-in responses were very interesting varying from Telecommunications to Journalism. The percentage of school professionals participating in diagnosing children via completion of behavioral checklists was calculated to be 92.6%, 6.5% have not (leaving the remaining .9 % for an unanswered question by a subject). Table 1 presents data on school professionals experience working with different disorders. The majority of school professionals have worked with the following disorders: ADHD (100%), Oppositional Defiant Disorder (99.1%), and Asperger's Disorder (96.3%). Table 2 presents data on school professionals overall views on what diagnoses can be applied to children. The highest numbers were found with ADHD (99.1%), Asperger's Disorder (97.2%), and Oppositional Defiant Disorder (96.3%). When analyzing data concerning question seven (see Appendix A), the majority of school professionals (39.8%) report that they believe their input in the diagnostic process is extremely important. Furthermore, 73.1% of school professionals

viewed their input in the childhood diagnostic process as very important or higher. Table 3 presents data related to the collective school professionals' opinion on who is important in the diagnostic procedure for children. The data shows that school professionals' believed that medical personnel (95.4%), psychologists (95.4%), psychiatrists (95.4%), parent(s) (91.7%), and school psychologists (91.7%) were all imperative in this process. Calculations showed an overwhelming view from school professionals that children should continue to be diagnosed with mental disorders (95.1%). However, many commented that children should be diagnosed only if necessary. Another common view from school professionals' is the belief that children should be medicated for their mental disorders (96%). Again, there were handwritten comments suggesting that this should occur for those who truly suffer and need medical treatment. Lastly, a majority of school professionals' that believe that children are being over-diagnosed and/or over-medicated in our society (77.9%). Data received demonstrated that school professionals' consider seven to nine years-old sufficient age to diagnose with mental disorders (36.1%). However, some did not answer this question (n = 20.4%) stating that this should only be on an individual case scenario and that there is not a general magical age.

This study had five research questions. They were:

1) Do school professionals who have worked with children affected by specific diagnoses have a different view of children's ability to be diagnosed with these disorders?
2) How do school psychologists and/or school counselors perceive their role in diagnosing children?

3) Were there any patterns in how school psychologists and/or school counselors viewed diagnosing children with mental health conditions?
4) Were there any patterns in how school psychologists and/or school counselors viewed medicating children with mental health conditions?
5) Are there specific patterns in answering questions related to diagnosing and/or medicating children for school psychologists and/or school counselors?

The main findings of this study based on the research questions were:

1) Table 4 and Table 5 present data includes responses from School Counselors and School Psychologists regarding what childhood mental disorders they have experience with, and what childhood mental disorders they believe exist. As shown, there was an increase in school professionals endorsing question five, "Have you worked with children who have any of the following disorders in your current employment setting?" and question six, "Please check the following disorders you believe children are affected with." There was a substantial increase in the responses regarding the diagnoses of Conduct Disorder, Borderline Personality Disorder, Schizophrenia, and Substance Abuse Disorder. A 16% increase (from 70% to 86%) by School Counselors and a 14.9% increase (from 75% to 88.9%) of School Psychologists, insinuating that these school professionals believe that a Conduct Disorder diagnosis is available to more children than they have worked with. School Counselors increased their responses by 34% (30% to 64%) and School Psychologists had increased by 20.4% (29.6% to 50%) about Borderline Personality Disorder. There were also notable increases found about Schizophrenia, School Counselors, 36% (from 18% to 54%), and School Psychologists, 22.3% (from 37% to 59.3%). Lastly, Substance Abuse Disorder increases were found

with School Counselors, 24% (from 32% to 56%), and School Psychologists, 35.2% (from 37% to 72.2%). A Pearson Chi-Square analysis revealed that .084. School Counselors and School Psychologists feel significantly different about children being diagnosed with Substance Abuse Disorder. Many more School Psychologists reported believing that children suffer with Substance Abuse Disorder, 72.2%, as compared to School Counselors, 56%. Of particular interest to this study is the significant decrease shown regarding the answers provided about Bipolar Disorder. These numbers seemed to shift in the opposite direction. Eighty-two percent of School Counselors and 92.6% of School Psychologists answered that he/she has worked with children diagnosed with Bipolar Disorder. Conversely, School Psychologists have answered opposite of that predicted response previously discussed. School Counselors showed an increase of 4% in question 6 (see Appendix A), however, School Psychologists showed a decrease of 5.6%. This phenomenon did not occur with any other diagnoses. Table 4 presents data about what disorders School Counselors and School Psychologists have primarily worked with. The most common disorder School Counselors and School Psychologists have worked with is children with Attention-Deficit/Hyperactivity Disorder (100%), ODD (98% and 100% respectively), and Asperger's (92% and 100% respectively). Table 5 presents information on the data collected about what school professionals believed that children could be affected with. As shown, the most common disorders coincide with the same diagnosis school professionals' work with, Attention-Deficit/Hyperactivity Disorder (98% and 100% respectively), ODD (98% and 96.3%), and Asperger's (94% and 100% respectively).

2) A t-test data analysis was conducted to evaluate School Counselors and School Psychologists perceptions of their importance in the diagnostic process. If there were a significant difference in the way, each professional group answered results would show numbers close to $p = .001$. A significant difference ($p = .001$, $df = 89.443$) was found in the response patterns of School Counselors and School Psychologists regarding their perceptions of their importance in the diagnostic process. This suggests a large degree of difference in how each professional group viewing their importance in diagnosing children with School Psychologists viewing their role more important than School Counselors. This phenomenon can also be seen in the Pearson Chi-Square analysis computed regarding question eight, "Who do you think should be included in diagnosing children,?" presented in Table 6. Eighty-six percent of School Counselors believed school counselors should be involved and 85.2% of School Psychologists believed school psychologists should be involved in diagnosing children. However, this significant data was found with School Counselors and School Psychologists perceptions on School Psychologists input in the diagnostic process with a Pearson Chi-Square value of .001, $df = 1$. However, further analysis was computed because of the weakness in this significance. Continuity Correction data analysis was computed in order to show significance. Significant differences are shown where values are close to .01. Data results were computed at .004 finding significant difference in opinion between the two groups. Eighty-two percent of School Counselors reported that School Psychologists should be included in the diagnostic process, whereas 100% of School Psychologists reported this. Table 6 presents information gathered regarding school professionals' beliefs about who should be involved in diagnosing children. School Counselors and School Psychologists

have answered this question differently. School Counselors answered that medical personnel (92%), psychiatrists (90%), parent(s) (88%), mental health professionals (88%), and psychologists (92%) are the most significant people involved in diagnosing children. Controversy, School Psychologists reported that school psychologists (100%), psychologists (100%), psychiatrists (100%), medical personnel (98.1%), and parent(s) (94.4%) are primary personnel involved in diagnosing children. Note that School Counselors placed more of an emphasis on mental health professionals, whereas School Psychologists placed this emphasis on psychologists.

3) No significant differences were found between School Counselors and School Psychologists views for question nine, "Do you think that children should be diagnosed with mental disorders?" Both professional groups reported they believe that children need to continue being diagnosed with mental disorders, 91.7% School Counselors and 98% of School Psychologists.

4) There were no significant findings from utilizing the Pearson Chi-Squared data analysis. School Counselors and School Psychologists answered question ten, "Do you think that children should be medicated for mental diagnosis?" One hundred percent of School Psychologists reported that they believe children should be treated with medication for their mental diagnosis. Furthermore, 91.7% of School Counselors reported the same.

5) There were no significant findings for question eleven, "Do you think that children are over-diagnosed and/or over-medicated in our society?" Both professional groups agree that there within society today children are over-diagnosed and/or over-

medicated. Seventy-three and a half percent of School Counselors and 84.3% of School Psychologists reported that they think this phenomenon is present.

Chapter V

Discussion

There were some interesting findings presented in this study. When comparing School Counselors' and School Psychologists' responses to questions five and question six, to infer if having worked with specific disorders had a correlation with what beliefs are held about disorders children are affected with a trend is apparent. While the top three diagnoses, Attention-Deficit/Hyperactivity Disorder, Asperger's Disorder, and Oppositional Defiant Disorder, remained the same for school professionals when comparing the two questions. This may be due to the numerous overlapping symptoms and quickness of a diagnosis. Furthermore, if the best diagnostic procedures are not utilized as suggested by researchers, i.e. subtraction and proportion methods, an inaccurate diagnosis could result. These methods often eliminate the overlap of symptoms to conclude at a more accurate diagnosis.

When analyzing these figures it also is interesting to find that the top three diagnoses, Attention-Deficit/Hyperactivity Disorder, Asperger's Disorder, and Oppositional Defiant Disorder, are three of the most commonly mistaken diagnoses when analyzing a child later on in life whose final diagnosis is Bipolar Disorder. This is due to the similarities in symptomology for each diagnosis. According to research often during childhood, children are misdiagnosed with these diagnoses, when in reality later in life the individual is found to have suffered with Bipolar Disorder. On retrospect, these individuals state that they could see trends of Bipolar Disorder stemming back when he/she were younger, during childhood. School professionals also show this belief regarding these diagnoses, as do the professionals diagnosing children with the disorders.

This may have an impact on the kinds of diagnoses that are given to children based on the conversations school professionals have with parents, teachers, and through behavioral checklists provided by psychiatrists, psychologists, mental health counselors, and/or medical health personnel. This is why it is so imperative that suggested best diagnostic practices are acknowledged and adhered to by school professionals.

There are no empirically researched, accepted diagnostic procedures and symptom overlap creates much hesitation by those involved in the diagnostic process. While misdiagnosing children with an inaccurate diagnosis, i.e. diagnosing a child with ADHD when in reality he/she suffers from Bipolar Disorder, will create numerous harmful effects, having a false positive diagnosis can also create the negative effects and additional ones. While this information makes strides in better diagnosing children it still falls short because of the lack of agreement among primary diagnosticians. So as of currently the DSM-IV TR diagnostic requirements are the most respected procedures available.

When considering that some of the prominent researchers state to stay away from diagnosing children with mental disorders due to misdiagnosing prominence school professionals were found to overwhelming disagree. School professionals reported that children are developed enough for a mental illness diagnosis, 90.7%.

Based on the beliefs of school professionals many gave specific ages under the general age of puberty, thirteen years old. However, a vast majority of school professionals (20.4%) wrote in unique comments concerning making a general age. Such comments referred to the type of "diagnosis/disorder," individual "circumstances" of the

youth, "severity" of situation, generally revealing an overall view that this question should be based on a "case-by-case" situation. Interpreted, a good percentage of school professionals do not have overall negative opinions or attitudes about mental illness diagnoses. This general belief is commonly accepted by the research for the purposes of this paper. Yet, a large majority of school professionals, 75%, believes that children are over-medicated and/or over-diagnosed in society. Again, comments were wrote in by 3.7% of school professionals stating that this issues is not as "cut and dry" as the question appears and needs to be looked at on a "case-by-case" basis.

Participants in this study indicated that a much wider range of childhood diagnoses were viable, and beyond what they have seen within the scope of their professional practice. School Counselors and School Psychologists showed a different pattern of responses with regards to Bipolar Disorder diagnosis availability to children. This phenomenon is of particular interest to this researcher due to research findings that a bipolar diagnosis in children is often overlooked because of the past stigma and diagnostic procedure difficulties. These percentage differences may conclude that this bias still exists or appropriate diagnostic procedures are not being adhered to resulting in inaccurate diagnosis. In turn, this bias may be transferred to other professionals and parents when conversing about a child's issues within the educational setting.

Both School Counselors and School Psychologists recognize their importance in the diagnostic process, which is an imperative part of the diagnostic process according to the research. School Psychologists viewed their importance in this process at an average of 8.19 (mean) on a 9-point Likert Scale, signifying a response of "extremely important." School Counselors reported an average of 6.42 (mean) on the same 9-point Likert Sale,

representing a response of slightly more important than “somewhat important.” School Counselors may have underestimated their significance of providing an unbiased account of the child’s behavior during a huge part of their life, school. School professionals also accounted for the teachers’ role in the diagnostic process. Eighty-two percent of School Counselors and 90.7% of School Psychologists agree that teachers should play a role in the diagnostic process. For these reasons, it is extremely important that school professionals set standards for how to interpret behavior untainted, provide education, and encouragement to those within the educational setting, i.e. teachers, to provide the same kind of unbiased information. This will better enable educational professionals and faculty to help make the diagnostic process the most efficient so that the outcome is a more accurate diagnosis.

Recommendations

Due to the controversy surrounding diagnosing children with mental illnesses, primarily Bipolar Disorder for the purposes of this research, and the inaccuracy of many childhood diagnoses, this study presents interesting findings related to the views of school professionals and their integral role in the diagnostic process. However, future research is needed to settle controversy and help better diagnose children at pivotal developmental ages in their life.

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Appendix A

School Professionals' Perspectives

This survey is apart of a study intended to help understand current school professionals' roles. Please answer all questions to the best of your abilities. Note that all answers will be held confidential. Thank you again for your participation.

1) What is your profession?
   - ❑ School Counselor
   - ❑ School Psychologist

2) How many years have you been working as a school counselor/psychologist?
   - ❑ 0 – 3 years
   - ❑ 4 – 6 years
   - ❑ 7 – 9 years
   - ❑ 10 years or more

3) What was your Bachelor's degree major?
   - ❑ Education
   - ❑ Psychology
   - ❑ Sociology
   - ❑ Social Work
   - ❑ Other (please list)____

4) Have you ever completed a behavioral checklist on a student?
   - ❑ Yes
   - ❑ No

5) Have you worked with children who have any of the following disorders in your current employment setting? (Please check all that apply.)
   - ❑ Oppositional Defiant Disorder (ODD)
   - ❑ Conduct Disorder (CD)
   - ❑ Bipolar Disorder or Manic Depression
   - ❑ Attention-Deficit/Hyperactivity Disorder or Attention-Deficit Disorder (ADHD or ADD)
   - ❑ Separation Anxiety Disorder
   - ❑ Obsessive-Compulsive Disorder (OCD)
   - ❑ Asperger's Disorder
   - ❑ Borderline Personality Disorder
   - ❑ Schizophrenia
   - ❑ Substance Abuse Disorder
   - ❑ Other ____

6) Please check the following disorders you believe children are affected with. (Please check all that apply.)
   - ❑ Oppositional Defiant Disorder (ODD)
   - ❑ Conduct Disorder (CD)
   - ❑ Bipolar Disorder or Manic Depression
   - ❑ Attention-Deficit/Hyperactivity Disorder or Attention-Deficit Disorder (ADHD or ADD)
   - ❑ Separation Anxiety Disorder
   - ❑ Obsessive-Compulsive Disorder (OCD)
   - ❑ Asperger's Disorder
   - ❑ Borderline Personality Disorder
   - ❑ Schizophrenia
   - ❑ Substance Abuse Disorder
   - ❑ Other ____

Please turn over to complete survey.

7) On a scale from 1 to 9 (9 being the highest), how important do you see your role in **aiding** the diagnosing of children?
   - ❑ 1 (I do not believe I should ever contribute to the diagnosing of children.)
   - ❑ 2
   - ❑ 3
   - ❑ 4
   - ❑ 5 (I believe it is somewhat important I give feedback regarding a child's behavior when asked.)
   - ❑ 6
   - ❑ 7
   - ❑ 8
   - ❑ 9 (I believe it is extremely important school professionals be involved in diagnosing children.)

8) Who do you think should be included in diagnosing children? (Please check all that apply.)
   - ❑ Parent(s)
   - ❑ Guardians(s)
   - ❑ School Counselors
   - ❑ Teachers
   - ❑ School Psychologists
   - ❑ Medical Personnel
   - ❑ Grandparent(s)
   - ❑ Mental Health Counselors
   - ❑ Psychologists
   - ❑ Psychiatrists
   - ❑ Aunts/Uncles
   - ❑ Other ______________________________

9) Do you think that children should be diagnosed with mental disorders?
   - ❑ Yes
   - ❑ No

10) Do you think that children should be medicated for mental diagnoses?
   - ❑ Yes
   - ❑ No

11) Do you think that children are over-diagnosed and/or over-medicated in our society?
   - ❑ Yes
   - ❑ No

12) At what age do you think children have developed enough for a mental disorder diagnoses and to be medicated for these diagnoses?
   - ❑ 3-5 years old
   - ❑ 4-6 years old
   - ❑ 7-9 years old
   - ❑ 10-12 years old
   - ❑ 13-15 years old
   - ❑ 16-18 years old
   - ❑ 19 years old and older

Thank you for participating in this survey.
Please return in envelope provided by Monday, March 14, 2005.

nelsonang@uwstout.edu

Appendix B

UNIVERSITY OF WISCONSIN - STOUT
CONSENT TO PARTICIPATE IN RESEARCH STUDY

TITLE OF STUDY:
"School Professionals' Perspectives"

INVESTIGATOR:
Angela Nelson, School Counseling Student
Phone Number: 715-675-0097. E-mail: nelsonang@uwstout.edu

PURPOSE:
You are being asked to participate in a research study. This voluntary study is seeking school counselors' and school psychologists' current prospective on diagnosing procedures.

PROCEDURE:
If you choose to participate, you will be asked to complete a survey asking you to respond to nine questions related to your current employment setting. After completing the survey questions please return to the survey via e-mail to the e-mail address provided both on this page and on the bottom of the survey provided, nelsonang@uwstout.edu.

RISKS:
The risks associated with this study are minimal. However, because the surveys will be sent back via e-mail the researcher will have access to your personal e-mail account addresses. To minimize this risk the survey has been sent as an attachment. This attachment will be printed out and then the e-mail will be deleted. Furthermore, the deleted files will be expunged on a daily basis to ensure your privacy.

BENEFITS:

This survey will help us learn more about the perspectives of school counselors and school psychologists related to issues occurring in school settings.

CONFIDENTIALITY:

As explained earlier precautions have been taken to ensure the privacy of your personal e-mail accounts and responses. Data reported will be separated be profession, but anonymity will remain.

RIGHT TO REFUSE OR WITHDRAW:

Participation in this study is voluntary. You may refuse to participate in this study without any negative impact. By completing and returning this survey you are consenting to participation. Do not return the survey if you do not wish to participate.

QUESTIONS:

If you have any questions, please ask. If you have additional questions after you have completed and returned the survey, contact Angela Nelson via e-mail, nelsonang@uwstout.edu. You may also contact Dr. Denise Zirkle-Brouillard at 715-232-2599 or via e-mail, brouillardd@uwstout.edu or Sue Foxwell, Director, UW-Stout research services at foxwells@uwstout.edu.

Table 1. School Professionals' Collective Experience with Children

ODD		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	107	99.1	99.1
	No	1	.9	100.0
Total		108	100.0	
Conduct Disorder				
Valid	Yes	78	72.2	72.2
	No	30	27.8	100.0
Total		108	100.0	
Bipolar Disorder				
Valid	Yes	94	87.0	87.0
	No	14	13.0	100.0
Total		108	100.0	
ADHD/ADD				
Valid	Yes	108	100.0	100.0
	No	0	0.0	100.0
Total		108	100.0	
Separation Anxiety Disorder				
Valid	Yes	78	72.2	72.2
	No	30	27.8	100.0
Total		108	100.0	
OCD				
Valid	Yes	88	81.5	81.5

	No	20	18.5	100.0
Total		108	100.0	
Asperger's Disorder				
Valid	Yes	104	96.3	96.3
	No	4	3.7	100.0
Total		108	100.0	
Borderline Personality				
Valid	Yes	31	27.8	27.8
	No	77	71.3	100.0
Total		108	100.0	
Schizophrenia				
Valid	Yes	31	28.7	28.7
	No	77	71.3	100.0
Total		108	100.0	
Substance Abuse Disorder				
Valid	Yes	36	33.3	33.3
	No	72	66.7	100.0
Total		108	100.0	
Other				
Valid	Yes	19	17.6	17.6
	No	89	82.4	100.0
Total		108	100.0	

Table 2. School Professionals' Collective Perspective on Mental Health Disorders

ODD		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	104	96.3	96.3
	No	4	3.7	100.0
Total		108	100.0	
Conduct Disorder				
Valid	Yes	94	87.0	87.0
	No	14	13.0	100.0
Total		108	100.0	
Bipolar Disorder				
Valid	Yes	94	87.0	87.0
	No	14	13.0	100.0
Total		108	100.0	
ADHD/ADD				
Valid	Yes	107	99.1	99.1
	No	1	.9	100.0
Total		108	100.0	
Separation Anxiety Disorder				
Valid	Yes	100	92.6	92.6
	No	8	7.4	100.0
Total		108	100.0	
OCD				
Valid	Yes	101	93.5	93.5

	No	7	6.5	100.0
Total		108	100.0	
Asperger's Disorder				
Valid	Yes	105	97.2	97.2
	No	3	2.8	100.0
Total		108	100.0	
Borderline Personality				
Valid	Yes	61	56.5	56.5
	No	47	43.5	100.0
Total		108	100.0	
Schizophrenia				
Valid	Yes	62	57.4	57.4
	No	46	42.6	100.0
Total		108	100.0	
Substance Abuse Disorder				
Valid	Yes	70	64.8	64.8
	No	38	35.2	100.0
Total		108	100.0	
Other				
Valid	Yes	25	23.1	23.1
	No	83	76.9	100.0
Total		108	100.0	

Table 3. School Professionals' Perceptions of People Involved in Diagnosing Children

Parent(s)		Frequency	Valid Percent	Cumulative Percent
Valid	Yes	99	91.7	91.7
	No	9	8.3	100.0
Total		108	100.0	
Guardian(s)				
Valid	Yes	93	86.1	86.1
	No	15	13.9	100.0
Total		108	100.0	
School Counselors				
Valid	Yes	93	86.1	86.1
	No	15	13.9	100.0
Total		108	100.0	
Teachers				
Valid	Yes	94	87.0	87.0
	No	14	13.0	100.0
Total		108	100.0	
School Psychologists				
Valid	Yes	99	91.7	91.7
	No	9	8.3	100.0
Total		108	100.0	
Medical Personnel				

Valid	Yes	103	95.4	95.4
	No	5	4.6	100.0
Total		108	100.0	
Grandparent(s)				
Valid	Yes	35	32.4	32.4
	No	73	67.6	100.0
Total		108	100.0	
Mental Health Counselors				
Valid	Yes	93	86.1	86.1
	No	15	13.9	100.0
Total		108	100.0	
Psychologists				
Valid	Yes	103	95.4	95.4
	No	5	4.6	100.0
Total		108	100.0	
Psychiatrists				
Valid	Yes	103	95.4	95.4
	No	5	4.6	100.0
Total		108	100.0	
Other				
Valid	Yes	25	23.1	23.1
	No	83	76.9	100.0
Total		108	100.0	

Table 4. School Counselors' versus School Psychologists' Direct Experiences with Children

	School Counselors		School Psychologists			
	Yes		Yes			
	Frequency	Percentage	Frequency	Percentage	X^2	significance
ODD						
	49	98.0%	54	100.0%	1.090	.296
Conduct Disorder						
	35	70.0%	41	82.0%	.463	.496
Bipolar Disorder						
	41	82.0%	50	92.6%	2.663	.103
ADHD/ADD						
	50	100.0%	54	100.0%	.000	.000
Separation Anxiety Disorder						
	39	78.0%	37	68.5%	1.186	.276
OCD						
	39	78.0%	48	88.9%	2.251	.134
Asperger's						
	46	92.0%	50	92.6%	.463	.496
Borderline Personality						
	15	30.0%	16	29.6%	.002	.967
Schizophrenia						
	9	18.0%	20	37.0%	4.679	.031

Substance Abuse Disorder					
16	32.0%	20	37.0%	.291	.590
Other					
13	26.0%	6	11.1%	3.854	.050

Table 5. School Counselors' v. School Psychologists' Beliefs about Diagnosing Children

	School Counselors		School Psychologists			
	Yes		Yes			
	Frequency	Percentage	Frequency	Percentage	X^2	significance
ODD						
	49	98.0%	52	96.3%	.269	.604
Conduct Disorder						
	43	86.0%	48	88.9%	.198	.656
Bipolar Disorder						
	43	86.0%	47	87.0%	.024	.877
ADHD/ADD						
	49	98.0%	54	100.0%	1.090	.269
Separation Anxiety Disorder						
	46	92.0%	51	94.4%	.247	.619
OCD						
	47	94.0%	52	96.3%	.299	.584
Asperger's						
	47	94.0%	54	100.0%	3.336	.068
Borderline Personality						
	32	64.0%	27	50.0%	2.073	.150
Schizophrenia						
	27	54.0%	32	59.3%	.293	.589

Substance Abuse Disorder					
28	56.0%	39	72.2%	2.981	.084
Other					
12	24.0%	13	24.1%	.000	.993

Table 6. School Counselors' v. School Psychologists' Beliefs about who should be Involved in Diagnosing Children

	School Counselors		School Psychologists			
	Yes		Yes			
	Frequency	Percentage	Frequency	Percentage	X^2	significance
Parent(s)	44	88.0%	51	94.4%	1.364	.243
Guardian(s)	41	82.0%	48	88.9%	.998	.318
School Counselors	43	86.0%	46	85.2%	.014	.906
Teachers	41	82.0%	49	90.7%	1.703	.192
School Psychologists	41	82.0%	54	100.0%	10.641	.001
Medical Personnel	46	92.0%	53	98.1%	2.144	.143
Grandparent(s)	16	32.0%	18	33.3%	.021	.885
Mental Health Professionals	44	88.0%	45	83.3%	.458	.499
Psychologists	46	92.0%	54	100.0%	4.493	.034

Psychiatrists					
45	90.0%	54	100.0%	5.673	.017
Aunt(s)/Uncle(s)					
10	20.0%	14	25.9%	.514	.474
Other					
5	10.0%	4	7.4%	.221	.638