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Lived Experiences of Postdoctoral and Licensed Psychologists Diagnosing Bipolar Disorder in Adolescents

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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2025

Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

This interpretative phenomenological analysis (IPA) was conducted to explore the lived experiences of licensed psychologists in diagnosing adolescents with bipolar disorder, aiming to answer two key questions: How do psychologists make sense of diagnosing bipolar disorder in adolescents? And do they rely on their education and lived experience in the diagnostic process? Drawing from developmental psychology, clinical decision-making theories, and ethical considerations, the study highlights the complexities and challenges of diagnosing bipolar disorder in youth. Semi-structured interviews with four psychologists were transcribed and analyzed to identify recurring themes, which emphasized the importance of collateral information, developmental context, and professional judgment. The findings suggest that diagnosing bipolar disorder in adolescents requires an approach grounded in ethics, collaboration, and clinical expertise, particularly through longitudinal assessment and consideration of environmental factors. The study also underscores the need for enhanced training, policy improvements, and future research to mitigate misdiagnosis and promote accurate, ethically sound care in adolescent mental health, contributing to a deeper understanding of how clinicians navigate these complex diagnostic decisions. The findings of this study contribute to positive social change by emphasizing potential advancements in the treatment of adolescent bipolar disorder, which could enhance the overall quality of life for affected individuals

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Dedication

I dedicate this dissertation to all who have stood by my side throughout this journey of obtaining knowledge, especially a Doctorate, which I thought was an impossible task for me, but through Christ, all things are possible through him! I encourage all those who seek out knowledge but feel it is impossible to ask, seek, and knock at the door of our Lord, and he will answer. Jeremiah 29: 11-14 For I know the plans I have for you," declares the Lord," plans to prosper you and not to harm you, plans to give you hope and a future. Then you will call on me and come and pray to me, and I will listen to you. You will seek me and find me when you seek me with all your heart. "I will be found by you,' declares the Lord."

I was told I was not smart enough to get an education. Here I am! I thank the only true God, the creator of the universe, for all his support in giving me my husband and a willing heart to learn. Joey, I would not have made it without your prayers and encouragement.

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I want to thank my chair, Dr. Yoly Zentella, my methodologist, for demonstrating their absolute love for the field of research and giving their talent and time. Dr. Daniel Parker, academic advisors, Catherine Heck, and Dr. La Toya A. Johnson, I appreciate your patience, support, and guidance. I would also like to thank my extended family members and friends who provided a listening ear and allowed me to cry on their shoulders. I appreciate every one of you! Thank you for giving the right words to encourage me.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

When looking at typical adolescent behavior and bipolar disorder, symptomologies are similar to each other. During puberty, adolescents may experience difficulty getting up in the morning, sleeping longer than usual, and quickly reviving with increased energy. Typical teenage behavior includes, but is not limited to, impulsivity; mood swings from sad to angry to happy; and variability in cognitive functioning (American Psychological Association [APA], 2002). Some adolescents are great at hygiene, while others refuse to bathe (American Psychological Association [APA], 2002). The teenage brain struggles to keep up with logical thinking and memory storage because it is not fully developed. Drastic hormonal changes can also cause moodiness and irritation (American Psychological Association [APA], 2002).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (2013), which uses universal symptoms to define bipolar disorder, there is no distinction between adult bipolar and pediatric/adolescent bipolar disorder (American Psychiatric Association, 2013). The DSM is used as a common language between professionals in the mental health field to communicate about patients and establish a reliable diagnosis. Psychologists and other professionals further use the DSM for designing treatment plans and billing purposes for insurance companies to pay for services. Specifically, the *Diagnostic and Statistical Manual of Mental Disorders* (2013) is used for coding children and adolescents, even though it is aimed at symptomatology in adults (American Psychiatric Association, 2013). Adolescents who are inaccurately diagnosed with bipolar disorder may experience the wrong medication (Weisz et al., 2015). Misdiagnosis in

adolescents may create mistrust and fear of further treatment or help (Weisz et al., 2015). Pandeti and Boyes (2021) stated that children and adolescents are overdiagnosed and prescribed treatments and medications. Bipolar disorder statistics show that 70% of adults diagnosed with bipolar disorder in 2016 were reported as misdiagnosed (Bipolar Disorder Statistics, 2016). However, 66% of children will develop bipolar disorder when both parents are diagnosed (Bipolar Disorder Statistics, 2016). The National Comorbidity Survey Adolescent Supplement estimated that of the 2.9% of adolescents with bipolar disorder, 2.6% had severe impairment (Bipolar Disorder Statistics, 2016).

The knowledge gained from this phenomenological study of the lived experience of post-doctoral and licensed psychologists in the diagnostic process of bipolar disorder in adolescents could assist others in the field of psychology with future intake evaluations. Incorporating policies, procedures, and guidelines can generate accurate diagnoses, benefiting the client and the psychologist with a more precise medication and treatment plan (Merten et al., 2017). By using interpretative phenomenological analysis (IPA), this qualitative research provides a deeper understanding of the lived experience of licensed psychologists in diagnosing bipolar disorder in adolescents (Alase, 2017; Pietkiewicz, 2012). It is necessary to understand the lived experiences of psychologists to correctly identify the process of diagnosis and develop the most beneficial solutions to a given problem (Post, 2015), which allows the psychologist's theory of knowledge to be incorporated into the diagnostic process. Only one-fourth of pediatricians reported that they relied on DSM criteria when making decisions based on professional judgment, versus DSM criteria. When the diagnosis is incorrect, there is a greater risk of adolescent

suicide, substance use, incarceration, and other adverse medical conditions. Diagnosing adolescents is difficult due to the overlap in symptomology, not meeting the DSM-5, and psychologists focusing on the comorbid condition, making an original contribution (Barke & Edmund, 2017). A better understanding of lived experiences with licensed psychologists diagnosing adolescents with bipolar disorder will increase other psychologists' knowledge about interactions with adolescents and critical components of bipolar disorder. In this manner, the findings of this study will promote positive social change by improving teaching strategies for diagnosing adolescents, which will benefit adolescents with the appropriate treatments. In Chapter 1, I present the background, problem statement, the purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

The DSM has brought to light how psychology views behavioral changes in men, women, and different age groups. When the DSM changed to DSM-5, many in mental health noticed there was a difference in the criteria for bipolar disorder in adults and children/adolescents (Pandeti & Boyes, 2021). In addition to changes that occur in the DSM, psychologists are confronted with many limitations, including health care policies that affect accuracy in diagnosing adolescents with bipolar disorder, and having the right resources to perform assessments that are well-designed with cut-off scores (Weisz et al., 2015). Many post-doctoral and licensed psychologists' epistemologies give a quick diagnosis, enabling adolescents to have a more robust psychopharmacological outcome

and prevent relapses (Merten et al., 2017). Insurance companies often pressure post-doctoral and licensed psychologists into making early diagnoses, creating a conundrum with adherence to the ICD-10, DSM-IV, or the DSM-5 (Merten et al., 2017). Post-doctoral and licensed psychologists who rely solely on symptomology and do not adhere to the ICD-10 code can misdiagnose adolescents with incorrect mental disorders, which can be typical adolescent behavior (Murphy et al., 2013).

A quick diagnosis harms the individual because the adolescent will not receive the proper medications, intervention, and treatment plans. Pandeti and Boys (2021) noted a 10% increase in misdiagnoses of pediatric bipolar disorder. Merten et al. (2017) also reported that insurance companies and the national rates show psychoactive medication prescriptions have increased, due to a worldwide increase in mental disorders diagnoses among adolescents. A system for cross-checking symptomology with clear guidelines of features of adolescent bipolar disorder could help clinicians understand how the disease manifests in adolescents.

The difficulties with diagnosing adolescents include the overlap in symptomology, not meeting the DSM-5, and post-doctoral and licensed psychologists' focus on the comorbid condition, making this research an original contribution (Barke & Edmund, 2017). For example, Jenkins et al. (2012) examined the effectiveness of evidence-based decision-making in relation to the clinical gold standard among African American adolescents aged 5–17 years old. The findings did not meet the DSM-IV criteria, yet children were misdiagnosed with bipolar disorder by human error (Jenkins et al., 2012). These results illustrate how the application of clinical judgment could have

prevented a misdiagnosis in this context. Additionally, episodes of mania and altered feelings, behaviors, thoughts, and perceptions are considered depressive symptomology for bipolar disorder, which many other diagnoses mimic (Berstein et al., 2015). The DSM-5 does not differentiate between adolescent-onset symptoms and adult-onset symptoms of bipolar disorder (Berstein et al., 2017). Typical adolescent behavior and differential diagnoses overlap. Differential diagnoses, ADHD, personality disorder, autism spectrum disorder, and mania all have overlapping features that mimic bipolar disorder, making diagnosis more difficult (Bernstein & Pataki, 2017).

Adolescents who are inaccurately diagnosed with bipolar disorder may experience the wrong medication (Weisz et al., 2015). Due to misdiagnosis, adolescents may fear further treatment or fear of seeking additional help (Weisz et al., 2015). Adolescents diagnosed with bipolar disorder later experience poor psychosocial functioning as adults and a higher frequency of mental health services (Weisz et al., 2015).Statistics from 2016 show an estimated 13.4% of adolescents with mental health issues suffer educationally, financially, and socially (O'Brien et al., 2016). Understanding the developing adolescents' cognitive, emotional, and physical behavior and how overlapping symptoms of various mental illnesses look similar can be challenging (American Psychological Association, 2002).

Looking at the step-by-step processes of the post-doctoral and licensed psychologists during the initial evaluation procedure can help the field understand the gradual approach of the diagnostic evaluation. Identifying guidelines for features, such as a prodrome protocol, to understand each disorder with various differential diagnoses, is

needed. Adolescents diagnosed with bipolar disorder experience poor psychosocial functioning as adults and a higher frequency of mental health services (Weisz et al., 2015). Focusing on treatment is vital, but treatment is only beneficial when there is a correct diagnosis. The DSM is used as a common language between professionals in the mental health field to communicate about patients and establish a reliable diagnosis. It is used by post-doctoral and licensed psychologists and other professionals to communicate with insurance companies and determine treatment plans. DSM is used for coding children and adolescents, even though the DSM focuses on symptomology for adults (Bernstein et al., 2015; Pandeti & Boyes, 2021). Not using the DSM due to time constraints influences psychologists to use the heuristic method when making a diagnosis (Weisz et al., 2015). Heuristics are widely used in all aspects of life, especially decision-making, problem-solving, and diagnosis (Cherry, 2016). Even though this process can speed up problem-solving, it also leads to stereotypes.

Post-doctoral and licensed psychologists are presented with limitations relating to health care policies that affect accuracy in diagnosing adolescents' bipolar disorder, and resources to perform well-designed research. Post-doctoral and licensed psychologists' lived experience is necessary to identify solutions to misdiagnosis (Post, 2015), allowing the post-doctoral and licensed psychologists' theory of knowledge into the diagnostic process. The knowledge gained from this phenomenological study of the lived experience of the post-doctoral and licensed psychologist in the diagnostic process of bipolar disorder in adolescent patients could assist other post-doctoral and licensed psychologists with future intake evaluations following a step-by-step method of diagnosing adolescents.

Incorporating policies, procedures, and guidelines provides an accurate diagnosis that benefits the client and the psychologist by facilitating a more precise medication and treatment plan (Merten et al., 2017).

Existing literature (Govaerts, 2016; Unsworth, 2004) reflects an understanding of clinical medical reasoning to reach a diagnosis, but no current literature references clinical reasoning in psychological diagnosis. This study explores the gap in the literature by applying post-doctoral and licensed psychologists' lived experiences to the diagnostic process of adolescents suspected of having bipolar disorder. My study will add to the literature using IPA, reflecting the licensed psychologist's lived experiences in diagnosing bipolar disorder in adolescents.

Problem Statement

The research problem is the misdiagnosis of bipolar disorder in adolescents. This study explored this topic through the experiences of post-doctoral and licensed psychologists in diagnosing adolescents. Pandeti and Boyes (2021), who present the most recent literature on this topic, stated that 2.5 % of adolescents and children misdiagnosed with bipolar disorder were prescribed treatments and prescriptions using the DSM-5 for the criteria. Still, when the children were reevaluated, it was determined that they were misdiagnosed. The differential diagnoses make diagnosing bipolar disorder in adolescents complex, with overlapping features such as borderline personality, ADHD, and personality disorders. Further, the criteria for the DSM are aimed at adults and not children and adolescents (Bernstein et al., 2015; Pandeti & Boyes, 2021).

The policy of insurance companies also dictates that the licensed psychologist's first contact with the adolescent be limited to a 1-hour intake evaluation and a diagnostic code from the DSM (Bernstein et al., 2015; Pandeti & Boyes, 2021). Psychologists who take insurance will need to provide a diagnostic code from the current DSM in order to receive reimbursement from the patient's insurance provider (Bernstein et al., 2015 & Pataki, 2017). Yet the literature has focused on clinical reasoning for medical diagnosis. To date, there is an absence of literature on the experience of post-doctoral and licensed psychologists in the diagnosis of bipolar disorder in adolescents (Chun et al., 2016). The literature lacks information regarding the experience of post-doctoral and licensed psychologists' process of diagnosing bipolar disorder in adolescents. Medical diagnosis is quantifiable by evidence from an X-ray machine, blood work, and symptomology patterns, but there is limited quantifiable evidence for a mental illness (Baalen et al., 2017). Psychological diagnosis presents more ambiguity and is challenging to quantify due to overlapping symptomology that a blood test cannot pinpoint (Merten et al., 2017). Psychologists and others in mental health are not given the necessary training, tools, or time to properly assess, evaluate, and consult with other clinicians (Merten et al., 2017).

Purpose of the Study

The purpose of this IPA qualitative research was to gain a deeper understanding of the lived experience of licensed psychologists diagnosing bipolar disorder in adolescents. IPA qualitative research provides a vehicle with which licensed psychologists can voice their experiences in diagnosing bipolar disorder in adolescents (Alase, 2017; Pietkiewicz, 2014).

Research Questions

RQ1: How do licensed psychologists make sense of their process of diagnosing bipolar disorder in adolescents?

RQ2: Do licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents?

Theoretical Framework

King and Kitchener's (2004) reflective judgment model (RJM) is the theory that grounds this study. The RJM moves through seven stages explaining pre-reflective, quasi-reflective, and thoughtful reasoning (King & Kitchener, 2004). The first three stages are pre-reflective reasoning, knowledge gained through authority figures or first-hand experience (King & Kitchener,2004). Stages 4 and 5, quasi-reflective reasoning, recognize that knowledge has missing elements, but there is a way to obtain the missing component (King & Kitchener, 2004). Stages 6 and 7 overlap with reflective reasoning, such as decisions on the premises of evidence that presents itself (King & Kitchener, 2004). King and Kitchener's RJM offers guidance on identifying ethical issues when arriving at a clinical diagnosis (King & Kitchener, 2004).

The research questions were developed to address the concept of misdiagnosis of bipolar disorder in adolescents. The application of IPA works well in the study design in that the method allows for the exploration of the lived experiences of licensed psychologists in misdiagnosing bipolar disorder in adolescents. The RJM also supports the question "How do licensed psychologists make sense of their process of diagnosing

bipolar disorder in adolescents?" Do licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents?

Psychologists utilize their education, personal, and work-related knowledge as points of reflection when diagnosing adolescents. The RJM was used to examine how licensed psychologists diagnose adolescents with bipolar disorder. An IPA approach allowed clinicians to share the details of their lived experiences when diagnosing adolescents with bipolar disorder. The RJM will be further explored in Chapter 2.

Nature of the Study

This qualitative study used IPA, focusing on lived experiences (Smith et al., 2009). IPA methodology aligns with the RQ: How do licensed psychologists make sense of their process of diagnosing bipolar disorder in adolescents, and do licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents? The design was used to address the problem of misdiagnosing adolescents with bipolar disorder, as well as the purpose of the study: to gain a deeper understanding of the lived experiences of licensed psychologists in diagnosing bipolar disorder in adolescents. IPA research aims to "make sense" of the participants sharing their lived experiences and the details in diagnosing bipolar disorder in adolescents by understanding the meaning of the description based on the experience. According to Smith (2012), the described personal experiences lead to a thorough account of the live event, which is necessary for answering the research question.

I developed the interview questions that addressed the RQs. The interview questions were open-ended, and I adjusted and rephrased questions to fit the nature of

how the licensed psychologist approached the client. I kept the questions mindful and straightforward to avoid words that introduced bias (Alase, 2017). I created a list of significant statements, treating each as equally important. Developing the list of non-repetitive and non-overlapping statements assisted the research in determining significant statements. After a more significant analysis of participants' statements, the researcher described the "what" and "how" of the lived experience of the participants (Alase, 2017).

Definitions

Bipolar I disorder: Includes major depressive episode and at least one manic episode. Bipolar disorder is considered an affective mood disorder (Kaplan, 2011).

Bipolar II disorder: Major depressive episode, at least one hypomanic episode. Bipolar disorder can also be explained as a pattern of depressive episodes and hypomanic episodes, and not as full-blown manic episodes found in bipolar I disorder. Bipolar II symptoms may have longer-lasting and severe bouts of depression (Kaplan, 2011).

Clinician: The term clinician refers to a healthcare professional qualified in the clinical practice of medicine. Clinicians are those who provide principal care for a patient where there is no planned endpoint of the relationship; expertise needed for the ongoing management of a chronic disease or condition; care during a defined period and circumstance, such as hospitalization; or care as ordered by another clinician. Clinicians may be physicians, nurses, pharmacists, or other allied health professionals, a doctor having direct contact with and responsibility for patients, rather than one involved with theoretical or laboratory studies (VandenBos, 2007).

DSM-5: A manual for assessment and diagnosis of mental disorders, does not include information or guidelines for treatment of any disorder (American Psychiatric Association, 2013).

Hypomania: Is a mild form of mania, which may involve hyperactivity and elation (Kaplan, 2011)

Misdiagnosis: Misdiagnosis is a wrong diagnosis, and overdiagnosis is a diagnostic medical condition that would never have caused any symptoms or problems (National Health Organization, 2017).

Mania: Mental illness identified by periods of great excitement or delusions, euphoria, and overactivity (APA Dictionary of Psychology, 2007).

Psychologist: An individual professionally trained in the research, practice, or teaching (or all three) of one or more branches of psychology. Training is obtained at a university or a school of professional psychology, leading to a doctoral degree (VandenBos, 2007).

Postdoctoral: A Postdoc is the next step on the academic career path after earning a PhD. A postdoc is a temporary position that allows a Ph.D. graduate to continue their training as a researcher and gain skills and experience that will prepare them for their academic career (National Academy of Science, 2000).

Assumptions

I assumed all licensed psychologists would be honest and truthful in their claims about their level of education and diagnosing adolescents with bipolar disorder. A second assumption was that participants provided open and truthful accounts of their experience

of diagnosing adolescents with bipolar disorder. These assumptions are necessary because participants have been made aware of the need for their professional and honest answers to understand further the process for new psychologists, as well as failing to meet the selection criteria, and not being able to provide data to answer the research question.

Scope and Delimitations

The delimitations for this study included the use of licensed psychologists. However, the participants in this study may not represent all licensed psychologists. The delimitations for this study included using licensed psychologists who have had exposure to diagnosing adolescents with bipolar disorder and administering psychometric assessments. I did not include practicum and pre-doctoral psychologists in this research, as they are still learning to diagnose and administer psychometric assessments.

An IPA allowed participants to describe their personal experiences and provided a meaning of their experiences. IPA research was more appropriate for understanding the lived experiences of licensed psychologists diagnosing adolescents with bipolar disorder. The goal was not to retell the participants' stories or develop a theory but to allow the participants to provide meaning to the licensed psychologist's personal experiences. Hermeneutical phenomenology focuses on and interprets the historical and social context surrounding actions when interpreting a text. This methodology could have been used, but IPA was chosen, aiming at exploring the participants' lived experiences (Frechette et al., 2020).

Limitations

The study was limited to licensed psychologists in the United States. The participants did not represent all licensed psychologists, but their findings may have transferability to other research. To establish dependability, the researcher will give an account of shifting conditions and ever-changing contexts and describe any changes during the interviews. I will discuss in Chapter 4 the interview process from beginning to finish.

Before data collection, a list of definitions was available to provide and discuss with the licensed psychologist. This was not needed as the participants verbalized. One limitation was that the sample was small, and open-ended interviews were the only collection method from the participants' accounts of details. Other researchers may question the validity and reliability of this study because qualitative phenomenological researchers employ an interpretive inquiry. Qualitative research seeks to answer "why, when, where, who, and how "questions with detailed field notes.

A bias is that I have worked with adolescents who have been misdiagnosed with bipolar disorder for the last 20 years. This experience has left me curious to learn more about the lived experiences of licensed psychologists. Acquiescence bias is known as confirmation and friendliness bias, the most common types of bias in research (Graeff, 2005). To prevent acquiescence bias, I did not ask whether there is a "right" answer or an agreement or disagreement with a predefined statement. According to Conroy (2003), the order in which questions are presented can influence respondents by introducing specific

ideas and terminology, which may shape their attitudes, thoughts, and emotions, thereby reducing the potential for bias.

Significance

The findings of this study fill the existing gap in the literature on licensed psychologists' experiences when diagnosing adolescents with bipolar disorder. The wisdom, knowledge, and insights that can come from lived experiences of licensed psychologists are fundamental to the work of social change because the value of lived experience can strengthen the legitimacy and accountability, improve the effectiveness of existing diagnostic styles, and cultivate new training methods for psychologists new to the field and those who are already licensed.

The literature currently focuses on misdiagnoses of bipolar disorder in adolescents. Current literature states that adolescents between the ages of 15 and 19 present as an expected period of the onset of bipolar disorder, but are often misdiagnosed as various other mental illnesses (Miller, 2023). A high percentage of adolescents are misdiagnosed with bipolar disorder and left with lasting effects of wrong medications, treatments, and stigma (Weisz et al., 2002), which may lead to increased risk of substance abuse, suicidal ideation, and attempted suicide in adolescents diagnosed with bipolar disorder are at a higher risk (Demeter et al., 2008).

Gathering the lived experiences from licensed psychologists, I have learned from their successes and struggles with diagnosing bipolar disorder in adolescents. Learning from a licensed psychologist has enhanced the understanding of psychological skills, which leads to finding the correct treatments and modalities for adolescents and

educating parents and teachers to create a wraparound program for adolescents who are suffering. What has been noted is the unique styles each psychologist possesses in order to provide the right treatments and modalities for the adolescents. The risk of increased risk of substance abuse, suicidal ideation, and attempted suicide in adolescents diagnosed with bipolar disorder is still a possibility. Post-doctoral and licensed psychologist can advance their career in the field of diagnosing adolescents with bipolar disorder.

Summary

There is a gap in the literature regarding research on the lived experiences of post-doctoral and licensed psychologists diagnosing bipolar disorder in adolescents. However, there is literature regarding the overdiagnosis of adolescents due to the difficulties of overlapping symptomology and hormonal changes (Weisz et al., 2015). Looking at the step-by-step processes post-doctoral and licensed psychologists experience through voicing their experiences with diagnosing adolescents with bipolar disorder, post-doctoral and licensed psychologists can help others in the field understand the approach of diagnostic evaluation. The problem statement expands on the research problem of misdiagnosis of bipolar disorder in adolescents, which was explored through the experiences of licensed psychologists diagnosing adolescents. Using IPA methodology in the study design allowed for exploration of the lived experiences of licensed psychologists diagnosing bipolar disorder in adolescents.

In Chapter 1, I have presented the background of the study, problem statement, purpose of the study, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and summary. In Chapter 2, I will provide a

literature search strategy, a theoretical foundation, and a literature review related to key concepts.

Chapter 2: Literature Review

The purpose of this IPA qualitative research was to gain a deeper understanding of the lived experience of postdoctoral and licensed psychologists in diagnosing bipolar disorder in adolescents. This chapter will include an introduction to the literature, a theoretical foundation, and a literature review on key concepts of bipolar disorder, which will include the DSM-5 definition of bipolar disorder, misdiagnosis of adolescents, adolescents and mental health, and clinician and patient experiences. There is an ongoing debate on the subject matter of bipolar disorder in adolescents and the misdiagnosis of bipolar disorder in adolescents (Malhi et al., 2023). The research problem is the misdiagnosis of bipolar disorder in adolescents, and licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents. This study explored the topic through the experiences of licensed psychologists diagnosing adolescents.

Literature Search Strategy

The resources used in this research were obtained from various search engines and databases. When I began my search, I searched materials by author, article title, journal name, DOI number, and book title. I spent several hours with the Additional Reference Services (ARS), a Library service through Walden University. The librarian worked with me one-on-one, sharing tips and strategies for foundational library research skills. My search led me to search through Academic Search Complete, articles by topics, ERIC, ProQuest Central, PsycINFO, PsycARTICLES, Ebsco Host, Sage, Academic Guide, and Google Scholar. The key search terms utilized were *adolescents*, *teens*, *youth*,

young adults, *bipolar*, *manic depressive*, *psychologist*, *assessment*, *diagnosis*, *screening*, *perception*, *opinion*, *experience*, and *attitude*.

Theoretical Foundation

The theory that grounds this study is King and Kitchener's (2004) Reflective Judgment Model (RJM). The RJM moves through seven stages that explain pre-reflective reasoning, quasi-reflective reasoning, and thoughtful reasoning (King & Kitchener, 2004). The model is a cognitive-developmental framework based on epistemology, which serves as a model for assessing the lived experiences of licensed psychologists diagnosing bipolar disorder in adolescents. The model moves from basic precepts of understanding to utilize all resources of licensed psychologists' lived experience, education, and knowledge in clinical judgment in diagnosing.

The RJM is used as a decision-making/critical thinking skill for the learning outcome of diagnosing. Studies show that with a higher level of education, reflective judgment was utilized (King & Kitchener, 2004). As the post-doctoral psychologist becomes skilled at the DSM and ICD, with observation, the level of interpretation becomes innate. When looking at this model for framing one's epistemology, the licensed psychologists are constantly and comfortably using evidence and reason to support their clinical decisions, referred to as reflective thinking (King & Kitchener, 2004). The approach shares how licensed psychologists construct and make meaning of their experiences through their education and environment (King & Kitchener, 2004).

Using the RJM from King and Kitchener (2004), Milner and Wolfer (2023) conducted research on reasoning with social work students to understand and appraise

student approaches to complex problems. Milner and Wolfer (2023) found that the RJM is fostered through not just maturity and experiences, but also educational experiences. Milner and Wolfer (2023) reported that the highest scores for the RJM were from doctoral students, and the lowest scores were from those who had not attended a program for a degree, which they explained as the higher level of education equipping the individual to understand the potential for solutions that need to be evaluated and examine the evidence as it arises, which shows the individual is at the optimal level of reflective judgment.

Friedman and Scheon (2009) also conducted a complex case study examining what stage of reflective judgement preservice teachers justify beliefs about classroom practices and knowledge claims. They looked at teachers in an educational setting and 16 female college students looking at programs to develop critical reflection, which suggested that reflective judgment could identify a practical framework for teachers to recognize knowledge development in students. As Friedman and Scheon stated, when at the optimal level of actively reflective thinking, ambiguity is met with a solution to resolve ill-defined dilemmas. Milner and Wolfer (2023) and Friedman and Scheon (2009) found that postdoctoral and licensed psychologists are at the optimal level for recognizing a dilemma and finding a solution using reflective thinking.

Literature Review Related to Key Concepts

In this section, I will define and review the literature of the following concepts: bipolar disorder, viewpoints of clinicians and doctors regarding misdiagnoses, mental health treatment for adolescents, and clinician and patient experiences.

Bipolar Disorder and the DSM-5 Definition

Psychiatric diagnosis is used by health professionals, psychiatrists, and psychologists to communicate and determine the best course of treatment. The DSM continually changes to reflect how people see things in today's society due to experts continually changing their minds. In fact, most diagnoses are in a moral judgment reflecting changes to societal values and preoccupations rather than scientific progress.

Dr. Kaplan, who is a child psychiatrist, has over 40 years of experience with children and is one of the many doctors and clinicians who understand that bipolar disorder does not exist in children but stated that bipolar disorder is an adult diagnosis and that kids have been diagnosed as early as 1994 (Kaplan, 2011). The adult terminology for the diagnosis of bipolar disorder is as follows: having one or more manic episodes and often also experiencing major depressive episodes, where manic episodes are when a person experiences an unusually euphoric or irritable mood that lasts for a week (Kaplan, 2011). According to the DSM-5, during a manic episode, a person may have an inflated self-esteem that can reach delusional proportions, feel full of energy and be more talkative than usual, even while not needing much sleep, do pleasurable things to excess, often with painful consequences, such as engaging in unrestrained shopping sprees, sexual indiscretions, and/or foolish business involvements. It is common during manic episodes for the person to alternate between euphoria and irritability, but major depressive episodes are described as at least 2 weeks of depressed mood or loss of interest (Kaplan, 2011). According to the DSM-5 (2013), patients may exhibit additional symptoms such as trouble sleeping, lack of interest, feelings of sadness, hopelessness, or

discouragement, decreased energy or feelings of worthlessness and guilt, and difficulty concentrating (American Psychiatric Association, 2013). Kaplan (2011) stated in his 40 years of practice as a psychiatrist at a children's psychiatric unit that he has never diagnosed a child with bipolar disorder because he states scientifically, it does not exist. Kaplan (2011) stated that "pediatric bipolar disorder" does not meet DSM criteria for bipolar disorder. He also explained that the DSM is a tool to understand how the diagnostic system works and how a skilled diagnostician uses DSM symptoms as a stepping stone into a patient's life experiences. The DSM-5 added new categories under childhood disorders, including a more specific definition of ADHD, social communication disorder, disruptive mood dysregulation disorder, and age-related diagnostic criteria for PTSD and ADHD (Substance Abuse and Mental Health Services Administration [SAMHSA], 2000). Adolescent bipolar and ADHD have overlapping symptomology that both disorders display, such as being talkative, psychomotor agitation, and distractibility, which confuses clinicians (Geidd et al., 2000; Kaplan, 2011). Similarly, the difficulty in distinguishing between bipolar disorder and the combined diagnosis of ODD and ADHD is that the symptomology is similar (Kaplan, 2011). According to Dr. Geidd, no responsiveness to pharmaceuticals should be the first suspicion of a misdiagnosis (Geidd et al., 2000).

In the United States, there are 2.7 million people between the ages of 10 and 52 who are diagnosed with bipolar disorder (Goetz et al., 2015). However, Ghaemi et al. (2022) proposed revising the diagnostic definition to include recommendations for mixed episodes, new definitions for mood temperaments, and the duration of most extended

episodes. Ghaemi et al. also proposed a clear definition between hypomania and mania, as the current definition of the two is unclear.

Bipolar Disorder and the DSM-5 Definition, Strengths, and Weaknesses in the Cited Literature

The division in the profession concerning bipolar disorder is long-standing as to whether bipolar disorder exists in children and adolescents. Kaplan argues he has yet to encounter a child or adolescent with bipolar disorder due to the criteria of bipolar disorder, and children and adolescents have not met the criteria (2011). Giedd clearly defines the differences between ADHD and bipolar disorder and proceeds to clarify how ODD and conduct disorder are a fit for meeting criteria for children and adolescents (2000). The literature clearly states that a clear definition of mania and hypomania is needed to identify mania and hypomania from adolescent behavior (Pandeti & Boyer, 2021).

Two terminologies are sprinkled in articles regarding adolescents diagnosed with a mental illness, stating that adolescents are either overdiagnosed or misdiagnosed. The National Library of Medicine says overdiagnosis is not the same as misdiagnosis, and misdiagnosis is a wrong diagnosis (National Health Organization [NHO], 2017). For this research, we will use the terminology misdiagnosis as a wrong diagnosis and overdiagnosis as a diagnostic medical condition that would never have caused any symptoms or problems (NHO, 2017). This kind of diagnosis can be harmful if it leads to psychological stress and unnecessary treatments (NHO, 2017). For this research, the term overdiagnosed refers to a condition or disease. Overdiagnosis would be significantly less

of a problem if we could accurately predict the course of the disease that is diagnosed (NHO, 2017). Pandeti and Boyes (2021), the most recent literature, state that 2.5 % of adolescents and children are misdiagnosed with bipolar disorder, prescribed treatments and prescriptions using the DSM-5 for the criteria, but when the children were reevaluated, they were misdiagnosed. The differential diagnoses make diagnosing bipolar disorder in adolescents complex, with overlapping features such as borderline personality, ADHD, personality disorder, and autism spectrum disorder, and the criteria for the DSM are aimed at adults and not children and adolescents (Pandeti & Boyes, 2021).

Why is bipolar disorder such a challenging diagnosis to pinpoint and often misdiagnosed? The dramatic highs and lows of depression to mania are like a roller coaster. Miller (2023), who writes for the *Child Mind Institute*, states that the first symptoms of bipolar disorder vary, and over time, the pattern of low and high moods becomes clear. Although the ICD-11 was created to help clinicians come to a more accurate diagnosis, professionals still struggle with diagnosing adolescents. According to Goetz et al. (2015), the quantitative research conducted on the early stages of pediatric bipolar disorder in the Czech Republic revealed that 30%-60% of adults diagnosed with bipolar disorder stated that the onset of symptoms was between the ages of 15 and 19 years. The issues stated in this research mentioned how there are issues that remain unresolved, such as various studies that recorded the frequency of mania in prepubertal (0% vs. 1.2% in preschoolers), phenomenology, and the course of pediatric bipolar disorder (Goetz et al., 2015). Some researchers argue that chronic irritability is a feature

of pediatric mania (Goetz et al., 2015). The problem is that researchers do not clearly define irritability, mania, and hypomania, as suggested by Kaplan (2011), who states that there is a clear definition in the DSM to follow.

Carlson states that at least 50% of adolescents have endorsed feeling depressed, irritable, sad, angry, impatient, and intolerant of being with others, as well as the inability to enjoy life (Carlson et al., 2016). Carlson et al. (2016) proceed by stating that these are common symptoms of adolescents and children, but when symptoms interfere with school and daily life functions such as sleep and eating, one needs to reexamine and seek professional evaluation.

The diagnosis of bipolar disorder in children and adolescents in the United States in 1994 was 10%, and in 2004, it was noted that 36% of adolescents were diagnosed with bipolar disorder as compared to Germany, 0.27%, Denmark, 1.2%, and Finland, 1.7% (Goetz et al., 2011). The debate continues regarding whether bipolar disorder exists in adolescents (Goetz et al., 2011). Sravanti et al. (2022) presented a critical message that clinicians, psychiatrists, and other professionals are struggling with delays in recognizing the symptomology, where there is significant distress in the families and individuals when help is sought.

Misdiagnosis—Strengths and Weaknesses in the Cited Literature

The study of early stages of pediatric bipolar disorder was conducted in a Czech inpatient unit for adolescents and children and concluded that the US has a higher prevalence of adolescents and children diagnosed with bipolar disorder than other countries. However, it cautioned the possibility of onset for adolescents and children who

have first-line relatives with BD and those who have experienced psychosocial stressors (Goetz et al., 2015).

Pandeti and Boyes (2021), Miller, and Carlson et al. (2016), all agree that bipolar disorder in children and adolescents is the most common misdiagnosis due to the overlapping symptomology. O'Connor et al. (2020) nicely summarize their research regarding documenting diagnosis in child and adolescent mental health, stating that diagnosis is a necessary tool but is imperfect, necessary for treatment decisions, and the prognosis is imperfect.

Adolescents and Mental Health

Diagnosing bipolar disorder in adolescents is an ongoing debate and has been for over two decades (Malhi et al., 2023). Malhi et al. (2023) state that there is a fundamental dysfunction in our thinking and the approaches to the classification of bipolar disorder and diagnosis. When evaluating and deciding on treatment and therapeutic intervention, the symptomology and the struggle highlighted in behavior should be a priority to address first. The body of research is focused on how the definitions for the disorder are unclear, and another complication within the profession is who conducts the assessments for this disorder (Malhi et al., 2023).

Sravanti et al. (2022) mention the barriers for therapists, families, and clients and how awareness is needed to identify problems early, possibly improving "help-seeking behaviors" and possibly reducing peer victimization. Adolescents with poor mental health may struggle with school in regards to grades, decision making, their health, behavioral risks like increased risk of drug use, experiencing violence, and higher risk

sexual behaviors that can lead to HIV, STDs, and unintended pregnancy (Uhlhaas et al., 2023).

According to Scheider et al. (2020), other countries do not spend as much money on mental health services as. Scheider et al. (2020) proposed a new approach to providing therapy to the vast number of underserved youths in need of treatment by proposing single sessions. A single session is a structured program that intentionally involves one encounter with a program provider, lasting 45 to 60 minutes (Scheider et al., 2020). The research revealed that there was a significant improvement for those who were diagnosed with anxiety and depression (Scheider et al., 2020). When looking at intervention and inquiring services, adolescents/children reported that therapy was helpful regarding long-term benefits such as self-discipline, improving academics, and interpersonal relationships (Sravanti et al., 2022). Other sources of treatment would also include medication due to the etiology of psychiatric comorbid conditions and possibly medical conditions in those diagnosed with bipolar disorder (Martinez et al., 2010). The medical conditions reported in the research were a higher risk of cerebrovascular/cardiovascular, diabetes, metabolic abnormalities, neurological disorders, and overweight/ obesity (Martinez et al., 2010).

Adolescents in treatment not only attend therapy but are seen by psychiatrists and medical providers and have frequent lab work. Layers of providers added, which may overwhelm many adolescents and families, create barriers for parents to take off work, and cause financial hardship not only from taking off work but also from purchasing medication not covered under insurance; some families do not have transportation to get

the minor to the providers. Many times, adolescents drop out of therapy due to the hardship on families (Uhlhaas et al., 2023). Through research, Headspace, a program for youth in Australia that is now being implemented in several countries, was discovered (Uhlhaas et al., 2023). Headspace is a national youth mental health program that is youth-friendly and highly accessible for intervention for substance abuse and mental disorders (Uhlhaas et al., 2023).

Adolescents and Mental Health—Strengths and Weaknesses in the Cited Literature

According to Uhlhaas et al. (2023), early intervention and prevention have been relatively neglected in adolescent care and face many barriers to accessing mental health care. Uhlhaas et al. (2023) indicate that clinical, cognitive, and neuroimaging measures constitute possible biomarkers that significantly increase accuracy for predicting clinical outcomes. According to the research Uhlhaas et al.(2023), conducted, the risk of mental disorders appears to be associated with elevated risk for other disorders, and a younger age of onset is predicated on a longer duration of symptoms, comorbidity, and worsened outcomes, highlighting the importance of interventions to target the earliest signs of mental ill health. Malhi et al. (2023) examined the ongoing debate concerning diagnoses of bipolar disorder in children and adolescents, even stating the uncertainty of bipolar disorder in adolescents due to unclear taxonomy. Malhi et al. (2023) discuss how changes are necessary for our current taxonomy to be clinically meaningful and provide professionals with a more developmentally informed diagnosis manual.

Sravanti et al.'s (2022) research examining the experiences of children and adolescents with OCD was limited due to research conducted with quantitative research

and only using adult subjects. Sravanti et al. (2022) examined lived experiences with children and adolescents using IPA, showing that the illness changes over time, which provides hope.

Clinician and Patient Experiences

Articles on patient and clinician experiences in the medical field and psychiatry have shed light on their experiences, attitudes, and diagnostic uncertainties that have influenced their clinical judgment.

Upon thorough research of the literature, there was no literature found on licensed psychologists diagnosing bipolar disorder in adolescents, nor was there any literature on the lived experiences of post-doctoral or licensed psychologists diagnosing. Research has shown that clinicians need to use assessments, guidelines, or evidence-based assessments, but due to the pressure to diagnose, authorization of services needs to be utilized (Jensen-Doss et al., 2011). In a survey with psychiatrists, counselors, and other clinicians in the field, it was found that they underdiagnose to avoid stigma, only use the DSM primarily for billing purposes, and "feel that the assignment of an accurate diagnosis is not clinically useful" (Jensen-Doss et al., 2011, p.2). Jensen-Doss et al. (2011) presume that improving the attitudes of psychiatrists, counselors, and other clinicians in the field may improve diagnostic processes through increased intentions. Through her research, Jensen-Doss et al. note that the level of understanding of psychiatrists, counselors, and other clinicians' characteristics and attitudes would help training efforts be more targeted to diagnostic practices and bridge the gap in training throughout the various disciplinary backgrounds.

Upon further investigation, some psychologists are beginning to speak up about their mental health sufferings and changing the double standard that is stacked against those in the professional field who have psychopathologies (Gwizdala, 2022). Fear looms around professionals who speak up regarding being diagnosed with a mental illness, fear of not being accepted into educational programs, fear of not being allowed to be licensed, judgment, losing their jobs/careers, and consequences of opportunities (Gwizdala, 2022). The same fear and stigma are felt by those not in the mental health profession. Pallesen et al. (2020) researched the experiences of adult men and women with receiving a diagnosis of bipolar disorder, which revealed having the same fears of being fired from their jobs, lack of education, worry about the side effects of medication, having to explain behavior, losing control, and being dependent on help. The overall experiences reported by the participants in the research conducted by Pallesen et al. (2020) were a rejection of the diagnosis, being the participants viewed bipolar as dangerous, did not identify with the diagnosis, and especially when the participant did not build a rapport with the therapist, the outcome was even more strenuous. The research was conducted on ten children aged 10-17, two of whom 10 dropped out of school (Sravanti et al., 2022). When looking at the lived experiences of children with OCD, the responses were fear, helplessness, confusion, grief, and acceptance (Sravanti et al., 2022). Martinez et al.(2010) state that mood disorder is associated with neurocognitive impairment, attention, verbal memory, and executive function, and further studies are needed to address long-term functional outcomes. The role of pharmacological treatments in cognition is controversial.

Clinician and Patient Experiences—Strengths and Weaknesses in the cited literature

The experiences of not just the patients but also clinicians struggling with their mental health and disparities come to the stigmatization if clinicians were to reveal their pathologies. Gwizdala researched the lived experiences of psychologists regarding their truths about their psychopathologies and the difficult decisions to disclose or not to disclose mental health difficulties, risking stigmatization or the inability to become licensed clinicians. Martinez et al. (2010) anticipate a medication to be developed explicitly for bipolar disorder to target critical aspects of illness, including cognitive enhancement, and to improve cognitive dysfunction and, ultimately, recovery with function in patients with bipolar disorder.

Sravanti et al.'s (2022) research on the lived experiences of children and adolescents with OCD states that there is a distinction in the illness between adults and adolescents with OCD. Children and adolescents suffer from dropping out of school due to academic impairment, being victims of bullying due to misinterpreted behaviors, and internal battles and chaos outside and inside; Sravanti et al. (2022) suggest future studies to identify the developing identities of adolescents in school and how peers and teachers misinterpret their behavior.

Pallesen et al.'s (2020) research states the negative and positive experiences of those receiving a diagnosis of bipolar disorder. The negative side of the diagnosis is labeling, which has led to ignoring context and focusing on symptoms (Pallesen et al., 2020). Upon further reading, the study focused on those whose experiences were positive rather than negative. More research is needed on the negative impact of the diagnoses

(Pallesen et al., 2020).The much-needed research on experiences of postdoctoral and licensed psychologists diagnosing bipolar disorder in adolescents to answer the questions of how they make sense of their process of diagnosing bipolar disorder in adolescents, as well as what they are relying on to diagnose bipolar disorder in adolescents. The literature review has shown the struggles and barriers professionals and clients face.

Summary and Conclusion

This chapter discussed the introduction, the literature search strategy, the theoretical foundation, and the literature review relating to critical concepts, stating the definition of bipolar disorder, misdiagnoses of adolescents, and adolescents and mental health. The literature gap is a lack of information regarding the experience of post-doctoral and licensed psychologists' process in diagnosing bipolar disorder in adolescents.

The resounding research throughout the literature was overlapping symptomology that complicates the diagnosis, a lack of training, and pressure to diagnose in order to bill. Exploring the voice of the post-doctoral and licensed professional may help find a solution to avoid over-diagnosing adolescents with bipolar disorder. What is known through the literature is the division between professionals, whether bipolar disorder exists in children and adolescents, and how to approach the diagnosis when adolescents do not meet the DSM-5 full criteria for bipolar disorder. Chapter 3 provides an introduction, research design and rationale, the researcher's role, methodology, trustworthiness issues, and a summary.

Chapter 3: Research Method

The purpose of this IPA qualitative study was to gain a deeper understanding of the lived experience of postdoctoral and licensed psychologists in diagnosing bipolar disorder in adolescents. IPA provided the vehicle through which licensed psychologists could voice their experiences in diagnosing bipolar disorder in adolescents (Alase, 2017; Pietkiewicz & Smith, 2014). In Chapter 3, I address the following topics related to the methodology I used for my investigation: research design and rationale, role of the researcher, methodology, data analysis plan, and ethical procedures. In discussing the methodology, I described participants' selection, instrumentation, procedures for the pilot study, and the procedures for recruitment, participation, and data collection for the final research. The chapter concludes with a summary of key points and a transition to Chapter 4.

Research Design and Rationale

The research question for this study was How do psychologists make sense of diagnosing bipolar disorder in adolescents? And do they rely on their education and lived experience in the diagnostic process? I used the research question to address the experiences of licensed psychologists relating to diagnosing bipolar disorder in adolescents. Adolescents and children are often misdiagnosed due to overlapping symptomology and hormonal changes (Barke & Edmund, 2017). The concepts of bipolar disorder in adolescents and the misdiagnosis of this population are addressed in the literature review. I engaged with previous studies focused on how postdoctoral and licensed psychologists process their decisions and the impact of misdiagnosing

adolescents with bipolar disorder. Previous research illustrates the consequences of misdiagnosing adolescents with bipolar disorder. Adolescents may feel like a failure when the course of treatment does not work and begin to feel shame and guilt (Merten et al., 2017). They may be confused. Also, when adolescents are misdiagnosed and placed on various types of medication, they may be at risk of recurrence of episodes, increased mood, psychomotor agitation, mixed state, induced manic symptoms, and increased risk of suicidal behaviors (Merten et al., 2017).

Postdoctoral and licensed psychologists with lived experiences of diagnosing adolescents with bipolar disorder may have valuable insights to offer about their decision-making process. I chose IPA for this study because of its focus on capturing participants' overall perceptions (Frechette et al., 2020). IPA allowed me to explore participants' lived experiences, which are defined as personal knowledge about the world gained through direct, firsthand involvement in everyday events rather than through representations constructed by other people (Alase, 2017). Postdoctoral and licensed psychologists with lived experiences of diagnosing bipolar disorder in adolescents may have awareness of what works, what does not work, and what resources (formal and informal) are available or needed when making diagnoses. A postdoctoral and licensed psychologist is better equipped to offer services that are focused, efficient, integrated, culturally appropriate, and sustainable (King & Kitchener, 2004). Interpretative researchers rely on the collection of qualitative data to examine the human experiences and social contexts (Alase, 2017; Pietkiewicz & Smith, 2014).

Data were gathered for this study by conducting semi-structured interviews. I did not use social media such as LinkedIn, but I did use the Walden participant pool to reach out to professionals and organizations to solicit participants. Data collected from the interviews were analyzed to answer the research questions. A phenomenological design has allowed me to obtain participants' personal descriptions of the lived experiences of licensed psychologists, as postdoctoral psychologists did not respond to the research study. Interpretive research relies on qualitative data, which allows for the human experience and social contexts (Alase, 2017; Pietkiewicz & Smith, 2014).

Role of the Researcher

My role as a researcher in this phenomenological research was to be an observer-participant, build rapport with participants, and collect data during interviews. I collected, created, and conducted the interviews. The focus was on (a) the lived experience of licensed psychologists in diagnosing adolescents with bipolar disorder and (b) how they use lived experience and education to conclude a diagnosis. My role as a researcher was to observe the participant, record the conversation, and pose open-ended questions to the participant. As a researcher, I not only focused on the context but also explored the more profound meaning for participants. I sought to maximize opportunities for participating licensed psychologists to tell their stories by allowing them to lead the interview. The role of a researcher also involves trying to understand what it is like for the participant to experience what they are sharing (Alase, 2017). It is necessary for the researcher to suspend judgment about the natural world and focus on the experience of analysis (Tuffour, 2017).

I do not have any professional relationship with any potential participant; this includes not having a supervisory or instructor relationship involving power over a participant. The participants were screened and evaluated for experience and knowledge of diagnosing bipolar disorder. A possible bias would be working with adolescents in group home settings and as a child protection service worker for several decades. Being mindful of what significance I can draw from the participant, paying attention to what my body is sensing, and building rapport with the participant were essential for me in this phenomenological research. I used a reflective journal to record my humanity as an internal dialogue to help minimize personal biases.

Methodology

This section includes details about the criteria for selecting the targeted population, the selection process, the number of participants, and the relationship between sample size and saturation. I will also discuss participant selection criteria as well as the sample size.

Participant Selection Logic

The eligibility criteria were for postdoctoral and licensed psychologists in the United States. I used semi-structured interviews to allow participants to share what was significant for them and not what I deem significant. Semi-structured interviews were used to allow the participant to take the lead in the interview. The participant and I engaged in a conversation (DeJonckheere & Vaughn, 2019). In my research role, I focused on listening to allow the participant to express their views.

I determined the number of participants based on IPA standards. Four to 10 participants are advised for professional doctorates (Alase, 2017). Smith stated that IPA researchers rely on a small sample size of between two and 10 participants, as the research focuses on the depth of participant response. My target sample size was four. This was enough to achieve data saturation, which is when further data collection would be redundant (Smith, 2012).

To recruit participants, I did not place an ad on LinkedIn or other social media, nor did I place an ad with the Fresno BEE. I did advertise at local colleges, universities, and agencies that focus on diagnostic procedures with adolescents. The ad specifically outlined the research purpose and included my contact information. When participants were identified, a location, time, and place were set for their interview. I anticipated that the interviews would take 45-60 minutes each. I audiotaped them, as well as wrote down my observations.

I created a flyer (see Appendix A) to invite post-doctoral and licensed psychologists to participate in the study and provided the criteria for participation. A private location for the interview was selected. Three of the four interviews were phone interviews, and one interview was in person. Selected locations of possible interview areas were a local church, a public library, a private room, or a school location with a private room or a psychologist's office. Interviews could also have been conducted via the Zoom videoconferencing application or a telephone call.

The location had good lighting, a table, chairs, and electrical outlets. Confidentiality included restrictions on access and disclosure, and protection of personal

privacy. I used a pseudonym for each participant. All personal identifiers have been removed from the study documents, and all data are kept confidential in a locked file box and a locked computer. Permission and consent were obtained before audio recording participants using the consent form. The consent form was sent to the participants by email, and when signed, the consent form was returned via email to the researcher. There were no incentives offered as the interview was voluntary. Participants were informed of the questions' nature and advised that if they desired to stop the interview, they could do so at any time.

Instrumentation

Using a qualitative method allowed the researcher to collect several forms of data, including observation and interviews with open-ended questions to allow the licensed psychologist to express their emotions and feelings regarding the research subject, documents, audiotape, and participant observation. I used an audio tape to capture the breadth and length of licensed psychologists' lived experiences. According to the literature on data collection, IPA face-to-face interviews are needed for direct data collection (Alase, 2017). Conducting a face-to-face interview created an atmosphere of comfort to allow the participant to share their thoughts, feelings, and experiences by creating an open-ended dialogue to allow for their personal experience. For the participants who were interviewed by phone, the rapport time took a little longer.

According to DeJonckheere and Vaughn (2019), semi-structured interviews allow the researcher and participant to interact relationally, allowing for active engagement, active listening, and curiosity, allowing the researcher to obtain quality data. Semi-

structured interviewing assisted the researcher in understanding the world of lived experiences of licensed psychologists diagnosing adolescents with bipolar disorder. Semi-structured interviewing allowed for the collection, analysis, and interpretation of the qualitative data, which involved the processing of interactive construction as my main instrument in data collection (DeJonckheere et al., 2019).

I designed the interview questions for the participants, licensed psychologists experienced in diagnosing adolescents, by researching the literature stating overlapping symptomology presenting in adolescents diagnosed with bipolar disorder, borderline personality disorder, Attention-deficit/hyperactivity disorder (ADHD), Post-traumatic stress disorder (PTSD), and generalized anxiety disorder (GAD). The list continues, along with frustrations from professional providers, to push to produce a diagnosis for billing, which in turn creates the wrong medication and the wrong treatment for the wrong diagnosis. I formulated the interview questions by researching literature discussing the misdiagnosis of bipolar disorder in children and adolescents (Malhi et al., 2023).

Before interviewing participants, each participant was invited to participate, and the criteria for participation in the study (Appendix A), a consent form, social media (Appendix B), interview questions (Appendix C), and demographics (Appendix D) were collected. I used an audiotape recorder to solicit and document verbal and nonverbal actions in field notes. I utilized note-taking, observation of the participant, and audio recording to keep the pure translation of the lived experience of licensed psychologists, and journaled some of my own experiences from the interview. Upon further reading the research, the study focused on those whose experiences were positive rather than

negative, which needed to provide more research on the negative impact of the diagnoses (Pallesen et al., 2020).

Researcher-Developed Instrument

I collected the data to answer the research questions, and the raw data was collected from the interview source through face-to-face and phone interviews with the participants. A tape recorder from my phone was used, and participants' observations were noted to gather accurate details of the lived experience of licensed psychologists. Manage the process of collecting original data to discover the lived experience of licensed psychologists. The collected data was used to further analyze using the qualitative method to ensure the integrity of the research questions. By reducing the likelihood of errors by ensuring the research questions are unbiased and maintaining their integrity.

The objective behind data collection is to capture the participants' rich, in-depth lived experiences, allowing the analysis to formulate convincing and credible responses. Data collection was in the form of semi-structured interviews. The first data set was a brief phone interview of the volunteers screened to collect demographics (Appendix D). After I utilized the invitation to participate in the study (Appendix A). I followed the criteria to participate. The researcher sent the informed consent via email to be signed and sent back to the researcher's email or handed to the researcher in person. The researcher and participant arranged a date and time to conduct the interview. At the time of the interview, the researcher obtained consent to record, to collect demographics (Appendix D), and to collect data from the interviews through a semi-structured

interview using (Appendix C) interview questions with four separate individual participants who were screened before the interview and signed informed consent to participate and be recorded.

Creating a comfortable environment for the participant can help the participant become comfortable. The demographics were used to screen the participants face-to-face or by phone. The demographic and interview questions were utilized to identify patterns and provide a contextual analysis of the qualitative findings. If the participant decides to drop out, the most critical questions will be asked first. Demographics and interview questions helped me to identify and understand the participants better.

The basis for the researcher-developed instrument is to ensure all steps are taken under the IPA guidelines to obtain the lived experience of licensed Psychologists who have experience with diagnosing bipolar disorder in adolescents, as well as gathering information using their education and lived experiences to come to the conclusion of a diagnosis. I conducted a thorough review of the literature, which provided me with instructions on how to conduct IPA research and the steps to develop the instrument. I examined how the research questions can define and limit what I can find. Reviewing the literature regarding the misdiagnosis of adolescents and adolescent mental health prompted the questions in an idiographic manner to explore the lived experiences of licensed psychologists (Pietkiewicz et al., 2012). Data collection instruments included, but are not limited to, interviewing the selected participants, note-taking, and audio recording. Semi-structured interviews were used to collect data to make the participants

feel free to engage and create rapport. I used open-ended questions to make the participant comfortable with a particular answer.

Procedure for Piloting the Interview Questions

A postdoctoral friend volunteered to participate in piloting the interview questions. The procedure I used for piloting the interview questions. I used my phone to record the interview, which was preferred over attempting to take notes. I could not keep up with capturing the lived experiences and collecting accurate data, as writing notes took away from observing. The research questions and demographics were collected by recording the participant with their consent. My attempt to utilize writing to document the participants' statements was a failed attempt. The questions and demographics presented were appropriate.

The demographics represent the background and knowledge of the participants, while the responses provide a fresh perspective on the lived experiences of diagnosing adolescents with bipolar disorder. The demographics and interview questions will be utilized to identify themes with participants to identify if there are similarities between licensed psychologists and postdoctoral psychologists.

Procedures: Recruitment, Participation, and Data Collection

I collected data from interviews with each participant meeting the criteria for the study in a designated location before the interview. Interviews are estimated to take approximately 45- 60 minutes using two instruments: the demographics and interview questions. All individual interviews with the participants were audio recorded with the researcher's phone, and observational notes were recorded in written form. According to

IPA, it is necessary to have audio recordings of the interview to produce verbatim transcriptions (Pietkiewicz, 2012). There was no follow-up with participants, as I recorded all individual sessions and reviewed the audio recordings and observation notes to rely on to transcribe the data. When the interview came to a close, I asked the participant if there was any additional information they would like to provide me to help me understand their process of diagnosing.

After the interview, a debriefing process included asking open-ended questions about the participants' experiences. I asked the participants how they experienced the interview and if they had any questions, and I expressed my deepest gratitude to the participants for their participation. Post-doctoral psychologists were not represented in this study, as there were no post-doctoral psychologists who volunteered.

Data Analysis Plan

The goal of this study is to understand the experiences of postdoctoral and licensed psychologists diagnosing bipolar disorder in adolescents. I will be using NVivo, which is a qualitative software program. NVivo will allow me to import and analyze text and tape recordings of the interview.

NVIVO is a computer software that organizes data. This software product will evaluate and analyze with comprehensive automatic coding into organized qualitative data. The recorded data from the interviews will be downloaded into the software for transcribing, and I will type up the transcribed data.

The data collected from the interview questions (Appendix C)connect directly to the research question. The interview questions (Appendix C) address the participants'

experiences with their pre- and post-doc diagnostic training, barriers with diagnosing adolescents, overlapping diagnoses, considerations when diagnosing, and describing their experiences diagnosing. The information will aid in extracting the lived experiences of postdoctoral and licensed psychologists in diagnosing adolescents with bipolar disorder. The first interview question asks the participants if they have any values connected to using the DSM-5 and provides an example of what a value means. The preceding interview question is based on the lived experiences of postdoctoral and licensed psychologists and their experiences with diagnosing adolescents with bipolar disorder. As the interview continues, the questions turn to more in-depth questions on knowing when they have enough information to determine a diagnosis and how to handle uncertainty. The interview questions ask if they will share their experiences of uncertainty and how to handle it. After the licensed psychologist has explained the uncertainty, the question flows into training, and if they feel they have had adequate training and feel prepared, they will then finally ask if there are other experiences the postdoctoral and licensed psychologist would like to share that they have not had an opportunity to share. The demographics form (Appendix D) will collect basic demographic information to determine if the length of licensure determines a plan of action for a correct diagnosis. Once the study is complete, the researcher will contact the participant via email to share the key findings, and the participant will have the option to choose whether they would like to receive this information. As mentioned earlier, the RJM will be used to examine how postdoctoral and licensed psychologists diagnose adolescents with bipolar disorder.

RJM will demonstrate how psychologists utilize their education and personal and work-related knowledge as points of reflection when diagnosing adolescents.

I will follow the steps in the IPA literature (Alase, 2017) for the data analysis. IPA is a qualitative approach that aims to provide detailed examinations of personal lived experiences (Alase, 2017). Step one is to interview participants using open-ended questions and encourage them to share their experiences. After the interview, I will listen to the audio recording and compare it to my notes to look for patterns and themes. I will read and re-read through the transcripts and address any biases or preconceptions that may arise. They look for emergent themes and create superordinate ones (Alase, 2017). I will then begin to transcribe the participants' experiences. I will be using thematic analysis for coding (Alase, 2017).

The first step is to familiarize myself with the data to code highlighted text sections(Caulfield, 2023). After familiarizing myself and highlighting the text, I will look for themes and review those themes to write up the data analysis (Caulfield, 2023). Handling discrepant cases in this research will be discussed and reported in written form within the body of this research. The data that will be collected will be analyzed in order to gain a deeper understanding of the lived experiences of post-doctoral and licensed psychologists diagnosing bipolar disorder in adolescents. Data gathered can be used to compare and contrast the data as I analyze it with those from those who are licensed and those who are not licensed to identify differences in diagnosing, values of the DSM, and using their clinical skills, judgment, and experiences from education and life experiences.

Issues of Trustworthiness

As a qualitative researcher, I demonstrated the findings by gathering and evaluating information, ideas, and assumptions from multiple perspectives to produce well-reasoned analysis and understanding, leading to new ideas, applications, and questions. Several issues with trustworthiness needed to be addressed to show credibility for the research conducted. Thematic analysis was used to assess trustworthiness. Thematic analysis identified patterns of thoughts, feelings, and opinions from licensed psychologists.

Credibility

Credibility is a measure of the truth value of qualitative research to determine whether the research findings are correct and accurate (Connelly, 2016). All participants were evaluated for the criteria to participate. All participants were licensed psychologists, and the responses from the participants were audio-recorded for accuracy.

Confirmability

Another criterion for trustworthiness is confirmability, which is neutral to the research findings and shaped by the participants, not the researcher's motivation, interest, or research bias (Connelly, 2016). According to IPA, it is necessary to have audio recordings of the interview to produce verbatim transcriptions (Pietkiewiez, 2012). Audio recordings and documentation of the interview provided confirmability.

Transferability

Transferability showed how the findings applied to other contexts (Connelly, 2016). Interviews with licensed psychologists provided great insight into the field of

psychology, with an understanding of the process of diagnostic procedures and lived experiences that may guide others in the field.

Dependability

Dependability has shown that the findings are consistent and repeatable (Connelly, 2016). I compared my notes and audio recordings from the interview to conclude a deeper understanding of the lived experiences of the licensed psychologist.

Ethical Procedures

As a researcher, I demonstrated how I remained ethical throughout this study by listing the steps that I took to address ethical dilemmas that arose. I sought out advice from the IRB and my chair when ethical decisions needed to be addressed. There is inherent risk when conducting research, and uncertainty about the degree of risks and benefits associated with clinical research. Risks may be long-term, transient, trivial, severe, psychological, or physical (Jenn, 2006). However, this research had a minimal risk by asking questions to licensed psychologists concerning their knowledge and their experiences with diagnosing adolescents with bipolar disorder, and respecting the participants' rights to their privacy and their right to withdraw from the research without penalty or being made to feel guilty (Jenn, 2006). There were no participants who showed any signs of adverse reactions or unexpected effects from the questions; the participants were provided an option to stop or continue.

An application seeking permission from the Walden University Institutional Review Board (IRB) for approval was made and obtained before posting any ad and collecting data for participants from colleges, Universities, online, and Clinics where

adolescents are seen and diagnosed. I did not use the local newspaper to solicit volunteers. I did not utilize participants with whom I have employed or have any power relationship to avoid risk. Informed consent means that the participant is informed of the purpose, methods, risks, benefits, and alternatives to the research. The participant was provided with both verbal and written information, stating their understanding of the information and how it relates to their clinical situation or interest. The participant made a voluntary decision about participating. All data is kept confidential, anonymous, and secured in a locked area. The data was disposed of by shredding written material, and audio will be erased after three years upon completion of this research.

Approval was obtained through the Walden University IRB committee. I recruited participants by using ads and flyers to recruit participants (Appendix A). Potential participants emailed me about their interest in this study. The screening form was utilized in order to determine eligibility to participate in the research with the participants (Appendix A). The participants who met the criteria were provided with the informed consent and were emailed to the participants to review. The participants who agreed to participate signed the consent form and emailed it to the researcher. I set appointments and clarified any questions participants had before the interview. The interview questions (Appendix C) were used during the interview with the participant. I asked about the demographics (Appendix D) before the interview began. I used the demographics I collected and analyzed the data. No incentives were offered to participate in the study. Ethical considerations concerning participants and the entire research process were maintained throughout the study.

Summary

In Chapter 3, I discussed the research design and rationale, the role of the researcher, the methodology, and issues of trustworthiness through a review of the literature and interviews with postdoctoral and licensed psychologists expressed through their lived experiences with processing their decisions, especially misdiagnosing adolescents with bipolar disorder and its impact. In the research design and rationale, the research question and defining the study's lived experience of postdoctoral and licensed psychologists diagnosing adolescents for bipolar disorder may provide resolutions for misdiagnosing adolescents. An explanation for the research tradition has been provided. The researcher will handle research bias and how the issues will be managed and discussed, as well as professional participation selection and the recruitment process, as they arise. The methodological section will include sampling, recruitment process, and participant selection information.

In Chapter 4, I will provide a description of any conditions that may influence participants at the time of the survey. The demographics of the participants will explain the relevance of the study. Data collection will describe the number of participants, location, frequency, and duration, and report any unusual circumstances. I will provide evidence of how trustworthiness will be obtained.

Chapter 4: Results

The purpose of this IPA study was to examine the lived experiences of licensed and postdoctoral psychologists diagnosing adolescents with bipolar disorder. There were no post-doctoral participants as they did not answer the recruitment flyer. Participants provided data that were analyzed to answer the following research questions: How do licensed psychologists make sense of their process of diagnosing bipolar disorder in adolescents? Do licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents? In this chapter, I describe the study's setting, data collection, demographics, data analysis, evidence of trustworthiness, and results. I conclude the chapter with a summary.

Piloting the Interview Questions

A pilot interview was conducted to refine the interview questions and assess their clarity, relevance, and effectiveness in capturing participants' lived experiences. The primary goal of the piloting process was to evaluate whether the questions were capable of eliciting detailed and meaningful responses that accurately reflected the central phenomenon of the study. During the pilot, it became clear that certain terms were ambiguous or overly technical, which could hinder participants' understanding and engagement. As a result, these terms were rephrased to ensure accessibility and avoid confusion. Additionally, the original sequence of questions was adjusted to create a more logical and natural flow, allowing for a more conversational exchange and reducing the risk of leading or biased responses. These refinements ensured that the final interview protocol was better aligned with the study's objectives, facilitating the collection of rich,

in-depth data that authentically captured the participants' experiences. This process ultimately enhanced the rigor of the main study by improving the clarity, relevance, and conversational tone of the interview questions. Some of the interview questions were used to collect data for this study:

- Interview Questions 1: Could you tell me about your experiences with diagnosing adolescents with bipolar disorder?
- Interview Questions 2: Could you tell me about your experience with the DSM-5?
- Interview question 3: Could you tell me about an experience when you were unsure about a diagnosis and how you handled the situation?
- Interview questions 4: Can you share your experiences with your training to prepare you for diagnoses?
- Interview question 5: What additional information could you provide me to help me understand your process of diagnosing?

The complete list of the nine interview questions can be found in Appendix D. The tenth question addressed additional information provided by the researcher.

Setting

Before data collection, I received approval from the Walden University IRB. Potential participants contacted me via email and then by phone. Three interviews were conducted by phone, and one was conducted in person. I screened each person to determine eligibility. All eligible participants signed the consent form and emailed it back to me. The participants and I set dates, times, and locations for face-to-face, audiotape, or

phone interviews. We worked together to complete the demographic form by asking and answering questions during the interview. I provided information about the researcher's duty, and this study is a volunteer study. Participants were informed they could withdraw at any time. No conditions influenced participants' participation, the data collection process, or the results of this study.

Demographics

Four licensed psychologists, two male and two female, ages ranging from 33 years old to 56 years old participated in the study. Three out of the four participants were licensed psychologists, and one psychologist was licensed as an educational psychologist. Three of the four psychologists used psychometric assessments. One out of the four psychologists had children. Three out of four psychologists are full-time, and one is part-time. One psychologist was from Wisconsin, and three were from California. Of the three psychologists from California, one licensed psychologist was raised in Wisconsin, moved to California for education, and stayed in California. The licensed psychologists I interviewed became licensed between 2007 and 2022. One of the four psychologists was a registered associate for 7 years before getting licensed. One of the four licensed psychologists stated they have worked with adolescents between 2 and 10 years old.

One licensed psychologist stated they had not diagnosed any adolescents with bipolar disorder, one stated approximately 400, another said there were too many to have kept count, and the last licensed psychologist stated maybe two to three adolescents having bipolar disorder when asking the four psychologists if there was a family member or self that are diagnosed with bipolar disorder two out of two denied and the other two

agreed on mental health issues. Three of the four licensed psychologists were White, one was Hispanic/White, and all four participants spoke English and reported no second language. One licensed psychologist has never been married, two are divorced, and one is married. Two of the licensed psychologists had children, and the other two did not. Of the four psychologists I interviewed, one was from Minnesota, and the other four were from California. Three of the four licensed psychologists identified as having a faith background, with one not identifying. Table 1 provides a summary of participant demographics.

Table 1

Participant Demographics

Participants' ID	Gender	Age	Years licensed
P1	Male	33	2.5
P2	Female	41	13
P3	Male	41	7
P4	Female	56	18

Data Collection

The recruiter flyer (Appendix A) promoting this study was hand-delivered to agencies providing mental health services to adolescents and sent via email to universities and colleges. The recruiter flyer (Appendix A) was also posted via email to the National Register of Health Service Psychology. The licensed psychologist who was interested contacted me via email. The potential participant and I set a date and time to speak for the screening. Once eligibility was determined, the participants and I selected a date and time. All participants signed the consent form and sent it back to me via email.

The first interview was conducted in the private office of a licensed psychologist. The office provided privacy, a table, a chair, and appropriate lighting. The other three interviews were conducted over the phone. I was in a private area and gained permission to audio record the conversation and interview. Participants were provided information about the consent form and reminded that the interview was voluntary and that they had the option of stopping at any time during the interview. The participants were made aware that the data collected would be confidential and kept secure. Participants were made aware that once the study is complete, I will contact them via email to share the key findings, and they will have the option to choose whether they would like to receive this information. A total of four participants were selected for the interview.

Interviews were conducted from November to January. Each participant completed the demographic questionnaire (Appendix D) and interview questions (Appendix C) during the interview. There was no follow-up interview or follow-up questions. Interviews were recorded, and the average length was from 23 minutes to 35 minutes. I did not notice any participants in distress or emotional turmoil. Each participant was thanked for their participation, and if they needed further discussion, they could contact me via email or phone. After the interviews had been completed, the statements from the participants were assigned a label, transcribed verbatim, and saved on a locked computer. I created field notes after each interview, noting key statements that stood out and behaviors at the time, and compared them to the recorded interview during data analysis. There was no variation from what was stated in Chapter 3. The participants were given enough time to reflect on their experiences through data

collection. I provided each participant time to express their experiences. Interview questions were open-ended. The research queried the licensed psychologist when clarification was needed for a deeper understanding. I recorded all interviews to capture the lived experiences of licensed psychologists.

Data Analysis

I transcribed the interviews and typed them verbatim into a Word document, then reviewed the notes I had taken alongside audiotaping the interview. I printed four copies to compare and sort the data for themes and similarities. Interpretive research relies on qualitative data, which allows for the human experience and social contexts (Alase, 2017; Pietkiewicz, 2014).

In Chapter 3, I stated I would be using NVivo, which is a qualitative software program. NVivo is utilized through importing and analyzing text and tape recordings of the interview. However, during the actual process of analyzing, I found that for the scope and depth of this study, manual coding would provide a more interpretative richness and flexibility to the psychologist's voice, with a more nuanced narrative of their experiences. Because the manual coding involved analyzing textual data by systematically identifying patterns, categories, or themes without using specialized software, the process required careful attention to detail. Manual coding allowed for a high degree of researcher reflexivity, enabling a nuanced interpretation of meaning and context (Smith, 2016). While more time-intensive than computer-assisted coding, manual methods provide flexibility and encourage a closer connection to the data. This method is particularly

appropriate for small to medium datasets where an in-depth understanding of participant narratives is essential.

Analyzing the data and then writing it to reflect the meaning of their experiences was a key part of the process. IPA is used to examine how the participants make sense of their experiences, providing a rich, detailed account of their experiences and highlighting commonalities and individual variations. IPA is a qualitative research approach designed to explore how individuals make sense of their lived experiences in depth. Rooted in phenomenology, hermeneutics, and idiography, IPA focuses on participants' subjective experiences and meaning-making processes. The researcher writes a compelling narrative that integrates the identified themes with supporting excerpts from the transcripts.

In line with Smith (2016), the analysis followed an inductive thematic approach, beginning with manual (hand) coding to identify recurring patterns across participants' narratives. This process allowed for themes to emerge directly from the data, rather than being imposed a priori. Throughout the coding, memos and reflective notes were regularly documented to track analytic decisions and emergent patterns, ensuring both transparency and rigor throughout the process. By following Smith's (2016) recommendations, I was able to maintain an open and systematic approach, ensuring that the analysis remained grounded in the participants' experiences while upholding the methodological integrity of the research.

A procedure described by Braun and Clarke (2006) involved organizing initial codes into conceptual categories that represented larger patterns of meaning across the data. These categories were then synthesized into overarching themes that captured the

essence of participants' experiences with adolescent bipolar disorder diagnosis. This process was informed by Smith's (2006) guidelines on IPA, ensuring that the resulting themes reflected the complexity of adolescent clinical presentations and the nuanced nature of the diagnostic process. This inductive approach, grounded in IPA, facilitated a deeper understanding of how clinicians navigate the diagnostic challenges of bipolar disorder in adolescents. Table 2 illustrates the progression from codes to categories and final themes.

Table 2

Stages of Thematic Analysis

Step	Description
Code generation	Identifying meaningful data segments labeling them with descriptive codes
Category Formation	Grouping related codes into higher order conceptional categories
Theme Development	Synthesizing categories into overarching themes that reflect core Meanings

The write-up highlights the participants' voices, conveying the lived experiences of training to prepare them for becoming psychologists and their struggles with diagnosing bipolar disorder in adolescents. The process began with reading the transcript several times to identify participant similarities. I highlighted and labeled statements with duplicate content and presented their significance. The initial descriptive statements are grounded in the participants' words or meanings. Through constant comparison, similar

statements and redefined statements, the researcher identified data, which was reviewed and merged with new data.

Each theme was supported by multiple participant quotations, offering a rich and credible depiction of their experiences. These examples demonstrate the analytic progression and illustrate the depth and nuance of participant narratives. Thematic analysis identifies four core themes that reflect participants' experiences with the diagnostic process.

Theme 1: Diagnostic Complexity and Risk of Misdiagnosis

Adolescent developmental variability and symptom overlap increase misdiagnosis risk. The complexities involved in diagnosing adolescents are captured, as their emotional and behavioral presentations often lead to diagnostic challenges. The theme also addresses how these complexities increase the likelihood of premature or incorrect diagnoses. This theme collapses multiple related elements, such as emotional immaturity and developmental changes, into a single overarching theme of the complexity of adolescent presentation, which contributes to high diagnostic risk.

This reflects the challenges that psychologists face when diagnosing adolescents due to developmental, emotional, behavioral, and contextual factors. These complexities often result in diagnostic ambiguity, especially when symptoms overlap with multiple disorders (e.g., ADHD, bipolar disorder, trauma-related symptoms, or personality disorders). Participants consistently described uncertainty, reliance on indirect evidence, and the risk of premature labeling. Diagnostic ambiguity due to developmental realities looks like difficulty pinpointing symptom timelines, and real-world complexity does not

fit the DSM's neat criteria. As one participant stated, conjecture is sometimes necessary: "It's very, very hard to get an exact timeline or exact length of different episodes, all very fuzzy in real life. You have to do a little bit of conjecture… see what makes the most sense"(P1).

Symptom overlap and misinterpretation are seen with overlap between bipolar, ADHD, and borderline personality disorder. Another issue is the difficulty with timelines and symptom tracking, which contributes to uncertainty. P2 stated, "A lot of times people will be like, I don't know if that lasted a couple hours or like a month. Very often they don't mean manic; they just mean energetic, or excited."

Diagnostic delay, caution, and systemic pressure from insurance companies pressure clinicians for fast diagnoses. Adolescents will often come in with their own self-diagnosis that they have looked up on social media. The participant then stated that one needs to have a willingness to defer diagnosis until sufficient clarity is achieved:

> Insurance companies want them treated in six weeks... but I'm not gonna give a diagnosis I'm not comfortable with. People are going to present what they want you to see right away… it takes time to get a clear picture. (P4)

The developmental variability and symptom overlap with trauma, ADHD, and environmental factors demand careful rule-outs and patience before assigning a definitive diagnosis. Pattern recognition over time is what P1described when explaining a case involving a teenage female who presented with significant oppositional behavior and comorbid conditions. A final diagnosis of bipolar disorder was made only after thorough review and pattern assessment: "With a careful review of the history and looking for

episodes of what I deemed to be manic episodes... There was a good fit in diagnosing bipolar disorder at the end of the day. But... quite a bit of other conditions considered as well" (P1).

This reinforces the idea that adolescents' developmental stage and contextual complexity make them particularly vulnerable to diagnostic error or premature labeling**.** These insights form the basis of which emphasize the high-risk nature of adolescent diagnosis due to developmental ambiguity and real-world complexities.

Theme 2: Importance of Longitudinal Assessment

Gathering extended data over time is essential to identifying consistent mood patterns. Multiple codes, such as collateral data and lack of symptom patterns, highlight the need for longitudinal observation to assess mood patterns accurately over time. These elements were collapsed into the need for longitudinal observation, which is a central aspect that highlights observation is critical for accurate diagnosis. Psychologists repeatedly emphasized the need for long-term observation, multi-source data**,** and diagnostic caution when assessing adolescents for bipolar disorder. P1 stated, "When working with children, I often have to observe them over an extended period to really understand the fluctuations in their behavior. It's not just about one moment or episode but rather looking at the whole picture over time." This comment points to the necessity of observing adolescent behavior across different contexts and situations to understand its true nature.

Building on this, another participant shared their experience of seeing behavior evolve: "One thing I've learned is that behaviors can change, and sometimes it takes

several months to really get a clear understanding of what's going on. I need to see how the symptoms evolve"(P2). This underscores the idea that adolescent behaviors, especially those linked to mood disorders, may not be consistent enough for a diagnosis to be made quickly. Psychologists, therefore, must be patient and vigilant, tracking changes over time before jumping to conclusions.

Another participant emphasized how initial impressions can sometimes be misleading: "With adolescents, you can't really make a definitive diagnosis unless you're observing them over time. Sometimes, what may look like mood swings or impulsivity in the moment might turn out to be a longer-term pattern that reflects something like bipolar disorder"(P2). This statement highlights how adolescent mood swings, a common concern in diagnosing bipolar disorder, can sometimes reflect more transient issues rather than a chronic condition. Only through extended observation can psychologists begin to differentiate between these transient behaviors and more persistent symptoms of bipolar disorder.

"Having longitudinal data, especially from teachers and parents, really helps clarify what's happening. I can see how the behaviors evolve over time, and it makes me more confident in my diagnosis" (P3). This participant's comment emphasizes the importance of collaborating with other adults in the adolescent's life**,** such as parents and teachers, to gain a fuller understanding of the child's behavior across different environments. Long-term observation from multiple sources ensures that the psychologist is seeing a complete and accurate picture of the adolescent's mental health.

"I've found that when I have the chance to see a child over time, I can better distinguish between behaviors like mania, which may last weeks, and the impulsivity seen in other disorders" (P3). Here, the psychologist points out that behaviors like mania(often linked to bipolar disorder) can be more easily distinguished from other disorders if there is a chance to observe their duration and context**.** This again reinforces the need for a long-term, comprehensive approach to diagnosis.

"I always recommend a longitudinal approach to assessment, especially with adolescents. You can see if the symptoms are part of a cycle or if they're more episodic, which is critical for diagnosing bipolar disorder" (P3). This further emphasizes the importance of distinguishing episodic mood changes from cyclical patterns, a key feature in diagnosing bipolar disorder. Without a long-term view, psychologists risk missing critical patterns that are only clear after several months of observation.

> "In my experience, a lot of what looks like mood instability can often be attributed to changes in environment or life stressors. It takes time to see whether these are temporary or part of a longer-term issue like bipolar disorder" (P4).

This participant cautioned that life stressors and environmental changes can sometimes mimic mood instability, a hallmark of bipolar disorder, but it takes time to distinguish between the two. Careful, ongoing evaluation helps clarify whether mood changes are situational or part of a chronic disorder.

"I've had cases where initial reports pointed to something like ADHD, but after several months of seeing the child and checking in with teachers and parents, it became clear that there were cyclical mood changes that suggested bipolar" (P4). This statement

highlights the importance of ruling out other potential diagnoses, like ADHD, and understanding how symptoms evolve over time. It's only after observing the child over several months that the full scope of their symptoms becomes clear, which could suggest a different diagnosis than originally considered.

All four participants agree that longitudinal assessments are crucial for accurately diagnosing disorders, particularly bipolar disorder, in adolescents. They each highlight the role of extended observation and the value of gathering data from various sources over time.

Theme 3: Environmental influences

Family and school contexts significantly affect symptom presentation and diagnostic interpretation. The role of environment and multi-source observation is explained as having access to the child across settings provides valuable insight, as well as collaboration with other psychologists enhances clarity. "Family dynamics and environmental stressors can sometimes exacerbate behaviors. For example, if a child's parents are going through a divorce or if there are other stressors at home, you might see behavioral changes that mimic symptoms of bipolar disorder" (P1).

"I've seen kids who are in very unstable family situations show patterns of mood swings that might not actually be bipolar disorder, but more of a response to the instability around them" (P1). This highlights the important role that external factors, such as family dynamics, can play in influencing adolescent behavior.

"I've often found that when adolescents are dealing with significant family conflict, trauma, or changes in their environment, it can cause emotional dysregulation

that looks a lot like the mood swings in bipolar disorder" (P2). Similarly, another participant emphasizes how specific stressful life events, like trauma or family conflict, can lead to emotional dysregulation that may initially mimic the symptoms of bipolar disorder.

"One thing that is often tricky is distinguishing between whether the emotional regulation issues are caused by something situational, like a recent traumatic event, or if it's part of a deeper underlying mental health condition like bipolar disorder"(P2). This complexity makes the diagnostic process more difficult, as it becomes essential to differentiate between temporary emotional responses and more chronic mental health conditions.

> "Environmental factors are definitely a piece of the puzzle when diagnosing kids. You have to think about what else is going on in their lives. A child with a highly chaotic home life may appear to be manic or agitated when, in fact, it's more about their environment causing them stress"(P3).

This further underscores the point that environmental influences, particularly chaotic or unstable home situations, can contribute to behaviors that may initially resemble the symptoms of bipolar disorder but are, in fact, rooted in situational stressors.

"You're able to directly see that kind of symptom come and go. That would narrow things down. Is there medication? Is there substance use? Whatever it may be, that could be a better explanation than bipolar"(P3). This emphasizes the importance of considering external factors, like medication or substance use, when evaluating adolescents with mood-related symptoms

> "I've had cases where the child's symptoms only really show up during certain life events, like the death of a parent or a family move, which suggests that their behavior is more about their response to the environment rather than a mental disorder"(P3).

Building on this, another participant discusses how life events, such as the loss of a loved one or major changes in a child's environment, can trigger emotional responses that appear similar to symptoms of bipolar disorder but are more likely rooted in situational stress.

> "I always look at the context of a child's environment when I'm diagnosing. If they're living in a stressful home situation, it can affect their behavior in ways that mimic mood disorders. For example, a child in an abusive or neglectful environment may display behaviors that look like bipolar mood swings"(P4).

This further reinforces the point that environmental stressors, particularly those involving abuse or neglect, can significantly affect a child's behavior and potentially lead to misdiagnosis if not carefully considered.

"It's hard to separate environmental stressors from clinical issues. If a child is facing a lot of turmoil at home or school, it can really trigger mood changes that might look like mania or depression" (P4). Similarly, the final participant highlights the challenge of distinguishing between environmental stress and clinical mood disorders, suggesting that external factors can often trigger mood changes that resemble symptoms of bipolar disorder.

All four participants agree that environmental influences, including family dynamics, trauma, life stressors, and unstable home situations, can cause mood swings or emotional dysregulation that mimic bipolar disorder. The participants emphasize the importance of considering these environmental factors during the diagnosis process to avoid misdiagnosis and to ensure an accurate understanding of the adolescent's mental health.

Theme 4: Ethical Responsibility and Systemic Pressures

Concerns about premature diagnosis, stigma, and insurance-driven pressures highlight the need for careful, ethical labeling. Diagnostic deliberation and watchful waiting were stated for all the participants when diagnosing. "When you're diagnosing, there's always this pressure to get it right because the consequences are huge. I mean, misdiagnosing a child can lead to improper treatment, and that can have lasting effects" (P1). This comment underscores the high stakes involved in diagnosing adolescents, emphasizing the serious consequences of misdiagnosis, particularly when it comes to treatment.

In response, P2 highlighted the importance of caution and restraint, especially when labeling adolescents:

> "I don't like giving some of those diagnoses until they are over 18… If I see an additional mood pattern on top of [ADHD], I'll do a rule out at that point… I want a provider that sees them eyes-on longer term to be able to differentiate if that's really happening" (P2).

P2's comment reflects a preference for caution, stressing the need for long-term observation to ensure an accurate diagnosis, particularly when mood patterns overlap with other disorders like ADHD. Additionally, P2 shared a case that illustrated the complexity of diagnosis, noting, "Everybody thought they were bipolar, when really it was just PTSD because they didn't know Grandpa was assaulting them" (P2). This further exemplifies the challenge of distinguishing between mood disorders and other conditions like PTSD, underscoring the importance of considering a full range of potential diagnoses. Building on the theme of real-time behavioral fluctuation, P3 described observing behaviors that seemed consistent with mood cycling but hadn't yet led to a formal bipolar diagnosis: "You almost see two different kids… What is causing this excitement, like a manic episode, and what is causing this to last for weeks… then you see sadness, crying, reclusiveness" (P3). This illustrates the challenge of recognizing mood patterns that might resemble bipolar disorder, but with more observation needed to confirm the diagnosis. As P3 continued, they emphasized the value of prolonged observation: "I feel that the behaviors and the reports can't be explained by anything else… The more I'm able to see, the more I feel like I'm in the right direction" (P3). This reinforces the idea that ongoing assessment is essential in reaching an accurate diagnosis, as behaviors evolve over time. Further exploring diagnostic tools, P4 shared insights about the role of collaboration in the diagnostic process, particularly with psychiatrists using pharmacological trials: "Psychiatrist… actually used the medication to distinguish if it was like an ADHD or if it was bipolar, depending on how he responded" (P4). This statement highlights how some providers use medication trials as part of the diagnostic

process, testing how a child responds to treatment as an additional observational tool to differentiate between conditions like ADHD and bipolar disorder.

Across participants, there was consensus on the need for longitudinal, contextualized assessment **i**n adolescent bipolar diagnosis. Whether through extended observation, historical pattern review, cautious differential diagnosis, or medication trials, all psychologists advocated delaying definitive labels until sufficient evidence accumulates. This careful, time-sensitive approach helps reduce misdiagnosis and respects the complexity of adolescent development and psychopathology.

This is an example of the process of specific codes, categories, and overarching themes that emerged from the analysis, as shown in Table 3.

Table 3

Codes, Categories, and Themes

Code	Category	Theme
Cognitive/emotional immaturity	Challenges of Developmental	Theme 1:
immaturity	Context	Diagnostic complexity and risk of misdiagnosis
Developmental Changes	Challenges of Developmental context	
Mood Swings, irritability	Symptoms overlap Diagnostic ambiguity	
Trauma, ADHD, Anxiety	Symptoms overlap	
overlap	Diagnostic ambiguity	
Use of Collateral Data	Need for Longitudinal	Theme 2:
	Assessment	Importance of longitudinal assessment
Lack of symptom patterns	Need for Longitudinal Assessment	
School/Family	Environmental/Relational	Theme 3: Environmental influences
Environment	Influence	
Stigma, Premature	Clinical Responsibility	Theme 4: Ethical responsibility and systemic pressures
Diagnosis	and ethics	

Note. This table presents selected examples of codes, their corresponding categories, and resulting themes identified through thematic analysis. Direct quotations used in the narrative illustrate how participants' lived experiences and perspectives informed the construction of each theme.

Discrepant Case

One discrepant case offered a contrasting lens. Participant 4 described collaborating with a psychiatrist who used medication response as a diagnostic tool, which deviated from the interpretive, observational approaches described by other participants. “You almost see two different kids when medication is introduced. It confirms or challenges your assumptions in real time” (P4). This reflects a more pharmacologically informed model of reasoning, with an emphasis on biological responsiveness. While differing from the dominant themes, this case was retained to enhance theoretical transparency and capture the full range of reasoning frameworks. It may reflect an epistemological stance aligned with earlier RJM stages, where knowledge is seen as more empirical and authority-based, fitting within Theme 4 on ethical responsibility and systemic pressures. This refers to the epistemological stance held by some clinicians when making diagnostic decisions, particularly regarding adolescents.

This case also underscores the systemic pressures that clinicians face, including the influence of pharmacological practices on diagnostic decision-making. While the observational approach is seen as more comprehensive and ethically cautious, the growing influence of pharmaceutical interventions and the drive for quicker diagnoses (driven, in part, by insurance and pharmaceutical pressures) can create conflicts in how best to proceed with adolescent diagnoses. Retaining this discrepant case enhances the study’s transparency, ensuring that all diagnostic reasoning frameworks, whether observational or pharmacologically driven, are captured and discussed.

This chapter presents the analysis of data collected from four licensed psychologists. As outlined in Chapter 3, this study used Interpretative Phenomenological Analysis (IPA) to explore how psychologists make sense of the diagnostic process for adolescents with bipolar disorder. IPA allowed for deep engagement with participants' lived experiences and meaning-making processes (Smith, 2016).

Evidence of Trustworthiness

To establish trustworthiness, qualitative researchers are responsible for demonstrating that findings that were obtained through critical inquiry through the findings I have gathered through evaluating information, ideas, and assumptions from the multiple perspectives of the participants, which has produced well-reasoned analysis and understanding of the licensed psychologist's thoughts, and of their well-reasoned analysis of their lived experiences of diagnosing adolescents with bipolar disorder. The thematic analysis assessed trustworthiness and identified patterns of thoughts, feelings, and opinions from licensed psychologists.

Credibility

Credibility is a measure of the truth value of qualitative research to determine whether the research findings are correct and accurate (Connelly, 2016). All participants were evaluated for the criteria of participating, and were licensed psychologists. There were no post-doctoral psychologists in this research. The responses from all participants were audio-recorded for accuracy. Each participant was screened to ensure they met the criteria and asked the same interview questions.

Transferability

Transferability showed how the findings applied to other contexts (Connelly, 2016). Interviews with licensed psychologists provided great insight into the field of psychology, with an understanding of the process of diagnostic procedures and lived experiences that may guide others in the field. I included a table that listed the demographics of gender, age, and years of experience of each participant. The demographics provide a rich, thick description and a summary of participants' experiences.

Dependability

Dependability has shown that the findings are consistent and repeatable (Connelly, 2016). I compared my notes and audio recordings from the interview to gain a deeper understanding of the lived experiences of the licensed psychologist. All licensed psychologists were interviewed using the same questions, and all interviews were analyzed using the same analysis process.

Confirmability

Another criterion for trustworthiness is confirmability, which is neutral to the research findings and shaped by the participants, not the researcher's motivation, interest, or research bias (Connelly, 2016). According to IPA, it is necessary to have audio recordings of the interview to produce verbatim transcriptions (Pietkiewicz, 2012). Audio recordings and documentation of the interview have provided confirmability.

Results

The research questions for this study were the following: How do post-doctoral and licensed psychologists make sense of their process of diagnosing bipolar disorder in adolescents? Do post-doctoral and licensed psychologists rely on their education and lived experience to diagnose bipolar disorder in adolescents? To assist in answering the research questions, the questions in Appendix D were used in the interview with four licensed psychologists who shared the details of their lived experiences of diagnosing adolescents with bipolar disorder. None of the licensed psychologists asked for the definition of bipolar disorder I, bipolar disorder II, clinician, DSM-5, hypomania, misdiagnosis, mania, psychologist, or postdoctoral.

As one participant explained, “Collateral information really helps… it’s not matching what you’re seeing” (P4). Participants underscored the importance of accurate and responsible labeling due to the stigma associated with a bipolar diagnosis. One psychologist remarked, “You have to give over a sense of confidence in your diagnosis... you cannot just kind of throw out a diagnosis to them, especially one as stigmatizing as bipolar disorder” (P1). Another expressed concern over systemic influences that pressure clinicians to diagnose prematurely, noting, “I do really struggle with providers who are slapping labels on things before we really know what’s happening” (P2). Insurance billing requirements were often cited as a factor that undermines the diagnostic process: “We are pushed to give a label… even before we think we might need it” (P2).

This discrepant case fits within Theme 4 on ethical responsibility and systemic pressures, introducing an approach where medication trials play a central role in

diagnostic validation, which contrasts with the more observation-based, longitudinal assessment methods discussed by other participants. The psychiatrist's reliance on medication response may reflect a more medicalized view of diagnosis, focusing on biological markers over environmental and developmental factors. It also brings to light systemic pressures that may influence diagnostic speed and accuracy, raising important questions about the ethical responsibility of clinicians in balancing quick diagnoses with thorough, ethical assessments.

Theme 1: Diagnostic Complexity and Risk of Misdiagnosis

All four psychologists emphasized that adolescent mental health presentations are often complicated by overlapping symptoms and comorbid conditions, making differential diagnosis, especially of bipolar disorder, particularly challenging (American Psychiatric Association [APA], 2013). As P1 explained, "There were a lot of comorbid conditions... looking for episodes of what I deemed to be manic episodes... quite a bit of other conditions considered as well." P2 shared, "Especially with adolescents, I try to be very careful... unless they're 18, I usually say: 'we need to watch for bipolar'... especially if they have any kind of trauma in their background."

Psychologists noted that normal developmental changes can resemble pathology. P3 observed, "You kind of begin to think like what is causing this excitement... and then you see it go away... and then we're seeing sadness... how you almost see two different kids." Similarly, P4 recalled a case where "a psychiatrist could not figure out what was going on... used medication to distinguish if it was ADHD or bipolar."

This developmental variability complicates diagnostic clarity. As P1 summarized, “Adolescents are still developing cognitively and emotionally, which makes it hard to distinguish between a disorder and developmentally appropriate behavior.” P2 added, “Mood swings and irritability can be mistaken for bipolar when they’re actually due to trauma or developmental issues.”

Theme 2: Importance of Longitudinal Assessment

Psychologists emphasized the need for long-term observation to identify consistent mood patterns critical for diagnosing bipolar disorder. P1 noted, “There were a lot of comorbid conditions… with a careful review of the history… I deemed [them] to be manic episodes.” P2 added, “I usually, unless they’re 18, do: ‘we need to watch for bipolar’... I want a provider that sees them eyes on longer term to be able to differentiate if that’s really happening.”

Participants acknowledged the difficulty of obtaining thorough timelines in fast-paced clinical settings. P3 shared, “You need a clear timeline and episode length, but real-life situations often lack that precision.” Building on this challenge, P4, drawing on years of experience, remarked, “I’ve been working in the field for a long time… at this point… You generally have a good idea of once you know what you’re leaning towards.” All clinicians agreed that accurate diagnosis relies on repeated interactions, structured assessments, and integration of collateral information over time.

Theme 3: Environmental Influences

Psychologists emphasized that external environments, particularly family and school contexts, strongly shape adolescents’ emotional and behavioral presentations. One

participant described “a lot of comorbid conditions… oppositional behavior at home” (P1). Another explained, “Peer relationships and family dynamics lead to fluctuations in mood not indicative of bipolar disorder” (P4).

Reports from caregivers and educators were considered essential for contextualizing symptoms. “What I’m hearing from the teachers or the parents… you kind of begin to think” (P3). Trauma was also highlighted as a complicating factor: “Especially if they have any kind of trauma in their background, that can be really problematic because their emotions go crazy anyway because of that” (P2).

To avoid misdiagnosis, clinicians described using collateral information to assess situational triggers. “In one case… Grandpa would come visit every two months… everybody thought they were bipolar, when really it was just PTSD because they didn’t know Grandpa was assaulting them” (P2).

Theme 4: Ethical Responsibility and Systemic Pressures

Participants expressed strong concern about premature bipolar diagnoses and emphasized the ethical responsibility of clinicians, school personnel, and insurance companies to avoid stigmatizing labels without comprehensive evaluation. “You really want to be sure that you are doing the right thing before diagnosing bipolar” (P1). Another participant cautioned, “Avoid premature labeling,” highlighting how difficult it can be to remove inaccurate diagnoses from a child’s record (P2).

Frustration with insurance company demands for quick diagnoses to authorize treatment was common. One psychologist shared, “Insurance companies don’t pay if there is no diagnosis… sometimes people don’t have one, or you’re not sure. I’ve actually

had to argue with insurance companies… I'm not comfortable giving a diagnosis, I'm not clear on" (P4). Another added, "Maybe it's ADHD, maybe it's depressive, maybe it's substance. That would be a better explanation than bipolar" (P3).

Accurate diagnosis was viewed as critical to protect adolescents' long-term mental health and avoid harm. "When you're diagnosing, there's always this pressure to get it right because the consequences are huge. I mean, misdiagnosing a child can lead to improper treatment, and that can have lasting effects" (P1). Psychologists described strategies such as collateral interviews, structured assessments, differential diagnosis, team consultation, and deferring diagnosis ("rule-out") to uphold ethical standards and ensure responsible labeling. "I feel like getting the diagnosis right is critical because if you label a kid with the wrong diagnosis, the wrong treatments will follow, and that can have long-term consequences" (P3).

Summary

This study explored how licensed psychologists diagnose adolescents with bipolar disorder and the role of their education and experience in that process. Four key themes emerged: diagnostic complexity and risk of misdiagnosis**,** the importance of longitudinal assessment**,** the influence of environmental factors, and ethical responsibility in diagnosis**.** Psychologists described adolescent symptoms as often overlapping with other disorders, such as ADHD, anxiety, and PTSD, which increases the risk of misdiagnosis. They emphasized the need for nuanced clinical reasoning, long-term observation, and consideration of external factors, such as family dynamics, school reports, and peer relationships. Ethical concerns around prematurely labeling adolescents with severe

mental health conditions were also highlighted, with psychologists stressing the importance of a careful, deliberative approach to diagnosis.

Psychologists relied heavily on their graduate training**,** ongoing supervision**,** and professional experience to navigate these complexities. Their approach went beyond the DSM-5 criteria, incorporating developmental context, historical behavior patterns, and input from parents and teachers. Despite the challenges posed by fast-paced clinical settings, participants underscored the necessity of multi-source data and repeated interactions to make an accurate diagnosis. They noted that while formal education provided essential diagnostic tools, clinical experience was crucial for adapting those tools to the complexities of adolescent behavior. Overall, their diagnostic approach was a balance of clinical expertise**,** contextual awareness, and collaborative input**,** ensuring an ethically responsible and well-rounded decision-making process.

These findings offer valuable insights into the diagnostic process for adolescent bipolar disorder, underscoring the importance of a careful, contextualized, and ethical approach**.** In Chapter 5, I will discuss the implications of these findings, limitations of the study, and recommendations for future research and clinical practice.

Chapter 5: Discussion, Conclusions, and Recommendations

This study was conducted to explore the complexities and challenges in accurately diagnosing bipolar disorder in adolescents. The aim was to understand how psychologists navigate overlapping symptoms, developmental factors, and external influences, such as family, school, and systemic pressures from insurance companies, to improve diagnostic accuracy and avoid premature or stigmatizing labeling. The study also sought to highlight the ethical responsibilities of clinicians, school counselors, psychiatrists, and insurers in making careful, evidence-based diagnoses that support adolescents' mental health and well-being over time.

Chapter 4 presents the findings organized around four core themes: (a) diagnostic complexity and risk of misdiagnosis, (b) importance of longitudinal assessment, (c) environmental influences, and (d) ethical responsibility and systemic pressures. These themes reflect the participants' lived experiences, clinical judgment, and the contextual challenges they encounter in practice. This case was factored into the analysis as an example of diagnostic diversity and served to broaden the understanding of potential strategies used in clinical practice. This chapter interprets the findings in relation to the research questions and the existing literature reviewed in Chapter 2. It also presents the study's limitations, offers recommendations for clinical practice and future research, and concludes with reflections on the significance of the findings for the field of adolescent mental health diagnosis.

This study used IPA to explore how licensed psychologists understand and approach diagnosing bipolar disorder in adolescents. The methodology aligned with the

research questions by enabling an in-depth examination of psychologists' lived experiences and meaning-making processes related to diagnosis. All four participants described a collaborative, cautious diagnostic process complicated by overlapping symptoms with PTSD, ADHD, trauma, and normative adolescent development. They emphasized the importance of longitudinal data, collateral information from parents, teachers, and medical records, and structured assessment tools. While DSM-5 criteria provided a framework, clinical judgment and contextual understanding were critical.

Regarding training, psychologists relied heavily on both formal education and practical clinical experience, noting that real-world cases refined their diagnostic skills beyond classroom knowledge. Continued learning and clinical supervision were also valued. Four overarching themes emerged. The first theme is diagnostic complexity and risk of misdiagnosis. Adolescent developmental variability and symptom overlap increase misdiagnosis risk. The complexities involved in diagnosing adolescents are captured, as their emotional and behavioral presentations often lead to diagnostic challenges.

Theme 2 was the importance of longitudinal assessment. Gathering extended data over time is essential to identifying consistent mood patterns. Multiple codes, such as collateral data and lack of symptom patterns, highlight the need for longitudinal observation to assess mood patterns accurately over time.

The third theme was environmental influences. Family and school contexts significantly affect symptom presentation and diagnostic interpretation. The role of environment and multi-source observation is explained as having access to the child

across settings provides valuable insight, as well as collaboration with other psychologists enhances clarity.

Finally, the participants highlighted ethical responsibility and systemic pressures. Concerns about premature diagnosis, stigma, and insurance-driven pressures highlight the need for careful, ethical labeling. Diagnostic deliberation and watchful waiting were stated for all the participants when diagnosing. These themes address the research questions by describing how psychologists balance education, experience, and systemic factors to make cautious, informed diagnostic decisions for adolescents.

Interpretation of the Findings

Understanding the experiences of both patients and clinicians regarding mental health is crucial in uncovering the broader complexities and disparities embedded within the healthcare system. One significant issue that arises is the stigma attached to mental illness, particularly when clinicians themselves are the ones struggling. Clinicians are often perceived as providers of care and not as individuals who may also experience psychological distress or psychiatric disorders. This societal expectation can contribute to profound internal and external conflict for clinicians who suffer in silence, fearing judgment, professional repercussions, or the loss of licensure if they disclose their mental health struggles. During the interview, two out of four participants discussed personal and family history of mental illness, learning disability, and addiction.

Theme 1: Diagnostic Complexity and Risk of Misdiagnosis

The findings from Chapter 4 confirm prior research highlighting the diagnostic complexity of bipolar disorder in adolescents. Researchers have found that adolescent

symptom presentations can overlap significantly with other disorders such as ADHD, PTSD, and conduct disorder (Bernstein & Pataki, 2017; Carlson & Pataki, 2016; Findling et al., 2018; Giedd, 2000; Merten et al., 2017; Miller, 2023). Psychologists in this study similarly reported diagnostic difficulty due to overlapping symptoms and emotional dysregulation, confirming this concern. Participant statements illustrated that developmental variability often complicates the clinical picture, reinforcing the literature on the challenges of making accurate diagnoses without longitudinal observation (Carlson, 2005; Findling et al., 2018). P2 stated, “There are adolescents where we’re still trying to figure out, are they emotionally immature, or are they experiencing something deeper, like bipolar?” Another participant stated, “ADHD, trauma, and even just adolescence can all look like bipolar if you’re not careful” (P3).

As outlined by Kaplan (2011) and Giedd (2000), symptoms of bipolar disorder in adolescents often overlap with those of other common disorders such as ADHD, anxiety**,** ODD, and PTSD. Adolescents with bipolar disorder may present with irritability, impulsivity, and hyperactivity, which can be mistaken for the behaviors typically seen in ADHD or ODD. The DSM-5 criteria for bipolar disorder are broad and sometimes vague, making it difficult for clinicians to discern the specific symptoms of bipolar disorder from other disorders.

Theme 2: Importance of Longitudinal Assessment

This theme extends previous literature by adding nuanced insight into clinicians’ reliance on repeated interactions and collateral information over time. While the importance of longitudinal assessment has been mentioned by Findling et al. (2018) and

Carlson and Pataki (2016), participants in this study emphasized that in real-world settings, comprehensive timelines are often difficult to obtain. They also discussed workarounds such as deferred diagnosis and ongoing observation. These findings align with and extend the recommendations in Jenkins et al. (2012), who advocated for extended monitoring and showed that such practices are not only ideal but necessary. Rather than making immediate diagnoses, psychologists emphasized iterative assessment. P1 noted, “You can’t just meet a kid a couple of times and make that call... sometimes you need months of observation, school input, and family history to really understand what’s going on.” Another psychologist stated, “I’ll defer the diagnosis if I’m not confident. I’d rather wait and see the trajectory” (P4).

Collateral interviews and information gathering from family members and schools were repeatedly cited as critical in forming a comprehensive picture of an adolescent’s functioning. Family dynamics, academic performance, and peer relationships often provide crucial insights into whether symptoms are part of a developmental process or indicative of a mental health disorder like bipolar disorder. Previous research, such as Carlson and Pataki (2016), highlights the family environment as central to the diagnostic process. Similarly, school records provide critical context regarding how an adolescent behaves in social and academic settings, offering additional clues to the psychologist about the severity and persistence of symptoms. P3 stated, “Sometimes you need months of observation, school input, and family history to really understand what’s going on.”

Longitudinal observation is needed for pattern assessment, which illustrates the importance of extended observation and ongoing assessment in accurately diagnosing

bipolar disorder in adolescents. The overlap of symptoms with other disorders, along with the challenges of assessing adolescents during a period of rapid developmental changes, makes an immediate diagnosis unreliable. Psychologists emphasized that long-term observation, input from families and schools**,** and the deferred diagnosis approach are essential tools to ensure accurate diagnosis. These practices not only align with previous literature such as Jenkins et al. (2012) and Carlson and Pataki (2016) but also extend the understanding of how real-world clinicians navigate the diagnostic complexities and challenges inherent in diagnosing adolescent bipolar disorder. By leveraging collateral data and remaining patient with the assessment process, psychologists can mitigate the risks of misdiagnosis and responsibly label adolescents with the most accurate diagnosis based on an evolving understanding of their symptoms and behavioral patterns.

Theme 3: Environmental Influences

Psychologists in the current study confirmed the role of family and school environments in shaping behavior, often contributing to mood swings that mimic bipolar disorder. This aligns with literature from Carlson and Pataki (2016), which cautioned against interpreting isolated behavioral symptoms without considering environmental stressors. The present findings support this view and further extend the literature by offering qualitative insight into how clinicians actively weigh this contextual data when assessing adolescent clients. Carlson and Pataki (2016) also highlighted the importance of considering environmental stressors in the diagnosis of mood disorders. Their research suggests that clinicians should avoid narrow symptom-focused diagnoses and instead consider how stressors in the adolescent's life may influence behavior**.**

These reflections suggest that clinicians are actively engaged in ecological thinking. They interpret adolescent symptoms as relationally embedded, rather than intrinsically disordered, indicating a shift from isolated symptom-focused models to contextually aware formulations. P2 stated, “Sometimes it’s not a mood disorder; it’s a reaction to chaos at home.” While another psychologist stated, “Kids who are in unsafe environments can look really dysregulated, but it’s not always bipolar, it’s survival behavior” (P3).

The literature, including Pandeti and Boyer(2021), underscores the importance of differentiating between bipolar disorder and other conditions that may share similar symptomatology, such as ADHD, oppositional defiant disorder (ODD), or conduct disorder. These conditions can present similarly to bipolar disorder, but environmental stressors and adolescent development must be considered when making a diagnosis. As noted by Kaplan (2011)**,** many adolescents diagnosed with bipolar disorder actually meet criteria for ADHD or ODD, and their behaviors are often misinterpreted without a full evaluation of their environmental context**.**

Theme 4: Ethical Responsibility and Systemic Pressures

This theme strongly confirms and expands on prior literature on the ethical concerns and systemic pressures affecting diagnostic integrity. Parents and Jensen-Doss et al. (2011), and Olfson et al. (2014), criticized the overuse of diagnostic labels due to systemic demands, including insurance reimbursement policies. Participants echoed this concern, reporting pressure to label prematurely and acknowledging ethical tensions. This study extends the literature by showing that clinicians actively resist these pressures and

rely on tools such as structured assessments, team consultations, and deferred diagnoses to maintain ethical standards.

Participants reported external demands to assign diagnoses for school accommodations or insurance billing, even when clinical certainty was lacking. P1 stated, "I've been asked to 'just give them a diagnosis' so the kid can get services, but ethically, I can't do that without confidence." P4 also noted, "There's pressure from systems, but I remind myself the label will follow them... I don't want to put something in their record unless it's absolutely justified."

The concern is that improper labeling or overdiagnosis can lead to misleading treatment plans**,** unnecessary medications**,** and stigma that could negatively affect the adolescent's development and self-concept. This concern is supported by literature from experts in the field, including Ghaemi et al. (2022) and Kaplan (2011), who caution against hastily diagnosing bipolar disorder in adolescents without a thorough and careful evaluation. This section will explore the role of multiple stakeholders in the diagnostic process and how caution, responsibility, and collaboration are necessary to ensure ethical and accurate labeling.

Friedman and Scheon (2009) and Kaplan (2011) suggest that overdiagnosis can be driven by external factors such as insurance requirements. Friedman and Scheon (2009) highlight how insurance and funding mechanisms often prioritize quick diagnoses to justify treatment expenses, without sufficient focus on the accuracy or appropriateness of the diagnosis itself. This, in turn, can lead to the misapplication of psychiatric labels, particularly with complex adolescent conditions like bipolar disorder.

Together, these interpretations provide a window into how experienced psychologists balance evidence, ethics, and systemic constraints while diagnosing bipolar disorder in adolescents. Their statements reflect clinical wisdom earned through experience and refined through reflection, consistent with the goals of IPA.

The study and findings confirm that while psychologists are trained to rely heavily on both formal education and standard assessments, such as the DSM-5 criteria, structured interviews, and evidence-based tools, these ideals and practices are often disrupted by real-world constraints and lived clinical experience, particularly in navigating ambiguous presentations. P3 noted, “We are expected to use the DSM, but sometimes it’s not about the best fit, it’s about what will get services authorized.” Participants described how their clinical judgment evolved through practical experience, supporting the RJM’s assertion that expertise develops through iterative reasoning. This reliance extends beyond textbook knowledge to include respect for client narratives and contextual understanding, addressing gaps noted in prior research (Jensen-Doss et al., 2011). As P4 noted, “It feels like putting a permanent stamp on someone for something that might just be a phase, or trauma-related.”

Despite this growing body of research, there remains a notable absence of studies specifically addressing the experiences of licensed or post-doctoral psychologists diagnosing bipolar disorder in adolescents. This gap is significant, given the complexities involved in diagnosing mood disorders during adolescence, where developmental factors can complicate symptom presentation.

In summary, the findings across all themes confirm, expand upon, and enrich the existing literature discussed in Chapter 2. The alignment between data and literature strengthens the trustworthiness of the findings and underscores the complexity of diagnosing bipolar disorder in adolescents.

Theoretical Framework

The findings of this study align closely with King and Kitchener's RJM**,** particularly stages 6 and 7, which represent advanced epistemological development. The RJM outlines seven stages of reasoning individuals use when addressing ill-structured problems—those without a clear or definitive solution. These stages fall into three phases:

1. Pre-Reflective Thinking (Stages 1–3): Knowledge is viewed as certain and directly observable. Individuals believe that truth is handed down by authority figures or directly experienced.
2. Quasi-Reflective Thinking (Stages 4–5): Individuals recognize that knowledge is uncertain and that some problems have no clear right answer, but they may struggle to evaluate evidence and often believe all opinions are equally valid.
3. Reflective Thinking (Stages 6–7): Individuals understand that knowledge is constructed, context-dependent, and evaluated using evidence and reasoning. They can compare perspectives, justify conclusions, and remain open to revision in light of new information (King & Kitchener, 2004).

The psychologists in this study consistently demonstrated reasoning aligned with Stages 6 and 7, showing an ability to integrate multiple data sources, tolerate ambiguity, and recognize the limits of diagnostic certainty. This reflects a mature epistemological stance rooted in professional ethics, clinical experience, and awareness of systemic limitations. In Stage 6, individuals recognize that knowledge must be justified through rigorous evaluation of evidence and that conclusions are subject to change with new data. This was evident in participants' cautious diagnostic approaches, especially in uncertain or overlapping symptom presentations. P1 stated, "You have to give over a sense of confidence in your diagnosis," one psychologist stated, "but you also have to be open to revising it as more information becomes available."

This aligns with King and Kitchener's (2004) description of Stage 6 thinkers who "weigh evidence and evaluate interpretations rather than simply accepting authority or intuition." Participants' use of collateral interviews**,** deferred diagnoses, and team consultation demonstrates Stage 6 behaviors grounded in clinical reasoning and openness to re-evaluation. This stage is supported in existing literature. Jensen-Doss et al. (2011) found that clinicians who engage in collaborative and iterative diagnostic practices often exhibit higher reflective reasoning skills. Similarly, Pallesen et al. (2020) noted that ethical decision-making in ambiguous cases is often a marker of Stage 6 cognition.

Stage 7, the most advanced stage, is characterized by the understanding that knowledge is constructed within a context and that conclusions must be continuously justified in relation to evidence, logic, and personal values. Psychologists in this study expressed a deep commitment to balancing clinical data, ethical considerations, and client

context. P3 said, “Maybe it’s ADHD, maybe it’s depressive, maybe it’s substance. That would be a better explanation than bipolar.” Similarly, P4 noted, “I’ve had to argue with insurance companies... I’m not comfortable giving a diagnosis I’m not clear on.”

These responses show not only a high level of epistemological awareness but also an understanding of the ethical and systemic dimensions of diagnostic labeling. Such reasoning mirrors King and Kitchener’s (2004) assertion that Stage 7 thinkers “integrate knowledge, experience, and values to construct the most justifiable conclusion,” even in complex, high-stakes situations. This interpretation is supported by Gwizdala (2020), who found that clinicians making decisions under diagnostic uncertainty often rely on internalized ethical principles and contextual awareness, which mark Stage 7 reasoning.

What I have found is that the earlier stages of the RJM are inconsistent with the findings in this study. Stages 1–3 (pre-reflective) involve reliance on authority or “right answers,” and participants in this study explicitly rejected such rigidity. P2 responded, “It’s not black and white…kids don’t come in with clear-cut symptoms. You have to look at the whole picture.”

The same was found for Stage 4 and 5 (Quasi-Reflective) thinkers may acknowledge uncertainty but often see all viewpoints as equally valid, without applying evidence to discriminate among them. In contrast, participants in this study justified their diagnostic choices with a deliberate weighing of evidence**,** context, and ethical responsibility.

All four themes developed in this study illustrate the kind of epistemologically mature thinking that the model describes. These practitioners engage in complex

meaning-making shaped by training, experience, and contextual awareness, ultimately embodying the model's vision of epistemologically mature, evidence-informed, and ethically grounded clinical judgment, grounded reasoning that King and Kitchener's RJM envisioned at its highest levels. This interpretation strengthens the argument that the RJM is an appropriate and insightful framework for understanding how licensed psychologists approach diagnostic decision-making in the face of ambiguity and complexity.

These clinicians show a capacity to engage in reflective, flexible, and ethically guided decision-making in the face of diagnostic ambiguity, suggesting that the RJM is not only a fitting but a powerfully illuminating framework for understanding the complexity of psychological diagnosis in adolescents.

One of the most significant findings from this study relates to the gaps in training. The finding that academic coursework often fails to prepare clinicians for applied diagnostic work supports concerns in the literature regarding insufficient experiential learning (Jensen-Doss et al., 2011). Participants' frustration with the disconnect between didactic instruction and hands-on diagnostic practice echoes studies emphasizing the importance of integrated learning models (Jensen-Doss et al. 2011). P4 noted, "It was more of the I didn't get into my practicum experiences, so I wasn't able to put it into use." The overlap of symptoms between bipolar disorder, ADHD, anxiety, and other disorders, such as PTSD, makes accurate diagnosis challenging (Giedd, 2000). Giedd (2000) emphasized the difficulty of distinguishing between ADHD and bipolar disorder, noting that both conditions share symptoms like hyperactivity, talkativeness, and

distractibility. This overlap suggests that psychologists may require additional training or refined diagnostic tools to accurately distinguish between these conditions.

The DSM-5 criteria themselves may be insufficient without a nuanced understanding of developmental psychology, suggesting a need for psychologists to be better trained in differential diagnosis and multidimensional assessments. P4 noted,

> "I often wish we were trained more on working with other professionals. A diagnosis like this requires input from teachers, psychiatrists, and even social workers. But sometimes, we're expected to make a decision on our own, which can be hard when the picture is unclear."

Statements from some of the participants demonstrate the epistemological gap between knowledge and practice. The RJM, King & Kitchener (2004), situates this gap at earlier stages (e.g., Stage 4 or 5), where individuals recognize uncertainty but lack the tools to resolve it through evidence-informed reasoning. P3 responded,

> "I've been in this field for over 10 years, and even now, every time I make a diagnosis like this, I'm still second-guessing myself. I think that's because no one ever really taught me how to integrate all the layers of information, like family history, school input, and the fluctuating nature of adolescence, into a cohesive diagnostic picture."

Limitations of the Study

I acknowledge there were several limitations of the study, including sample size, but consistent with the methodological approach of IPA, which restricts the generalizability of the findings. This study yielded valuable insights into the diagnostic

experiences of licensed psychologists; several limitations must be acknowledged. The focus of IPA is depth over breadth, yet a more diverse sample could have revealed additional perspectives.

As noted in Chapter 1, the original design included both postdoctoral and licensed psychologists; no postdoctoral participants responded to recruitment efforts. This limits the ability to compare early-career and more seasoned diagnostic approaches, as intended in the original research design. However, despite targeted recruitment efforts, no postdoctoral participants elected to participate. This limitation restricts the study's ability to contrast early-career and more seasoned diagnostic approaches, as originally planned. Consequently, the findings primarily reflect the perspectives of experienced, licensed psychologists and may not fully represent the reflective processes or challenges encountered by those in earlier stages of professional development.

Third, the study relied exclusively on self-reported data through interviews. While participants were candid and reflective, their narratives may be influenced by memory, professional identity, or a desire to present themselves in a certain way. Observational or document-based data could have added additional dimensions to the findings.

Finally, all participants were from the same geographic region. Regional practices, access to resources, and training models may have influenced their responses. Broader geographic representation may have enhanced the transferability of the findings.

Recommendations

Future research for training programs for psychologists, such as evaluating training curricula across multiple psychology doctoral programs to determine how well

they prepare students for complex diagnosis, which would include curriculum review, surveys, and focus groups with recent graduates to identify gaps and best practices. To address these gaps, a mixed-methods research design is recommended. This approach would combine qualitative methods, such as focus groups with recent graduates and interviews with experienced clinicians, with quantitative data from surveys and curriculum reviews. Mixed methods would allow researchers to capture both the breadth of training practices and the depth of lived experience with diagnostic challenges.

Research should prioritize the experiences of clinicians through mixed methods research, particularly those involved in diagnosing complex conditions in youth, and explore how their attitudes, training, and personal experiences shape diagnostic practices. For the methodological approaches, a sequential explanatory design could begin with a curriculum analysis of APA-accredited doctoral programs to assess diagnostic training coverage. Surveys could then be distributed to current PsyD and PhD graduates, assessing perceived preparedness, confidence in diagnosing, and attitudes toward labeling. These data could be followed by focus groups to explore training gaps, emotional preparedness, and ethical dilemmas in more depth. A document analysis protocol would guide the review of course syllabi, practicum objectives, and internship materials across multiple institutions.

To further the studies, expand on these findings by examining how diagnostic training varies across a broader range of graduate programs. A sequential explanatory design could begin with a curriculum analysis of APA-accredited doctoral programs, including both PhD and PsyD tracks as well as counseling psychology and clinical social

work programs, to assess the scope and depth of diagnostic training. Surveys could then be administered to recent graduates across these disciplines, measuring perceived preparedness, diagnostic confidence, and attitudes toward labeling. To enrich this data, follow-up focus groups could explore training gaps, emotional readiness for complex diagnostic work, and ethical dilemmas encountered during clinical training. A document analysis protocol could guide the systematic review of course syllabi, practicum objectives, and internship materials across diverse institutions, providing a comprehensive understanding of how programs prepare clinicians for real-world diagnostic challenges.

At the same time, continued attention must be given to understanding the patient perspective, especially the subjective experiences of stigma, misdiagnosis, and the long-term implications of psychiatric labeling. Bridging these gaps will require interdisciplinary efforts, targeted training, and a commitment to dismantling stigma both within the profession and in society at large.

Implications

This study offers meaningful contributions to the field of clinical psychology by highlighting several avenues for positive social change, both within clinical practice and at broader systemic levels. The findings support a shift toward more reflective, flexible, and person-centered diagnostic practices, challenging rigid, outdated systems that may hinder accurate assessment and ethical care for adolescents.

The lived experiences of licensed psychologists, as captured in this study, highlight the importance of clinical wisdom and judgment that extend beyond textbook

knowledge. These insights can promote social change by enhancing the legitimacy and accountability of diagnostic decisions, improving the effectiveness of current diagnostic models, and informing the development of training programs for both early-career and experienced clinicians.

In addition, these findings provide support for advocacy aimed at reforming mental health policy, particularly in areas where insurance requirements influence diagnostic practices. Participants voiced concerns about how billing pressures often encourage premature labeling, which can have lasting consequences for youth. A broader societal awareness of how economic systems affect clinical decision-making may prompt institutional changes that prioritize individualized treatment over diagnostic expediency. Such changes have the potential to improve mental health outcomes for adolescents and reduce the long-term impacts of misdiagnosis and stigma on youth and their families.

Methodological Implications

By centering the lived experiences of licensed psychologists, this study highlights the utility of IPA as a valuable approach for examining complex, context-sensitive diagnostic processes. IPA proved especially effective in capturing the nuanced ways clinicians interpret ambiguous adolescent behaviors, apply DSM-5 criteria within real-world contexts, and exercise reflective judgment in ethically sensitive situations.

The methodological implications of this research extend beyond the immediate findings. This study demonstrates the importance of employing rigorous qualitative methods, such as IPA, that honor the subjective dimensions of clinical reasoning, particularly when addressing the diagnostic challenges associated with developmental

and comorbid presentations in youth. The richness of the data reflects how clinicians navigate uncertainty, systemic pressures, and evolving understandings of psychopathology.

Furthermore, this study supports the integration of qualitative inquiry with developmental and cognitive theories of professional reasoning. By exploring how psychologists construct meaning from clinical encounters, the study contributes to a more comprehensive understanding of diagnostic decision-making as a dynamic, reflective, and contextually embedded process. Future research may benefit from applying IPA or other experiential qualitative methodologies to similar areas where clinical practice intersects with ethical complexity and systemic constraints.

Conclusion

When I began this research, I did not fully anticipate the depth and complexity of the themes that would emerge. Through the voices of licensed psychologists, I gained a deeper understanding of the multifaceted challenges involved in diagnosing adolescents with bipolar disorder. These challenges include limitations in training, systemic pressures from insurance companies, the emotional weight of diagnostic responsibility, and the ongoing struggle to arrive at a diagnosis that leads to therapeutic relief and improved outcomes for youth.

This study's findings confirm that adolescent presentations often overlap with other disorders, making bipolar disorder particularly difficult to diagnose during this developmental stage. P1 responded, "Adolescents are tricky because mood swings, irritability, and impulsivity can all be part of normal development, but they can also

mimic bipolar or ADHD. It's not always clear." In alignment with the literature from (Bernstein & Pataki, 2015; Carlson & Pataki, 2016; Findling et al., 2018; Giedd, 2000; Merten et al., 2017; Miller, 2023), psychologists discussed the challenge of distinguishing normative emotional variability from clinical pathology. One participant shared, "Teenagers are already moody, impulsive, irritable; it's hard to tell when that becomes a disorder versus just adolescence" (P1).

Findings extend the literature on longitudinal assessment, highlighting how real-world demands can disrupt the ideal of extended diagnostic monitoring. As one psychologist stated, "You don't get to see the whole picture in one or two sessions. That's why I always say, 'Let's hold off on the label until we're sure'" (P3).

The path to licensure is long and demanding. It requires resilience, flexibility, and a deep commitment to the profession. Many who pursue this path give up considerable time, financial resources, and personal stability in order to achieve the goal of becoming a licensed psychologist. This study affirms that the journey is not just one of academic achievement but one of personal endurance, ethical responsibility, and professional growth.

Ultimately, this research underscores the importance of systemic change in training programs, policy structures, and diagnostic practices. It calls for a deeper integration of real-world clinical application into graduate education and a more ethically responsive system that supports clinicians in making thoughtful, developmentally informed, and stigma-sensitive diagnoses. The journey of becoming and practicing as a

psychologist is ongoing, and so too must be our commitment to improving the systems that shape it.

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Appendix A: Invitation to Participate

FLYER

Interview study seeks post-doctoral and licensed psychologists

There is a new study about the experiences of post-doctoral and licensed psychologists diagnosing bipolar disorder in adolescents. This study aims to benefit society by providing wisdom, knowledge, and insight from those diagnosing adolescents with bipolar disorder, with the possibility of creating new training methods for psychologists new to the field and those already licensed.
For this study, you are invited to describe your experiences diagnosing bipolar disorder in adolescents.

About the study:

- One 45-60 minute in-person interview that will be audio recorded (no video recording)

Volunteers must meet these requirements:

- Post-Doctoral and Licensed psychologist
- History of diagnosing adolescents

This interview is part of the doctoral study for a Ph.D. student at Walden University. Interviews will take place in September 2024.

To confidentially volunteer, contact the researcher:

Appendix B: Social Media Invitation

An interview study seeks post-doctoral and licensed psychologists diagnosing bipolar disorder in adolescents

Caption: This study aims to benefit society by providing wisdom, knowledge, and insight from those who share their life experiences with diagnosing adolescents with bipolar disorder and a possibility of cultivating new training methods for psychologists new to the field and those already licensed.

For this study, you are invited to describe your experiences diagnosing bipolar disorder in adolescents.

About the study:

- One 45-60 minute in-person interview that will be audio recorded (no videorecording)

Volunteers must meet these requirements:

- Post-Doctoral and Licensed psychologist
- History of diagnosing adolescents

This interview is part of the doctoral study for a Ph.D. student at Walden University. Interviews will take place in November 2024.
You can ask questions of the researcher by emailing

Appendix C: Interview Questions

1. Do you have any values assigned to using the DSM-5?

Example: Values can be defined as guides to human action that are subject to praise or blame and that are present, implicitly or explicitly, in all human activities

2. Could you tell me about your experience with using the DSM-5?
3. Can you tell me about an experience with diagnosing adolescents with bipolar disorder?
4. When do you know you have enough information to assign a working diagnosis for the patient?
5. How do you handle uncertainty with a diagnosis?
6. Could you tell me about an experience when you were unsure about a diagnosis and how you handled the situation?
7. Can you share with me your experience of feeling confident when diagnosing?
8. Can you share your experiences with your training to prepare you for diagnosis?
9. What additional information could you provide me to help me understand your process of diagnosing?
10. Before we conclude this interview, is there anything else you want to share with me?

Appendix D: Demographics

How many years have you been a licensed psychologist?

What State are you from

Are you licensed?

What year did you get your license?

When did you graduate with your PhD?

Are you employed full-time, part-time, or as a consultant?

How many years have you worked with adolescents?

Approximately how many adolescents have you diagnosed with bipolar disorder?

Do you have children?

Do you have a family history of family members or yourself who are diagnosed with bipolar disorder?

Are you married?

What is your ethnicity?

What is your primary language?

Are you fluent in other languages?

Where is your place of birth?

Do you have a religious preference?

What is your gender?

What is your age?