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Attribution of Behavior and Misdiagnosis in Mental Health Evaluation of Primary School Children

E'mon Ambers
Walden University

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Walden University

College of Psychology and Community Services

This is to certify that the doctoral study by

E'mon Ambers

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2026

Abstract

Attribution of Behavior and Misdiagnosis in Mental Health Evaluation

of Primary School Children

by

E'mon Ambers

MSW, Walden University, 2019

BSW, Virginia State University, 2017

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Human Services

Walden University

February 2026

Abstract

The problem of misdiagnosis of mental health conditions in primary school aged children because of attributions related to misbehavior is a significant issue. The purpose of this qualitative multiple case study was to explore a selected sample of educators' and mental health professionals' experiences and perceptions of the risks of attribution errors in mental health misdiagnosis among primary school-aged children in Richmond, VA. The research questions addressed how stakeholders perceive the role of attribution errors in professional practice contributing to misdiagnosis, as well as what practice-based and systemic changes stakeholders propose to enhance diagnostic accuracy. Narrative data was collected from educators and mental health professionals in semistructured interviews and analyzed using comparative content analysis. Findings from the study revealed key themes: 1) attributions by professionals about the children included misunderstood behaviors, childhood trauma, and socioeconomic and cultural influences; 2) structured yet limited diagnostic procedures; 3) inadequate tools and resources for accurate diagnoses; 4) the need for holistic, trauma-informed practices, and 5) recommended strategies emphasizing staff training, collaboration, comprehensive evaluations, and culturally responsive support systems to improve diagnostic accuracy and child mental health outcomes. The study contributes to social change by promoting more accurate mental health assessments that reflect children's actual needs and improving the overall well-being of primary school-aged children in Richmond, VA.

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Dedication

This capstone project is dedicated to the children and families whose experiences within educational and mental health systems are often misunderstood or misinterpreted. Their lived realities underscore the importance of accurate, ethical, and equitable assessment practices and served as the foundation for this scholarly work.

This project is also dedicated to my family, whose consistent encouragement, patience, and support made the completion of this doctoral journey possible. Their belief in the value of this work provided strength and motivation throughout the process.

Finally, this dedication extends to human services professionals and advocates committed to trauma-informed, culturally responsive, and child-centered practice. Their efforts to promote understanding, fairness, and positive social change continue to inform and inspire the field.

Acknowledgments.

I would like to thank my doctoral committee for their guidance and scholarly feedback throughout this capstone project. I am also grateful to the participants who contributed their time and perspectives to this study. Finally, I acknowledge the support of my family and colleagues, whose encouragement made the completion of this doctoral journey possible.

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Section 1: Introduction to the Problem

Background of the Human Services Problem

The misdiagnosis of mental health conditions among some primary school children is a widespread issue in human services that has long-lasting effects on children's academic, social, and emotional well-being (Hus & Segal, 2021; Stahnke, 2021). Historically, misdiagnosis often happened when children's behaviors, such as inattentiveness, defiance, or hyperactivity, were wrongly attributed to psychiatric disorders like attention deficit hyperactivity disorder (ADHD) or oppositional defiant disorder (ODD), instead of being seen as reactions to environmental stressors, trauma, or developmental challenges (Abdelnour et al., 2022; Bitsko, 2022). Although mental health in children and adolescents is regarded as a national healthcare crisis, with depression, behavioral issues, anxiety, and ADHD frequently diagnosed and often occurring together, mental health issues in children with chronic conditions are not fully understood or characterized (Bhatnagar et al., 2024).

Eva et al. (2021) noted that because young children regulate their behavior and emotions through interactions with caregivers, it is often unclear whether observed behavioral and emotional problems should be diagnosed as psychopathology or interpreted as signs of a dysfunctional caregiver–child relationship. This challenge in evaluation and diagnosis is worsened by the fact that children under 7 years old may develop mental disorders that present differently than in adolescents or older children (Vasileva et al., 2021). Additionally, Bhatnagar et al. (2024) reported that identifying and diagnosing mental health conditions is more difficult in children with conditions such as

cerebral palsy (CP) due to their intellectual, motor, communication, and functional impairments, which hinder their responses to standard screening tools and their ability to express feelings of sadness or depression. Therefore, further assessment was necessary to determine whether certain mental health issues or behaviors were being misdiagnosed as impulse disorders, anxiety, stress, or other behavioral problems (Bhatnagar et al., 2024). Furthermore, although children with remediable language and communication challenges who are misdiagnosed may benefit from healthcare services, their diagnoses can divert resources from children with genuine disorders (Hus & Segal, 2021). The “recovery” of misdiagnosed children may promote the myth that some mental health conditions are curable, rather than the recognition that disorders like autism are lifelong and require ongoing support (Hus & Segal, 2021).

The effects of misdiagnosis go beyond the individual child and affect the larger educational system and community. He et al. (2023) conducted a meta-analysis showing that comprehensive and well-coordinated school mental health services greatly boost student outcomes, including academic success and social-emotional development. However, when misdiagnosis happens, children might get unsuitable or limited interventions, which can harm their educational and social progress, as Nguyen and Parson (2021) observed. Solving this problem required a multifaceted approach that included reducing mental health stigma in schools, enhancing teacher training on mental health issues, and expanding access to mental health resources for students, especially in underserved areas (Wilson & Hayes, 2022). By focusing on these areas, human services professionals could support efforts to address the persistent issue of misdiagnosis in

schools, ensuring that children receive the appropriate mental health support needed to succeed academically and emotionally.

Social Problem

In the United States and many other countries, teachers and school professionals are often the first to identify behavioral and mental health issues in children (Ohrt et al., 2020). However, a lack of proper training and understanding of mental health can lead to misattributing behavioral symptoms to disorders like ADHD, while ignoring other possible causes such as trauma, posttraumatic stress disorder (PTSD), or developmental changes (Kumar & DeCuir-Gunby, 2023). This misdiagnosis not only results in inappropriate interventions, like unnecessary medication or behavioral plans, but also misses chances to address the root causes of the child's behavior. Marginalized groups, including children from low-income families and minority communities, are more likely to experience these diagnostic errors because of wider disparities in access to quality mental health care (Jones et al., 2019; Smith & Garcia, 2020). This issue becomes even more urgent considering that early childhood interventions are vital for achieving positive long-term mental health outcomes (Hus & Segal, 2021).

As noted by Patel and Singh (2020), school-based mental health services in underserved districts often lack sufficient resources, leading to a higher risk of diagnostic errors. Recent research highlights several barriers to effective mental health evaluation in schools. Brown and Lee (2022) emphasized that educators frequently lack the training to accurately identify and refer students for mental health services, which contributes to the ongoing problem of diagnostic errors. Additionally, Clark and Gresham (2021) argued

that attribution errors—when school professionals wrongly attribute behavior to internal psychological issues instead of external factors—are a major factor in the misdiagnosis of emotional and behavioral issues and disorders.

These attribution errors are often caused by a lack of professional development and insufficient collaboration between educators and mental health professionals, as noted by Davis and Harper (2023), who conducted a systematic review on school-based mental health interventions. Additionally, Martinez and Cooper (2021) emphasized that trauma is frequently misinterpreted as a behavioral disorder in children, which worsens the problem of misdiagnosis. These recent studies highlight the necessity for better mental health services, professional training, and partnership between schools and mental health providers to lower the risk of misdiagnosis.

In addition, the lack of culturally competent mental health care further worsens the problem of misdiagnosis (Bitsko, 2020). Mental health professionals and educators in the United States often lack the training and resources needed to identify and address the specific mental health needs of diverse populations (Mongelli et al., 2020). A study by Bitsko (2020) found that the prevalence of mental disorders and related indicators varied by race and ethnicity, with Black children showing the highest rates of conduct or behavioral problems. Bitsko attributed this difference to racial bias, where certain behaviors in Black children are wrongly seen as disruptive, which further indicates that this leads to misdiagnoses that hide other forms of mental distress among African American children. Anderson and Lamb (2021) stressed that cultural competence is essential for accurate diagnosis, as cultural backgrounds can influence how children

express mental health symptoms. Without culturally sensitive approaches, children from minority backgrounds are more likely to be misdiagnosed, stigmatized, and given inappropriate care (Bitsko, 2020). Moreover, the shortage of mental health professionals in schools limits their ability to provide prompt and accurate mental health evaluations (Hoover & Bostic, 2021). Incorporating mental health systems into educational settings—including training educators and staff to promote mental health and aid in the detection and treatment of mental illnesses—will help create a comprehensive range of mental health support for students (Hoover & Bostic, 2021).

Local Problem

Approximately 47% of students attending public high and middle schools in Virginia reported experiencing a mental health need within the past year or currently (Hughes, 2023). This included 36% who felt hopeless or sad for at least 2 weeks, enough to disrupt their daily routines; 32% who experienced uncontrollable worry and nervousness at least half the time, indicating a positive screen for generalized anxiety disorder; 12% who seriously considered suicide; 21% who engaged in self-harm; and 28% who felt depression, sadness, and loss of interest more than half the time, which suggests a positive screen for major depressive disorder (Hughes, 2023). These statistics underscore the widespread nature of mental health issues among students in Virginia. The situation is particularly troubling in Richmond, VA, where limited access to mental healthcare resources and personnel has led to an overreliance on hospitalization (Rankin, 2024).

Amid the increasing concern about mental health issues in schools, members of the Virginia General Assembly introduced several mental health bills, including House Bill 308, to make changes in Virginia’s public education system (Mental Health America of Virginia, 2020). Before this bill, Virginia did not have a standard for addressing mental health problems in its schools (Voices for Virginia’s Children, 2020). However, although local schools are often the first to identify behavioral and emotional challenges in children, many educators and school staff lack the training to distinguish between behavioral issues caused by environmental factors, trauma, or developmental stages and those caused by mental health disorders (Ohrt et al., 2020).

Based on recent communications with local school counselors and mental health professionals, there has been a reported increase in referrals for conditions such as attention-deficit/hyperactivity disorder (ADHD), including cases in which observed behavioral challenges may be more appropriately attributed to trauma exposure or socio-environmental stressors rather than a psychiatric disorder.. Furzer et al. (2023) discovered that students who are relatively younger than their classmates—those born closer to the school start age cutoff—are diagnosed and treated for ADHD more frequently. Since the prevalence of ADHD should not vary significantly with age, Furzer et al. concluded that schools and clinicians often overlook the “developmental immaturity of a child compared to peers.” Therefore, ADHD diagnoses tend to depend heavily on subjective judgment. A study by Sadek (2023) also found that children with insufficient sleep may display symptoms that overlap with ADHD, such as inattention and behavioral issues. Behaviors typical of ADHD, like overactivity, impulsivity, and inattention, can be normal for

certain developmental stages, with some symptoms being temporary, which makes screening and diagnosing ADHD in school-aged children challenging (Furzer et al., 2023). This overreliance on mental health labels such as ADHD can lead to inappropriate treatments, including unnecessary medication, while underlying causes of the behavior—such as developmental differences, family instability, housing insecurity, or past trauma—remain unaddressed.

School districts have also reported significant gaps in support for these children due to the limited availability of school-based mental health professionals and culturally competent care (Heinrich et al., 2023). This situation has been worsened by a notable increase in mental health needs among students, related to longstanding disparities in access to social supports and healthcare for low-income and historically marginalized children in America (Heinrich et al., 2023). Data from the Richmond Public Schools (RPS) district shows that many schools have an uneven ratio of school counselors and psychologists to students, with some schools having only one counselor for every 400 to 500 students (RPS Data, 2022). This shortage results in an overwhelming caseload for school mental health staff, making it hard to provide personalized attention or conduct comprehensive assessments. The issue is further worsened by the fact that many of these professionals have limited training in cultural competence, which increases the risk of misattribution and misdiagnosis, especially for children from marginalized backgrounds (Cycyk et al., 2022; Mongelli et al., 2020). Consequently, these children face not only the academic and social impacts of incorrect diagnoses, but also systemic barriers to accessing suitable mental health care (Cycyk et al., 2022).

The need for this study arose from the understanding that improving the accuracy of mental health assessments in Richmond's primary schools required a more nuanced approach that considered environmental, cultural, and social factors affecting children's behavior. By filling these gaps, human services professionals could help develop more effective mental health support systems in schools, decrease the chances of misdiagnosis, and ensure that children receive the appropriate care and interventions. This research aimed to offer insights and practical solutions to these local issues, ultimately helping improve educational and mental health outcomes for children in Richmond.

Purpose of the Study

This qualitative study aimed to explore educators' and mental health staff's perceptions in schools about the risk of attribution errors leading to misdiagnosis of mental health conditions in primary school-aged children in Richmond, VA. I examined the practice-based and systemic changes proposed by stakeholders to improve mental health assessments for these children in Richmond. My goal was to provide new insights into school mental health practices and help improve outcomes for children.

Research Questions

The research questions for this study were the following:

- RQ1. How do stakeholders perceive the role of attribution in cases of misdiagnosing mental health issues among primary school-aged children in Richmond, VA?
- RQ2. What practice-based and systemic changes do stakeholders suggest to improve diagnostic accuracy for primary school-aged children?

Theoretical or Conceptual Framework

The framework for this study was attribution theory, initially developed by psychologist Fritz Heider in 1958. Heider's work, published in *The Psychology of Interpersonal Relations* (1958), introduced the idea that people naturally seek to understand the causes of behavior by attributing it either to internal dispositions (personality traits or mental states) or external circumstances (environmental or situational factors). Heider's theory was later expanded by scholars such as Harold Kelley and Bernard Weiner, who further explored how attribution influences decision-making and perception (Knafo & Weinberger, 2024). The central tenets of attribution theory are that individuals often make judgments about others' behavior based on perceived causes, which can lead to attribution errors—misjudging behavior as being caused by internal traits rather than external circumstances (Horne & Weinman, 2020; Malle, 2022). These attribution errors can have profound impacts, particularly in contexts such as education and mental health, where misinterpretation of behavior may lead to improper interventions (Malle, 2022).

In this study, attribution theory served as the framework for examining how educators and mental health professionals interpret and assign explanations to children's behaviors in schools. The theory provided the basis for understanding the causes of misdiagnosis by clarifying why certain behaviors are mistakenly attributed to mental health disorders instead of environmental or developmental factors. This aligned with the research questions, which I used to explore how professionals perceive attribution errors and their impact on diagnostic results, as well as strategies to enhance diagnostic

accuracy. By applying attribution theory, I analyzed the decision-making processes of individuals involved in children's mental health assessments. I investigated how attributions might affect the precision of diagnoses and the types of interventions used. Using this theoretical perspective, I aimed to contribute to improving mental health practices in schools by addressing potential cognitive biases that may lead to misdiagnosis.

Nature of the Study

Through this exploratory multiple case study, I aimed to understand what professional providers perceive—based on their own experiences—as contributing to the misdiagnosis of mental health conditions in primary school-aged children in Richmond, VA. I used a qualitative research method, seeking to grasp phenomena from participants' perspectives, highlighting their meanings, experiences, and views in their natural environments (Creswell & Poth, 2017). I chose a case study design, which is especially effective for exploring complex issues in real-world settings in depth (Yin, 2018). I selected this approach because it provides a detailed and comprehensive examination of the factors influencing mental health misdiagnosis in schools, focusing on how educators and mental health professionals interpret children's behaviors.

The sampling strategy used in this study was purposeful convenience sampling, where participants were chosen based on their accessibility and involvement in the mental health and education of primary school-aged children. I collected data through semistructured interviews with a select group of educators and mental health professionals, allowing for open-ended responses that provide in-depth insights into their

experiences and perspectives. I used thematic analysis as the primary data analysis method. This analysis ultimately helped improve how school-based mental health diagnoses better reflect children's needs and support their overall well-being. This qualitative method and design were selected to capture the complexity of real-world educational environments and the lived experiences of those involved in mental health evaluations, with the goal of generating practical solutions to reduce misdiagnosis.

Defined Terms

Attribution error: Misjudgment that occurs when individuals incorrectly attribute the cause of someone's behavior to internal factors, such as personality or mental health disorders, rather than considering external situational influences. These errors are common in educational settings and can lead to inaccurate diagnoses (Clark & Gresham, 2021).

Misdiagnosis: The incorrect identification of a mental health condition, often occurring when behaviors are attributed to mental disorders without fully considering environmental or developmental factors. Misdiagnosis can result in inappropriate interventions and exacerbate behavioral or academic challenges in children (Jones et al., 2019).

Cultural competence: The ability of professionals to understand, communicate with, and effectively interact with individuals from diverse cultural backgrounds. In mental health evaluations, a lack of cultural competence can lead to misinterpretation of behaviors and contribute to diagnostic errors (Anderson & Lamb, 2021).

Environmental factors: External influences, such as trauma, family instability, or socioeconomic challenges, that can impact a child’s behavior. These factors are often overlooked in mental health evaluations, leading to misattributions and potential misdiagnosis (Patel & Singh, 2020).

Professional preparedness: The level of training and expertise that educators and mental health professionals have in accurately identifying and addressing mental health issues in school-aged children. Low levels of preparedness are linked to higher rates of diagnostic errors and improper interventions (Brown & Lee, 2022).

Significance of the Study

Significance of the Study for Community or Organization

This study was important for the Richmond, VA community and local schools because it aimed to address the ongoing problem of mental health misdiagnosis among primary school-aged children. The results offer practical insights for educators, school counselors, and local mental health professionals to improve how they evaluate and respond to children’s behavioral issues. By understanding how attribution errors contribute to misdiagnosis—and how to consider better external factors like trauma and family dynamics—local organizations could strengthen their mental health practices. This could lead to more accurate diagnoses, better interventions, and fewer children being wrongly labeled with mental health disorders. Additionally, the findings could help local schools develop more culturally competent and holistic evaluation methods, ensuring that children receive the support they need to succeed both academically and emotionally.

Significance of the Study for Human Services

This study tackled mental health misdiagnosis, a vital issue in human services with long-lasting effects on children's well-being. The study advocated for accurate diagnoses and interventions to help professionals reduce health disparities, especially in marginalized children's communities. The findings could foster positive social change by providing evidence-based strategies to minimize diagnostic errors and improve mental health support systems in schools. These strategies may align with the social determinants of health, as factors like education, access to mental health care, and social support are essential in shaping children's development. Additionally, the findings could guide policy changes and training programs at the national level, equipping educators and mental health professionals with the tools needed to better address the diverse needs of children and ultimately promote healthier, more resilient future generations.

Literature Review

Literature Search Strategy

For the literature review, I followed a systematic process to ensure thorough coverage of relevant research and theoretical foundations. The main databases selected were PsycINFO, PubMed, Google Scholar, and the Education Resources Information Center (ERIC), as these are well-known for peer-reviewed literature in psychology, education, and mental health fields. Google Scholar was also used to gather a wide range of interdisciplinary studies. I chose these databases based on the accessibility of research in human services, mental health, and education. Key search terms included "misdiagnosis of mental health in children," "attribution theory," "mental health

evaluation in schools,” “cultural competence in education,” and “attribution error in mental health,” among others. The search was limited to studies published in the last 5 years (2019–2023) to include the most recent trends and findings. For the review, I focused on peer-reviewed journal articles, systematic reviews, meta-analyses, and theoretical papers that offered insights into attribution theory, misdiagnosis, and practices in human services within educational settings. This method enabled a comprehensive review of both empirical evidence and theoretical perspectives relevant to the study focus.

Conceptual Framework

The core principles of attribution theory, developed by Fritz Heider in 1958, center on the idea that individuals try to understand the causes of behavior by attributing it either to internal factors (e.g., personality traits, abilities, or mental states) or external factors (e.g., situational or environmental influences). This theory suggests that people are naturally inclined to make these attributions to explain others' behavior, which can sometimes lead to mistakes known as attribution errors (Heider, 1958). These mistakes often happen when individuals wrongly attribute behavior to internal causes and overlook external influences. In education and mental health, this can lead educators or mental health professionals to diagnose behavioral problems as internal psychological issues rather than considering environmental factors like trauma or social stressors.

Bernard Weiner later expanded the theory by emphasizing the importance of stability and controllability in attributions, which also affect how educators and professionals evaluate behavior and decide on interventions (Graham, 2020). Weiner

specifically considered motivation and enhanced attribution theory by examining the mental processes through which perceivers interpret others' behavior and assign causal explanations (Graham, 2020). Weiner argued that perceivers are more likely to apply positive causal attributions to others' actions if they believe that individuals are internally motivated and acting in a favorable way (Kasap & Ünsal, 2021). Weiner's attribution theory of motivation has been referenced in other studies (McCullough et al., 2022; Woodcock & Moore, 2021) to investigate causal attributions educators make regarding challenging behavior. Recent researchers have also applied attribution theory to issues in human services related to mental health and education.

For instance, Clark and Gresham (2021) used attribution theory to examine how school staff often misattribute behavioral issues in children to mental health disorders like ADHD, instead of seeing these behaviors as responses to environmental stressors such as trauma or instability at home. Similarly, Nguyen and Parson (2021) investigated how attribution errors contribute to the overdiagnosis of minority students, highlighting the role of cultural bias and the lack of cultural competence among educators in schools. These studies emphasize how attribution errors impact misdiagnosis, especially in underserved populations, and stress the need for better training and awareness among professionals. By applying attribution theory in this study, I sought to explore further how these cognitive biases influenced mental health evaluations in primary school settings, offering insights into how these errors could be reduced through improved practices and cultural competence training.

Themes and Subthemes of Literature Related to Human Services Problem

The Misdiagnosis of Mental Health Conditions in Primary School-Age Children

The misdiagnosis of mental health conditions in primary school-aged children remains a challenge in human services. Recent research indicates that misdiagnosis often results from attribution errors, lack of cultural competence, and insufficient professional training in schools. Studies such as Clark and Gresham (2021) and Nguyen and Parson (2021) highlight how children's behaviors are frequently misattributed to internal disorders rather than external factors like trauma in educational settings. Research also points to disparities in diagnosis among different populations, especially underserved or minority groups, further underscoring the need for a nuanced understanding of the issue.

The effects of misdiagnosing children are especially harmful because of the side effects of medication and other social and financial consequences (Pandeti & Boyes, 2021). For example, treatment for bipolar disorder involves giving mood stabilizers, which can cause permanent changes in brain chemistry (Orsolini et al., 2020). As a result, children who receive a false-positive diagnosis of bipolar disorder might develop a lifelong dependence on mood stabilizers or develop behavioral problems if they stop taking medication (Pandeti & Boyes, 2021). Giving mood stabilizers, like lithium, which boost neurotransmitters such as gabapentin or serotonin in the brain, can lead children to become dependent on them regardless of whether they actually have a mental disorder (Pandeti & Boyes, 2021). Moreover, a false-positive result—where a child is diagnosed with a condition they do not have—increases healthcare costs for the family and causes

unnecessary worry for the child. Conversely, a false-negative result denies the child early intervention opportunities that could help reduce clinical symptoms (Hus & Segal, 2021).

Cultural Competence and Its Role Reducing Misdiagnosis

According to Ogundare (2020), objective health indicators and the subjective aspects of what constitutes abnormal health vary across different cultures, as do perceptions, conceptualizations, diagnoses, help-seeking behaviors, and treatments. Cultural influences on health can be understood through variations in health approaches and disparities in health outcomes (Gurung, 2019). Therefore, culture shapes how people display symptoms, seek help, communicate their symptoms, and cope with psychological and environmental challenges (Gurung, 2019). It is especially significant to the origins of mental disorders because it establishes standards for what is considered normal or abnormal (Ogundare, 2020). Some cultures emphasize conformity, while others are more tolerant of deviance (Ogundare, 2020). These differences influence the prevalence of specific mental disorders in children. For example, Ogundare (2020) noted that ADHD diagnosis rates differ across countries, reflecting the societal acceptance of particular behaviors in children. Variations in the phenomenology of psychopathology and mental disorders across cultures impact the reliability of diagnostic tools and highlight the importance of cultural competence in understanding and diagnosing illness (Messas & Fernandez, 2022).

The role of cultural competence in reducing misdiagnosis has been widely discussed in human services literature. Ogundare (2020) described cultural competence as the ability to provide quality services to diverse cultural groups by gaining a better

understanding of their culture's knowledge, history, and way of life. In mental healthcare settings, this involves overcoming structural, organizational, and clinical barriers to access by bridging the cultural gap between mental health professionals and patients (Ogundare, 2020). Additionally, when patients and healthcare providers share similar backgrounds or ethnicity, shared experiences and knowledge should not be assumed, as this can lead to misdiagnoses due to incorrect assumptions (Ogundare, 2020). Anderson and Lamb (2021) argue that a lack of cultural awareness among school professionals often causes misinterpretation of students' behaviors, especially among minority groups. Jones et al. (2019) conducted a study showing that children from marginalized communities are more likely to be misdiagnosed because educators are unfamiliar with the cultural factors influencing behavior. This body of literature emphasizes the importance of culturally competent practices in mental health assessments to prevent bias and ensure accurate diagnoses.

Richmond, VA, is a diverse community with a complex cultural landscape shaped by its African American heritage, growing Hispanic and Latino populations, and various refugee groups from Asia, the Middle East, and Africa (Ooten & Sawyer, 2023). Given this multicultural environment, cultural competence among mental health and education professionals is crucial to reduce the risk of misdiagnosis among primary school-aged children (Mathur & Rodriguez, 2023). Understanding local traditions, language preferences, communication styles, and values is vital for better understanding the behaviors and emotional responses of children from these diverse backgrounds (Mathur & Rodriguez, 2023). For example, African American families may prioritize resilience

and communal support, while Latino communities often emphasize family unity and respect for authority, which can influence how children express stress or discomfort in different ways (Lopez et al., 2022).

To accurately evaluate mental health needs, professionals must understand how cultural norms can influence behaviors that might otherwise be misinterpreted. For instance, a child's reserved nature in a Latino family could be due to respect (Lopez et al., 2022), while in some Middle Eastern families, boys might show assertive behavior as part of cultural expectations of masculinity (Almalki, 2020). Misreading such behaviors as signs of defiance, depression, or anxiety could result in incorrect diagnoses if cultural contexts are ignored (Kyrillos et al., 2023).

Key components of culturally competent care for Richmond's population include acknowledging the potential effects of systemic discrimination, historical trauma, and socio-economic disparities on African American communities (Smith et al., 2022). Additionally, Richmond's schools and mental health services need to address language barriers and acculturative stress among Hispanic, Latino, and immigrant children. Incorporating cultural training that covers these regional nuances, along with involving parents and community leaders, can help ensure that mental health assessments are accurate and culturally sensitive (Smith et al., 2022).

Professional Preparedness and Mental Health Diagnosis

Teachers are considered “frontline mental health workers”; therefore, they must be trained to help identify and manage mental health conditions beyond their usual roles of supporting students' social and emotional development (Hoover & Bostic, 2021). Since

school staff interact with students for at least 30 weeks each year and face “performance demands,” they are well-positioned to notice ongoing or emerging struggles among students (Hoover & Bostic, 2021). Furthermore, school staff can effectively coordinate responses to student needs with parents and community mental health services, aligning interventions and encouraging problem-solving while delivering their curricular instruction (Dimitropoulos et al., 2021; Singh et al., 2020). Therefore, teachers and school staff must be equipped to recognize and assess symptoms, as well as provide diagnoses or referrals for students facing mental health challenges (Dimitropoulos et al., 2021).

Professional preparedness, especially in mental health assessment, is vital in reducing diagnostic errors (Howard, 2019). Research such as Davis and Harper (2023) highlights that educators and school counselors often lack the specialized training needed to accurately identify mental health conditions. Without proper training, educators might base judgments on surface-level behavior observations, increasing the risk of misdiagnosis. He et al. (2023) discovered that schools providing ongoing professional development in mental health assessment experienced significantly lower rates of misdiagnosis, emphasizing the importance of continuous education for school staff.

Professional preparedness in mental health diagnosis is closely linked to the quality and frequency of training provided to educators and school counselors. A study by Bohnenkamp et al. (2019) reported that efforts to support school staff's mental health professional development are limited and often focus on a single topic, such as suicide prevention, which restricts the ability to address the various mental health concerns in

schools. Additionally, existing training opportunities often lack implementation support and ongoing education to help school staff retain and apply the skills they acquire (Bohnenkamp et al., 2019). In many cases, mental health issues are overlooked or misunderstood due to the absence of a standardized framework for identifying and responding to these conditions (Hua et al, 2024). A study by Larson et al. (2022) highlighted that educators who received training on trauma-informed care and mental health first aid were better equipped to distinguish between behavioral issues and underlying mental health disorders. These educators were more prepared to intervene early, reducing the risk of long-term misdiagnosis and inappropriate interventions. However, the same study pointed out that such training is not universally accessible, leading to gaps in mental health support across different school districts.

Another important aspect of professional preparedness is the collaboration between educators and mental health professionals within the school environment. Hoover and Bostic (2020) found that the availability of special child mental health services and the density of these services vary among communities, making task-shifting necessary in regions with limited resources. Schools that adopt a collaborative, interdisciplinary approach, where teachers, school counselors, psychologists, and external mental health professionals work together, experience better diagnostic outcomes (McGorry et al., 2022). According to Jenkins and Lee (2021), schools that promote this type of collaboration are more likely to identify mental health issues early. When teachers receive guidance from mental health experts, they can address behavioral issues with a deeper understanding, resulting in more accurate identification of potential mental health

concerns (Moore et al., 2023). This collaborative approach reduces the pressure on teachers to act as mental health professionals and enables more comprehensive support (Moore et al., 2023).

Despite the recognized need for increased training, many schools face challenges in implementing comprehensive mental health training programs (Maqsood et al., 2021). Budget constraints, lack of resources, and varying priorities within school districts contribute to the difficulty of sustaining ongoing professional development in mental health (Hoover & Bostic, 2020). Schools often focus on academic achievement, leaving mental health training underfunded and underutilized. A review by Clark and Wheeler (2022) revealed that only 35% of surveyed schools had access to regular mental health training programs, with many educators expressing frustration at their inability to adequately support students' emotional and psychological needs. This lack of training not only contributes to diagnostic errors but also exacerbates the overall mental health crisis in schools (Royce et al., 2019).

Investing in professional preparedness for mental health diagnosis has significant long-term benefits for both students and the school environment. When educators are well-equipped to recognize and address mental health conditions, students receive more targeted and effective interventions, which leads to improved academic performance, better social-emotional development, and decreased behavioral issues (Wiedermann et al., 2023). Studies such as Patterson et al. (2022) demonstrate that schools with robust mental health training programs saw a marked decrease in suspension rates, as behavioral issues were better understood as symptoms of underlying mental health conditions. Thus,

Bohnenkamp et al. (2019) advocated for training in mental health problem identification and screening to facilitate identification and differentiation of mental health and somatic concerns among students, to identify mental health “red flags, and to improve the ability to use evidence-based assessment tools to screen for some mental health concerns, such as anxiety. These findings highlight the broader impact of professional preparedness not only on mental health outcomes but also on the overall school climate, fostering an environment where students feel supported and understood.

The Impact of Environmental Factors on Child Behavior

Research increasingly recognizes the importance of considering environmental factors—such as trauma, family instability, and socio-economic conditions—in diagnosing mental health conditions in children. Patel and Singh (2020) found that children exposed to chronic stressors often exhibit behaviors that mimic those of ADHD or anxiety disorders, leading to potential misdiagnosis when these environmental influences are not adequately considered. Additionally, Smith and Garcia (2020) argued that misdiagnosis is more likely in underserved populations, where external stressors may be more prevalent but less recognized by school professionals.

A study by Huang et al. (2022) found that the causes of youth mental health and behavioral problems are multifaceted. Similarly, studies on child development highlight the role of contextual factors such as socio-economic status, family background, and neighborhood on children’s behavior (St. John & Tarullo, 2020). Huang et al. (2022) suggested that behavioral problems often begin in family and community settings before leading to problems in school contexts and impacting academic and social outcomes.

Bronfenbrenner's (1979) ecological model of child development also pinpoints family and environmental factors as major contributors to child behavior. A study conducted by Iqbal and Zahoor (2024) found that the home and class environment, exposure to social media, and societal factors were the major causes behind problematic behaviors in classrooms. Children from broken homes are more anxious and likely to create problems in school, while lack of parental interaction is also linked to mental issues in school-going children (Iqbal & Zahoor, 2024). Neighborhood factors, including living in public housing areas or in areas with high crime rates may lead to behavioral issues, with exposure to community violence being linked to externalizing problems in children (Huang et al., 2022).

Trauma, whether from witnessing violence, experiencing abuse, or living through adverse childhood experiences, has a profound impact on a child's emotional and psychological development (Briggs et al., 2021). Children exposed to trauma often exhibit behaviors such as hyperactivity, aggression, or withdrawal, which can easily be mistaken for mental health disorders such as ADHD or ODD. A study by Thompson and Reyes (2021) highlighted that many children who experience trauma are misdiagnosed with behavioral disorders because their symptoms mirror those seen in mental health conditions. This suggests a critical need for mental health professionals and educators to incorporate trauma-informed approaches when evaluating child behavior, as overlooking trauma can lead to inappropriate diagnoses and treatment plans that fail to address the root cause of the child's distress.

Family instability, such as divorce, domestic violence, or parental substance abuse, can create an unstable environment that significantly affects a child's mental health (Iqbal & Zahoor, 2024). Children in these circumstances may act out in school or show signs of anxiety and depression (Iqbal & Zahoor, 2024). However, without a comprehensive understanding of the family dynamics at play, these behaviors are often misinterpreted as being solely related to the child's psychological state. According to Harper and Jones (2022), children from unstable family backgrounds are at a higher risk of being misdiagnosed because educators and mental health professionals may not always have access to the full picture of what is happening in the home. This underscores the importance of including family context in mental health evaluations to avoid misdiagnosing children who may simply be responding to external stressors in their environment (Mesman et al., 2021).

Socioeconomic status plays a pivotal role in shaping a child's mental health and behavior (Hatem et al., 2020). Children from low-income families are more likely to experience chronic stress due to factors such as food insecurity, housing instability, and lack of access to healthcare (Hatem et al., 2020; Sano et al., 2021). These external pressures can manifest as anxiety, irritability, or difficulty concentrating, which are often mistaken for mental health disorders like anxiety or learning disabilities (Sharma et al., 2020). In their study, Lee and Harrison (2020) found that children from lower socioeconomic backgrounds were more frequently misdiagnosed with behavioral disorders compared to their peers from higher-income families. This disparity is often due to a lack of recognition of how poverty and external stressors can impact a child's

mental health, further emphasizing the need for a more holistic approach to diagnosis that accounts for socioeconomic factors (Sharma et al., 2020).

Cultural and environmental factors also play a significant role in how children express their emotions and behaviors (Huang et al., 2022). For instance, children from different cultural backgrounds may have varying norms regarding emotional expression, which can lead to misunderstanding or mislabeling of certain behaviors (Leany, 2020). Martinez and Liu (2021) argue that without culturally sensitive diagnostic tools, school professionals risk misinterpreting behaviors that are influenced by cultural norms, further increasing the likelihood of misdiagnosis. Furthermore, children who grow up in environments with high levels of community violence or social instability may display hypervigilant behaviors that could be mistaken for anxiety or conduct disorders (Huang et al., 2022). To prevent such misdiagnoses, mental health evaluations must incorporate an understanding of the child's cultural and environmental context, ensuring that behaviors are evaluated within the appropriate framework (Leany, 2020).

One of the most significant environmental impacts on child behavior post-COVID has been the rise in anxiety and social isolation (Bill et al., 2021). The pandemic disrupted the routines and social structures that children rely on for emotional and psychological stability (Kindred & Bates, 2023). Remote learning, physical distancing, and prolonged school closures led to increased feelings of loneliness and disconnection among children (Bill et al., 2021). According to a study by Harper et al. (2022), children who experienced extended isolation during the pandemic exhibited higher levels of anxiety, difficulty in social interactions, and withdrawal from peers upon returning to

school. These changes in behavior are a direct response to the stress and uncertainty caused by the pandemic, underscoring the need for mental health support in schools to help children re-engage with their peers and adjust to the new normal (Kindred & Bates, 2023).

The economic fallout from the COVID-19 pandemic placed additional stress on families, particularly those in lower-income brackets. Job losses, housing instability, and food insecurity became more prevalent, creating stressful home environments that deeply affected children's behavior (Votruba-Drzal et al., 2021). Children from families facing these economic challenges often displayed increased aggression, irritability, and defiance in school, as the instability at home compromised their emotional well-being (Brown et al., 2020). A report by Jenkins and Clark (2021) highlighted that children from economically disadvantaged households were more likely to develop behavioral issues post-COVID due to the heightened stress and uncertainty in their living conditions. This suggests that socioeconomic factors, exacerbated by the pandemic, have a profound impact on children's emotional and behavioral regulation (Kindred & Bates, 2023).

Many children experienced the trauma of losing loved ones or witnessing the illness and death of family members during the COVID-19 pandemic (Bill et al., 2021). The fear of contracting the virus or seeing others fall ill caused heightened levels of distress and fear. For children who have experienced these losses, their behavior in school often reflects unresolved grief and trauma, manifesting in withdrawal, hypervigilance, or emotional outbursts. In their study, Martinez and Lee (2021) found that children who had experienced a loss or had family members affected by COVID-19

were more likely to exhibit symptoms of PTSD, including difficulty concentrating, increased irritability, and sleep disturbances. Schools must be equipped to recognize and address these trauma-related behaviors by providing trauma-informed care and creating supportive environments that help children process their emotions in healthy ways (Bill et al., 2021; Kindred & Bates, 2023)

Gaps in the Literature

Despite the breadth of research on misdiagnosis and its contributing factors, gaps remain, particularly in the intersection of attribution errors, cultural competence, and environmental factors. Most studies focus on one factor in isolation, and there is limited research exploring how these elements interact to influence diagnostic accuracy. Moreover, while many studies highlight the importance of professional training, fewer studies have empirically tested the effectiveness of specific interventions aimed at reducing misdiagnosis in real-world settings. These gaps suggest the need for further research that integrates multiple factors and tests comprehensive interventions.

One of the key reasons children may misbehave in school is that their emotional needs are not adequately recognized or addressed. Children often lack the vocabulary or emotional awareness to express their feelings, leading to frustration and acting out in the form of disruptive behaviors. This is particularly true for children who have experienced trauma or chronic stress, as they may exhibit behaviors like aggression, defiance, or withdrawal as coping mechanisms. According to Smith and Owens (2021), emotional regulation difficulties, when left unaddressed, can lead to persistent behavioral problems, especially in children who do not receive proper support from educators or mental health

professionals trained to recognize these emotional cues. By focusing solely on the behavior rather than understanding the underlying emotional needs, schools may unintentionally exacerbate misbehavior.

Peer relationships and social pressures also play a significant role in children's behavior in school. Children often feel a need to fit in with their peer group, which can result in misbehavior if they believe that disruptive actions will gain them attention or social approval. Studies such as Collins and Bennett (2020) show that children who experience social exclusion or bullying may act out as a defense mechanism or to gain peer acceptance. This behavior is often mistaken as ODD, when it may be a reaction to social stressors or a desire to establish a sense of belonging. Addressing these underlying social factors, rather than solely disciplining misbehavior, is critical to reducing disruptive actions in the classroom.

Environmental factors, such as family instability, poverty, and community violence, contribute to a child's misbehavior in school. Children who face unpredictable home environments or unsafe communities may carry the stress of these external conditions into the classroom, where it manifests in behavioral problems. Research by Gonzalez and Taylor (2022) found that children who experience frequent moves, food insecurity, or family conflict are more likely to misbehave in school because of the anxiety and instability they experience outside of school. These children may find it challenging to focus on academics or follow rules because their attention is consumed by the stressors they face at home. Addressing the root causes of misbehavior, such as

providing access to supportive services and creating a stable school environment, can help alleviate some of the external pressures contributing to a child's behavior in school.

While there is a growing body of research on the immediate effects of the COVID-19 pandemic on children's behavior, there is a notable gap in long-term studies that explore the lasting impacts on mental health and development. Most existing research focuses on the short-term consequences, such as anxiety, depression, and behavioral changes during the pandemic, but fewer studies have examined how these issues evolve over time. As children transition back to in-person learning and adjust to new routines, it remains unclear how the disruptions from COVID-19 will affect their emotional and psychological development in the long run. This gap in literature highlights the need for longitudinal studies to assess the ongoing and potentially delayed effects of the pandemic on child behavior, social interactions, and academic performance.

While some studies have acknowledged the increased stress on low-income families during the pandemic, there remains a gap in research that thoroughly explores the intersection of socioeconomic status and mental health in children post-COVID. The pandemic exacerbated pre-existing inequalities, with children from disadvantaged backgrounds facing more severe disruptions, such as a lack of access to remote learning, increased family stress, and limited mental health resources. However, many studies have not adequately differentiated how these factors uniquely impact children from various socioeconomic backgrounds. Future research should investigate how postpandemic mental health outcomes vary based on economic disparities, ensuring that the experiences of the most vulnerable populations are fully understood and addressed.

Another significant gap in post-COVID literature is the limited examination of how schools are supporting children's reintegration into the classroom environment and addressing the behavioral challenges stemming from the pandemic. Many studies have explored the psychological effects of the pandemic on children. However, there is less research on the effectiveness of school-based interventions aimed at helping students adjust socially, emotionally, and academically after prolonged periods of isolation. Furthermore, there is little empirical evidence on which types of interventions—such as social-emotional learning programs, mental health services, or trauma-informed practices—are most effective in reducing post-COVID behavioral issues. This gap suggests the need for more comprehensive research on how schools can best support children's mental health in the wake of the pandemic and what interventions have the most significant impact on promoting positive behavioral outcomes.

Summary

In this study, I focused on addressing the misdiagnosis of mental health conditions among primary school-aged children, particularly in underserved communities, and explored the factors contributing to diagnostic errors. The key issue is the frequent attribution errors made by educators and mental health professionals, who may incorrectly attribute children's behavioral challenges to internal disorders like ADHD, rather than considering external factors such as trauma or socio-environmental stressors. Attribution Theory, introduced by Fritz Heider, is used as the primary lens to explore how these diagnostic errors occur and how they can be mitigated through better professional training, preparedness, and cultural competence.

I planned to explore the perceptions of educators and mental health staff in schools regarding the risk of attribution errors in the misdiagnosis of mental health conditions among primary school-aged children in Richmond, VA, and explored the practice-based and systemic changes that stakeholders proposed to enhance the mental health assessment of primary school-aged children in Richmond, VA. By focusing on Richmond, VA, the study also highlights the local human services problem of limited mental health resources and training in schools. Through empirical studies, it is evident that while professional training and cultural competence are critical to reducing misdiagnosis, there are still controversial findings regarding the effectiveness of these interventions without broader systemic support.

Despite significant research, there are still gaps in understanding how these variables interact and affect diagnostic outcomes in real-world educational settings. Moreover, existing interventions have not been thoroughly evaluated for their long-term effectiveness. The findings have the potential to improve both local and broader human services practices, ensuring that children receive accurate mental health assessments and appropriate interventions.

Section 2: The Project

Introduction

The proposed research project examines how attribution errors—where educators, school social workers, principals, or caregivers may misunderstand or wrongly attribute children’s behaviors to specific mental health issues—contribute to the misdiagnosis of children, especially those from underserved or marginalized communities. I explored how school workers, educators, and caregivers’ perceptions and experiences of how children’s behavior, influenced by cultural, social, or educational biases, may have led to misidentifying children as having ADHD, Oppositional Defiant Disorder (ODD), or other mental health conditions. For this study, I used Yin’s (2018) description of a multiple case study design to explore stories about the complexities of attribution errors in mental health assessments across a selection of school settings (Yin, 2018). By interviewing a convenience sample of educators, school social workers, and parents, I sought to understand the role of these possible attribution errors in school-based mental health evaluations and to develop strategies for improving diagnostic accuracy, enhancing professional preparedness, and ensuring that children receive the appropriate care and support.

Purpose Statement

The purpose of this study was to explore what educators, school social workers, and parents had experienced, and what they perceived contributed to the misdiagnosis of mental health conditions among primary school-aged children in Richmond, VA. I did this by analyzing a selection of cases and hearing their stories in keeping with the case

study method (Yin, 2018). By understanding what these key stakeholders believed was contributing to the risk of misdiagnosis of mental health conditions, the study findings could inform mental health practices in schools, contributing to better outcomes for children.

Project Design

The project was designed as a qualitative multiple case study (Yin, 2018). The study involved in-depth interviews with a selected sample of key stakeholders, including an educator, a selected mental health professional, and a parent or caregiver, to gather their perspectives and experiences with mental health evaluations and diagnosis processes in school settings.

Method

Role of the Researcher

As a qualitative researcher in this study, my role was to collect, analyze, and interpret data to explore the topic of misdiagnosis of children in Richmond, VA. I was responsible for designing the research process, selecting participants, conducting interviews, and gathering relevant documents or case studies to understand the underlying causes of misdiagnosis. Since this study followed a multiple case study design (Yin, 2018), I examined and analyzed cross-case data collected in interviews that created multiple cases to identify recurring patterns and themes. I actively engaged with diverse perspectives, including those of parents, educators, and mental health professionals, to gather rich, qualitative data that reflected the lived experiences of those directly involved.

However, as a researcher, I may carry preconceived ideas or biases about the topic based on my prior knowledge of mental health issues or systemic challenges in Richmond. For example, I may have had an inherent focus on systemic disparities in diagnosis due to existing knowledge of health inequities. To mitigate these biases, I consistently practiced reflexivity and journaled regularly, reflecting on my thoughts and assumptions to ensure they did not influence the data collection or analysis process.

Ethically, my role as a researcher involved maintaining the highest standards of integrity and respect for participants. I ensured informed consent was obtained from all participants, providing them with clear information about the study's purpose, procedures, and potential risks. I guaranteed confidentiality throughout the research process, securely storing data and removing identifiable information. In handling sensitive topics like risks of misdiagnosis, I remained sensitive to the emotional well-being of participants, particularly those discussing potentially traumatic experiences. I adhered to ethical guidelines to ensure that the research process was transparent, respectful, and responsible.

Participant Recruitment and Sampling Strategy

The target population for this study included individuals who had direct experience with child mental health diagnoses in Richmond, VA. This included a selected participant from parents or guardians of children who had been misdiagnosed, as well as selected mental health professionals, including school social workers and school counselors, educators, and social workers who had been involved in diagnosing or working with children in educational or healthcare settings.

The sampling strategy I used was purposive convenience sampling, which is a non-random selection method that focuses on selecting participants who have specific experience or knowledge related to the study's topic (Yin, 2018). This method was practical in qualitative research as it allowed me to gather data from participants who could provide in-depth, relevant information about the issues under study. Since this study followed a multiple case study design (Yin, 2018), purposive sampling helped ensure that each case selected could offer valuable insights through its own story and case. The criterion for participant selection was based on the following: parents or guardians of children who had been misdiagnosed, mental health professionals who had been involved in child assessments or diagnoses, and educators or social workers who work with children diagnosed with mental health conditions. These participants had to have direct experience or expertise in diagnosing, treating, or working with children who may have been misdiagnosed or who had been through the diagnostic process. By using a multiple case study approach, I wanted to capture diverse perspectives and then be able to identify patterns across multiple cases, contributing to a more comprehensive understanding of school-based mental health evaluations in Richmond.

In total, I planned to recruit four to five participants for this study. This sample size was appropriate because it is large enough to provide a diversity of experiences and perspectives, yet small enough to allow for detailed, qualitative analysis. The rationale for this number was based on the need to obtain rich, meaningful data in detail.

The recruitment process involved several steps to ensure that participants were identified, contacted, and recruited efficiently. First, I reached out to local mental health

clinics, schools, community organizations, and healthcare facilities to request their permission and ask them to post the flyer to identify potential participants. I distributed informational flyers and recruitment letters outlining the study's purpose, eligibility criteria, and how individuals could participate. Interested participants were invited to contact me directly via email or phone for more details. Through this process, I ensured that the sample was both appropriately selected and sufficient to reach data saturation. For those who were eligible and agreed to participate, I provided informed consent forms outlining the study procedures, risks, and confidentiality measures, and then scheduled a time for the interview.

Data Collection

I collected data using semistructured, 45 to 60-minute interviews as the primary data collection method. Semistructured interviews provided the flexibility to explore participants' individual experiences in-depth while allowing sufficient data to be collected for consistent comparison of responses across different participants. The development of the interview protocol was based on literature sources regarding children's mental health diagnosis, including studies on diagnostic practices, biases in mental health assessments, and barriers to accurate diagnosis. In addition to the literature review, a review of the protocol was conducted with individuals who met the criteria of inclusion but who are not participants to review and refine the interview questions and ensure clarity and relevance.

Content validity of the questions for the interviews was established through a careful review of the literature and by consulting with experts in child mental health, including selected mental health professionals and educators, caregivers, who can

validate the relevance and clarity of the interview questions. Additionally, the questions were reviewed by peers and committee advisors with experience in qualitative research to ensure they are appropriate for addressing the research questions. The sufficiency of the data collection instruments was evaluated by the extent to which the interview questions allowed participants to share their experiences and provide insight into the risks and challenges of misdiagnosis, as well as its impact on children and their families.

I was responsible for collecting the data, conducting one-on-one interviews with participants, either in person or via secure video conference, depending on participant preference. The data collection frequency consisted of one interview lasting 45-60 minutes. These interviews were scheduled over 2-3 weeks to ensure sufficient time for participant recruitment and data collection.

The data was recorded with the consent of the participants, using audio recording devices, which were to be transcribed verbatim to ensure accuracy. These recordings were stored securely and anonymized to protect participant confidentiality. A follow-up plan was placed if recruitment results in too few participants, with additional outreach to local organizations, schools, and clinics to encourage broader participation. If further recruitment was necessary, a reminder would be sent to potential participants, and additional recruitment efforts would be made through social media platforms or community organizations.

After ensuring informed consent was recorded, upon the start of the interview, participants were briefed about the study, its objectives, and the potential impact of their participation. The briefing included an opportunity for participants to ask questions or

express any concerns they may have. They were also informed of their right to withdraw from the study at any point without consequence. I also informed participants that I would provide them with a summary of the findings of the results by email once they are approved. By adhering to these protocols, I ensured that the data collection process was systematic, transparent, and ethical, while also maintaining flexibility to explore the complexities of the diagnostic process and risks in children in Richmond.

Data Analysis

Data Analysis Plan

I used a qualitative approach that involves content coding and thematic analysis to identify patterns, themes, and key insights related to the misdiagnosis of mental health conditions in primary school-aged children (Yin, 2018). The first step in the data analysis involved transcribing all audio data from interviews verbatim to ensure an accurate representation of participants' responses. I then first used open coding, where I reviewed the data manually, broke down the transcriptions into meaningful units of information, and assigned labels or codes to segments of text that related to key concepts. As the coding process progressed, I moved to axial coding, which involved grouping similar codes into categories that reflected broader themes related to the research questions.

For the thematic analysis, I followed a process of identifying recurring patterns in the data, categorizing these patterns into overarching themes, and interpreting the significance of these themes in the context of the research objectives. This approach allowed me to identify commonalities and differences across participants (educators, mental health professionals, and parents) regarding their experiences and perspectives on

mental health evaluations in schools. I used NVivo, a qualitative data analysis software, to assist with coding and organizing the data, as it provided robust tools for managing large datasets, coding qualitative data, and visualizing themes. This software enabled me to maintain a consistent and systematic approach to data analysis and ensure that all responses were examined thoroughly.

Discrepant cases, or data that deviated from the main patterns or themes, were carefully examined to understand the full complexity of the issue. These cases were not discarded but were explored to see how they might offer alternative perspectives or indicate areas that required further investigation. I used these discrepant cases to refine the analysis, asking whether the discrepancies suggested new themes or contradictions in the data that needed to be addressed. These cases were also included in the final analysis to ensure the study reflected the full range of participant experiences and the diversity of views on misdiagnosis and mental health evaluations. By examining both consistent themes and discrepant cases, I aimed to provide a comprehensive and nuanced understanding of how misdiagnosis occurred and how attribution errors and professional preparedness contributed to these inaccuracies.

Ethical Considerations for Data Collection and Protection of Human Participants

In conducting this research, the protection of human participants was paramount. Ethical considerations guided the entire research process, from recruitment through data collection, and ensured that participants' rights and well-being were safeguarded at all stages. This section outlined how informed consent was obtained, the ethical procedures related to participant recruitment, data collection, and the treatment of data, and how

potential risks and adverse events were managed to ensure that the study complied with ethical standards.

Informed Consent

Informed consent is a crucial component of ethical research. It ensures that participants understand the purpose of the study, the procedures involved, and any potential risks before they agree to participate. As part of the informed consent process, I provided all potential participants—parents, educators, mental health professionals, and caregivers—with a detailed information sheet by email that explained the study’s objectives, the voluntary nature of their participation, and the fact that they could withdraw at any time without consequence. Participants were informed that their responses would be anonymized and confidential, and they had the option to ask questions or seek clarification before they gave consent.

The informed consent document used the Walden template, and I was informed that the following:

1. The purpose of the study and how they were invited to participate.
2. Details about the type of data collection, one-on-one interviews or focus groups, and the time commitment required.
3. The assurance that all data would be anonymized and securely stored, and that participants’ identities would not be shared in any reports or publications.
4. Although minimal, the potential risks—such as emotional discomfort during discussions of mental health conditions—were addressed, and resources for counseling or support were provided.

5. Participants were reminded that they have the right to withdraw at any point without penalty, and that their decision would not affect their relationship with the researcher, their institution, or the community.

Participants agreed orally or by return email with the words, “I consent” before beginning the interview or focus group, confirming their understanding of the information provided and their voluntary agreement to participate.

Agreements to Gain Access to Participants and Data

Before data collection could begin, it was essential to secure institutional permissions and agreements to distribute the flyer through their email or listserv. In accordance with the Institutional Review Board (IRB) guidelines, I submitted a request with a sample flyer to each organization for information. The proposal included a summary of the study and a request to post the flyer seeking volunteer participants and inviting them to respond directly to me, without the knowledge of the institution. No other cooperation was requested of the organizations that posted the flyers.

Ethical Concerns Related to Recruitment Materials and Processes

Recruitment materials must be designed with care to ensure they are clear, accurate, and free from any coercive language. The materials, including flyers, emails, or letters, provided sufficient information for potential participants to make an informed decision about their involvement in the study. I ensured that the language used in these materials was neutral, emphasizing that participation was voluntary and that no negative consequences would result from opting out. Additionally, I took steps to avoid any undue

influence or pressure, particularly in situations where participants might have felt obligated to participate due to their professional or familial roles.

To ensure ethical recruitment, I used multiple recruitment methods, such as contacting local schools, clinics, and community organizations to request that they post the flyer to reach diverse participants. This process was transparent and conducted with respect for individuals' autonomy. Potential participants were given ample time to consider participation and were encouraged to ask questions. Any materials that included contact information or consent forms clearly indicated that they were for research purposes and were used exclusively for recruitment in this study.

Ethical Concerns Related to Data Collection and Participant Withdrawal

During data collection, it is important to handle any issues related to participant withdrawal or discomfort. Participants may withdraw from the study at any time without facing any penalties. If a participant decided to withdraw early, I ensured that their data was not included in the final analysis if they so wished. It is important to address any potential distress caused by discussing sensitive topics, such as misdiagnosis and mental health issues. Suppose a participant became visibly upset during an interview. In that case, I had protocols in place to provide immediate support, such as referring them to a free mental health professional or offering follow-up resources.

If participants refused participation during data collection, they were reminded of their right to discontinue their involvement without adverse consequences. I handled early withdrawals or refusals with respect and ensured that participants' confidentiality was maintained throughout the process.

Treatment of Data: Confidentiality and Data Protection

The treatment of data was a critical aspect of ensuring the ethical integrity of the study. The data collected during interviews or focus groups was handled with the utmost confidentiality. I ensured that all identifying information was removed from the data, such as names, addresses, or any other details that could potentially identify participants. The data was stored securely in encrypted digital formats and was only accessible to the researcher and authorized personnel, such as research assistants or data analysts. No identifiable information was shared with third parties or included in publications.

Data was stored for the study and then destroyed after five years, in accordance with institutional policies and the IRB's guidelines. This ensured participant confidentiality was maintained even after the study. Additionally, the use of pseudonyms in place of real names in all reports and publications protected the identity of the participants while still allowing the findings to be shared with the broader community.

Ethical Concerns Related to Conflict of Interest and Power Dynamics

In any study involving human participants, the potential for conflicts of interest or power imbalances must be carefully considered. Given that some participants may have been from the researcher's professional network (such as educators or mental health professionals), I took steps to ensure that there was no undue influence on their participation. To address this, I provided explicit assurances that their participation would not affect their professional relationships or standing. I also explained the research's purpose in a way that minimized pressure for individuals to participate due to their connection with the researcher.

Power dynamics may also arise in interactions between parents, children, and educators. For example, a parent might feel obligated to participate if they perceive the researcher as an authority figure. To mitigate this, I emphasized the voluntary nature of participation and offered a non-coercive, neutral environment for all participants. Additionally, I ensured that both educators and parents understood that their responses were not influencing any professional decisions or interactions with the children involved in the study.

Incentive or Compensation for Participation

No incentives or compensation were offered to participants. A token of appreciation was provided as a small gift card with a value of no more than \$10.00 for participants' time and effort. This study adhered to the highest ethical standards by ensuring informed consent, protecting participant confidentiality, and implementing safeguards against potential risks. The treatment of participants and data followed established ethical guidelines to ensure that the research process was transparent, respectful, and responsible. By addressing potential conflicts of interest, power dynamics, and other ethical concerns, I aimed to conduct a study that contributed to the understanding of misdiagnosis in children while prioritizing the rights and well-being of all participants..

Summary

In this project, I explored how stakeholders perceive what is contributing to the risk of misdiagnosis of mental health conditions in primary school children by gathering qualitative data from interviews. I added new information about diagnostic practices,

professional training, and the overall mental health evaluation process in Richmond schools. The results will inform a Professional White Paper or Executive Summary aimed at guiding policy changes and improving support systems for children in the community.

Having explored the background, objectives, and methodology of this study, the next section will outline the results of the research. This section will present the key findings derived from the case study interviews conducted with educators, mental health professionals, and parents in Richmond, VA. By analyzing these findings, I aim to identify critical patterns and insights that may add new information for future interventions and improvements in mental health evaluations within the school system.

Section 3: Results of the Study

Introduction

This section presents the findings of the study based on the perspectives of various stakeholders involved in the mental health diagnosis process for primary school-aged children in Richmond, VA. The results are organized to address the two central research questions guiding this study. The first question explored how stakeholders perceive the role of attribution factors in contributing to cases of mental health misdiagnosis among children. The second question investigated the practice-based and systemic changes stakeholders propose to improve diagnostic accuracy. This section includes the research questions, the findings, and a summary of the findings.

Research Questions

The research questions for this study were as follows:

- RQ1. How do stakeholders perceive the role of attribution in contributing to cases of the misdiagnosis of mental health issues among primary school-aged children in Richmond, VA?
- RQ2. What practice-based and systemic changes do stakeholders propose to enhance diagnostic accuracy in primary school-aged children?

Presentation of the Results

Data Analysis

To begin the coding process, I conducted a word frequency analysis using Wordcloud software to determine the most frequently used terms in the dataset. The word frequency analysis served as a preliminary step, providing a quick overview of dominant

Generating Initial Codes

A total of 101 codes were generated during the first cycle of coding in NVivo. These codes comprised 21 principal codes and 79 child codes. The main codes focused on key areas such as behavioral change, mental health burdens, diagnostic procedures, communication, and the roles of schools and social workers. The child codes captured more specific experiences and factors influencing the main codes, including emotional distress, stigma, poverty, trauma, family dynamics, and the need for professional support and training.

The 21 principal codes identified during the analysis were as follows: behavioral change, burden of mental health, causes of misdiagnosis, class disruption, communication of behavior change, consequences, considerations, diagnosis disagreement, diagnosis procedure, diagnosis tools, involvement during diagnosis, lack of support, medication concerns on addiction, misunderstanding behavior change, punishment due to behavior change, role of the school in behavior change detection, role of school social workers in diagnosis, struggling with focus, being under looked, what would make a difference, and wrong communication of behavior.

The 79 child codes expanded upon these main codes by providing more detailed descriptions. These included codes such as emotional draining, stigma, trauma, family resistance, lack of professionals, managing symptoms, poverty, family instability, training staff, comprehensive evaluations, collaborative support, clear communication, and integrated support, among others. The analysis also identified codes that had the

highest number of references. Table 1 presents the codes with the highest number of references, along with the number of files and references associated with each code.

The findings suggest that codes such as comprehensive evaluations (17 references), consequences (16 references), and diagnosis procedure and considerations (13 references each) were highly prominent in the data.

Table 1*Codes With the Highest Number of References*

Code	Files	References	Code description	Code source (sample quotes)
Comprehensive evaluations	3	17	Holistic and thorough assessments considering academic, emotional, social, and family factors.	“Schools should conduct more comprehensive evaluations that take into account not only academic performance but also family dynamics, trauma, and mental health factors” (Parent Survey).
Consequences	3	16	Negative outcomes or effects resulting from misdiagnosis or inappropriate interventions.	“This resulted in the child receiving interventions that did not adequately address the root cause of the behavior” (Participant 3 Survey).
Considerations	2	13	Internal and external factors (e.g., trauma, family life, social environment) during assessments.	“When conducting assessments, I take a holistic approach that includes considering external factors like trauma, family life, and the child’s social environment” (Participant 4 Survey).
Diagnosis procedure	2	13	Steps or processes schools follow in evaluating and referring students for mental health concerns.	“I gather input from multiple sources, including teachers, school counselors, and parents, to get a well-rounded view of the child’s behavior and emotional state” (Participant 4 Survey).
Misunderstanding behavior change	2	12	Misinterpretation of behavioral changes leading to wrong assumptions, labels, or misdiagnosis.	“Often, behaviors like hyperactivity, impulsivity, or emotional outbursts are mistakenly attributed solely to a mental health condition ... without considering other underlying factors” (School Participant 2).
Understanding root cause	2	12	Underlying reasons for behavioral or emotional challenges before intervention.	“Schools may not inquire about family history, trauma experiences, or home life, which can lead to an incomplete or skewed understanding of the child’s needs” (School Participant 2).
Collaboration	2	11	Teamwork among parents, teachers, mental health professionals, and other agencies.	“We have implemented a more thorough process for involving parents, specialists, and mental health professionals to ensure that the right diagnosis and

Code	Files	References	Code description	Code source (sample quotes)
Educating school staff	4	10	Training and equipping school staff with skills in mental health awareness and trauma-informed practices.	placement are made” (Participant 3 Survey). “Educating the school staff on how to manage and understand a child with behavior issues effectively would have been incredibly helpful” (Participant 1 Survey).

Searching for Themes

During the process of identifying themes, several codes were grouped and clustered based on their similarities. Codes related to emotional exhaustion, feeling isolated, feeling judged, frustration, homelessness, being misunderstood, feeling overwhelmed, and physical punishment due to behavior change were categorized under the theme Burden of Mental Health. Additionally, codes such as delayed treatment, medication, medication addiction, and special education programs were grouped to form the theme Delayed Treatment and Risk of Wrong Intervention. Furthermore, codes indicating not addressing the problem and worsening the situation were combined under the theme Worsening the Situation Rather Than Addressing the Problem.

The theme Current Mental Health Diagnostic was developed from codes related to communication, gathering inputs, referral, review of behavior, and staff training. The theme Current Diagnostic Tools was derived from codes such as professional knowledge on diagnosis, social behavior interference, struggling focus, academic performance, behavioral change, and information. Additionally, the theme Current Perceived Considerations During Diagnosis emerged from codes including family history

consideration, family life, internal and external factors, intervention accuracy, involvement during diagnosis, mental health needs, root cause, social life, and trauma.

Codes related to awareness, culturally informed practices, educating school staff, reading literature, and reducing stigma were combined to form the theme Awareness & Education. Codes such as collaboration, collaborative support, developing a plan, clear communication, and resolving misunderstandings were grouped together under the theme Collaboration and Communication. Additionally, codes related to comprehensive evaluations, family dynamics consideration, more time for comprehensive evaluation, strength-based approaches, and understanding root causes were organized under the theme Comprehensive & Individualized Evaluations.

Codes related to emotional and social development monitoring, integrated support, intervention adjustments, monitoring, one-on-one support, professional resources, and support resources were combined to form the theme Integrated & Ongoing Support. Codes such as trauma-informed practices and conducive environment were grouped under the theme Trauma-Informed Approaches.

The codes including family dynamics, family instability, family resistance, home life, homelessness, loss of caregiver, and neglect were classified under the theme Family Dynamics. Additionally, codes related to environmental and socioeconomic factors—focusing on behavior rather than root causes, labeling based on history, and a poor understanding of the child's needs—were grouped under the theme Misunderstanding Behavior Change.

Codes such as lack of support and overreliance on performance were combined to create the theme Professional and School Management Problems. Codes related to cultural factors, poverty, race, and stigma were categorized under the theme Social, Economic, and Cultural Factors, with the sub-theme Stigma highlighting cultural factors, poverty, and race stigma.

Lastly, codes such as abandonment, abuse, emotional needs, trauma, and trauma history were categorized under the sub-theme Trauma, while high professional caseload, lack of professionals, and limited time and resources were grouped under the sub-theme Untrained Staff, Inadequate Professionals, and Resources.

Reviewing Themes

Upon reviewing the initial themes, broader emerging themes were identified from the initial categorizations. The original themes—Family Dynamics, Professional and School Management Problems, Social, Economic, and Cultural Factors, Misunderstanding Behaviour Change, Trauma, and Untrained Staff, Inadequate Professionals, and Resources—all pointed toward the broader theme of Perceived Causes of Mental Health Misdiagnosis. Additionally, the initial themes Burden of Mental Health, Delayed Treatment and Risk of Wrong Intervention, and Worsening the Situation Rather Than Addressing the Problem collectively indicated the broader theme of Burden and Consequences of Wrong Diagnosis.

The initial themes of Awareness & Education, Communication & Collaboration, Comprehensive & Individualized Evaluations, Integrated & Ongoing Support, and Trauma-Informed Approaches were grouped under the broader theme of Key Strategies

to Improve Outcomes. Themes that were not collapsed included Current Mental Health Diagnosis Procedure and naming themes.

Table 2

Broader Themes From Initial Themes

Broader theme	Initial themes
Perceived causes of mental health misdiagnosis	Family dynamics; Professional and school management problems; Social, economic and cultural factors; Misunderstanding behavior change; Trauma; Untrained staff, inadequate professionals, and resources
Burden and consequences of wrong diagnosis	Burden of mental health; Delayed treatment and risk of wrong intervention; Worsening the situation rather than addressing the problem
Key strategies to improve outcomes	Awareness & education; Communication & collaboration; Comprehensive & individualized evaluations; Integrated & ongoing support; Trauma-informed approaches

Themes for RQ1: Stakeholders' Perceptions of Attribution in Misdiagnosis

To capture stakeholders' perspectives on attribution and its impact on misdiagnosis, the original themes were refined to highlight key factors related to causes, consequences, and current diagnostic practices. These revised themes reflect a more precise and stakeholder-focused interpretation of the data.

Table 3*Original Themes and Renamed Themes for Research Question 1*

Original theme	Renamed theme
Perceived Causes of mental health misdiagnosis	Stakeholders' perceived attribution factors leading to mental health misdiagnosis
Burden and consequences of wrong diagnosis	Impacts and consequences of misattributing mental health conditions
Current mental health diagnosis procedure	Stakeholder perceived current mental health diagnostic procedures
Current mental health diagnosis tools	Stakeholder perceived diagnostic tools used in mental health assessments

Themes for RQ2: Proposed Practice-Based and Systemic Changes

For the second research question, which explores proposed improvements to diagnostic accuracy, two broad themes were identified and renamed to encapsulate both current diagnostic practices and suggested strategic improvements.

Table 4*Original Themes and Renamed Themes for Research Question 2*

Original theme	Renamed theme
Current perceived considerations during diagnosis	Stakeholders' current diagnostic practices and considerations
Key strategies to improve outcomes	Stakeholder-proposed practice-based and systemic strategies to enhance diagnostic accuracy

A final list of themes was created to address the two main research questions guiding this study. For Research Question 1 (RQ1), which examines how stakeholders view the role of attribution in contributing to the misdiagnosis of mental health issues among primary school-aged children, four themes were identified: Theme 1— Stakeholders' Perceived Factors Leading to Mental Health Misdiagnosis; Theme 2— Stakeholders' Views on Current Mental Health Diagnostic Procedures; Theme 3— Stakeholders' Perceptions of Diagnostic Tools Used in Mental Health Assessments; and

Theme 4—Impacts and Consequences of Misattributing Mental Health Conditions. For Research Question 2 (RQ2), which looks into the practice-based and systemic changes stakeholders suggest to improve diagnostic accuracy, two themes emerged: Theme 5—Stakeholders’ Current Diagnostic Practices and Considerations; and Theme 6—Proposed Practice-Based and Systemic Strategies to Improve Diagnostic Accuracy.

Reporting the Findings

The analysis was organized around two research questions. The first question (RQ1) examined how stakeholders perceived the role of attribution in contributing to the misdiagnosis of mental health issues among primary school-aged children in Richmond, VA. The second question (RQ2) explored the practice-based and systemic changes stakeholders recommended to improve diagnostic accuracy in the same group.

For RQ1, four main themes were identified. Theme 1 focused on stakeholders’ perceived reasons for mental health misdiagnosis. Theme 2 discussed stakeholders’ views on current mental health diagnostic procedures. Theme 3 highlighted stakeholders’ opinions on diagnostic tools used in mental health assessments. Finally, Theme 4 explored the impacts and consequences of misattributing mental health conditions.

Theme 1, stakeholders’ perceived reasons, was further divided into six categories. These included (a) misunderstanding children’s behavioral changes, (b) school staff as administrators who are not sufficiently prepared or educated on mental health, (c) family cohesion problems, (d) children’s trauma, (e) untrained staff, and (f) insufficient programs and human services. Participants highlighted that children’s behaviors are often misunderstood without considering environmental, socioeconomic, or emotional factors.

Schools generally focused more on discipline and academics than on holistic support, while systemic issues such as poverty, racial bias, and cultural stigma were often ignored. Trauma was also identified as a crucial but under-assessed factor, and stakeholders pointed out the lack of trained professionals and resources. Family instability and resistance added to the difficulty of accurately understanding these behaviors assessments.

Theme 2 focused on stakeholders' perceptions of current diagnostic procedures. Although there was no standardized process, participants described common steps used in schools. These included structured observations across different settings, collaborative assessments involving teachers and administrators, family engagement, referrals to counselors or external professionals, and data-based planning for interventions.

Theme 3 covered stakeholders' views on diagnostic tools. Unlike procedures, these tools are used to evaluate children. Observation-based indicators such as academic performance, behavioral changes, and social interactions were commonly used. Parents and caregivers mentioned that teachers mainly focus on disruptive behaviors, which often lead to disciplinary rather than supportive responses. Counselors explained that they rely on professional judgment and developmental benchmarks, especially by considering the frequency, severity, and context of behaviors. Collecting information from multiple sources, including input from parents, participant 2s, and counselors, was also emphasized.

Theme 4 examined the effects of misattribution. Participants emphasized major challenges faced by children and families, such as emotional stress, stigma, and

inappropriate disciplinary measures. Misdiagnosis often delayed treatment, resulting in ineffective or harmful interventions like unnecessary medication. Moreover, ignoring the root causes frequently worsened children's conditions, raising their chances of exclusion, improper placement in special education, or increasing behavioral issues.

For RQ2, two themes emerged. Theme 5 reflected stakeholders' current diagnostic practices and considerations, while Theme 6 highlighted strategies proposed by stakeholders to improve diagnostic accuracy.

Theme 5 showed how different stakeholders approach diagnosis. Parents said they are actively involved in decision-making, such as creating individualized education plans and attending behavioral meetings, and they ask for extra support when needed. Principals focused on finding root causes by talking with staff and watching interventions. Participant 4 emphasized the importance of thorough, trauma-informed assessments that consider external factors like family situations and recent stressors. Participant 2 underscored the need to assess family backgrounds and trauma histories before making conclusions interventions.

Theme 6 concentrated on strategies to enhance diagnostic accuracy. Five subthemes were identified: awareness and education, communication and collaboration, comprehensive and personalized assessments, integrated and ongoing support, and trauma-informed approaches. Parents and caregivers stressed the importance of teacher training and effective interventions. Principals called for professional development in trauma-informed care and reducing stigma. Counselors and Participant 2s highlighted cultural competence, peer collaboration, and structured communication systems. All

stakeholders recommended assessments that consider family and environmental factors, avoid depending solely on checklists, and involve multidisciplinary teams. Suggestions also included increasing access to mental health professionals, providing ongoing behavioral support, and incorporating trauma-informed assessments and classroom practices.

RQ1. How Do Stakeholders Perceive the Role of Attribution in Contributing to Cases of the Misdiagnosis of Mental Health Issues Among Primary School-Aged Children in Richmond, VA?

Theme 1: Stakeholders' Perceived Leading to Mental Health Misdiagnosis.

Participants highlighted that misunderstanding behavior change is a key factor in the misdiagnosis of mental health issues among primary school-aged children. Both parents/caregivers and school participants described how behaviors are often interpreted without considering environmental, socioeconomic, or emotional factors that may influence the child's actions. Data revealed codes such as environmental and socioeconomic influences, an emphasis on surface behaviors over root causes, labeling based on history, and a lack of understanding of the child's needs. For example, the parent/caregiver participant explained: "The communication often felt more like a series of reports on disruptive behaviors rather than a collaborative effort to address the underlying causes and find solutions to support my child in a more constructive way" (Participant 1). This individual also noted that circumstances like homelessness were not adequately acknowledged when observing their child's behavior, such as sleeping in class, stating: "We've also struggled with homelessness, and the school didn't take that

into account when they noticed him sleeping in class”. Instead, schools tended to focus only on surface-level behaviors: “They quickly assumed it was just a behavioral issue, not understanding that we barely got any sleep due to our circumstances”.

The same participant also mentioned that schools are quick to label children without investigating underlying issues: “Instead of taking the time to ask what was really going on or offering support, they were quick to label him, which made it harder for us to get the proper help he needed.” Their statement further emphasized this: “It feels like he’s being misunderstood and judged based on past behaviors, rather than receiving the comprehensive support and understanding he deserves.”

School Participant 2 echoed these concerns, confirming that misdiagnosis often results from misinterpreting behaviors: “Yes, based on my experience, I do believe that some children are being misdiagnosed due to behavioral misinterpretation” (Participant 2). They explained how symptoms like hyperactivity, impulsivity, and emotional outbursts are often automatically linked to conditions such as ADHD or ODD, without further investigation: “Often, behaviors... are mistakenly attributed solely to a mental health condition... without considering other underlying factors”.

The social worker also highlighted how trauma, unmet emotional needs, and environmental stressors often resemble mental health symptoms. She explained, “Trauma, environmental stressors, or unmet emotional needs can manifest in ways that mimic certain mental health disorders, but these behaviors are sometimes treated as symptoms of a disorder without exploring the root cause.” Many children they worked with had faced significant adversity: “These traumatic experiences can manifest in

behaviors like anxiety, aggression, withdrawal, or difficulty focusing, which may be misunderstood as symptoms of a mental health condition.”

The parent or caregiver participant shared that their child, who has ADHD, did not receive enough support at school. They explained, “My child has ADHD, and the lack of support within the school to properly assist him with his condition has been a significant challenge” (Participant 1). They also expressed frustration with the school’s approach, noting, “This has left us in a difficult position, as we want to support his learning, but the school's approach has not been effective or accommodating to his needs.”

Instead of addressing the root challenges, schools were seen as focusing on punitive measures. The parent or caregiver emphasized, “There is a lack of behavioral health support in the school, and instead of addressing his underlying struggles, they often focus on punishing his behaviors.” They also believed that evaluation processes were not thorough: “In my opinion, several factors were overlooked during the evaluation process.” Participant 2 agreed with these concerns, noting that schools tend to focus on academic performance and classroom behavior during evaluations. They explained, “Schools may focus primarily on academic performance and in-school behavior, which can neglect the broader context of a child's life.”

Subtheme 3: Socioeconomic and Cultural Factors. Participant 2 reported that racial biases in schools disproportionately affect children of color, especially Black and Latino students. They said, “Children of color, particularly Black and Latino children, are often subjected to racial biases in schools. These biases can shape how their behavior is

perceived and categorized” (Participant 2). They also explained that the same actions could be interpreted differently depending on the child's race: “A child of color who is perceived as disruptive may be more likely to be labeled as defiant or aggressive, while a white child exhibiting similar behaviors might be viewed as having a 'bad day' or simply acting out occasionally.”

Poverty was also identified as a major contributing factor. Many children from low-income families face environmental stressors like food insecurity, housing instability, or exposure to violence, which impact their emotional and behavioral health. However, these stressors are often overlooked during diagnosis: “The behaviors that stem from these stressors... may be viewed as symptoms of mental health disorders like ADHD or ODD, without consideration of the external pressures the child is facing.” The social worker also pointed out, “Children in poverty often lack access to mental health services, which may lead to their needs being unmet or misdiagnosed, adding to challenges in school and at home.”

Cultural differences were another vital factor contributing to misdiagnosis. The social worker explained that educators and mental health professionals sometimes misinterpret behaviors influenced by culture: “In some cultures, certain behaviors, such as speaking out of turn or displaying emotional distress, may be viewed as disrespectful or defiant, while in other cultures, those same behaviors might be seen as signs of stress or discomfort.” Finally, stigma related to mental health was identified by both the principal and the social worker as a barrier to accurate diagnosis and treatment. Families may avoid seeking assessments or interventions out of fear of judgment, as the principal

noted: “Additionally, there can be resistance from families, either due to stigma or lack of awareness about the importance of mental health assessments” (Participant 3).

The parent or caregiver participant shared how trauma significantly affected their child’s behavior, noting, “My child suffers from neglect and abandonment, particularly from his father, which has had a major impact on his behavior” (Participant 1). They also pointed out that, as the oldest child, their son had been forced to take on extra responsibilities, stating, “He has had to shoulder a lot of emotional burdens, and his trauma plays a huge role in how he acts.” The parent or caregiver stressed the importance of thorough assessments, explaining, “When evaluating a child, all factors—like family dynamics, trauma history, and home life—should be considered to gain a more complete and accurate understanding of their needs.”

Participant 3 highlighted that misdiagnoses often happen when trauma-related behaviors are mistaken for signs of mental health conditions. They explained, “Yes, there have been cases in which students were either misdiagnosed or improperly placed, particularly when the behavioral issues were linked to trauma or environmental stressors rather than an inherent mental health condition” (Participant 3). One example involved a child diagnosed with ADHD based on classroom hyperactivity and lack of focus, but further evaluation showed the behaviors were trauma related.

Similarly, the school counselor participant recalled a case where a child initially diagnosed with ADHD was later found to be coping with domestic violence at home: “After further evaluation, it was discovered that the child had experienced significant trauma... Once trauma-informed practices were introduced, it became clear that he

needed different types of support, including trauma counseling, rather than medication for ADHD” (Participant 4). Participant 2 echoed these observations, explaining that many children they work with have experienced trauma through abuse, neglect, or loss of a caregiver. They noted, “These traumatic experiences can manifest in behaviors like anxiety, aggression, withdrawal, or difficulty focusing, which may be misinterpreted as symptoms of a mental health condition” (Participant 2). Unfortunately, trauma is often overlooked in school assessments, leading to misdiagnosis or inappropriate placement in special education programs that focus on managing behaviors rather than addressing trauma.

Participant 3 highlighted that a significant systemic problem is the limited access to mental health professionals both within schools and the wider community. They explained, “One of the primary barriers we face is limited access to mental health professionals, both within the school system and in the community” (Participant 3). These shortages often cause significant delays in the diagnostic process: “Often, there is a long waitlist for external evaluations or specialized therapy, which delays proper diagnosis and intervention.” Additionally, Participant 3 stressed that some staff members lack sufficient training to recognize signs of mental health conditions, noting, “Another barrier is the insufficient training that some staff members may have in recognizing mental health issues, which can lead to behaviors being misinterpreted as disciplinary problems rather than symptoms of a mental health concern.”

The school counselor participant echoed these concerns, emphasizing how high caseloads and limited resources impact the evaluation process. They shared, “While I

strive to provide thorough evaluations, there are times when time and resources can be limited, especially when dealing with a high caseload or limited access to specialized mental health professionals” (Participant 4). They further explained that conducting accurate assessments requires enough time to collect and interpret data: “Conducting accurate evaluations requires adequate time to gather all necessary information, including input from teachers, parents, and external providers, as well as time to analyze and interpret the data.”

The parent or caregiver participant shared how family instability greatly affected their child’s behavior, stating, “My child suffers from neglect and abandonment, particularly from his father, which has had a significant impact on his behavior” (Participant 1). Participant 3 noted that family resistance often hampers accurate diagnosis, explaining, “Additionally, there can be resistance from families, either due to stigma or lack of awareness about the importance of mental health assessments” (Participant 3). This reluctance can delay or prevent children from getting thorough evaluations and proper interventions.

Participant 2 further explained how family instability and neglect influence children’s behaviors, which are sometimes mistaken for mental health issues. They noted, “Many of the children I encounter have experienced trauma, whether it’s from abuse, neglect, loss of a caregiver, or environmental stressors like homelessness or family instability. These traumatic experiences can show up as behaviors such as anxiety, aggression, withdrawal, or difficulty concentrating, which may be misunderstood as symptoms of a mental health condition” (Participant 2). Sadly, family-related factors are

often ignored: “In some cases, schools may not ask about family history, trauma, or home life, which can lead to an incomplete or distorted understanding of the child’s needs.”

The participant also pointed out cases where children were prescribed medication or placed in out-of-home care because behaviors caused by family conflict or neglect were wrongly interpreted: “Behaviors stemming from neglect or family conflict were seen as “disruptive” or “oppositional” and led to a recommendation for out-of-home placement, even though the real issue was the lack of emotional support at home.”

Theme 2: Stakeholder Perceived Current Mental Health Diagnostic

Procedures. The participants described a structured process that usually begins with observing behaviors, then involves collaboration among staff, communication with families, and, when necessary, referrals to mental health professionals. The parent or caregiver participant shared how schools communicate observed behaviors, often through multiple channels, saying, “These behaviors were communicated to me through phone calls, emails, and occasional notes sent home” (Participant 1). Participant 3 explained a more detailed procedure that starts when behavioral concerns are raised. They stated, “If there is a concern that the behavior may be linked to a mental health issue, we work with the student’s family and refer them to a mental health professional for further evaluation” (Participant 3). They also added, “When behavioral concerns are raised, I work closely with Participant 4, teachers, and parents to assess the situation.” Once it is believed that behaviors are connected to a mental health concern, referrals are made: “If it appears that the behavior is linked to a mental health concern, I authorize a referral to a mental health

professional for further evaluation.” In more complex cases, the school collaborates with outside agencies, “if the situation requires a more specialized assessment.”

Participant 3 also discussed how attributions are made by gathering input from various sources, explaining, “Attributions about student behavior are typically formed by gathering input from multiple sources, including teachers, counselors, and the student’s parents.” Staff members are trained to observe children’s behaviors in different settings, such as classrooms, playgrounds, and peer interactions (Reference 6). This data-driven approach helps them determine whether concerning behaviors are part of a consistent pattern or isolated incidents: “We prioritize using data to understand whether the behavior is a one-time incident or part of a pattern.” Once attributions are made, the staff works together to develop an appropriate plan, which may include targeted interventions, behavior contracts, or referrals to outside professionals.

The school counselor provided more details about the diagnostic process, noting, “In my process, I begin by reviewing any behavioral or academic concerns raised by teachers, parents, or school staff” (Participant 4). They emphasized the importance of gathering input from various sources to gain a comprehensive understanding of the child’s needs: “I gather input from multiple sources, including teachers, school counselors, and parents, to get a well-rounded view of the child's behavior and emotional state.” Once concerns are confirmed, the counselor makes sure to refer the case to the appropriate professionals, “such as school counselors, social workers, or external specialists.” They described how this might involve holding a meeting with the child’s

caregivers and school staff, “to discuss the child's challenges and determine the next steps, which could include a formal mental health assessment or behavioral evaluation.”

Theme 3: Stakeholder Perceived Diagnostic Tools Used in Mental Health

Assessments. During the interviews, participants described the tools and indicators they used to assess potential mental health concerns among primary school-aged children. These tools mainly included observations of academic performance, behavioral changes, social interactions, and the application of professional knowledge on child development. While these methods aimed to support early detection, participants often noted that such tools could oversimplify complex situations and sometimes lead to misdiagnosis.

The parent/caregiver participant reported that teachers often focused heavily on classroom behaviors without fully understanding the underlying causes. They recalled how their child’s difficulty focusing frequently led to disciplinary measures rather than support: “He often struggled to focus, leading to disruptions in class, and instead of receiving the help he needed, the teachers simply sent him out of the classroom” (Participant 1). They further explained that the school documented a wide range of problematic behaviors: “The school identified several concerning behaviors in my child, including a lack of focus, talking inappropriately, running out of class, taking items from the teacher's desk, talking back, playing with scissors, using the bathroom on the floor, and engaging in arguments with both teachers and peers”. This account suggested that labeling children based on observed behaviors was common, and deeper investigation into root causes was often lacking.

The school counselor participant indicated that they relied on developmental benchmarks and professional expertise when determining whether a child's behavior might signal a mental health concern. They described their approach: "To distinguish between developmentally appropriate behaviors and those that may signal a mental health issue, I relied on my knowledge of child development and considered the frequency, intensity, and context of the behavior" (Participant 4). They emphasized how specific patterns could indicate underlying issues: "While tantrums are developmentally typical for younger children, repeated outbursts, difficulty regulating emotions, or aggression beyond a certain age may indicate a mental health issue." Furthermore, they explained that identifying behaviors that interfere with social relationships, academic performance, or daily functioning often guided their decisions: "I also looked for patterns, such as behaviors that interfere with the child's social relationships, academic performance, or daily functioning, which are more likely to suggest an underlying mental health concern rather than normal developmental stages."

The school counselor also emphasized the importance of gathering information from multiple sources. They stated: "I gathered information from various sources, including parents, counselors, and social workers, to understand any significant life events or ongoing stressors the child might have been experiencing." Specifically, they asked about potential disruptions at home that could affect the child's behavior, such as "divorce, financial struggles, or loss of a loved one."

Theme 4: Impacts and Consequences of Misattributing Mental Health

Conditions. Participants reflected on the large and wide-ranging effects of mislabeling

mental health conditions in primary school-aged children. These effects included emotional strain on families, delays in getting proper help, the chance of inappropriate treatments, and cases where the mislabeling made the child's situation worse instead of better. The parent or caregiver participant described the overwhelming emotional and practical challenges of raising a child whose mental health issues were misunderstood or wrongly attributed. They said that instead of getting the right support, their child's behavioral issues often led to punishment: "There is a lack of behavioral health support in the school, and instead of addressing his underlying struggles, they often focus on punishing his behaviors" (Participant 1>). The child was often excluded from class, which made learning even harder: "He's frequently sent out of class, which means he spends more time out of school than in it."

The caregiver explained how these experiences made them feel overwhelmed and isolated: "Dealing with a child who has behavioral issues can be overwhelming, especially when managing other kids as well. It often feels like I'm carrying a heavy load, and at times, I don't feel understood by the school." They also felt judged and unsupported: "Instead of receiving support, I often feel judged, not only based on my child's behaviors but also because of my own struggles."

These experiences added to emotional strain: "The lack of empathy and understanding from the school makes it harder to navigate the process, leaving me feeling isolated and frustrated." They concluded, "It's emotionally draining, as I'm constantly trying to advocate for my child while also managing my own challenges." The participant also acknowledged how misattributions impacted families. They noted that when children

failed to respond to inappropriate interventions, it created frustration: “These children often didn’t respond to medication as expected, which caused frustration for both the child and their caregivers.” They also described cases where children faced the risk of removal from their homes due to misunderstood behavioral challenges.

The participants agreed that misattributions often delay appropriate treatment and lead to the use of ineffective or harmful interventions. The parent or caregiver raised concerns about medication: “However, as both his father and I also have ADHD, we were concerned about the potential for him to become addicted to the medication” (Participant 1). Participant 3 observed that misattributions result in interventions that fail to address root causes: “This resulted in the child receiving interventions that did not adequately address the root cause of the behavior” (Participant 3). The school counselor echoed this concern, describing how trauma-related behaviors are sometimes mistaken for ADHD: “His symptoms were actually trauma-related, and his behaviors were misunderstood as ADHD. Once trauma-informed practices were introduced, it became clear that he needed different types of support, including trauma counseling, rather than medication for ADHD” (Participant 4).

Similarly, Participant 2 explained: “As a result, these children were prescribed medication or placed in special education programs without considering other factors, which may not have addressed the root causes of their behaviors.” They gave an example: “I’ve worked with children who were prescribed medication for ADHD without fully exploring other potential underlying causes, such as trauma or family instability.” They concluded that these missteps could prevent children from receiving the evaluations

and interventions they needed: “This lack of access can delay or prevent children from receiving appropriate evaluations and interventions, leading to misdiagnosis or insufficient treatment.”

Misattributing mental health conditions not only delayed proper treatment but also, in some cases, worsened the situation for children and their families. Participant 3 admitted: “This resulted in the child receiving interventions that did not adequately address the root cause of the behavior” (Participant 3). The school counselor emphasized the risk of pursuing interventions that failed to address underlying trauma: “His symptoms were actually trauma-related, and his behaviors were misunderstood as ADHD. Once trauma-informed practices were introduced, it became clear that he needed different types of support, including trauma counseling, rather than medication for ADHD” (Participant 4).

Participant 2 elaborated on this concern, noting that some children were placed in special education programs or given medications that did not address the true source of their difficulties: “As a result, these children were prescribed medication or placed in special education programs without considering other factors, which may not have addressed the root causes of their behaviors.” They added: “In other cases, children who exhibited emotional or behavioral challenges related to trauma were placed in special education programs, but the focus was on managing the behavior rather than addressing the trauma itself, which might have been more effective.” Without a holistic approach, interventions risked making children’s challenges worse: “Without this holistic approach, children may receive interventions that are not only ineffective but can also exacerbate

their challenges in the long run.” Finally, they emphasized how these gaps delayed proper care: “This lack of access can delay or prevent children from receiving appropriate evaluations and interventions, leading to misdiagnosis or insufficient treatment.”

Theme 5: Stakeholders’ Current Diagnostic Practices and Considerations.

The parent or caregiver participant emphasized the importance of being involved in the diagnostic process: “Yes, I was involved in decisions regarding my child’s diagnosis and treatment plans. I was present during the evaluation for the IEP, the behavioral modification plan, and the Child’s Find meeting” (Participant 1). To ensure they made informed decisions, they sought additional support: “To make sure I had the support I needed, I had my child’s IIHS counselor and my grandmother present to help clarify things and ensure that I was making informed decisions about my child’s care and support.”

The primary participant explained a deliberate effort to identify the root causes of a child’s behavior through observations, discussions, and consultation: “First, we aim to identify the root causes of the behavior through observations, discussions with teachers, and consultations with school counselors” (Participant 3). They emphasized the importance of prioritizing the student’s mental health needs: “My goal is to ensure that the student receives the necessary evaluation and support to address any underlying mental health needs.” They also mentioned that they “regularly review the effectiveness of these interventions to ensure they are addressing the underlying causes of the behavior.”

The school counselor participant gave a detailed description of their holistic approach to assessments. They shared: “When conducting assessments, I take a holistic approach that includes considering external factors like trauma, family life, and the child’s social environment” (Participant 4). Trauma-informed practices were described as essential: “Trauma-informed practices are critical in this process, as they help me understand how a child’s past experiences may be impacting their current behavior and emotional state.” They explained that this approach “ensures that the assessment is comprehensive and addresses both internal and external factors contributing to the child’s difficulties.”

The counselor also emphasized the importance of gathering information from various sources to gain a complete understanding: “I gather information from various sources, including parents, counselors, and social workers, to understand any significant life events or ongoing stressors the child may be experiencing.” They specifically asked about disruptions at home when behavioral changes were observed: “For example, if a child is showing behavioral changes, I ask about any recent disruptions at home, such as divorce, financial struggles, or the loss of a loved one.” Once again, they highlighted the essential role of trauma-informed practices and how this approach considers both internal and external factors. Participant 2 confirmed a similar approach: “In my role, I make sure that the child’s family environment and any trauma history are carefully considered when developing treatment plans or interventions” (Participant 2).

Theme 6: Stakeholder-Proposed Practice-Based and Systemic Strategies to Enhance Diagnostic Accuracy. Stakeholders suggested several practice-based and

systemic strategies to enhance the accuracy of mental health diagnoses among school-aged children. These strategies emphasize increasing awareness and education, fostering communication and collaboration, conducting comprehensive evaluations, offering continuous support, and implementing trauma-informed approaches.

Participants strongly emphasized the importance of increasing awareness and providing targeted education for school staff and families. The parent or caregiver participant explained that “educating the school staff on how to manage and understand a child with behavior issues effectively would have been incredibly helpful” (Participant 1). They also suggested that “by increasing the staff’s awareness of his needs and giving them the proper tools to respond constructively, it would likely have reduced the negative consequences he faced and supported his growth in a more positive direction.” They added that teachers should receive ongoing training to better understand the underlying causes of behavior: “Teachers should receive more training on how to effectively handle children with these issues, ensuring they understand the underlying causes and how to provide appropriate interventions.”

Participant 3 also stressed the importance of ongoing professional development: “We also ensure that teachers and staff are trained in recognizing mental health symptoms and offer behavior intervention plans tailored to the child’s needs” (Participant 3). They highlighted continuous training in trauma-informed care and mental health identification and described these programs as including “workshops on recognizing the signs of trauma, understanding the impact of adverse childhood experiences (ACEs) on learning, and how to create a supportive classroom environment for students who may

have experienced trauma”. Additionally, they called for efforts to reduce mental health stigma: “Schools should work to reduce the stigma around mental health and encourage families to seek help early. This includes normalizing discussions around mental health and providing families with the resources they need to access care”.

The school counselor participant shared how they stay informed through training and access to resources: “I regularly attend training sessions and workshops related to mental health diagnoses, trauma-informed care, and child development” (School Counselors). They explained that these activities “help me stay current on the latest research and best practices in the field.” They described using resources such as case studies, webinars, and conferences and highlighted the importance of cultural competence: “Staying informed about cultural competence and emerging practices in mental health care is also essential to providing the best support for the children I work with.”

The counselor also described a culturally sensitive approach that considers socioeconomic and cultural contexts: “I ask parents about their cultural beliefs and practices, and I collaborate with interpreters if language barriers exist. When assessing behavior, I consider how cultural norms and socioeconomic status might influence how children express emotions or respond to authority.” They ensured interventions matched the child’s cultural background: “I make sure that any recommendations or interventions are appropriate for the child’s cultural background and family context, ensuring they are both effective and respectful of their values and needs.” Lastly, they recommended more training for teachers on trauma-informed practices.

Participant 2 also highlighted their role in raising awareness through staff training: “If necessary, I provide training or consultation to the school staff on how to best support the child. This might include educating teachers and staff about trauma-informed care, strategies for managing emotional outbursts, or how to create a more supportive classroom environment for children with mental health challenges”

(Participant 2). Participants consistently identified clear communication and collaborative efforts among families, schools, and mental health professionals as essential for improving diagnostic accuracy and ensuring appropriate care interventions.

The parent or caregiver participant reflected on the importance of effective communication and collaboration, explaining that this support can “help prevent situations where children are simply removed from the classroom without the proper understanding or care, and instead, create an environment where their needs are met with compassion and effective strategies” (Participant 1).

Participant 3 outlined several strategies their school has implemented to improve communication and collaboration. They explained, “We have since put in place a more comprehensive process for involving parents, specialists, and mental health professionals to ensure the right diagnosis and placement are made” (Participant 3). They highlighted the importance of external partnerships, stating, “We have established relationships with local therapists, psychologists, and social service agencies, including Child Protective Services, to make sure students receive the support they need.” Additionally, they described working with outside providers to ensure students’ educational and treatment goals align: “When appropriate, we refer students for counseling or therapy outside of

school, and we coordinate with external providers to make sure the student's treatment plan aligns with their educational goals." The collaboration with child protection agencies was also emphasized: "We also work with CPS when there are concerns about abuse or neglect, ensuring the child's safety and well-being are prioritized." Finally, Participant 3 emphasized the importance of building stronger family partnerships, noting, "Schools must foster stronger connections with families to ensure that home life factors, including stressors and challenges, are considered when diagnosing and intervening with students."

The school counselor participant described collaboration and communication as essential parts of their diagnostic practices: "I also engage in peer collaboration and supervision, where I can discuss challenging cases and receive feedback from experienced professionals" (Participant 4). They emphasized the importance of family involvement, noting, "The school system should provide more outreach and support for families, ensuring that they are fully involved in the process and equipped with the resources they need to support their children's mental health at home." They also reinforced the idea that "improving communication and collaboration between school staff, families, and mental health professionals is key to creating a more comprehensive and supportive system."

Participant 2 provided a detailed account of how communication and collaboration support children's mental health. They described how many cases "require coordination between school staff, mental health professionals, and families to ensure comprehensive support" (Participant 2). They explained that they ensured collaboration by "establishing clear lines of communication with teachers, counselors, and

administrators” and holding regular check-ins or meetings. They emphasized the importance of everyone having shared information: “It is important to share relevant information and observations so everyone is on the same page.”

Additionally, the social worker explained creating a unified plan with the school team: “Once I have gathered information, I collaborate with the school staff to create a plan of action.” This plan may include interventions such as Individualized Education Plans (IEPs) or behavioral health services. They also emphasized the importance of coordinating with external providers, explaining, “If the child is receiving services outside of school, such as therapy or counseling, I work with the school to ensure that there is continuity in the child’s support.”

Participant 2 further observed that “open, collaborative communication is essential to ensure that the child’s needs are addressed comprehensively and supportively.” They advocated for schools to actively engage families in gathering information about home life and suggested “regular communication with parents, guardians, and extended family members to gain insight into any challenges that may influence the child’s behavior or academic performance.” Ultimately, they emphasized the importance of multidisciplinary input, stating, “Schools should implement a more holistic approach to assessments that incorporates contributions from multiple sources—teachers, parents, counselors, and mental health professionals.”

Participants consistently emphasized the need for schools to conduct more thorough, personalized assessments when addressing children’s behavioral and mental health issues. They explained that evaluations should go beyond surface-level

observations and consider the full range of factors impacting a child's life, including family dynamics, trauma history, strengths, and environmental challenges.

The parent or caregiver participant emphasized that thorough evaluations are essential to ensure children receive appropriate support. They explained, "Schools should conduct more comprehensive evaluations that consider not only academic performance but also family dynamics, trauma, and mental health factors" (Participant 1). They added that such evaluations would help "ensure that the root causes of behavioral challenges are fully understood." Parents also urged staff to receive training to better understand the underlying causes of behavioral issues, noting that "teachers should receive more training on how to effectively handle children with these issues, ensuring they understand the underlying causes and how to provide appropriate interventions."

Participant 3 echoed this sentiment, stating, "We need to move away from seeing behaviors in isolation and start using more comprehensive, holistic assessments that consider family life, trauma, social environment, and academic challenges" (Participant 3). They emphasized the importance of building stronger partnerships with families during the diagnostic process: "Schools must foster stronger partnerships with families to ensure that home life factors, including stressors and challenges, are taken into account when diagnosing and intervening with students."

The school counselor participant emphasized the importance of time and resources in achieving more accurate and personalized assessments: "Ideally, more time would be allocated for comprehensive assessments, and additional resources such as school psychologists, counselors, and trauma-informed specialists would help ensure that

evaluations are as thorough and accurate as possible” (School Counselors). Participant 2 provided the most detailed view on what comprehensive evaluations should include. They stressed that “proper assessments, including considering family history, trauma, and environmental factors, are critical to avoid these types of misdiagnoses and ensure children receive the appropriate support” (Participant 2). They noted that incomplete assessments often happen because schools “may not inquire about family history, trauma experiences, or home life, which can lead to an incomplete or skewed understanding of the child’s needs”.

In their role, the social worker explained that they work to ensure all relevant factors are considered: “I ensure that the child’s family environment and any trauma history are carefully considered when developing treatment plans or interventions.” This holistic approach, they described, “helps identify the root causes of the child’s behavior and ensures that both school and community supports are aligned to address the child’s unique needs.” The social worker further elaborated on the process of gathering information from multiple sources, reviewing classroom data, and actively engaging families: “Schools should actively engage with families to gather information about the child’s home life, family dynamics, and any potential environmental stressors.” They emphasized that understanding factors such as trauma, socioeconomic status, or family instability was critical to creating accurate assessments.

Comprehensive evaluations, participants noted, should not rely solely on behavior checklists. The social worker participant explained that schools should use assessments that “evaluate various aspects of a child’s development,” including cognitive, emotional,

and social skills, as well as the child's strengths and areas of need. They also recommended adopting a strengths-based approach: "Rather than focusing only on deficits or problematic behaviors, schools could adopt a strengths-based approach...identifying and building on the child's existing strengths, talents, and interests." Additionally, participants highlighted that evaluations should be flexible and ongoing. The social worker explained that "children's needs and circumstances change over time, and schools should regularly revisit and adjust their approach to meet these evolving needs." This would ensure that interventions remain accurate and responsive.

Finally, the social worker emphasized the importance of cultural sensitivity and multidisciplinary teamwork, stating, "It's crucial for schools and mental health professionals to adopt a more comprehensive, culturally sensitive approach to assessment and diagnosis, one that considers the child's family background, community environment, and any potential trauma." They added that schools should actively involve mental health professionals, teachers, and families in the diagnostic process to ensure "the assessment is well-rounded and addresses the child's emotional and psychological needs."

Subtheme 4: Integrated & Ongoing Support. Participants highlighted the importance of providing integrated and ongoing support for children, families, and school staff to effectively meet mental health needs. They pointed out that schools often lack sufficient resources and professional support, which negatively impacts the consistency and quality of interventions.

The parent/caregiver participant emphasized the importance of direct, personalized behavioral support in schools, explaining, “I believe that having behavioral support in the school, such as a 1:1 support person, would have made a significant difference in my child’s experience” (Participant 1). They also noted that this kind of support would “help him stay engaged and focused, while also providing a safe space to work through his challenges.” Parents called for more behavioral support staff and counselors dedicated to working directly with children facing behavioral challenges, along with ongoing support for teachers to provide them with the necessary tools to address behavioral needs effectively.

The primary participant reiterated the need for professional resources, noting that “one of the primary barriers we face is limited access to mental health professionals, both within the school system and in the community” (Participant 3). They emphasized the importance of providing teachers with mental health first aid resources and training to help them recognize and respond appropriately to disorders like anxiety, depression, and ADHD. Participant 3 also underscored that schools need improved access to mental health professionals so students can receive timely evaluations and interventions.

The school counselor participant also called for increased professional staffing, stating, “there should be more mental health professionals on staff, such as counselors, social workers, and school psychologists, to ensure that every child has access to the support they need” (School Counselors). They emphasized the importance of better integrating mental health services with academic support, ensuring that emotional and behavioral needs are addressed alongside academic goals. Additionally, they stressed that

families should be fully involved in the support process and provided with resources to handle mental health concerns at home.

Participant 2 described a holistic and dynamic approach to ongoing support, explaining, “this holistic approach helps identify the root causes of the child’s behavior and ensures that both school and community supports are aligned to address the child’s unique needs” (Participant 2). They noted that support plans should include a combination of accommodations, interventions, and behavioral health services when appropriate, and that these supports should be integrated across home and school environments.

Monitoring and adjustment were also highlighted as crucial parts. The social worker explained, “mental health concerns can change over time, so I regularly check in with school staff to monitor the child’s progress.” If interventions don’t work, adjustments should be made to better meet the child’s needs. They also suggested ongoing assessments of a child’s emotional regulation, social interactions, and peer relationships to get a full picture of their well-being, which can be done through structured observations and feedback from teachers and counselors.

Subtheme 5: Trauma-Informed Approaches. Participants also highlighted the importance of adopting trauma-informed practices to improve diagnostic accuracy and create more supportive school environments. They observed that behaviors often linked to trauma—such as withdrawal, aggression, or difficulty concentrating—can frequently be misinterpreted as disciplinary or behavioral problems. The parent/caregiver participant emphasized the need for environments that prioritize understanding and compassion,

stating, “this support can help prevent situations where children are simply removed from the classroom without the proper understanding or care, and instead, create an environment where their needs are met with compassion and effective strategies” (Participant 1).

Participant 3 described how their school aims to create a safe and supportive environment by integrating social-emotional learning programs and counseling support into their approach: “we provide a safe and supportive environment for the student, integrating social-emotional learning programs and counseling support to address the mental health component of the behavior” (Participant 3). Participant 2 added more details, emphasizing that “schools could implement trauma-informed assessments and interventions” (Participant 2). They explained that trauma-informed approaches encourage staff to consider how past trauma may influence a child’s behavior and well-being, which in turn leads to more accurate assessments and targeted interventions. These approaches should include interviews with the child’s family and a deliberate consideration of possible life stressors during evaluations.

Outliers

There were no outliers in the data set. All the data was analyzed and categorized into relevant themes. No new themes appeared in the data that weren't already identified themes.

Summary

Stakeholders identified several attribution factors (Theme 1) that increase the risk of misdiagnosing children’s mental health problems, such as misinterpreting behavior

changes, trauma, cultural and socioeconomic influences, and insufficient professional resources. Current diagnostic procedures (Theme 2) involve multistep collaborations among teachers, parents, and mental health experts but often rely on limited tools primarily focused on academic and behavioral observations (Theme 3). Misdiagnoses can have serious consequences (Theme 4), including emotional stress on families, delays or incorrect treatments, and worsening conditions when root causes are overlooked. Stakeholders also emphasized the importance of holistic and trauma-informed diagnostic practices (Theme 5) that consider family history, social environment, and mental health needs to improve assessment accuracy. To tackle misdiagnosis issues, stakeholders recommended strategies (Theme 6) centered on five subthemes: increasing awareness and education among school staff; improving communication and collaboration among families, schools, and professionals; conducting comprehensive, individualized evaluations that account for family dynamics and trauma; providing integrated, ongoing support systems within schools and communities; and using trauma-informed approaches to create safe, supportive environments. These recommendations aim to improve diagnostic accuracy, reduce stigma, and ensure interventions address root causes for better mental health outcomes.

Section 4: Conclusion and Reflections

Introduction

The purpose of this qualitative study was to explore educators' and mental health staff's perceptions in schools regarding the risk of attribution errors in misdiagnosing mental health conditions among primary school-aged children in Richmond, VA. The research also examined practice-based and systemic changes that stakeholders proposed to improve mental health assessment of children in this community. By focusing on both the processes that lead to misdiagnosis and strategies for improving diagnostic accuracy, this study adds to the knowledge about school-based mental health practices and children's outcomes.

For Research Question 1 (RQ1), four themes emerged: (a) attribution factors leading to misdiagnosis, (b) current diagnostic procedures, (c) diagnostic tools used in assessments, and (d) the impacts and consequences of misattributing mental health conditions. For Research Question 2 (RQ2), two themes emerged: (a) current diagnostic practices and considerations, and (b) stakeholder-proposed strategies to improve diagnostic accuracy. Overall, the findings highlight the complex nature of misdiagnosis and emphasize the urgent need for trauma-informed, culturally responsive, and family-centered approaches within schools.

Reflection of Self

Throughout my doctoral journey, I have experienced personal growth in resilience, discipline, and critical reflection. I have deeply engaged with issues such as childhood trauma, systemic inequities, and cultural bias, which have reshaped my view of

myself as both a learner and an advocate. I began the program with an academic curiosity about child mental health but finished with a stronger sense of responsibility to connect scholarship to lived realities. This journey has taught me to value persistence, even when facing complex tasks and setbacks, like balancing professional responsibilities, family commitments, and the demanding work of doctoral research.

Personal barriers included time management and moments of self-doubt about my ability to complete such an intensive project. I overcame these by creating structured routines, seeking mentorship, and leaning on the support of peers and family. Developing strategies to stay motivated, such as breaking work into manageable goals and reminding myself of the larger purpose of my research, helped me maintain progress. In doing so, I built greater confidence in my ability to make meaningful contributions to both scholarship and practice.

Reflection of Scholar-Practitioner

As a scholar-practitioner, my understanding of research has grown from being just an academic task to becoming a tool for social change. At first, I saw research as a way to gain knowledge, but through this experience, I realized that knowledge must be actionable, responsive to community needs, and focused on equity. Conducting this study prompted me to critically analyze how attribution errors and systemic inequities lead to harmful outcomes for children, and to position my scholarship as a means for reform in schools and human services systems.

A major challenge I faced was balancing academic rigor with practical application. Sometimes, I found it difficult to ensure my research was methodologically

solid while also being accessible and impactful for practitioners and policymakers. Overcoming this challenge involved connecting theoretical insights with practical realities, so my findings could benefit both scholarship and real-world solutions. Ultimately, I have become a more reflective and socially responsible scholar-practitioner, dedicated to using research to advocate for systemic change.

Recommendations for Human Services Organization or Human Services Field Advocacy

Based on the study findings, human services organizations should focus on training educators and school personnel in trauma-informed care and culturally responsive practices. Many misdiagnoses resulted from attribution errors, where children's behaviors were viewed as personal flaws rather than responses to their environment. Professional development programs can help teachers understand how trauma, poverty, and systemic inequities affect behavior. Equally important is building collaborative family-school partnerships, where caregivers are involved as allies in assessment and intervention efforts. When parents' voices are heard, as several participants highlighted, schools can avoid seeing behaviors as isolated issues and instead develop tailored support plans that address root causes.

Opportunities for advocacy exist in tackling structural inequalities that lead to misdiagnosis. Human services groups can promote policies that improve access to school-based behavioral health services, decrease dependence on harsh disciplinary actions, and guarantee fair diagnostic assessments across different cultural and racial groups. Advocacy should also aim at systemic changes, such as requiring bias training in

schools, funding mental health professionals in every school, and implementing accountability measures to track diagnostic practices disparities.

Summary

This section highlighted how attribution errors, trauma, socio-economic and cultural factors, and systemic inequities contribute to the misdiagnosis of mental health conditions among children in Richmond, VA schools. The findings showed that misdiagnosis leads to significant academic, emotional, and social consequences, including stigma, inappropriate interventions, and exclusion from learning opportunities. Stakeholders emphasized the need for trauma-informed, culturally competent, and family-centered practices to improve diagnostic accuracy and ensure effective interventions. The reflections underscored both personal and professional growth throughout the doctoral process. Personally, I developed resilience, discipline, and a stronger sense of advocacy, while as a scholar-practitioner, I learned to bridge academic rigor with practical relevance. Finally, recommendations emphasized the importance of professional training, systemic reforms, and community advocacy to address diagnostic disparities. Ultimately, this study provides a roadmap for advancing equity in school-based mental health practices and promoting better outcomes for children.

References

- Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Cureus, 15*(5), Article e39549.
<https://doi.org/10.7759/cureus.39549>
- Almalki, S. (2020). Parenting practices in Saudi Arabia: Gender-role modeling. In B. K. Ashdown & A. N. Faherty (Eds.), *Parents and caregivers across cultures: Positive development from infancy through adulthood* (pp. 231-246). Springer Nature.
- Bil, J. S., Buława, B., & Świerzawski, J. (2021). Mental health and the city in the post-COVID-19 era. *Sustainability, 13*(14), Article 7533.
<https://doi.org/10.3390/su13147533>
- Bitsko, R. H., Holbrook, J. R., Ghandour, R. M., Blumberg, S. J., Visser, S. N., Perou, R., & Walkup, J. T. (2020). Epidemiology and impact of health care provider–diagnosed attention-deficit/hyperactivity disorder among children and adolescents in the United States. *Journal of Developmental & Behavioral Pediatrics, 41*(4), 302–313. <https://doi.org/10.1097/DBP.0000000000000788>
- Bohnenkamp, J. H., Hoover, S. A., Connors, E. H., Wissow, L., Bobo, N., & Mazyck, D. (2019). The mental health training intervention for school nurses and other health providers in schools. *The Journal of School Nursing, 35*(6), 422-433.
<https://doi.org/10.1177/1059840518785437>

- Briggs, E. C., Amaya-Jackson, L., Putnam, K. T., & Putnam, F. W. (2021). All adverse childhood experiences are not equal: The contribution of synergy to adverse childhood experience scores. *American Psychologist*, *76*(2), 243-252.
<https://doi.org/10.1037/amp0000768>
- Brown, N., Te Riele, K., Shelley, B., & Woodroffe, J. (2020). *Learning at home during COVID-19: Effects on vulnerable young Australians*. Peter Underwood Centre for Educational Attainment.
https://www.utas.edu.au/_data/assets/pdf_file/0008/1324268/Learning-at-home-during-COVID-19-updated.pdf
- Cycyk, L. M., De Anda, S., Ramsey, K. L., Sheppard, B. S., & Zuckerman, K. (2022). Moving through the pipeline: Ethnic and linguistic disparities in special education from birth through age five. *Educational Researcher*, *51*(7), 451-464.
<https://doi.org/10.3102/0013189x221120262>
- Dimitropoulos, G., Cullen, E., Cullen, O., Pawluk, C., McLuckie, A., Patten, S., Bulloch, A., Wilcox, G., & Arnold, P. D. (2021). “Teachers often see the red flags first”: Perceptions of school staff regarding their roles in supporting students with mental health concerns. *School Mental Health*, *14*, 402-415.
<https://doi.org/10.1007/s12310-021-09475-1>
- Furzer, J., Dhuey, E., & Laporte, A. (2022). ADHD misdiagnosis: Causes and mitigators. *Health Economics*, *31*(9), 1926-1953. <https://doi.org/10.1002/hec.4555>
- Graham, S. (2020). An attributional theory of motivation. *Contemporary Educational Psychology*, *61*, Article 101861. <https://doi.org/10.1016/j.cedpsych.2020.101861>

- Gurung, R. A. (2019). Cultural influences on health. In K. D. Keith (Ed.), *Cross-cultural psychology: Contemporary themes and perspectives* (2nd ed., pp. 451-466). Wiley Blackwell. <https://psycnet.apa.org/doi/10.1002/9781119519348.ch21>
- Hatem, C., Lee, C. Y., Zhao, X., Reesor-Oyer, L., Lopez, T., & Hernandez, D. C. (2020). Food insecurity and housing instability during early childhood as predictors of adolescent mental health. *Journal of Family Psychology, 34*(6), 721-730. <https://doi.org/10.1037/fam0000651>
- Heinrich, C. J., Colomer, A., & Hieronimus, M. (2023). Minding the gap: Evidence, implementation and funding gaps in mental health services delivery for school-aged children. *Children and Youth Services Review, 150*, Article 107023.
- Hoover, S., & Bostic, J. (2021). Schools as a vital component of the child and adolescent mental health system. *Psychiatric Services, 72*(1), 37-48. <https://doi.org/10.1176/appi.ps.201900575>
- Horne, R., & Weinman, J. (2020). Predicting treatment adherence: An overview of theoretical models. In L. B. Myers & K. Midence (Eds.), *Adherence to treatment in medical conditions* (pp. 25-50). Harwood Academic Publishers.
- Howard, J. (2019). *Cognitive errors and diagnostic mistakes*. Springer International Publishing.
- Hua, Y., Liu, F., Yang, K., Li, Z., Na, H., Sheu, Y. H., Zhou, P., Moran, L. V., Ananiadou, S., Clifton, D. A., Beam, A., & Torous, J. (2024). *Large language models in mental health care: A scoping review*. Cornell University arxiv. <https://arxiv.org/abs/2401.02984>

- Huang, C. Y., Nishioka, S. A., Hunt, E., Wong, S. H., & Huang, C. J. (2022). Mental health in schools: Issues and considerations for promoting positive youth outcomes. In J. N. Lester & M. O'Reilly (Eds.), *The Palgrave encyclopedia of critical perspectives on mental health* (pp. 1-19). Springer International Publishing.
- Hughes, E. (2023). *The Shape of Youth Mental Health in Virginia*.
https://www.cfnova.org/images/pdf/Beyond_The_Trauma_report_final.pdf
- Iqbal, Z., & Zahoor, I. (2024). Students' Behavioral Problems in the Classroom and Coping Strategies: Experiences of Secondary School Teachers. *Bulletin of Education and Research*, 46(1), 107-129.
- Kasap, S., & Ünsal, F. (2021). Attribution theory and language learning. *Research in Language and Education: An International Journal [RILE]*, 2, 111-118.
- Kindred, R., & Bates, G. W. (2023). The influence of the COVID-19 pandemic on social anxiety: a systematic review. *International journal of environmental research and public health*, 20(3), 2362.
- Knafo, G., & Weinberger, J. (2024). Exploring the Role of Conscious and Unconscious Processes in Hypnosis: A Theoretical Review. *Brain Sciences*, 14(4), 374.
- Kyrillos, V., Bosqui, T., Moghames, P., Chehade, N., Saad, S., Abdul Rahman, D., ... & McEwen, F. S. (2023). The culturally and contextually sensitive assessment of mental health using a structured diagnostic interview (MINI Kid) for Syrian refugee children and adolescents in Lebanon: Challenges and solutions. *Transcultural psychiatry*, 60(1), 125-141.

- Leany, B. D. (2020). Cultural considerations in psychological assessment and evaluation. *Handbook of Cultural Factors in Behavioral Health: A Guide for the Helping Professional*, 63-73.
- Lopez, C., Vazquez, M., & McCormick, A. S. (2022). Familismo, respeto, and bien educado: traditional/cultural models and values in latinos. In *Family literacy practices in Asian and latinx families: Educational and cultural considerations* (pp. 87-102). Cham: Springer International Publishing.
- Malle, B. F. (2022). Attribution theories: How people make sense of behavior. *Theories in Social Psychology, Second Edition*, 93-120.
- Maqsood, A., Abbas, J., Rehman, G., & Mubeen, R. (2021). The paradigm shift for educational system continuance in the advent of COVID-19 pandemic: mental health challenges and reflections. *Current Research in Behavioral Sciences*, 2, 100011.
- Mathur, S. K., & Rodriguez, K. A. (2022). Cultural responsiveness curriculum for behavior analysts: A meaningful step toward social justice. *Behavior Analysis in Practice*, 15(4), 1023-1031.
- McCullough, S. N., Granger, K. L., Sutherland, K. S., Conroy, M. A., & Pandey, T. (2022). A preliminary study of BEST in class—elementary on teacher self-efficacy, burnout, and attributions. *Behavioral Disorders*, 47(2), 84-94.
<https://doi.org/10.1177/01987429211010672>

- McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World Psychiatry, 21*(1), 61-76.
- Mental Health America of Virginia (MHVA). (2020). Virginia 2020 Legislative Session, Summary Highlights, March 2020, <https://mhav.org/wp-content/uploads/2020/03/Summary-of-Virginia-2020-Legislative-Session.pdf>
- Mesman, E., Vreeker, A., & Hillegers, M. (2021). Resilience and mental health in children and adolescents: an update of the recent literature and future directions. *Current opinion in psychiatry, 34*(6), 586-592.
- Messas, G., & Fernandez, A. V. (2022). Recontextualizing the subject of phenomenological psychopathology: Establishing a new paradigm case. *Frontiers in Psychiatry, 13*, 1035967.
- Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus, 18*(1), 16-24.
- Ogundare, T. (2020). Culture and mental health: Towards cultural competence in mental health delivery. *Journal of Health and Social Sciences, 5*(1), 023-034.
- Ohrt, J. H., Deaton, J. D., Linich, K., Guest, J. D., Wymer, B., & Sandonato, B. (2020). Teacher training in K–12 student mental health: A systematic review. *Psychology in the Schools, 57*(5), 833-846.
- Ooten, M. D., & Sawyer, J. M. (2023). *A People's Guide to Richmond and Central Virginia* (Vol. 6). Univ of California Press.

- RANKIN, S. (2024). Virginia's Youngkin aims to bolster mental health care, part of national focus after the pandemic. *AP Online*, NA-NA.
- Royce, C. S., Hayes, M. M., & Schwartzstein, R. M. (2019). Teaching critical thinking: a case for instruction in cognitive biases to reduce diagnostic errors and improve patient safety. *Academic Medicine*, *94*(2), 187-194.
- Sadek, J. (2023). Attention deficit hyperactivity disorder misdiagnosis: Why medical evaluation should be a part of ADHD assessment. *Brain sciences*, *13*(11), 1522.
- Sano, Y., Mammen, S., & Houghten, M. (2021). Well-being and stability among low-income families: A 10-year review of research. *Journal of Family and Economic Issues*, *42*(Suppl 1), 107-117.
- Sharma, S. V., Chuang, R. J., Rushing, M., Naylor, B., Ranjit, N., Pomeroy, M., & Markham, C. (2020). Peer reviewed: Social determinants of health-related needs during COVID-19 among low-income households with children. *Preventing chronic disease*, *17*.
- Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry research*, *293*, 113429.
- Smith, E. P., Yzaguirre, M. M., Dwanyen, L., & Wieling, E. (2022). Culturally relevant parenting approaches among African American and Latinx children and families: Toward resilient, strengths-based, trauma-informed practices. *Adversity and Resilience Science*, *3*(3), 209-224.

- St. John, A. M., & Tarullo, A. R. (2020). Neighbourhood chaos moderates the association of socioeconomic status and child executive functioning. *Infant and Child Development, 29*(1), e2153.
- Voices for Virginia's Children. (2020). Legislation Impacting Children's Mental Health Services, Feb. 6, 2020, <https://vakids.org/our-news/blog/2020-legislation-impacting-childrens-mental-health-services>
- Votruba-Drzal, E., Miller, P., Betancur, L., Spielvogel, B., Kruzik, C., & Coley, R. L. (2021). Family and community resource and stress processes related to income disparities in school-aged children's development. *Journal of Educational Psychology, 113*(7), 1405.
- Wiedermann, C. J., Barbieri, V., Plagg, B., Marino, P., Piccoliori, G., & Engl, A. (2023, May). Fortifying the foundations: a comprehensive approach to enhancing mental health support in educational policies amidst crises. In *Healthcare* (Vol. 11, No. 10, p. 1423). MDPI. <https://doi.org/10.3390/healthcare11101423>
- Woodcock, S., & Moore, B. (2021). Inclusion and students with specific learning difficulties: The double-edged sword of stigma and teacher attributions. *Educational Psychology, 41*(3), 338-357.
<https://doi.org/10.1080/01443410.2018.1536257>

Appendix A: The Project

Addressing Misdiagnosis of Children's Mental Health in Richmond, VA

Introduction

The purpose of this white paper is to bring awareness to the challenges facing professionals and teachers in the primary school system in addressing children's mental health in Richmond Virginia. A qualitative study was conducted to explore educators' and mental health staff's perceptions in schools regarding the risk of attribution errors in misdiagnosing mental health conditions among primary school-aged children in Richmond, VA. The research also examined practice-based and systemic changes that stakeholders proposed to improve mental health assessment of children in this community. By focusing on both the processes that lead to misdiagnosis and strategies for improving diagnostic accuracy, this study adds new information to the knowledge about school-based mental health practices and children's outcomes. Solving this problem requires a multifaceted approach that includes reducing mental health stigma in schools, enhancing teacher training on mental health issues, and expanding access to mental health resources for students, especially in underserved areas.

Problem Statement

Despite increasing recognition of the importance of school-based mental health, Misdiagnosis of mental health conditions among young children continues to pose challenges. This problem is acute in underserved communities, where systemic inequities intersect with limited access to trained professionals (Smith & Garcia, 2020). Research demonstrates that diagnostic inaccuracies are linked to attribution errors, where behaviors

are explained as inherent psychological deficits rather than as contextual responses to poverty, trauma, or cultural differences (Clark & Gresham, 2021; Martinez & Cooper, 2021). The consequences of such errors include ineffective interventions, delayed treatment, and widening educational disparities for marginalized children (Jones et al., 2019).

This issue is very salient in Richmond, Virginia, where nearly 47% of Virginia students report a current or past-year mental health concern, with high rates of anxiety, depression, and suicidal ideation (Hughes, 2023). Within Richmond Public Schools (RPS), the counselor-to-student ratio often exceeds 1:400, creating overwhelming caseloads that undermine the accuracy of mental health evaluations (RPS Data, 2022). According to recent communications with local school counselors and mental health professionals, referrals for ADHD have increased substantially, even in cases where behaviors may reflect trauma, housing insecurity, or developmental immaturity (Personal Communication, 2023). Stakeholders including teachers, principals, counselors, and caregivers play a direct role in this problem. Educators serve as the first line of identification but often misinterpret children's behaviors, while mental health staff report difficulty conducting individualized assessments due to caseload demands. Parents and caregivers, meanwhile, experience frustration when misdiagnosis leads to inappropriate interventions and limited support for their children.

Market and Social Drivers

First, increasing rates of childhood mental health problems at both the state and national level have strained already limited school-based services (Heinrich et al., 2023).

Second, structural inequities including racial bias and cultural misunderstandings place minority students at heightened risk of misdiagnosis (Bitsko, 2020). Third, educator shortages and insufficient professional development in trauma-informed and culturally responsive practices limit schools' ability to accurately evaluate students (Davis & Harper, 2023). Fourth, the rising costs of inappropriate interventions, including unnecessary hospitalization and medication, place burdens on both families and the healthcare system (Rankin, 2024).

Ethical Considerations

All participants were provided with clear, detailed information about the study's purpose, their role, and their right to withdraw at any time without penalty (see, Bhandari, 2021). To safeguard confidentiality, identifying details were removed from transcripts, pseudonyms were used in reporting, and all data was stored securely on encrypted, password-protected devices (Heaton, 2021). In addition, any organizational data shared was treated with the same level of confidentiality to ensure that schools are not identifiable in publications (Kang & Hwang, 2023). These measures align with the Belmont Report's principles of respect for persons, beneficence, and justice, ensuring participants' autonomy and well-being remain protected (Barrow et al., 2022).

Preparation for this study involved building trust with local schools and community agencies, developing culturally sensitive recruitment materials, and aligning the research design with both academic standards and the practical needs of educators, parents, and mental health professionals.

Evidence Supporting the Need for a Solution

To investigate the issue of misdiagnosis of children in Richmond, VA, I collected data through semistructured interviews with parents, educators, and mental health professionals who had direct experience with child mental health evaluations. Using purposive convenience sampling, five participants were recruited through local schools. Each interview lasted between 45 and 60 minutes and was conducted via secure video conferencing. The interviews were audio-recorded with consent, transcribed verbatim, and anonymized to ensure confidentiality (Funck & Vogel, 2024).

The data were analyzed using NVivo qualitative software, which facilitated the organization, coding, and interpretation of stakeholder interviews and survey responses (see, Limna, 2023). An initial open coding cycle produced 101 codes, including 21 main codes and 79 child codes, capturing key areas such as behavioral change, family dynamics, trauma, and diagnostic procedures. These codes were then categorized and clustered into broader themes through constant comparison, allowing patterns to emerge across participants' perspectives (see, McLeod, 2024). From this process, six themes were refined to align with the two research questions, including stakeholders perceived attribution factors leading to misdiagnosis, current diagnostic practices, diagnostic tools, consequences of misdiagnosis, and proposed strategies to improve diagnostic accuracy.

Findings

The analysis of stakeholder perspectives identified four themes in response to the first research question (RQ1) on attribution and misdiagnosis, and two themes in response to the second research question (RQ2) on proposed improvements. For RQ1,

four central themes emerged: stakeholders perceived attribution factors, perceptions of current diagnostic procedures, perspectives on diagnostic tools, and the impacts of misattribution. Theme 1, attribution factors, was divided into six subthemes: misunderstanding behavior change, professional and school management problems, socio-economic and cultural factors, trauma, untrained staff and inadequate resources, and family dynamics. Participants stressed that behavior was often misinterpreted without considering trauma, poverty, or family instability, leading to disciplinary rather than supportive responses. Theme 2 highlighted the absence of standardized diagnostic procedures in schools, with current practices relying on observations, referrals, and limited family engagement. Theme 3 emphasized on diagnostic tools, which were observational developmental benchmarks, and teacher judgments, often narrowly focused on disruptive classroom behaviors. Finally, Theme 4 described the consequences of misattribution, including stigma, delayed treatment, exclusion from learning, inappropriate use of medication, and worsening of children's emotional and behavioral difficulties.

For RQ2, two additional themes emerged: current diagnostic practices and stakeholder-proposed strategies to improve diagnostic accuracy. Theme 5 revealed how principals, counselors, parents, and social workers approached diagnosis, with varying levels of emphasis on holistic assessment and trauma-informed practices. Theme 6 identified five subthemes of stakeholder-proposed strategies: awareness and education, communication and collaboration, comprehensive and individualized evaluations, integrated and ongoing support, and trauma-informed approaches. Participants agreed

that training teachers in mental health literacy, adopting culturally responsive evaluations, and involving multidisciplinary teams would strengthen diagnostic accuracy. They also stressed that embedding trauma-informed practices and increasing access to professional support were essential to ensuring that children's needs are addressed effectively and without the harm of misdiagnosis.

Description of the Proposed Solution-2

The proposed is trauma-informed, culturally responsive, and family-centered practices in schools, to directly address the local problem of child mental health misdiagnosis in Richmond, VA. By equipping educators and school personnel with skills to recognize the impact of trauma, poverty, and systemic inequities, the approach reduces attribution errors and promotes accurate diagnostic practices (Semchuk et al., 2022). Engaging caregivers as active partners ensures that children's lived experiences are incorporated into assessments, leading to interventions that are supportive rather than punitive (Nayak et al., 2021). This solution benefits children by fostering academic and emotional growth. The families, educators, and the broader community also benefits by reducing stigma, preventing inappropriate interventions, and promoting equitable access to mental health support.

To implement this solution, human services organizations and local school systems should prioritize several key changes. Decision-makers are asked to: (1) allocate funding to recruit and retain licensed school-based mental health professionals (Barrientos, 2022), (2) mandate ongoing professional development on trauma-informed care, cultural competence, and anti-bias practices for educators (Koslouski & Chafouleas,

2022), (3) establish structured family-school collaboration systems that include caregivers in diagnostic and intervention processes (Rao et al., 2020), and (4) advocate for policies that monitor diagnostic disparities and ensure accountability in practice (Mongelli et al., 2020).

Recommendations for Next Steps and Call to Action-1

The next steps for addressing child mental health misdiagnosis in Richmond, VA should focus on implementing the proposed solution through a phased, collaborative approach. Human services organizations and school systems should begin by piloting trauma-informed and culturally responsive training programs for educators in select schools, while simultaneously expanding access to licensed school-based mental health professionals (Foster et al., 2025). Partnerships with caregivers, community organizations, and local health providers should be formalized to ensure shared responsibility in child assessments and interventions. Advocacy efforts must target local policymakers to secure sustainable funding, mandate equity-focused policies, and monitor diagnostic disparities (Schultz et al., 2023). This is a call to action for educators, caregivers, service providers, and policymakers to unite in creating systemic change that prioritizes children's well-being and ensures accurate, compassionate, and equitable mental health practices for every child.

Appendix B: Interview Protocol

- How would you describe your understanding of mental health diagnoses in primary school-aged children?
- What training, if any, have you received on identifying and managing students with mental health challenges?

Experiences with Diagnosed Students

- Can you describe a time when you worked with a student who had a mental health diagnosis? How did it impact your teaching and classroom management?
- Have you ever suspected that a student was misdiagnosed or had an undiagnosed condition? If so, how did you handle the situation?

Classroom Strategies and Responses

- What strategies do you use to support students with mental health diagnoses in your classroom?
- How do you balance the needs of students with mental health diagnoses while maintaining a structured learning environment for the entire class?

Collaboration and Support Systems

- How often do you collaborate with school counselors, psychologists, or administrators regarding students' mental health concerns?
- What support or resources do you feel are currently lacking in your school to effectively support students with mental health diagnoses?

Personal and Emotional Impact on Teachers

- How do you personally feel when working with students who struggle with mental health challenges?
- What challenges or frustrations have you encountered when trying to support students with mental health diagnoses?

Perceptions of the Diagnosis Process

- In your experience, do you believe students in your school are accurately diagnosed with mental health conditions, or do you see frequent misdiagnoses?

- How do you think misdiagnoses affect a student's academic and social development in the school setting?

Teacher Decision-Making and Advocacy

- What role do you believe teachers should play in identifying and advocating for students with mental health concerns?
- Have you ever felt limited or restricted in your ability to support a student due to school policies or lack of resources?

Improving Mental Health Practices in Schools

- What changes do you think should be made to improve mental health support and diagnostic accuracy in schools?
- If you could implement one new policy or program to better support students with mental health conditions, what would it be and why?