



Pediatric Bipolar Disorder in Schools

Cleveland Association of School Psychologists
September 30th, 1:00-3:00pm

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Qualifications for this Presentation

- 2002-2004 OSU Postdoc w/ Mary Fristad, Ph.D., Project coordinator & co-coordinator of Individual Family Psychoeducation (IFP) & Multi-Family Psychoeducation Group (MFPG) studies for families of children w/ bipolar & depressive spectrum disorders
- Lofthouse, N, & Fristad, M. (2004). Psychosocial interventions for children w/ early-onset bipolar spectrum disorder. *Clinical Child & Family Psychology Review*, 7(2), 71-88
- Lofthouse, N, Mackinaw-Koons, B, & Fristad, M. (2004). Early-onset bipolar spectrum disorders. In Andrea Canter, Leslie Paige, Mark Roth, Ivonne Romero, & Servio Carroll. (Eds.) *Helping Children at Home and School* (2nd Ed.)
- Lofthouse, N, & Fristad, M. (2006). Bipolar disorder & school functioning. In George Bear & Kathleen Minke (Eds.) *Children's Needs III: Understanding & Addressing the Developmental Needs of Children* (3rd Ed.)

Qualifications for this Presentation (cont.)

- Lofthouse, N, Fristad, M, Splaingard, M, & Kelleher, K. (2007). Parent & Child Reports of Sleep Problems Associated w/ Early-Onset Bipolar Spectrum Disorders. *Journal of Family Psychology*, 21 (1), 114-123.
- Lofthouse, N, Fristad, M, Splaingard, M, Kelleher, K, Hayes, J, & Resko, S. (2008). Web-Survey of Sleep Problems Associated w/ Early-Onset Bipolar Spectrum Disorders. *Journal of Pediatric Psychology*, 33, 349-357
- Lofthouse, N, Gilchrist, R, & Splaingard, M. (2009). Sleep & Mood Disorders. In Anna Ivanenko, M.D, & Jess Shatkin, M.D. (Eds.) *Child & Adolescent Psychiatric Clinics of North America: Pediatric Sleep Disorders*, 18, 893-916.
- Lofthouse, N, Fristad, M, Splaingard, M, Kelleher, K, Hayes, J, & Resko, S. (2010). Web-survey of Pharmacological & Non-pharmacological Sleep Interventions for Children w/ Early-Onset Bipolar Spectrum Disorders. *Journal of Affective Disorders*, 120, 267-271.

Qualifications for this Presentation (cont.)

- Lofthouse, N, Mackinaw-Koons, B, & Fristad, M. (2010). Bipolar disorder in children & adolescents. In Andrea Canter, Leslie Paige, Mark Roth, Ivonne Romero, & Servio Carroll. (Eds.) *Helping Children at Home & School* (3rd Ed.)
- Lofthouse, N., Fristad, M.A., & Kljun, J. (in-preparation). *The effects of early-onset bipolar spectrum disorders on past & current school & peer functioning.*
- 2006-Current: Provided evidence-based assessments & treatments for children, adolescents & families in an outpatient setting

Presentation Plan

- A. Background on Pediatric Bipolar Disorder (PBD)
- B. Assessment of PBD
- C. Established Tx's for PBD
- D. School-Based Recommendations for PBD – Building Your, the Child's & Family's "Toolbox"
- E. Resources for PBD

Presentation Plan

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A. Background on PBD

- Pediatric BP – Science or Fad?**
 - Increased Academic Interest:
 - Medline/PsychInfo: 1980's (36) → 1990's (66) → 2000-2002 (46) (Lofthouse & Fristad, 2004)
 - 2000-2005 = 227 (Moreno et al 2007)
 - Increased Public Interest:
 - 2003 Amazon.com search = 18 books on PBD, 15 since 2000 (Lofthouse & Fristad, 2004)
 - 2005 (Leffler & Fristad, 2006) & 2009 (Danner et al 2009) Google searches for “childhood bipolar disorder” (483,000 → 3.25 million results) & “childhood mania” (248,000 → 2.93 million)
 - Websites devoted to topic flourished (e.g., Child & Adolescent Bipolar Foundation, [est. 1999], Juvenile Bipolar Research Foundation [est.2002])
 - 2002 Time magazine cover story “Young & Bipolar”
 - The Bipolar Child (Paplos & Paplos, 1999) now in it's 3rd revision (2007)

A. Background on PBD

- Pediatric BP – Science or Fad?**
 - Increased Diagnosis of PBD:
 - Inpatient, 1995 = 11% → 2000 = 18% (Harpaz-Rotem et al 2005)
 - Outpatient, private insurance claims for dx 1999 = 0.9% → 2000 = 1.5% (Harpaz-Rotem et al 2005, Harpaz-Rotem & Rosenheck, 2004);
 - Why the Increase? (Lofthouse & Fristad, 2004, Danner et al 2005)
 - Improved ability to assess...or misdiagnosis
 - Better insurance coverage for mental illness
 - Decreased stigma
 - “Pendulum effect”
 - Dx criteria expanded (BP Spectrum & BP-NOS)
 - 1990's ↑ recognition youth dep & ADHD & ↑ use of SSRI's & stimulants → trigger for latent PBP
 - Cohort effect

A. Background on PBD

- Bipolar Disorder (BP) Defined**
 - DSM-IV Manic or hypomanic & depressed sx's
 - Mania Episode (most of day for ≥ 7 days or hospital)
 - Hypomania Episode (most of day for 4-6 days)
 - Elevated, expansive &/or irritable (high energy) mood
- & 3 (4 if irritable mood) of:**
 - Inflated self-esteem or Grandiosity
 - Decreased need for sleep
 - Increased talking
 - Flight of ideas or Racing thoughts
 - Distractible
 - Increased in goal-directed activity/agitation
 - Foolish/reckless behavior

& significant psychosocial impairment (@ home, work, school, peers, hospitalization, psychosis)

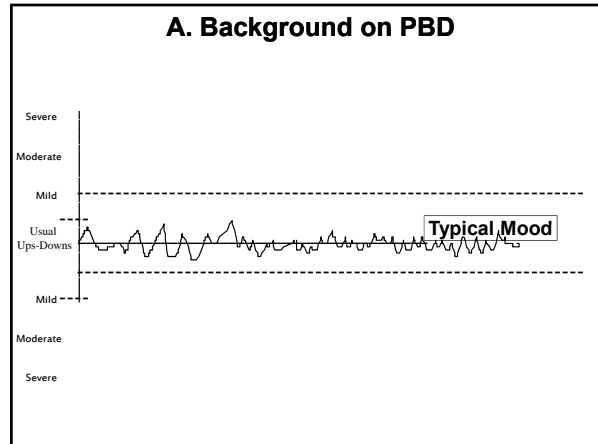
A. Background on PBD

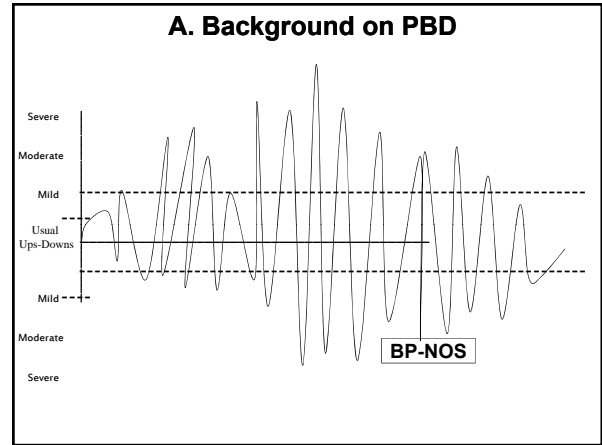
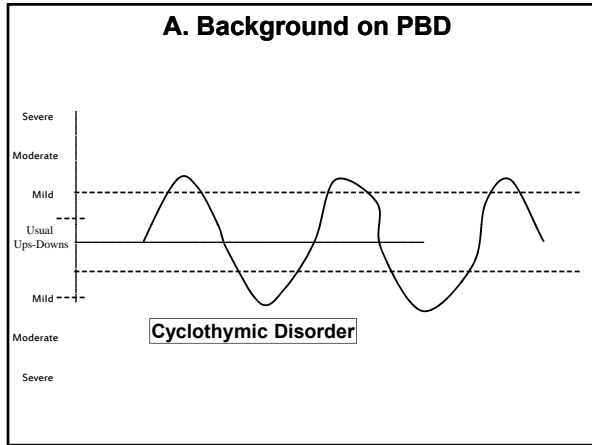
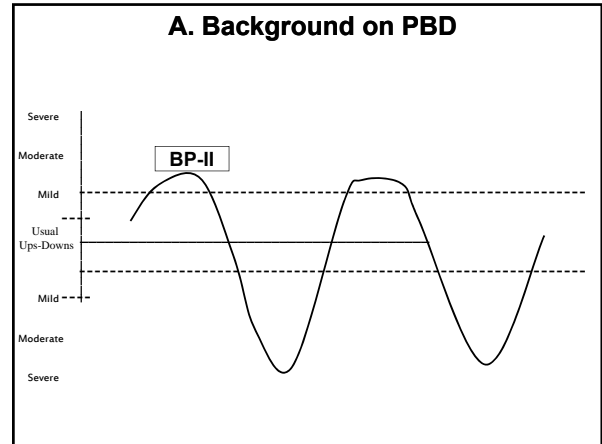
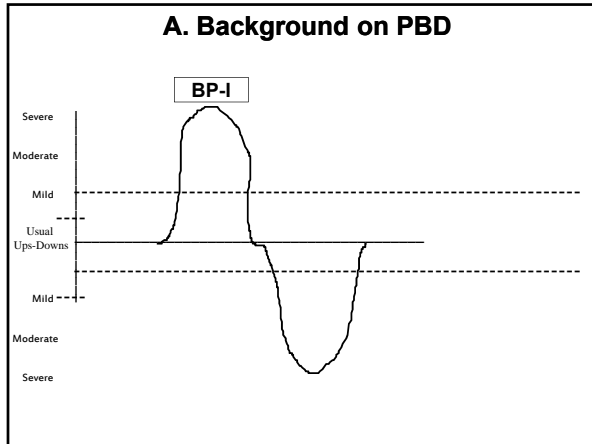
- BP Defined (cont.)**
 - DSM-IV Depressive Episode (most of day, ≥ 2 wks)
 - Depressed mood (sad, empty, low energy irritable)
- &/or**
 - Loss of interest or pleasure in most activities
- & 3 (4 if irritable mood) of:**
 - Significant ↓ / ↑ appetite or weight
 - Insomnia/hyposomnia
 - Psychomotor agitation/retardation
 - Fatigue
 - Feelings of worthlessness/guilt
 - ↓ ability to think/concentrate/make decisions
 - Suicidal/morbid ideation/suicide attempt/plan

& significant psychosocial impairment (@ home, work, school, peers, hospitalization, psychosis)

A. Background on PBD

- BP Defined (cont.)**
 - DSM-IV Bipolar Diagnoses (N=4):
 - Bipolar I Disorder (BP-I)
 - At least 1 manic episode, w/ or w/out MDD
 - Further specified by noting current/previous mood episodes (manic, hypomanic depressed or mixed)
 - Bipolar II Disorder (BP-II)
 - At least 1 hypomanic episode, w/or w/out MDD & no history of a manic/mixed episode
 - Cyclothymic Disorder
 - Multiple episodes of hypomania & dep sx's (not MDD) for 1 year
 - Bipolar Disorder – Not Otherwise Specified (BP-NOS)
 - Presence of BP sx's, which do not meet frequency or durability of above 3 Dx – frequently given to children/adolescents “rapid cycling”





- A. Background on PBD**
- 3. Comorbidity**
- Rates vary between studies (Diler et al 2010)
 - ADHD: 50-88%
 - ODD or Conduct Disorder: 20-60%
 - Anxiety Disorders: 30-70%
 - Substance Use Disorders: 5-35% (low in childhood, increasing in adolescence) ~35% adults w/ BP
 - Psychotic Sxs: 17-60%
 - Suicide (Algorta et al 2011)
 - 14% lifetime suicide attempts
 - 46% past/current suicide ideation
 - 40% free of suicide ideation/attempts
 - In sum, several problems co-occur w/ PBD

- A. Background on PBD**
- 4. Neuropsychological Deficits**
- Recent Review of 10 studies (*Joseph et al 2008*)
 - Comparison to healthy controls using an Effect Size (ES) - standardized measure of size of difference
 - ES ≤ 0.3 = small, 0.4-0.8 = moderate, >0.8 large
 - Verbal Memory (ES = 0.77)
 - Attention (ES = 0.51)
 - Executive Functioning (ES = 0.62)
 - Working Memory (ES = 0.60)
 - Visual Memory (ES = 0.51)
 - Visual Perceptual Skills (ES = 0.48)
 - Verbal Fluency (ES = 0.45)
 - Reading (ES = 0.40)
 - Motor Speed (ES = 0.33)
 - Full Scale IQ (ES = 0.32)

A. Background on PBD

4. **Neuropsychological Deficits (cont.)**
- Executive function, attention, working memory & verbal memory deficits predicted reading & writing problems, while attention deficits predicted math problems (*Pavuluri et al 2006*)
 - 3 yr FU cognitive development of PBD lags behind healthy youth & treating the BP sxs does not seem to prevent the lag - is dysmaturation due to illness &/or meds effect on brain? (*Pavuluri et al 2009*)
 - Compared neuropsych data from adults & teens w/ BPD & found similar deficits in attention, memory & executive functioning suggesting continuity (*Cahill et al 2007*)
 - In sum, several widespread neuropsych problems

A. Background on PBD

5. **Prevalence**
- Adults 3% - 6% (*Weissman et al., 1996*)
 - Community - *Lewinsohn et al (1995)* 14-18 yr-olds
 - BP-I = 0.12%
 - BP-II = 1%
 - Cyclothymia = 1%
 - BP-NOS = 5.7%
 - Inpatient = 2% BPI, 30% manic sxs (*Youngstrom et al 2005*)
 - Outpatient = 6-8% (*Youngstrom et al 2005*)
 - Gender Differences = boys > girls, whereas in non-PBD gender ratio is equal (*Biederman et al 2005*)
 - In sum, PBD relatively prevalent

A. Background on PBD

6. **Child (vs. Adult-Onset) BP**
- Less euphoria, more irritability & reckless behavior, w/ duration typically hours-days (*AACAP, 2007*)
 - ↑ psychosis, poorer prognosis, slower recovery times, more recurrence, high comorbidity, high suicidality (*Finding et al 2001, Kyte et al 2006, Lewinshon et al, 1995*)
 - More psychomotor retardation, psychosis, substance use weight loss & thought disorder (*Patel et al 2006*)
 - More mixed episodes, rapid cycling & comorbidity w/ ADHD (*Findling et al 2001*)
 - Usually manic/mixed onset than dep (*Kyte et al 2006*)
 - In sum, child-onset different from adult-onset BP

A. Background on PBD

7. **Onset**
- 7.3-9.3 yrs old (*Geller et al 2004, Birmaher et al 2006*)
 - Lish et al (1994) Retrospective survey of adults self-identified w/ BP 31% sxs started in childhood, 28% sxs started in adolescence, so > 50% early-onset
 - Lag of 8-10 b/w Dx of BP & Tx & a 10% lower likelihood of recovery for every yr not in Tx (*Pavuluri et al, 2005*)
8. **Course**
- Geller et al (2008) 87.8% recovered from initial episode but 73.3% relapsed over 8yrs, spent 60.2% wks w/ any mood episodes & 39.6% wks w/ mania episodes
 - Birmaher et al (2009) 81.5% recovered from index episode but 62.5% relapsed within 1.5 yrs, 25% w/ BP II → BP I, 38% w/ BP-NOS → BP I or BP II
 - In sum, PBD = chronic & highly relapsing

A. Background on PBD

9. **Overall Functioning**
- >50% children/adolescents w/ PBP functioning poorly & < ADHD & healthy controls in social, family & academic functioning (*Geller et al 2000*)
 - Adolescents w/ PBP < national norms in nearly all quality of life domains (*Rademacher et al 2007*)
 - Despite high rates (85%) of recovery from sxs, at 1 yr FU, only 39% of BP adolescents achieved functional recovery (*DelBello et al 2007*)
 - BP youth in-episode > impaired than those in partial remission/recovery but even latter sig. psychosocial impairment (*Goldstein et al 2009*)
 - In sum, PBD = causes severe & global dysfunction

A. Background on PBD

10. **School Functioning**
- Several widespread neuropsych deficits (*slide #18*)
 - Math difficulties = 30-40% (*Wozniak et al 1995*)
 - PBD sig. > math difficulties vs. MDD/healthy controls (*Lagace et al 2003*)
 - PBD < FSIQ, WRAT math %iles, & WRAT/Gilmore Reading SS's vs ADHD (*Wozniak et al 1995*)
 - PBD sig. > more school services vs. healthy controls (*Doyle et al 2005*), PBD + ADHD sig more school services vs. ADHD (*Henin et al 2007*)
 - Hospitalized children w/ PBD: repeated a grade (24%), previous or current Special Education placement (43%), tutoring (58%), learning disability (13%) (*Biederman et al 1999*)

A. Background on PBD

10. School Functioning (cont.)

- *Quakenbush et al (1996)* Pre-Post Illness
- Adolescents prior to PBD
 - 70% “excellent” work effort
 - Strong in creative pursuits
 - 1/3 leadership qualities
 - 2/3 extra-curricular activities
- Post-illness
 - Serious decline in work effort, grades, motivation attendance
 - None had leadership potential
 - 2/3 peer difficulties (loss of previous activities & friendships)
 - 38% of eligible H.S. seniors graduated (Canada)

A. Background on PBD

10. School Functioning (cont.)

Kljun, Lofthouse, Fristad, & Dingus (2004) 8-11 yrs olds

- 77% parents recalled past & 55% current behavior problems in school
- 80% parents recalled previous & 64% current special education services
- 78.5% parents & 45.5% children school is currently hard
- 70.9% parents & 59.7% children reported peer difficulties
- 48.7% parents & 67.9% children reported no friends
- 62.1% parents & 23.7% children reported no best friend
- Children w/ average-to-optimal school services had sig. fewer current behavior problems at school vs. children w/ below-average school services

A. Background on PBD

10. School Functioning

- *Griffith, Lofthouse, Fristad, & Dingus (2004)* 8-11 yrs olds
- 79% parents, 46% children & 72% teachers reported current difficulties w/ academics at school
- On Teacher Report Form (TRF, Achenbach, 1991) teachers reported moderate to severe difficulties w/ antisocial behavior, social competence, withdrawn behavior, interpersonal skills & self management skills
- In sum, PBD causes severe school/peer dysfunction

A. Background on PBD

11. Etiology - Diathesis-Stress Model (*Findling et al 2003*)

- **Diathesis:**
 - Genetics, family hx mood &/or alcohol-drug issues
 - Neurotransmitters (serotonin & dopamine)
 - Hormones (cortisol, corticotropin-releasing hormone, thyrotropin-releasing hormone & somatostatin)
 - Neuroanatomical (frontal-striatal-limbic regions)
 - Intracellular calcium in blood system
 - “Stress sensitization,” over time less affected by external factors & more spontaneously activated by internal biological mechanisms
- **Stress:**
 - High levels of family expressed emotion
 - Psychosocial stressors at home, school, peers.
 - Comorbidity
 - Sleep

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B. Assessment of PBD

- In addition to standard developmental, Tx & medical Hx. 4 areas are particularly important for pediatric BD
- 1. Assessment of all DSM-IV Sxs:
 - Rating Scales - Child & Adolescent Sxs Inventory-4R (CASI-4R, *Gadow & Sprafkin, (2005)*. Checkmateplus
 - Ages 5-18, Parent, teacher & youth (12-18 yrs)
 - Sxs freq., count, severity & impairment scores
 - For each dx category need to ask re freq. (daily, weekly, monthly), age of onset & course since onset (better, worse, same)
 - Structured Clinical Interview: Child Interview for Psychiatric Syndromes Child & Parent Versions (ChiPS/ChiPS-P: *Weller et al., 1999*). Western Psychological Services (WPS) publishers
 - Ages 5-18, Parent & child/teen versions
 - Sxs count, dx cutoff, onset, duration & impairment

B. Assessment of PBD

2. Assessment of Worst Manic & Depressive Episodes:

- **B/c mood sx's are episodic ask, "was there a time when your (your child's)..**
 - way too happy/angry mood was worse than now?"
 - sad, grumpy, or unmotivated mood was worse than now?"
- For each worse manic/depressive episode assess:
 - a) Freq. & duration of mood during that time
 - b) Presence of additional 7 manic or 7 depressive sx's during that time
 - c) Impairment of home/school/peers during that time

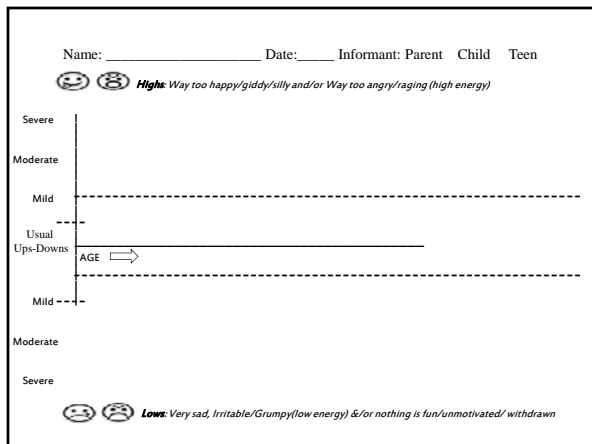
WORST MANIC EPISODE	INFORMANT: PARENT CHILD TEEN		
MANIC SYMPTOMS	Worst Episode		
EUPHORIA	Frequency:		
	Duration:		
IRRITABLE (high energy)	Frequency:		
	Duration:		
INFLATED SELF-ESTEEM OR GRANDIOSITY	No	Yes:	
DECREASED NEED FOR SLEEP	No	Yes:	
FLIGHT OF IDEAS OR RACING THOUGHTS	No	Yes:	
DISTRACTIBLE	No	Yes:	
INCREASED IN GOAL-DIRECTED ACTIVITY/AGITATION	No	Yes:	
FOOLISH/RECKLESS BEHAVIOR (INCLUDING HYPERSEXUALITY)	No	Yes:	
PSYCHOTIC SXS	No	Yes:	
IMPAIRMENT	No	Yes:	Home School Peers

WORST DEPRESSED EPISODE	INFORMANT: PARENT CHILD TEEN		
DEPRESSIVE SYMPTOMS	Worst Episode		
SAD	Frequency:		
	Duration:		
IRRITABLE (low energy)	Frequency:		
	Duration:		
LOSS OF INTEREST/PLEASURE	Frequency:		
	Duration:		
SIGNIFICANT ↓ / ↑ APPETITE/WEIGHT	No	Yes:	
INSOMNIA/HYPOSOMNIA	No	Yes:	
PSYCHOMOTOR AGITATION/RETARDATION	No	Yes:	
FATIGUE	No	Yes:	
FEELINGS OF WORTHLESSNESS/GUILT	No	Yes:	
↓ ABILITY TO THINK/CONCENTRATE/MAKE DECISIONS	No	Yes:	
SUICIDAL/MORBID IDEATION SUICIDE ATTEMPT/PLAN	No	Yes:	
PSYCHOTIC SXS	No	Yes:	
IMPAIRMENT	No	Yes:	Home School Peers

B. Assessment of PBD

3. Assessment of Mood Hx:

- **B/c mood sx's are episodic & need information re mood hx for specific DSM-IV diagnoses & qualifiers**
- **Separately ask parents & youths to draw their mood across their lifetime on following diagram**
- **Need to write age markers on line to help them**
- **Need to explain about the areas of "usual ups & downs," "way too happy/angry" & "lows"**
- **Also ask about & note on diagram specific triggers associated w/ mood change (both -ve & +ve)**



B. Assessment of PBD

4. Differentiating PBD Sxs From Other Dx Sxs
Danner et al (2009)

- **ADHD – w/ PBD inattention, hyperactivity & impulsivity waxes & wanes but is omnipresent w/ ADHD**
- **ODD/CD – w/ PBD episodic nature & lack of intent w/ conduct-type behaviors**
- **Psychosis – w/ PBD episodic nature**
- **PTSD – assess for presence of a trauma & temporal relationship w/ sx's after trauma**

B. Assessment of PBD

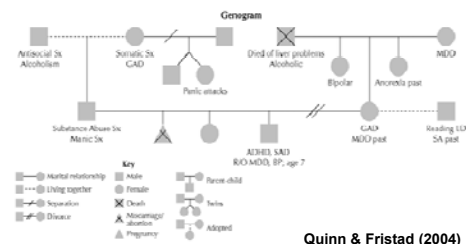
- Broad vs. Narrow Phenotype of PBD
 - Broad Phenotype ("severe mood & behavior dysregulation [SMD]) Uses DSM-IV criteria & < 4 days
 - Narrow Phenotype = DSM-IV criteria, except mood has to be elevated/expansive or grandiose \geq 7 days
 - Geller et al (2000) 7-16 yr-olds w/ PBD w/ & w/out ADHD vs. ADHD-only on manic sx's

Manic Sxs	PBD	ADHD
Elated Mood	89%	14%
Grandiosity	86%	5%
Flight of Ideas/Racing Thoughts	71	10
↓ Need for Sleep	40%	6%
Hypersexuality	43%	6%

- DSM-V = Disruptive Mood Dysregulation Disorder

B. Assessment of PBD

- Assessment of Family Hx:
 - B/c mood sx's are heritable, gives you more info
 - 3 generation genogram & ask parents/guardians re possible psychiatric problems in relatives



B. Assessment of PBD

- Neuropsychological Assessment:
 - B/c of neuropsychological deficits
 - Wechsler Intelligence Scale for Children 4th Ed.
 - Woodcock-Johnson Psychoeducational Battery-3rd Rev.
 - Based on Joseph et al (2008), refer to pediatric neuropsych. for tests of: Verbal Memory, Attention, Executive Functioning, Visual Memory, Visual Perceptual Skills, Verbal Fluency & Motor Speed

B. Assessment of PBD

- Key Papers:
 - Danner et al (2009). Early Onset Spectrum Disorders: Diagnostic Issues. *Clinical Child & Family Psychology Review*, 12, 271-293
 - Quinn & Fristad (2004). Defining & Identifying Early Onset Bipolar Spectrum Disorder. *Current Psychiatry Reports*, 6(2),101-107.
 - Danner et al (2009). Assessment of BP in Children. In J.L. Matson et al. (eds.) *Assessing Childhood Psychopathology & Developmental Disabilities*.
 - Youngstrom et al. (2005). Toward an Evidence-Based Assessment of Pediatric Bipolar Disorder, *Journal of American Academy of Child & Adolescent Psychiatry*, 34, 433-448.

C. Evidence-Based Tx for PBD

- Medication
 - Foundation of effective Tx for PBD
 - 1st line pharmacological Tx
 - Mood stabilizers (e.g., Depakote, Lithium, Tegretol, Gabitril, Lamictal, Topamax, Trileptal)
 - Atypical anti-psychotics (e.g., Abilify, Clozaril, Geodon, Risperdal, Seroquel, Zyprexa)
 - Lithium, Risperdal, Abilify, Zyprexa & Seroquel FDA-approved for Tx acute mania in adolescent w/ PBD
 - Anti-hypertensives (e.g., Clonidine & Tenex) for aggression/sleep sx's After mood stabilized w/ mood stabilizer:
 - Adjunctive anti-depressants for ↓ depression & anxiety (e.g., Prozac, Paxil, Zoloff, Luvox, Celexa, Lexapro, Remeron, Wellbutrin, Effexor, Cymbalta)

C. Evidence-Based Tx for PBD

- Medication (cont.)
 - Adjunctive psychostimulants for ADHD (e.g., Ritalin, Concerta, Metadate, Adderal, Dexedrine, Focalin, Daytrana, Vyvanse) &/or norepinephrine reuptake inhibitors (Strattera, Intuniv)
 - "Use Solo, Start Low, Go Slow, Monitor the Flow"
- Key Papers:
 - Pfeifer et al (2010). Pharmacotherapy of BP in Children & Adolescents *CNS Drugs*, 24(7) 575-593
 - Nandagopal & DelBello (2010). Pharmacotherapy for PBD *Psychiatric Annals*, 40 (4), 221-230
 - Liu et al (2011) Pharmacologic treatments for pediatric bipolar disorder: a review and meta-analysis. *Journal of American Academy of Child & Adolescent Psychiatry*, 50(8),749-762

C. Evidence-Based Tx for PBD

2. Psychotherapy
- As recently as 1999, no evidence-based guidelines for psychosocial Tx's for PBD. Since then, 5 Tx's:

4 Adjunctive Psychoeducation Tx's & 1 Adjunctive Psychotherapy Tx

Adjunctive Psychoeducation

- Multi-Family Psychoeducation Group (MFPG)
 - Fristad & colleagues @ OSU
 - 8-11-yr-olds w/ PBD & Depressive Disorders
 - 8 separate parent/child group sessions of psychoeducation, support & CBT skill building
 - Randomized Control Trial (RCT, N=35): ↑ children's perceived support from parents & peers, ↑ knowledge re mood disorders @ post-Tx & 6-mth FU, ↑ family interactions & ability to get services @ post-Tx & 6-mth FU (Fristad et al 2002, 2003)

C. Evidence-Based Tx for PBD

2. Psychotherapy (cont.)

- MFPG (cont.)
 - RCT (N=165): ↑ knowledge re mood disorders, ↑ higher quality of services utilized → ↓ mood sx severity (Mendenhall et al 2009)
- Individual-Family Psychoeducation (IFP)
 - Fristad & colleagues @ OSU
 - 8-11-yr-olds w/ PBD
 - 16 separate parent/child sessions of support, psychoeducation, CBT skills & healthy habits
 - RCT (N=20) ↓ mood severity sx post-Tx & 12-mths FU, ↑ positive family climate, ↓ in mood severity ↑ family climate & Tx utilization > @ 12 mths FU (Fristad, 2006)

C. Evidence-Based Tx for PBD

2. Psychotherapy (cont.)

- Child & Family-Focused CBT (CFF-CBT, RAINBOW)
 - Pavuluri et al (2004) @ University of Illinois
 - 8-12 yr-olds w/ PBD, 12 parent/youth sessions of psychoeducation, CBT, interpersonal therapy
 - Nonrandomized trial (34) ↓ sx, ↑ global functioning & Tx adherence (Pavuluri et al 2004)
- Functional Family Therapy for Adolescents (FFT-A)
 - Miklowitz et al (2004) @ University of Colorado
 - 12-17 yr-olds w/ BP I, 20 parent/youth sessions of psychoed., communication & problem-solving
 - Open trial (N=20) ↓ sx 2 yrs later (Miklowitz et al 2006)

C. Evidence-Based Tx for PBD

2. Psychotherapy (cont.)

- FFT-A (cont.)
 - Multisite RCT (58): FFT + Meds > than brief therapy or meds-alone ↑ recovery from dep sx, ↓ episode length & improving course of dep sx (Miklowitz et al 2008)
- All above Tx's are all time-limited & adjunctive psychoeducation to treatment as usual – "a starter kit" for coping with PBD (Young & Fristad, 2007)
- However, components of 4 Tx's can be used to continue to help child/teen/family improve, maintain Tx gains & cope w/ relapse

C. Evidence-Based Tx for PBD

2. Psychotherapy (cont.)

Adjunctive Psychotherapy - Dialectical Behavior Therapy

- Goldstein et al (2007) @ Western Psych. Institute
- 1-yr open trial (N=10), 14-17 yr-olds, 24 family & individual DBT sessions (distress tolerance, mindfulness, emotional regulation, & interpersonal effectiveness)
- Sig. ↓ suicidality, nonsuicidal self-injury, emotional dysregulation & depressive sx
- Omega-3 Fatty Acids
 - Wozniak et al (2007) 8 wk open-label trial w/ 6-17 yr-old → sig. but modest reduction in manic sx
 - Gracious et al (2010) 16 wk placebo-controlled trial, 6-17 yr-olds, no sig. differences but reduction in illness severity associated w/ increases in serum omega-3 suggesting individual differences

C. Evidence-Based Tx for PBD

4. School-Based Interventions

- Unfortunately no research-supported, school-based interventions currently exist for PBD

Key Papers:


- Young & Fristad (2007) Evidence-based treatments for BP in child & adolescents, *Journal of Contemporary Psychotherapy*, 37, 157-164.
- Miklowitz et al (2004). Family focused treatment for adolescents w/ BP. *Journal of Affective Disorders*, 82, S113-128.
- Pavuluri et al (2004). Child- & family-focused cognitive behavioral therapy for PBD: Development & preliminary results. *Journal of American Academy of Child & Adolescent Psychiatry*, 43, 528-537
- Goldstein et al (2007). Dialectical behavior therapy for adolescents with BP: A 1-year open trial. *Journal of American Academy of Child and Adolescent Psychiatry*, 46(7), 820-830.

Presentation Plan

- A. Background on PBD
- B. Assessment of PBD
- C. Established Tx's for PBD
- D. School-Based Recommendations for PBD – Building Your, the Child's & Family's "Toolbox"
- E. Resources for PBD



Building Your, the Child's & Family's Toolbox


- "Moving Target" – Due to mood fluctuations, children may not present w/ same problems everyday
- Therefore, important to have a variety of "tools" in your, the child's & family's "toolbox"



Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry; Nicholas.Lofthouse@osumc.edu.

Two Broad Types of "Tools"

- External "Tools" – Strategies to change the child's external environment which may be triggering or contributing to the problems 
- Internal "Tools" – Strategies to help the child change their internal environment (i.e., feelings, moods, thoughts, body responses &/or behaviors) 




Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry; Nicholas.Lofthouse@osumc.edu.

Which Tool to Use First?

- Depends on the overall case-conceptualization
- Depends on the case-conceptualization for that day!
- Depends on severity of problem (See following 2 ways to measure severity):
 - If > 5 problem is more in control of child → try external tools 1st
 - If ≥ 5 child is more in control of problem → try internal tools 1st
- Ask parent or child which one to use 1st


IFP & MFPG

- Several of following internal & external tools have been adapted from Dr. Mary Fristad's IFP & MFPG psychoeducation treatments



- <http://www.moodychildtherapy.com/>

Internal Tools



- It's not your fault, but it is your challenge!
- What is the real me & what are my symptoms?
- Identify the Feeling
- How Strong is the Feeling?
- Know Your Triggers
- 3 Not 1 (Tripartite model of feeling)
- Body Reactions
- The Feelings Volcano
- Relaxation Skills # 1 - Belly Breathing
- Relaxation Skills # 2 - Muscle Relaxation
- Relaxation Skills # 3 - Imagery
- How do you if the tool worked?

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry; Nicholas.Lofthouse@osumc.edu.


Internal Tools (cont.)

- Fire-drills before the Feelings Volcano blows!
- Changing Unhelpful to Helpful Thoughts
- Changing Unhelpful to Helpful Actions
- Building a Toolbox
- In With The New Out with the Old
- Planning for Future Fun Activities
- Problem Solving #1
- Problem Solving #2 Compromising
- Stress Management Plan
- Communication

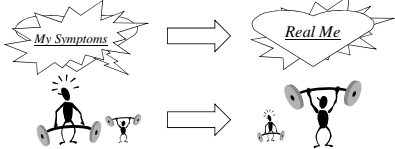
Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

“No-Fault Disorders” – But Whose Challenge?

*It's not your fault, but it's your challenge!**



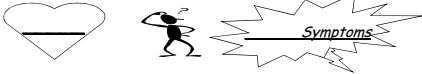
Challenge = gain control over the symptoms so they don't get in the way of your life at home, in school or with friends.



It's not just your challenge, it's your parents, your teachers, your therapists and your psychiatrist's challenge! It's a team effort.

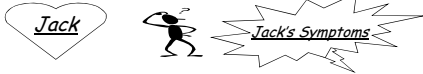
*Quote by Dr. Mary Fristad – OSU Psychiatry

“What is the Real Me and What Are My Symptoms?”



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“What is the Real Me and What Are My Symptoms?” - Example















<p><i>Caring</i></p> <p><i>Creative</i></p> <p><i>Good swimmer</i></p> <p><i>Very loving</i></p> <p><i>Good student</i></p> <p><i>Likes computers</i></p> <p><i>Good at math</i></p> <p><i>Smart</i></p> <p><i>Shares well with siblings and friends</i></p> <p><i>Sensitive</i></p> <p><i>Spontaneous</i></p> <p><i>Uncoordinated</i></p>	<p><i>Anger</i></p> <p><i>Way too happy</i></p> <p><i>Sleep</i></p> <p><i>Attention</i></p> <p><i>Suicide</i></p> <p><i>Too much energy</i></p>
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Identifying Feelings

How Am I Feeling?

			
Happy	Sad	Angry	Scared
			
Calm/Relaxed	Bored	Proud	Stressed
			
Jealous	Excited	Tired	Stubborn

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How Strong is the Feeling?

10

9

8

7

6

5

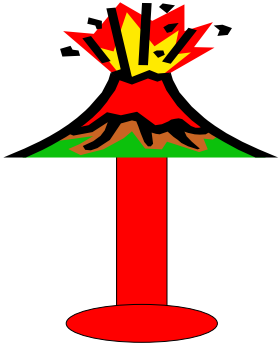
4

3

2

1

0



Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

How Strong is the Feeling?

High
Middle
Low

0 1 2 3 4 5 6 7 8 9 10

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Identifying Triggers

What Makes Me _____?

Feeling Strength

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

3 Not 1

Thoughts/Images

Feeling or Mood
N=3

Body Reaction

Behavior

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

BODY REACTIONS

Just like traffic signals, your bodily reactions send you information

ANGRY = RED
SAD = BLUE
SCARED = YELLOW
WAY TOO HAPPY = GREEN

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

The Feelings Volcano

-When is the Best Time to Catch Your Feeling?

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Relaxation Skills # 1. "Belly-Breathing"

1. Put one hand on belly & other on chest.
2. Breathe in, taking long (1,2,3,4,5) deep breaths in through the mouth, inflating belly like a balloon & pushing "belly hand" out but keeping "chest hand still"
3. Breathe out, taking long (1,2,3,4,5) deep breaths out through nose, deflating belly like a balloon & letting "belly hand" down but keeping "chest hand still"
4. Repeat 20 times.
5. Practice daily before applying to small intensity easy situation to set yourself up for success.

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Relaxation Skills #2. Muscle Relaxation

1. Draw attention to feeling like a "stiff robot or piece of wood" & how you're going to change into a "floppy doll or wet noodle."
2. Do each muscle group for a count of "10-9-8-7-6-5-4-3-2-1-relax:" & then feel the tension leave your body.
3. To set yourself up for success, practice daily & then use with a mildly anxious event.

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Relaxation Skills #3. Imagery

1. Pick a relaxing image from memory, the Internet, a magazine, photo or above.
2. Close your eyes, take 10 deep/slow breaths, imagine a door appearing & you going through it & walking toward that relaxing place.
3. While walking to that place, use all 5 senses to bring the image to life – What do you: See? Hear? Smell? Feel on Your Skin? Taste?
4. Imagine yourself sitting/laying down in that place, taking 10 deep/slow breath & once again using all 5 senses to bring the place to life.
5. Take 10 more deep/slow breaths, then imagine yourself standing-up & walking back to the "door."
6. Before you go back through the door, take one last look at your relaxing place use all 5 senses to get one last memory & then step through the door.
7. Take 10 more deep/slow breaths & slowly open your eyes.
8. Practice daily before applying to a small intensity easy situation to set yourself up for success.
9. Know you can always return to that relaxing place in your brain whether your body is!

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

How Do You Know if the Tool Worked?

- Reuse "How Strong is the Problem?"
- Use after applying each external/internal tool

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Fire Drills Before the Volcano Blows

- When's the best time to practice a fire-drill?
- Answer = Before a fire!
- When's the best time to practice your tools?
- Answer = Before the Feelings Volcano blows!

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

CHANGING THE UNHELPFUL "STUFF INSIDE"...

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

...TO HELPFUL "STUFF INSIDE"

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Building a Tool Box

Relaxation Tools

Helpful Thought Tools

Physical Tools


Creative Tools

Social Tools

Adapted, with permission, from Dr. Mary Fristad's OSU MFG/IFP program, by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

In With the New, Out With the Old

Helpful Actions to Go in Toolbox




Unhelpful Actions to Take Out of Toolbox

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Planning for Future Fun Events

One day a week, sit down to identify future fun events & when they will or can happen





Why:  = ☺ and less ☹

Future Fun Event	When Is It Going to Happen?

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Problem-Solving #1

LET'S SOLVE THAT PROBLEM!


1.  WHAT'S the Problem? →
2.  STOP, SLOW DOWN & THINK of 5 solutions →
 1.
 2.
 3.
 4.
 5.
3.  CHOOSE the most likely helpful solution & DO IT! → #
4.  CHECK if it worked →

YES! - Use solution again
NO! - Choose another solution

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Problem-Solving #2

"MEETING IN THE MIDDLE"
THE ART OF COMPROMISING



1. "Cleanup your room"

● Cleanup all room
What's in the middle?
● Don't cleanup any part
2. "Go to bed"

● Go to bed now
What's in the middle?
● Bedtime 2 hours
3. "You can't have a friend over"


● You can't have a friend over tonight
What's in the middle?
● I want a friend over tonight
4. Your turn! What is something you and your parent(s) argue about?


● _____
What's in the middle?
● _____
5. Your turn! What is something you and your parent(s) argue about?

● _____
What's in the middle?
● _____

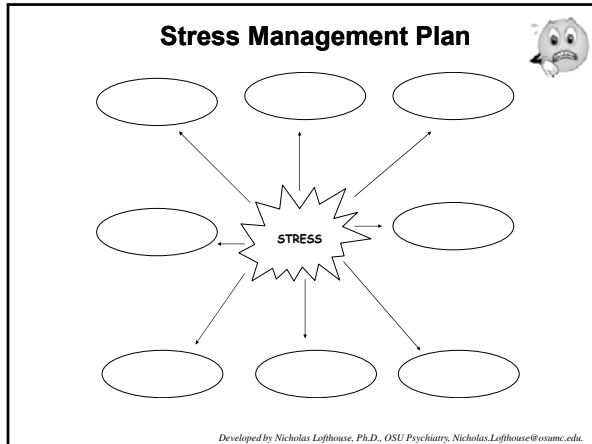
Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Stress Management Plan

1. Identify All Stressors on Attached Diagram 
2. Questions to decide which stress to manage first:
 - What is causing me the most stress?
 - What will be the easiest to solve?
 - Is there something I can solve that would have a knock-on effect on others stressors?
3. Use tools in your toolbox to manage one stress at time.



Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.



Communication

- **What is Communication?**
 - Sending and getting information about thoughts and feelings
- **Why is it Important?**
 - To let others know what you are thinking and feeling and for them to let you know what they are thinking and feeling.
- **Two Types of Communication:**
 1. With words
 2. Without Words

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Communication With Words

- **What to say**
- **When to say it**
- **When to stop saying it**
- **Why you're saying it (rationale)**
- **Where to say it**
- **How to say it**

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Communication Without Words

- Facial Expressions
- Body Gestures
- Body Postures
- Tone of Voice
- Personal Space
- Listening

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Helpful & Unhelpful Communication

- Just like thoughts, feelings and behaviors, communication can be either helpful or unhelpful.

Helpful

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Changing Unhelpful Communication

Unhelpful	→	Helpful

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

"PASSING ON YOUR KNOWLEDGE"

TO HELP _____ TEACHER(S) BETTER UNDERSTAND AND HELP HIM/HER, PLEASE COMPLETE THE FOLLOWING TWO COLUMNS ON "THINGS THAT WORK" AND "THINGS THAT DON'T WORK" FOR HELPING _____ WITH HIS/HER CHALLENGES.

"THINGS THAT WORK"	"THINGS THAT DON'T WORK"

91
Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu

School Team Goals

Child/Teen Goals:

1. _____
2. _____
3. _____

Parent Goals:

1. _____
2. _____
3. _____

School Personnel Goals:

1. _____
2. _____
3. _____

Shared Goals:

1. _____
2. _____
3. _____
4. _____

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Tracking & Communicating Goal Progress

Name: _____ Date: _____

How Are You Doing With Your School Goals?
Goal # _____

Goal Performance	Really Well	10																				
		9																				
		8																				
		7																				
		6																				
		5																				
		4																				
		3																				
		2																				
		1																				
		0																				
		Week Number																				

○ = My Rating X = School Rating

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Example

Name: _____ Date: _____

How Are You Doing With Your School Goals?
Goal # Control Anger


Goal Performance	Really Well	10																				
		9																				
		8																				
		7																				
		6																				
		5																				
		4																				
		3																				
		2																				
		1																				
		0																				
		Session Number																				

○ = My Rating X = School Rating

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu

Collaborative Problem Solving (CPS)


- *The Explosive Child (2005)*
- *Lost At School: Why Our Kids w/ Behavioral Challenges are Falling Through the Cracks & How We Can Help Them (2009)*
- **3 Basket Approach:**
 - **Basket A:** Behaviors important enough to have meltdowns over (you stand your ground!)
 - **Basket B:** Behaviors important but not worth meltdowns but worth training child cognitive skills to tolerate frustration & think flexibility in midst of frustration (you use CPS)
 - **Basket C:** Behaviors you choose to remove from child's life to reduce their overall level of frustration (you let it go!)



Collaborative Problem Solving (CPS)

- CPS (cont.)
- **Basket B CPS 3 Steps:**
 1. **Empathy:** Identify child's emotion, gather info from child's perspective re problem, empathize w/ child via reflective listening
 2. **Define the Problem:** Share your perspective re the problem & then note both perspectives
 3. **Invitation:** Ask child to brainstorm some possible solutions w/ you that are mutually satisfying ("win-win")

Daily Touch Base Meeting




BEGINNING OF DAY:

- How am I feeling? _____
- How STRONG is that feeling?
 1 2 3 4 5 6 7 8 9 10
 Low Middle High
- How can I GAIN MORE CONTROL of that feeling?
 1) _____ 2) _____
- How can OTHERS HELP ME GAIN CONTROL of that feeling?
 1) _____ 2) _____
- What are some possible TRIGGERS today?
 1) _____ 2) _____
- How can I DEAL WITH THOSE TRIGGERS?
 1) _____ 2) _____

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Daily Touch Base Meeting




END OF DAY:

- HOW DID I DO managing my feelings today?
 Well OK Not So Well
- What HELPED? _____
- What DIDN'T HELP? _____
- What COULD HELP? _____
- How did I do with MY TRIGGERS today?
 Well OK Not So Well
- What HELPED? _____
- What DIDN'T HELP? _____
- What COULD HELP? _____

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Daily Touch Base Meeting




BEGINNING OF WEEK:

- How am I feeling? _____
- How STRONG is that feeling?
 1 2 3 4 5 6 7 8 9 10
 Low Middle High
- How can I GAIN MORE CONTROL of that feeling?
 1) _____ 2) _____
- How can OTHERS HELP ME GAIN CONTROL of that feeling?
 1) _____ 2) _____
- What are some possible TRIGGERS this week?
 1) _____ 2) _____
- How can I DEAL WITH THOSE TRIGGERS?
 1) _____ 2) _____

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Weekly Touch Base Meeting




END OF WEEK:


- HOW DID I DO managing my feelings this week?
 Well OK Not So Well
- What HELPED? _____
- What DIDN'T HELP? _____
- What COULD HELP? _____
- How did I do with MY TRIGGERS this week?
 Well OK Not So Well
- What HELPED? _____
- What DIDN'T HELP? _____
- What COULD HELP? _____

Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

Fire Drills Before the Volcano Blows



- When's the best time to practice a fire-drill?
- Answer = Before a fire!
- When's the best time to practice your tools?
- Answer = Before the Feelings Volcano blows!



Developed by Nicholas Lofthouse, Ph.D., OSU Psychiatry, Nicholas.Lofthouse@osumc.edu.

School-Based Recommendations for PBD

- Several potentially beneficial clinical & educational recommendations available from several sources:
 - Child & Adolescent Bipolar Foundation (CABF)
 - Juvenile Bipolar Research Foundation (JBRF)
 - Understanding & Educating Children & Adolescents w/ BP: Guide for Educators (*Anderson et al 2003*)
 - Raising a Moody Child: How to Cope w/ Depression & Bipolar Disorder (*Fristad & Goldberg-Arnold, 2004*)
- Summarized & expanded in *Lofthouse & Fristad (2006)* Bipolar disorder & school functioning. In George Bear & Kathleen Minke (Eds.) *Children's Needs III: Understanding & Addressing the Developmental Needs of Children (3rd Ed.)*

School-Based Recommendations for PBD

7 Fundamental Recommendations:

1. **Build, Maintain, & Educate School-Based Team re PBD & the individual child's strengths & limitations & case-conceptualization**
2. **Prioritize IEP Goals: Attendance, emotional stability & physical safety, knowledge acquisition, relationship building, & work production**
3. **Provide Predictable, +ve & Flexible Class Environment:**
 - Good for all students but esp. w/ PBD b/c of unpredictable moods
 - ↑ predictability by organized classrooms, daily routines that are structured & consistent, & clear expectations coupled w/ +ve discipline strategy

School-Based Recommendations for PBD

3. **Predictable, +ve & Flexible Classroom Environ. (cont).**
 - Negative consequences often used to reduce unwanted behaviors but if behavior (e.g., euphoric or irritable mood) is not one child has cognitive, emotional, or behavioral skills to control, negative consequences may not only be ineffective in reducing that behavior, could actually increase it!
 - As PBD sxs wax/wane, critical to maintain flexibility
 - May be necessary to modify expectations re amount, content of & time allowed for activities, tests & assignments, based on child's fluctuations in mood, attention, energy & motivation

School-Based Recommendations for PBD

4. Be Aware of & Manage Medication Side Effects

- Children w/ PBD frequently prescribed multiple meds, keep updated w/ child's meds & side-effects (e.g., increased thirst & urination, drowsiness, or sluggishness)
- Common classroom interventions include unlimited access to fluids & restroom, & rescheduling of most challenging activities to times when side effects are less pronounced (e.g., after lunch)

School-Based Recommendations for PBD

5. Develop Social Skills

- Many children w/ PBD social-emotional skills deficits, misinterpret jokes, act shy, be bossy/bully, victim of bullying
- Provide support from guidance counselor, social worker or psychologist; allow child to participate in social skills group & increase playground supervision to avert bullying

School-Based Recommendations for PBD

6. Prepare for Episodes of Intense Emotion

- Functional behavior assessment to identify triggers that precede losses of control & guide behavior plan (e.g., episodes triggered by boredom → provide enrichment activities; hunger/low blood sugar → mid-morning & afternoon snacks; during difficult activities → temporarily reduce demands to level child can manage)
- Essential intervention use of safe/private place to visit to regain control (e.g., guidance office or resource room)
- Establish secret signal for child & teacher to covertly communicate need to take brief timeout during class
- Develop crisis management plan involving crisis prevention strategies & include
 - a) Explicit instructions to manage unsafe behaviors (i.e., who does what, when, & where)

School-Based Recommendations for PBD

6. Prepare for Episodes of Intense Emotion (cont.)

- Crisis management plan involving
 - b) Details re location, supervision of & expectations surrounding safe & private places (e.g., designating guidance counselor's office as a safe place & making sure child gets there & returns to classroom ASAP after calming down)
 - c) Development/practice of a specific communication system to implement procedures quickly (e.g., child could give a "T" hand signal to communicate need to go safe place)
 - d) Alternative backup plans (e.g., walking around gym w/ an adult if time in the safe place didn't work)
 - e) Recovery procedure for all involved following crisis (e.g., de-stress & debrief as a class, w/ child included, in order not to ostracize child)

School-Based Recommendations for PBD

6. Prepare for Episodes of Intense Emotion (cont.)
- Following hospitalization/missed school b/c of ↑ sxs, critical school team prepare for child's transition back to prevent further disruption
 - Team might arrange for temporary homebound instruction, followed by gradual transition back to school, if needed, or partial days at school
 - Consider Alternatives to Regular Classrooms
 - If sxs escalate & become harmful to child/others in regular classroom, school team consider more restrictive educational environments
 - Reg. classroom w/ a 1:1 aide → special ed. teacher or resource room support → self-contained classroom → home schooling → therapeutic day school → hospital day Tx program → residential Tx center or therapeutic boarding schools (see National Association of Therapeutic Schools & Programs www.natsap.org)

School-Based Recommendations for PBD

Key Papers:

- Lofthouse, N, Mackinaw-Koons, B, & Fristad, M. (2010). Bipolar disorder in children & adolescents. In Andrea Canter, Leslie Paige, Mark Roth, Ivonne Romero, & Servio Carroll. (Eds.) *Helping Children at Home & School (3rd Ed.)*
- Lofthouse, N, & Fristad, M. (2006). Bipolar disorder & school functioning. In George Bear & Kathleen Minke (Eds.) *Children's Needs III: Understanding & Addressing the Developmental Needs of Children (3rd Ed.)*
- McIntosh & Trotter (2006). Early onset bipolar spectrum disorder: psychopharmacological, psychological, & educational management *Psychology in the schools, 43(4)*, 451-460.

Presentation Plan

- A. Background on PBD
- B. Assessment of PBD
- C. Established Tx's for PBD
- D. School-Based Recommendations for PBD – Building Your, the Child's & Family's "Toolbox"
- E. Resources for PBD

General Resources

- For Children with Mood Disorders
 - Brandon & the Bipolar Bear - *T. Anglada*
 - The Storm in My Brain - *Child & Adolescent Bipolar Foundation (CABF) www.bpkids.org*
 - Kid Power Tactics for Dealing with Depression - *N. & S. Dubuque*
 - Matt, The Moody Hermit Crab - *C. McGee*
 - My Bipolar Roller Coaster Feelings Book - *B. Hebert*
 - What to Do When You Grumble Too Much: A Kid's Guide to Overcoming Negativity – *D. Huebner*
 - What to Do When Your Temper Flares: A Kid's Guide to Overcoming Problems with Anger – *D. Huebner*
 - Turbo Max: A Story For Siblings of Bipolar Children -- *T. Anglada*

General Resources

- For Adolescents with Mood Disorders
 - The Bipolar Workbook for Teens: DBT Skills to Help You Control Mood Swings – *S. Van Dijk*
 - Beyond the Blues: A Workbook to Help Teens Overcome Depression – *L. Schab*
 - Don't Let Your Emotions Run Your Life for Teens: Dialectical Behavior Therapy Skills for Helping You Manage Mood Swings, Control Angry Outbursts, & Get Along with Others – *S. Van Dijk*
 - Conquering the Beast Within: How I Fought Depression & Won...& How You Can, Too - *C. Irwin*

General Resources

- For Parents of Children & Teens w/ Mood Disorders
 - Raising a Moody Child: How to Cope with Depression and Bipolar Disorder - *M. Fristad & J Goldberg-Arnold www.moodychildtherapy.com*
 - The Bipolar Teen: What You Can Do to Help Your Child and Your Family – *D. Miklowitz & E. George*

Cleveland Resources

- **NAMI (National Alliance on Mental Illness), 2012 West 25th St. (216) 875-7776 www.namigreatercleveland.org**
- **Bipolar Support System, 900 Tollis Parkway Broadview Hts. (440) 832-7313 www.bipolarsupportsystem.org**
- **Recommended Psychologists w/ Expertise in PBD**
 - Ethan Schafer, Ph.D.
 - Norah Feeny, Ph.D.
 - Jeremy Shapiro, Ph.D.
- **Ohio Psychological Association (OPA) online referral program search for pediatric neuropsychologist**
 - Thomas P. Swales PhD ABPP
CWRU MetroHealth Psychiatry
2500 MetroHealth Dr. Cleveland OH 44109
(216) 778-4646

Cleveland Resources

- **For Psychiatry**
 - The Discovery & Wellness Center For Children at Case Western Reserve University
 - Director: Robert Findling, M.D.
 - (216) 844.3922
 - Current research trials & register for future research studies for 5-17 yr-olds - Contact Becky Weintraub (216)-844-3922
Becky.Weintraub@uhhospital.org