The Society for Clinical Child and Adolescent Psychology (SCCAP): Initiative for Dissemination of Evidence-based Treatments for Childhood and Adolescent Mental Health Problems

With additional support from Florida International University and The Children's Trust.

SOCIETY OF CLINICAL CHILD & ADOLESCENT PSYCHOLOGY

practice into science into practice

DIVISION 53

American Psychological Association

The Children's Trust

FIU Center for Children and Families

Workshop

Psychotherapy for Children with Bipolar Disorder

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Just Because I'm Bipolar

14 Year Old 8th Grader
Former MF-PEP Study Participant

Just because I'm bipolar
I'm not a freak
I'm not weird
I just want to be noticed
Just because I'm bipolar
I still have feelings
I still have emotions
I just have trouble expressing them
Just because I'm bipolar
I can still be trusted
I can still be reliable
Just because I'm bipolar—I'm still a normal kid

Conflict of Interest/Funding

- Dr. Fristad receives royalties from
  - CFPSI: *MF-PEP and IF-PEP Workbooks*
  - Guilford Press:
    - *Raising a Moody Child: How to Cope with Depression and Bipolar Disorder*
    - *Psychotherapy for Children with Bipolar and Depressive Disorders*
  - APPI:
    - *Clinical Manual for Management of Bipolar Disorder in Children and Adolescents*
    - *Children's Interview for Psychiatric Syndromes (ChIPS)*

Workshop Goals

- Participants will learn:
  - ***How BPSD presents in children***
  - Biological interventions
  - Psychosocial treatment for BPSD
    - Multi-family psychoeducational psychotherapy (MF-PEP)
    - Individual-family psychoeducational psychotherapy (IF-PEP)

Part 1 of 6

Childhood Bipolar Disorder—On the Rise?

Lofthouse & Fristad, 2004, *Clinical Child & Family Psychology Review*

- Literature review—174 articles/chapters
  - 26 before 1980
  - 36 during the 1980s
  - 66 during the 1990s
  - 46 from 2000-2002
- Amazon search—18 books
  - 15 from 2000 to 2003
- Websites—5 since 1999
- Time—cover article, Aug 19, 2002

2005 Google Internet Search

Leffler & Fristad (2006)

Topic	*Number*
childhood mood disorders	517,000
adolescent mood disorders	577,000
childhood depression	3,100,000
adolescent depression	3,630,000
childhood bipolar disorder	483,000
adolescent bipolar disorder	757,000
childhood mania	248,000
adolescent mania	645,000

National Trends in the Outpatient Diagnosis and Treatment of Bipolar Disorder in Youth

***Moreno, et al, Arch Gen Psychiatry.* 2007; 64:1032-1039**

- Compared outpt visits in 1994-1995 and 2002-2003 for individuals aged 0 to 19 years vs those aged 20 years or older diagnosed with bipolar disorder
- Demographic, clinical, and treatment characteristics were compared from '99-'03
- Patient visits (n=962) were tallied from the Nat'l Ambulatory Medical Care Survey
- Estimated annual number of office-based visits with a diagnosis of bipolar disorder
  - Youth: 0.0025% (94-95), 1% (02-03)
  - Adults: 0.9% (94-95) 1.7% (02-03)

Under- or Over-diagnosis?

- "It is possible that pediatric bipolar disorder, previously underdiagnosed, is now being appropriately recognized at earlier ages. The median age at onset of bipolar disorder has been located between ages 19 and 23 years, indicating that in 50% of patients, the illness starts at a younger age. Long delays in treatment seeking have been previously documented when the onset occurs in childhood or in adolescence, perhaps owing to problems with clinical recognition.

Under- or Over-diagnosis?

- In recent years, there has been an increase in academic attention devoted to pediatric bipolar disorder… In addition, childhood bipolar disorder has been regularly featured in the popular press. *These developments may have raised clinical and public awareness and promoted appropriate treatment seeking and clinical recognition of the condition at earlier ages*"

Additional Thoughts

- If 50% of patients have their onset prior to age 19, the # of patients should be roughly half the adult figures (ie, 0.45% [94-95], 8.5% [02-03]). This suggests a 180-fold *underutilization of visits* in 94-95

- Any good pendulum swings before settling in the middle. Overdiagnosis typically follows underdiagnosis. It is critical that clinicians learn to accurately diagnose so they can settle in the middle.

What Makes Diagnosing Mood Disorders Tricky with Children?

- What's the mood disorder and what are the child's traits?
- How do I tell the ordinary ups and downs apart from the "clinical" ups and downs?
- What's a "normal" reaction to a bad event (eg, divorce) and what's not?
- If Mom/Dad has a mood disorder, "whose illness is it?”

Rule #1:
Take a video, not a snapshot

- Assess behaviors
  - over time
  - in context
- TAKE YOUR TIME!
  - If truly BPSD, this is *probably* a lifetime diagnosis and is *not* to be considered "casually"—the stakes are FAR too high
- Longitudinal review of symptoms
  - Determine symptom onset, offset, duration in relation to:
    - Social history
    - Treatment history
    - Functioning at home, school and w/ peers

Lifeline—Document

Above line: pregnancy, labor and delivery, age in yrs, calendar yrs, moves, life stressors, child care arrangements, school placement

Below line: physical health (onset, offset) & treatment, mental health (onset, offset, mood & co-morbid diagnosis) & treatment, current functioning (home, school, peers)

Pregnancy
L &D Child Care School History
Moves SLE

DOB_____DOI
Sx Hx

Tx Hx

Home: School: Peers:

How to Diagnose BPSD

- Medical history
  - Allergies, asthma, chronic illnesses, staring spells, injuries (especially head trauma)
  - Treatments for the above
    - 7-10 day washout for prescription drugs
    - 2-3 week washout for steroids, fluoxetine
  - Review previous lab findings, brain imaging
  - Drug screen if ANY suspicion of illicit use

Rule #2: Decide what's in and what's out

- Comorbid conditions (what's in)
- Differential diagnosis (what's out)

Children's Interview for Psychiatric Syndromes

Weller, Weller, Rooney & Fristad, 1999, American Psychiatric Press, Inc. (www.appi.org)

- Does NOT assess
  - personality
  - cognitive capacity (mental retardation, learning disabilities)
  - tic/Tourette, autistic spectrum, panic disorders
- Does NOT replace a clinician
- DOES provide a standardized initial assessment procedure for clinical and research purposes
  - Brief
  - Thorough coverage--20 disorders & stressors
  - Psychometrics available for 6-18 year olds
  - Easy to administer, score, interpret
  - Storage requirements are minimal

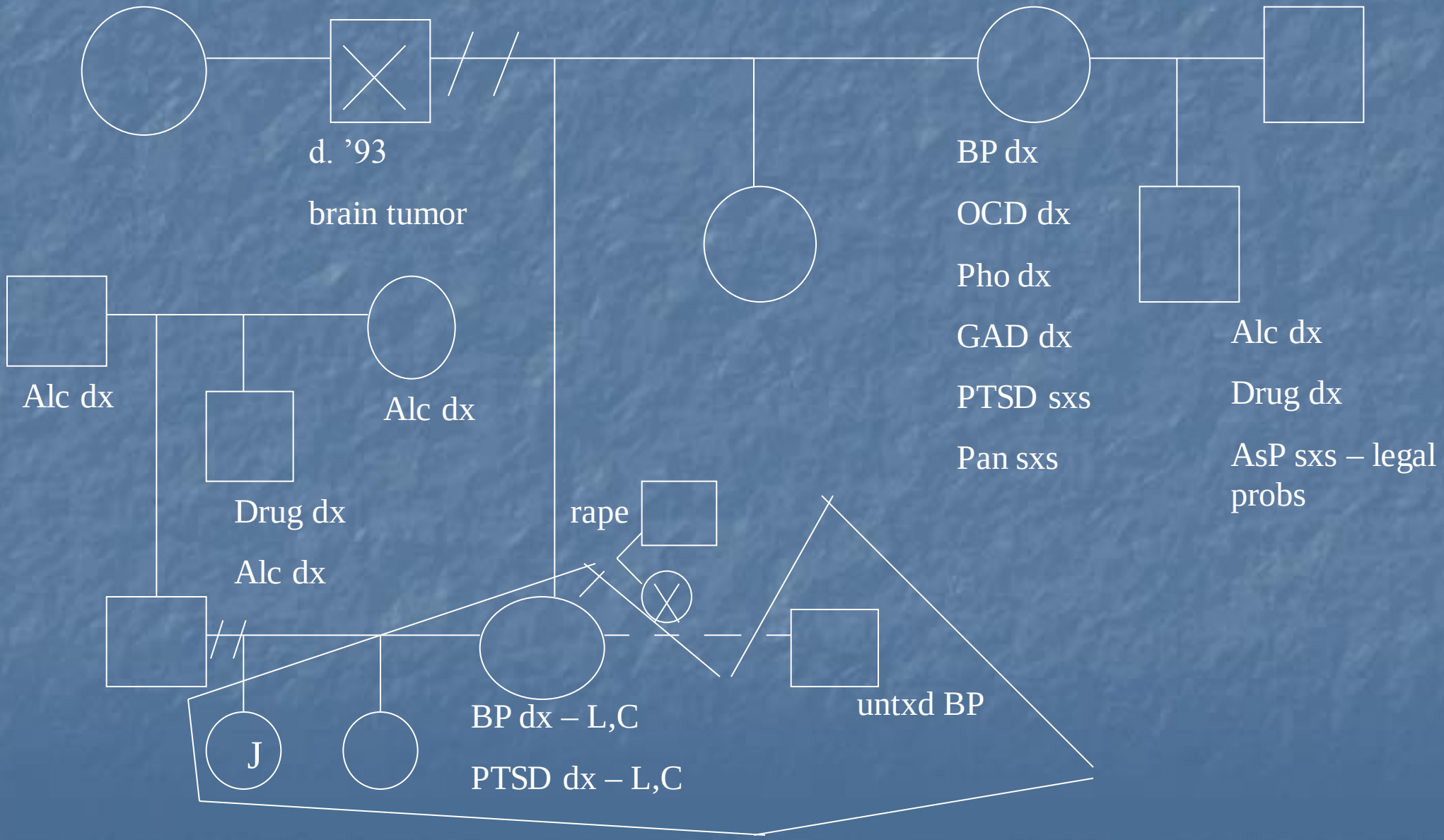
Rule #3: We diagnose children, not families BUT, families give us good clues and therapeutic material

Why Do People Get Mood Disorders?

- Part of the story is genetics…
  - 1 in 3 adopted persons *with* bipolar disorder have biological parents with mood disorders (compared to 1 in 50 adopted persons *without* bipolar disorder)
  - If 1 parent has a mood disorder, 27% offspring +
    If 2 parents have a mood disorder, 74% offspring +
  - If one twin has a mood disorder--

The Other Twin…	Identical	Non-identical
Depression	54%	19%
Bipolar Disorder	67-79%	15-20%

FH – RDC GENOGRAM—"Jenna"



Rule #4: Measure progress

Paper-and-Pencil Measures

- Youngstrom EA, Findling RL, Youngstrom JK & Calabrese JR (2005). Toward an evidence-based assessment of pediatric bipolar disorder. *J Clinical Child and Adolescent Psychology, 34*, 433-448.
  - Parent report: best source of information
  - Child report: doesn't provide incremental data
  - Teacher report: not validated

How is _____feeling today?





-5 -4 -3 -2 -1 0 1 2 3 4 5

M.....

T.....

W.....

Th.....

F.....

S.....

How to Diagnose (Cont'd)

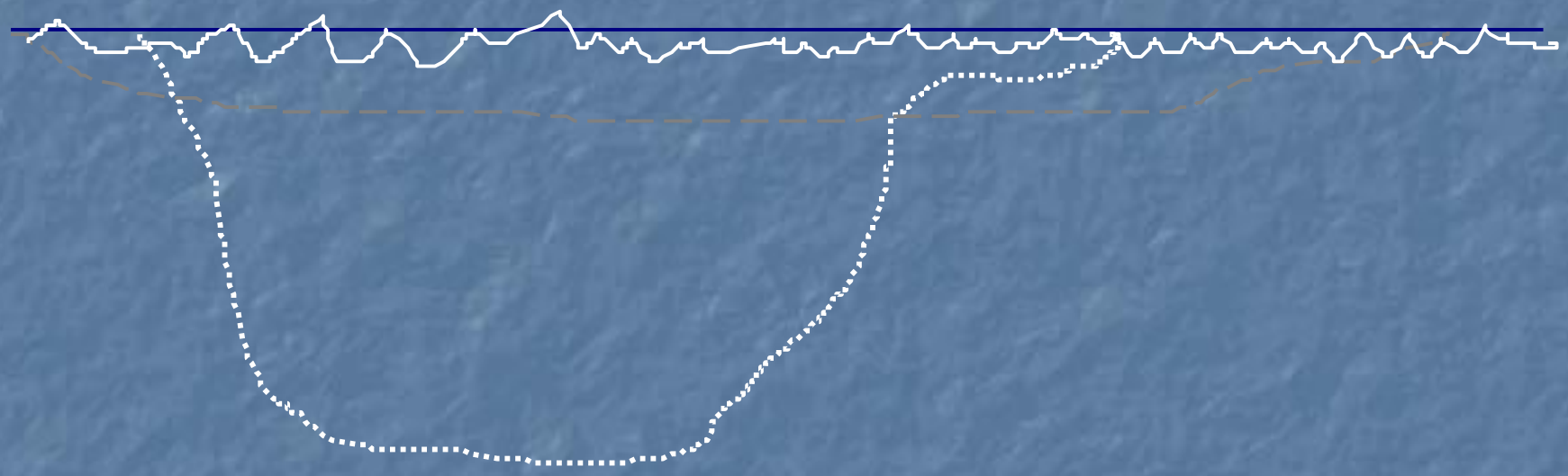
- Obtain information from
  - AT MINIMUM--Parent and child
    - Parents: Ask about current, best, worst
    - Children: Ask about current, try for best, worst
    - Adolescents: Use your judgment
    - 1/3 of symptoms reported by child only
    - "classic" manic symptoms frequently reported by child only *Tillman et al, 2004*
    - Use "tie breaker" strategy if one says YES and the other says NO (ie, observation, other parent, other source)
  - PREFERABLY—Primary care physician, teacher, other clinicians

FIND Criteria: Treatment Guidelines for Children and Adolescents with Bipolar Disorder:

Kowatch, Fristad, Birmaher, Wagner, Findling, Hellander & the Child Psychiatric Workgroup on Bipolar Disorder, *J Am Acad Child Adol Psychiatry, 2005*

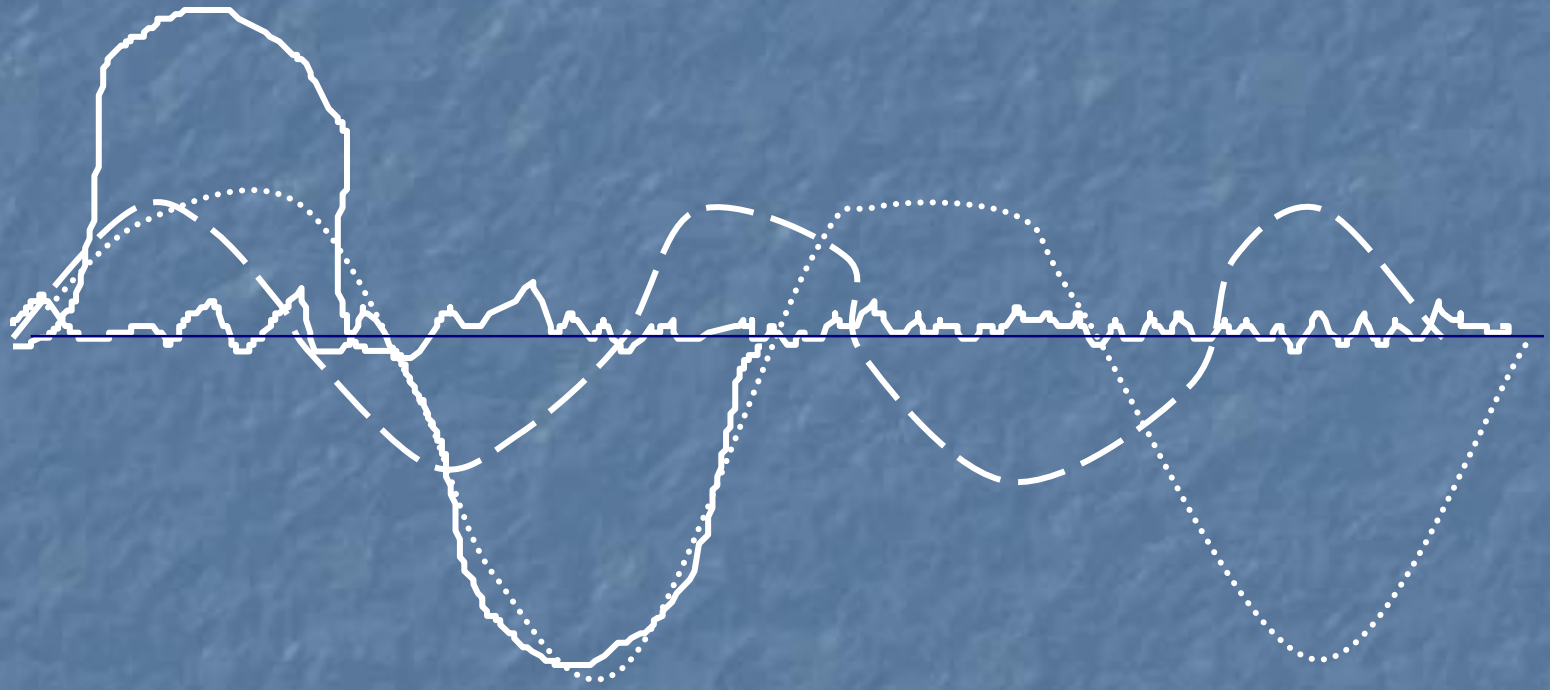
- **F***requency:* Symptoms occur most days of the week
- **I***ntensity:* Symptoms cause
  - extreme disturbance in one domain
  - Moderate disturbance in two or more domains
- **N***umber:* Symptoms occur 3-4 or more times/day
- **D***uration:* Symptoms occur $\geq$ 4 hours/day (total)

Tracking Mood Changes: Depressive Spectrum Disorders



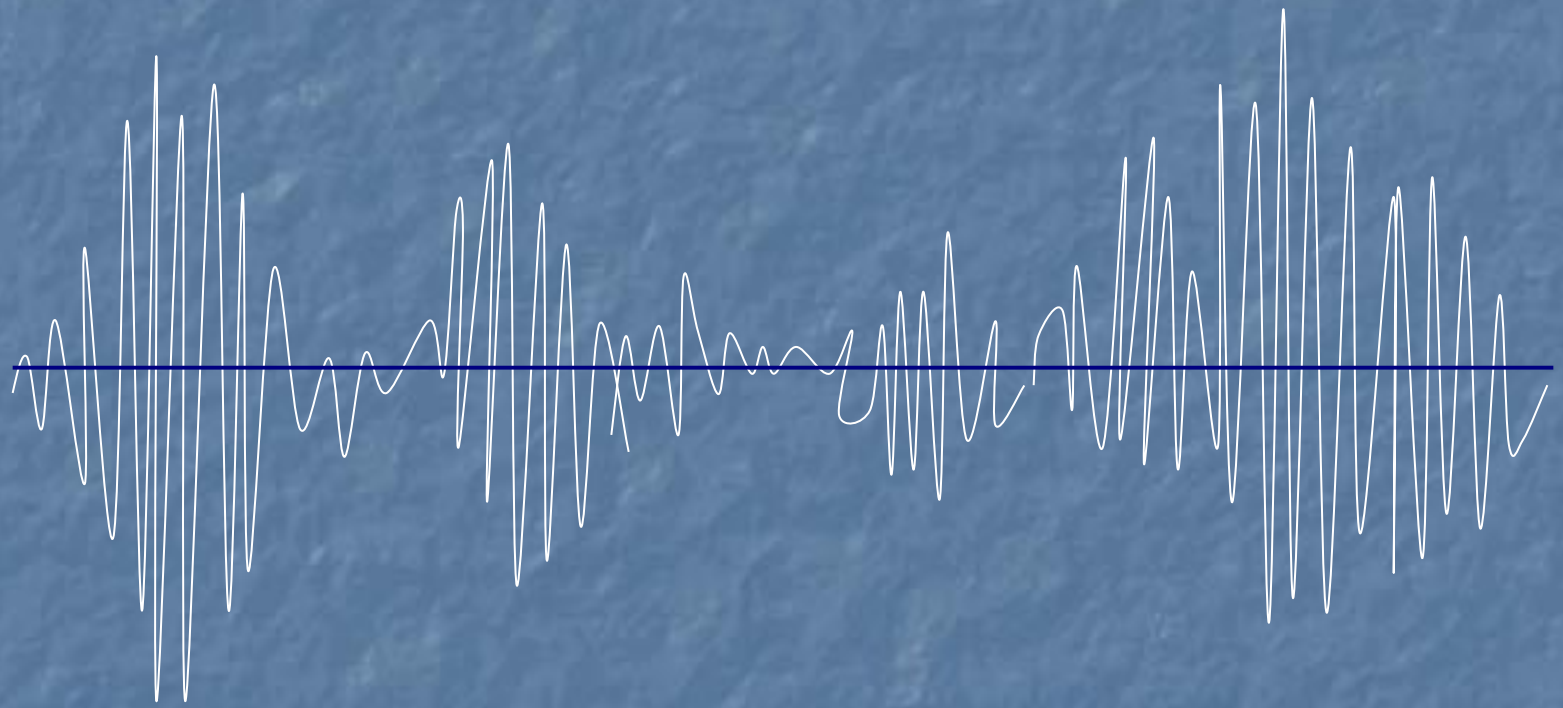
Normal
Major Depressive Disorder
Dysthymic Disorder

Tracking Mood Changes: Bipolar Spectrum Disorders

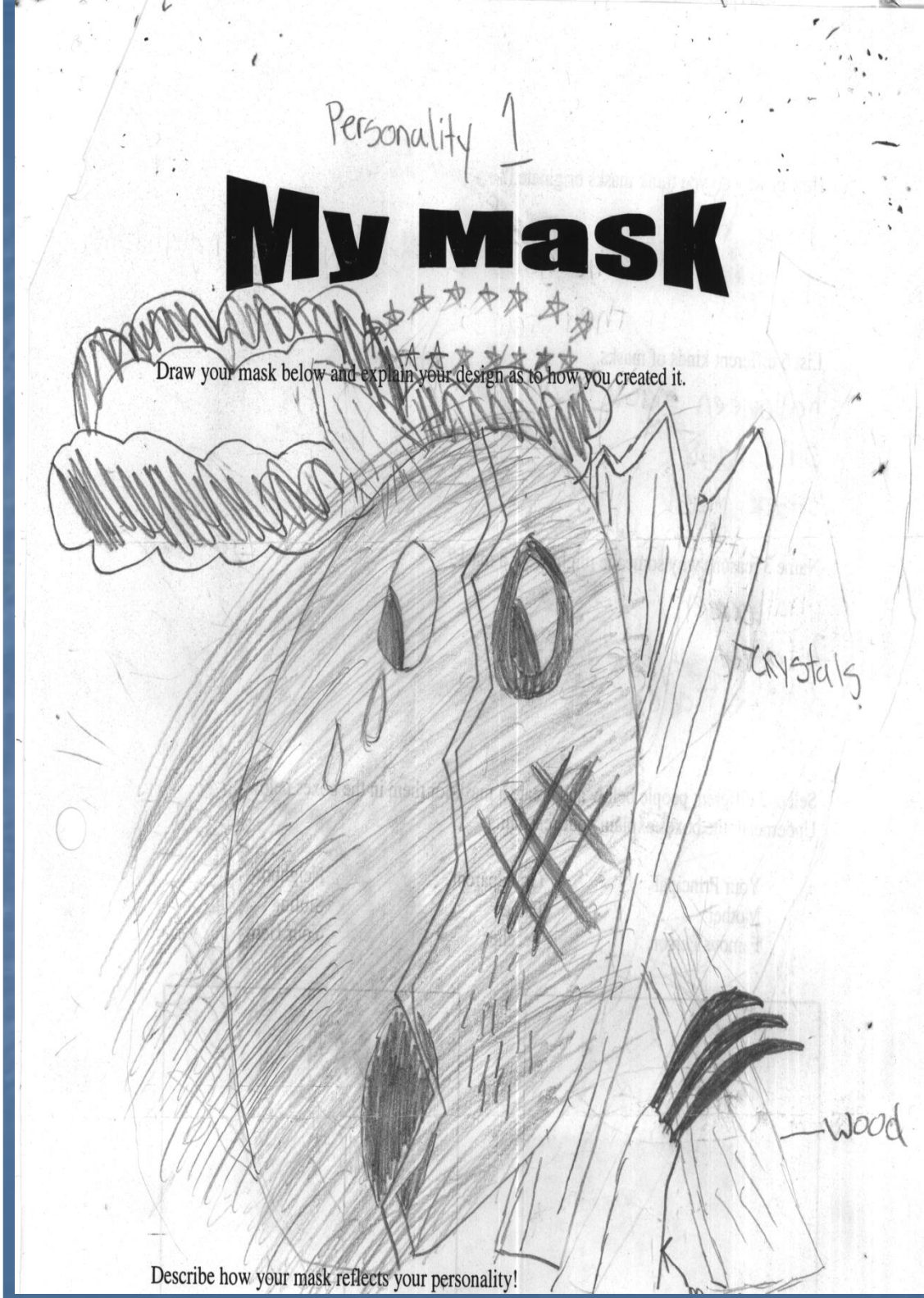


Bipolar I
Bipolar II
Cyclothymia

Tracking Mood Changes: Rapid Cycling/Mixed States



- *Describe how your mask reflects your personality!*
- The black eye represents all the mental punches I get from people. The stars circling above my head represents how I'm confused. My searching eyes represent that I'm trying to find the right path, but I'm lost so I can't find it. My broken face represents that I'm a broken person. The hair across my face shows that I can be whipped around easily. The tears are of loneliness. The crystals= dreamer/pretender. Claw and hand = outcast.



Defining Mood Disorders

- Symptoms cause distress &/or interfere with family, school, friends or work
- Symptoms are NOT because of other drugs or illness
- Symptoms do NOT directly follow the loss of a loved one
- Symptoms occur at the same time and for an extended period of time

Defining the Conditions: MDD Major Depressive Disorder

- Need 1 or both of these:
- Impaired mood
  - Sad/anxious
  - Irritable/angry
- loss of interest
  - Complaints of boredom
  - Previously fun activities aren't fun anymore

- Need 3-4 of these (5 total):
  - impaired sleep
  - impaired appetite
  - poor concentration
  - fatigue
  - restlessness/lethargy
  - worthlessness/guilt
  - suicidal/morbid ideation
- Symptoms last $\geq$ 2 weeks

When Will My Child Get Better...? The MDD Picture

Birmaher et al, 96

- Single episode length: 7-9 months
- 90% get well by 1.5-2 years
- 6-10% stay impaired

- Recurrence
  - 40%, 2 yrs
  - 70% 5 yrs

Defining the Conditions: Dysthymia

- The "low grade fever" of mental health!
- Particularly hard to diagnose
- This can and should be treated

Dysthymic Disorder (DD)

- MOOD (lasting 1 year)
  - sad
  - irritable
- Two or more of:
  - Impaired appetite
  - Impaired sleep
  - Fatigue
  - Low self-esteem
  - Impaired concentration/thinking
  - Hopeless feelings

When Will My Child Get Better? The DD Picture

Kovacs et al, 94

- Single untreated episode: 4 years
- MDD episode usually comes 2-3 years after DD onset

- Can lead to:
  - Bipolar disorder: 13%
  - Substance abuse: 15%

Defining the Conditions: Seasonal Affective Disorder (SAD)

- Most common:
  - fall/winter: "hibernating" depression--increased sleep and appetite, carbohydrate craving, decreased activity
  - spring/summer: nondepressed or manic

Defining the Conditions: Psychotic Symptoms

- Some children with mood disorders experience:
  - hallucinations
    - hearing voices
    - seeing things
    - sometimes-- smelling or feeling
  - delusions
    - special messages
    - special powers
    - other unusual thoughts/ideas
- These occur when mood symptoms are severe
- They go away when the mood disorder is treated
- This is NOT schizophrenia!

Defining the Conditions: Suicidal Risks

- Time
  - During/right after inpatient treatment
  - During a crisis
  - Following suicide of a close friend/relative
  - +/- life events
- Warning signs
  - Talking about death/suicide
  - Saying good-byes, making wills, giving away belongings
- Other factors:
  - depressed, hopeless
  - drug/alcohol use
  - impulsive/angry
  - physical/sexual abuse
  - runaway
  - past attempt
  - self-destructive
  - perfectionistic
- ACCESS TO GUNS!

Who is at Risk for Bipolar Disorder? Birmaher et al, 96

- About ¼- ½ of depressed children develop bipolar disorder within 2-5 yrs

- Risk factors include:
  - symptoms of psychomotor retardation or psychosis
  - + family history-- bipolar disorder
  - ++ family history--mood disorder
  - Medication induced hypomania

Defining the Conditions: Mania (Bipolar Disorder)

- MOOD (1 week—this differs for children)
  - elevated
  - expansive
  - irritable
- 3 (4 if irritable mood) of:
  - grandiosity
  - decreased need for sleep
  - increased talking
  - racing thoughts
  - distractible
  - increased activity/agitation
  - foolish/reckless behavior

Defining the Conditions: Hypomania

- MOOD changes (4-7 days)
- Associated symptoms (same as mania)
- Functioning clearly "out of character"
- Altered mood & behavior noted by others
- Symptoms not severe enough to be called MANIA

Bipolar Spectrum Diagnoses

- Bipolar Disorder I (BP-I): M + D
- Bipolar Disorder II (BP-II): m + D
- Cyclothymia: m + d
- Bipolar Disorder NOS (BP-NOS)
  - Define why
    - One symptom short?
    - Duration insufficient?
    - Episodes not clearly defined?
    - Informants sketchy, need to observe before finalizing diagnosis?

Defining the Conditions: Cyclothymia

- Less severe highs and lows than bipolar disorder
- Causes disruption
- Can be tricky to diagnose
- Decide when/how to treat

Part 2 of 6

Differential Diagnosis & Comorbidities

Health Conditions that Mimic BPD

- Temporal lobe epilepsy
- Hyperthyroidism
- Closed or open head injury
- Multiple sclerosis
- Systemic lupus erythematosus (SLE)
- Alcohol related neurodevelopmental disorder
- Wilson's disease

Medications that May Increase Cycling

Abouesh et al, 2002, J Clin Psychopharmacol

- ANY biological intervention for depression
  - Tricyclic antidepressants
  - Serotonin specific reuptake inhibitors
  - Serotonin and norepinephrine reuptake inhibitors
  - Light box
- Aminophylline
- Corticosteroids
- Sympathomimetic amines (eg, pseudoephedrine)
- Antibiotics (eg, clarithromycin, erythromycin, amoxicillin)
- Illicit drugs

BPD vs ADHD: Symptoms that Overlap Geller et al. (2002)

Symptoms	EOBD	ADHD
Irritability	98%	72%
↑ Speech	97%	81%
Distractibility	93%	96%
↑ Energy	100%	95%

BPD vs ADHD: Symptoms that Differ

Geller et al. (2002)

Symptom	EOBD	ADHD
Elated Mood	89%	13%
Grandiosity	86%	5%
↓ Sleep	40%	6%
Flight of ideas	71%	10%
Hypersexuality	43%	6%
Suicidality	25%	0%
Psychosis	60%	0%

Is it BPD or A/PTSD?

- Symptoms of BPD and A/PTSD overlap
- Symptoms can also co-occur
  - *Post 2006-% of adults w/ BPD who experienced abuse/neglect in childhood*
    - 52%--childhood onset
    - 34%--adolescent onset
    - 21%--early adult onset (19-29 yrs)
    - 20%--late adult onset (30+ yrs)

Posttraumatic Stress Disorder

- ***Traumatic event*** occurred
- The ***child's reaction*** involved intense fear, helplessness, or horror that might appear as disorganized or agitated behavior, with ***new*** and ***persistent*** examples of:
- ***Reexperiencing*** the trauma-- ≥ 1 of:
  - recurrent and intrusive distressing recollections (can be displayed as repetitive play)
  - recurrent distressing dreams (these may be frightening but w/o recognizable content)
  - acting or feeling like the traumatic event is recurring (this can include a sense of reliving the experience, illusions, hallucinations, and dissociative flashbacks)
  - intense psychological distress at exposure to internal or external reminders of the trauma
  - physiological reactivity on exposure to internal or external reminders

Posttraumatic Stress Disorder (continued)

- ***Avoiding*** reminders of the trauma /emotional numbing--≥3 of:
  - avoiding thoughts, feelings, or conversations associated with the trauma
  - avoiding activities, places, or people that remind one of the trauma
  - forgetting an important aspect of the trauma
  - losing interest in activities
  - feeling disconnected from others
  - restricted range of affect (e.g., unable to have loving feelings)
  - expecting a shortened life (e.g., does not expect to have a career, marriage, children, or a normal life span)
- ***Increased arousal–*** ≥ 2 of:
  - difficulty falling or staying asleep
  - irritability or outbursts of anger
  - difficulty concentrating/hypervigilance
  - exaggerated startle response

Acute Stress Disorder

- ***Traumatic event*** occurred
- Child experienced an ***intense emotional response***
- ***Reexperiencing, avoidance, and arousal*** ~PTSD
- During or after the trauma, ***dissociative symptoms*** occur-- ≥ 3 of:
  - feeling numb, detached, or devoid of emotions
  - Feeling "in a daze" (unaware of surroundings
  - Derealization
  - Depersonalization
  - dissociative amnesia (i.e., can't recall an important aspect of the trauma)
- Lasts ≥ 2 days and ≤ 4 wks, occurs within month of event

Is it Mania or Something Else?

- **Euphoria**
  - *Normal*: Special occasions, transitory
  - *Drug-induced disinhibition:* Steroids, illicit drugs
  - *Carefully examine contextual cues to determine +/-*

- **Irritability**
  - *Ubiquitous:* MDD, DD, ODD, PDD, Anxiety disorders, ADHD, schizophrenia
  - *Medication side-effects:* stimulant wear off, SSRI adverse event
  - *Normal:* hungry, hot, tired children

Is it Mania or Something Else?

- **Grandiosity:**
  - *True talent:* check it out
  - *Peers unavailable:* fantasy play may persist—can the child distinguish fantasy from reality?
  - *Normal:* understand the
    - child's age
    - developmental context
    - persistence
    - effects on behavior (eg, playing Superman vs jumping out of the window because you *are* Superman)

Is it Mania or Something Else?

- **Decreased Need for Sleep**
  - *NOT the same as decreased sleep!*
    - Ruminations of a depressed, anxious child
    - Poor sleep hygiene
    - Excessive environmental stimuli
    - Excitatory medications
    - Results in fatigue the next day
  - *Full of energy*
    - Common time to get in trouble (eg, sexual content on TV)

Is it Mania or Something Else?

- **Pressured Speech**
  - *Affective arousal:* excited, nervous or angry children may speak quickly
  - *ADHD:* often chronic "motor mouths"
- **Racing Thoughts**
  - *Young/Low IQ/Language Disorder:* Get an "interpreter"!

Is it Mania or Something Else?

- **Distractibility**
  - *ADHD:* Establish a baseline. There needs to be a ***change*** from baseline for children with ADHD to count as a symptom of mania (not just when medications are wearing off)
  - *Depression:* impaired concentration common
  - *Anxiety:* preoccupation common
  - *Learning disabilities:* distracted while doing schoolwork

Is it Mania or Something Else?

- **Increased Goal Directed Activity**
  - *Psychomotor agitation:* common and nonspecific
  - *Gifted children:* may be highly productive—work tends to be focused and accomplishments accrue
  - *Depressed/anxious/traumatized children:* may be agitated or demonstrate "nervous habits"

Is it Mania or Something Else?

- **Excessive Involvement in Pleasurable/Risky Activities**
  - *Sexual abuse:* sexual acting out often anxious/compulsive in nature
  - *Hypersexuality:* often has erotic, pleasure-seeking quality, excessive, violates social norms (OK in private between consenting adults, NOT OK in public with a child initiating unwanted behavior toward adult)

Is it Mania or Something Else?

- **Psychosis**
  - *Perceptual distortions:* falling asleep (hypnogogic)/waking up (hypnopompic)—see or hear things
- **Suicidality**
  - *Not pathognomonic*
  - *Critical to assess*

Co-occurring Disorders

- ***Behavior Disorders***
  - attention deficit hyperactivity disorder (ADHD), oppositional-defiant, conduct, tic/Tourette, substance use/abuse
- ***Anxiety Disorders***
  - separation anxiety, generalized anxiety, phobias, acute/post-traumatic stress, obsessive-compulsive, social phobia, panic disorder
- ***Eating Disorders***
  - anorexia, bulimia, obesity
- ***Learning Disorders***
  - reading, writing, math, language
- ***Developmental Disorders***
  - Autism, Asperger's, PDD-NOS

Treating Co-occurring Disorders

- Some co-occurring disorders will be successfully treated IN PART by mood disorder treatments
  - many anxiety disorders
  - some behavior disorders
  - some eating disorders
- Most will require some other specialized intervention
  - other medications/psychotherapy
  - school intervention
  - learning to cope with symptoms of those disorders

Workshop Goals

- Participants will learn:
  - How BPSD presents in children
  - ***Biological interventions***
  - Psychosocial treatment for BPSD
    - Multi-family psychoeducational psychotherapy (MF-PEP)
    - Individual-family psychoeducational psychotherapy (IF-PEP)

Types of Treatment

- ***Biological***
  - Medications
  - Lights
  - ECT
  - Nutritional
- ***Psychological***
  - Individual Therapy
  - Family Therapy
  - Parent Guidance
  - Group Therapy
- ***Social***
  - school-based interventions
  - Home-based interventions
  - Respite
  - Out-of-home placement

Medication Issues--#1

- Medications do not *cure* a mood disorder, but they help *manage* it
  - They can STOP or LESSEN current symptom severity
  - They can PREVENT or DECREASE impairment from future episodes
- Medications DO NOT:
  - solve every problem
- For medications to do their best, it is ESSENTIAL that families are an *active partner* in treatment!

Medication Issues--#2

- Partial responses are common
  - Don't despair!
  - May need to change
    - Dose
    - Time medicine is taken
    - Type of medicine
- Full response
  - Is NOT necessarily a reason to discontinue medication
  - May be useful to prevent future episodes
  - Plan with your doctor when/how to stop medicine

Medication Issues--#3

- If/when you stop medicine
  - Do so ***with input from your doctor***
  - Stopping abruptly may lead to unpleasant side effects
- Mood stabilizers are NOT addicting!

Medication Issues--#4

- Ask for fact sheets about medications
- Know common & serious side-effects (side effects often decrease as the body adjusts to new medicine)
- Know what to do if a serious side-effect occurs
- Know how to monitor the medication
- ALWAYS tell both the primary care doctor and psychiatrist about ALL medications ***(including herbal remedies)*** being taken

Medication Issues--#5

- Timetable
  - Many medicines take several weeks to work
  - BE PATIENT, DON'T GIVE UP TOO SOON!
  - “Physical" symptoms may improve before mood and thinking does
- Make a plan (& a backup plan!) to remember to take medicine
  - eg, pill holder, morning ritual...
- Know what to do about missed doses (check w/ your doctor)
- Plan ahead to get refills on time

Medication Issues--#6

- Why Blood Levels?
  - Some medicines need to be monitored by blood tests
  - Same dose can produce different levels in different people
  - Need this to stay safe
- How to do?
  - Get levels
    - 12 HRS AFTER THE LAST DOSE
    - BEFORE THE NEXT DOSE
  - Postpone the morning dose until AFTER the blood draw

Medication Update

Kowatch & Post, Bipolar Network News '08, 12(2): 1-4

- Much progress in the past 3 years
- 11 RCTs of substantial size
- Unequivocal evidence for atypicals
- Topirimate (Topomax): 4 – RCTS in adults; + on some secondary outcomes in youth; wt loss

Mood Stabilizers

Kowatch & Post, Bipolar Network News '08, 12(2): 1-4

Drug	Evidence	Problems	Tolerability	Utility
Valproate (Depakote)	(++)	Weight gain, polycystic ovarian syndrome	B+	B+/A-
Lithium	++ FDA	Weight, GI, thyroid, acne, requires blood levels	B	B+
Carbama-zepine	(++) (Tegretol)	Rash, rare bone marrow suppression	C+	B
Oxcarba-zepine	(+/-) (Trileptal)	Hyponatremia, sedation	B	B-
Lamotrigine (Lamictal)	(0)	1:2500, severe rash	B	D

() Ambiguous data; ++ substantial evidence/multiple series; +/- minimal evidence; 0 no effect; FDA=approved or approval pending

Atypical Antipsychotics

Kowatch & Post, Bipolar Network News '08, 12(2): 1-4

Drug	Evidence	Problems	Tolerability	Utility
Aripiprazole (Abilify)	+++ FDA	Akathisia, minimal wt gain, GI upset	A-	A
Clozapine (Clozaril)	+++	Seizures, drooling, wt gain, requires white blood cell monitoring	C	C
Olanzapine (Zyprexa)	+++ FDA	Weight gain +++, sedation	B-	B-
Quetiapine (Seroquel)	+++ FDA	Weight gain ++, sedation	B	A-
Risperidone (Risperal)	+++ FDA	Prolactin increases, weight gain ++	B	B
Ziprasidone (Geodon)	+++ FDA	Minimal wt gain, increases QTc (not clinically problematic)	A-	A

+++ strong evidence, placebo controlled RCT; FDA=approved or approval pending

Medication Algorithm

Kowatch & Post, Bipolar Network News '08, 12(2): 1-4

STEP	MEDICATION
1	AA or MS *If poor tolerability, switch within drug class*
2	Add other drug class (AA or MS)
3	Add lithium
4	Add combination within class
5	Add an AA
6	Switch the AA
7	Switch MS to carbamazepine

AA=atypical antipsychotic; MS=mood stabilizer. Add low dose stimulant (amphetamine/methylphenidate) for residual ADHD; if +, continue; If -, switch type of stimulant

Treating Comorbid Disorders
Kowatch et al, 2005, JAACAP

- Guidelines primarily anecdotal
- Stabilize the mania FIRST
- Review what problems remain
- Treat sequentially
- Use psychosocial treatments when
  - Treatments are evidence-based
  - Families are willing
  - Trained therapists are available

Treating Comorbid ADHD
Kowatch et al, 2005, JAACAP

- Occurs in 70-90% of children and 30-40% of adolescents with BPD
- Medications—first-line
  - Low and slow
- Psychosocial
  - parent training
  - school consultation

Treating Comorbid ODD-CD
Kowatch et al, 2005, JAACAP

- Medications: those for mood may help for behavior disorders
- Psychosocial: parent training
- Environmental: may need residential placements, foster care, etc.

Treating Comorbid Anxiety
Kowatch et al, 2005, JAACAP

- Psychosocial: USE FIRST!
  - CBT
- Medications:
  - SSRIs: be cautious
  - Buspirone *(Buspar)*: not effective
  - Benzodiazepines: limited data, ↑ abuse potential, cognitive side-effects; might want to use short-term until other meds begin to work

Treating Comorbid Substance Abuse
Kowatch et al, 2005, JAACAP

- TREAT BOTH IMMEDIATELY
  Wilens et al, 1999, JAACAP
- Medications
  - Lithium *Geller et al, 1998, JAACAP*
- Psychotherapy
  - Family therapy *Latimer et al, 2003, Drug & Alcohol Dependence; Liddle & Dakof, 1995, NIDA Research Monograph*

Treating Other Comorbid Conditions
Kowatch et al, 2005, JAACAP

- Pervasive developmental disorder
  - PDD program
- Mental retardation
  - Ditto
- Seizures and/or migraines
  - Use dual-purpose medications (eg, DVP, CBZ, OXC)
- Premenstrual dysphoric disorder
  - SSRIs AFTER stabilization of mood

Maintenance Treatment
Kowatch et al, 2005, JAACAP

- Agents that get you well keep you well
- Discontinuation leads to relapse
  - 37.5% vs 92.3% relapse in those who stayed on vs went off meds, *Strober et al, 1990*
- Work toward monotherapy
  - Try reductions in summer/over breaks
  - Environment should be stable
  - Go slow
  - Stay on maintenance dose 18 months post-stabilization
- Use cost-benefit analyses to decide

Managing Side-Effects

- Dizzy:
  - Stand up slowly
- Dry mouth:
  - Drink water
  - Use sugarless gum/candy
- Constipation:
  - Eat high fiber diet
  - Drink 6-8 glasses of water/day
- Persistent nausea:
  - Take medicine with meals or in divided doses

Managing Side-Effects

- Increased thirst/urination:
  - Drink 6-8 glasses of liquid/day
  - Avoid high calorie beverages!
  - Make school plan to use the bathroom more frequently
- Tremor:
  - Take with meals or in divided doses
  - Avoid caffeine
- Excessive weight gain:
  - Balanced diet & regular exercise
  - Avoid drastic diets &/or diet pills

Managing Side-Effects

- Skin Sensitivity
  - Use sunscreen
  - Wear protective clothes
  - Avoid sunlight/sunlamps
- Impaired Sleep
  - Have routine sleep habits
  - Don't let the weekend disrupt this by > 1 hour
  - No exercise/caffeine in late evening
  - Wake at regular time EVEN IF TIRED!
  - Don't nap during the day

Part 3 of 6

Treatment: Light Therapy

Swedo et al, 1997, JAACAP, 36(6): 816-821

- N=28, 7-17 yrs (Boston, Washington, DC)
- Double-blind, placebo-controlled crossover design
- 1 hr bright-light tx+2 hours dawn stimulation
- Total depression, atypical depression, typical depression scores improved with phototherapy
- 78% parents, 80% children reported phototx was "best" condition

<u>CLINICAL GUIDELINES</u>

- Move to a warmer, sunnier climate

OR

- Sit for 20-40 minutes, 1-2X/day in front of a special lamp

ECT: Electroconvulsive Therapy *Walter & Rey, 6/97*

Epidemiologic study (NSW) of all adolescent ECT from '90-'96

Results from 42 pts mimic adult lit

- half had marked/total improvement
- pts w/ mood disorders derived the most benefit
- side effects were transient and minor
- comorbid personality disorder predicted poorer response
- propofol was associated w/ shorter seizures

Electroconvulsive Therapy (ECT)

Practice Parameters, *J Am Acad Child Adol Psychiatry, 2004;43(12):1521–1539*

- Treatment of choice for adults w/: pregnancy, catatonia, neuroleptic malignant syndrome, other medical conditions that contraindicate standard medication regimens
- Limited case studies indicate ECT is beneficial for youth w/:
  - Mania, rapid cycling, depressed phase--BPD
- Requires two board certified child and adolescent psychiatrists to independently review records and recommend ECT
- Uncommonly used, has potential for adverse events but often provides significant symptomatic relief

Nutritional Interventions

- Omega-3 Fatty Acids
- Multi-nutrient complex

Changes in Dietary Ω3

Scheffer, 2008, in Geller & Del Bello
"Treatment of Bipolar Disorder in Children and Adolescents"

- Hunter-gatherers: Ω3:Ω6, 1:1
- Modern ratio: 1:100 or greater
- <10% adult Americans obtain sufficient Ω3 in their diets
- Rates are worse for children

Ω3 Treatment: Depression in Children

Nemets et al, '06, Amer J Psychiatr, 163(6): 1098-1100

- 28 children aged 6 to 12 with MDD, 16-week RCT
- N=13, Ω3 (2:1 EPA: DHA, 380-400 mg EPA and 180-200 DHA); n=15, placebo (pbo)
- 8 children dropped out and were deleted from analyses (5, pbo; 3, Ω3)
- No clinically significant side effects reported

Ω3 Treatment: Depression in Children

Nemets et al, '06, Amer J Psychiatr, 163(6): 1098-1100

- >50% ↓ in depressive sxs: 7/10 Ω3 vs 0/10 pbo
- Remission: 4/10 Ω3 vs 0/10 pbo
- Most response noted at Wk 16 was achieved by Wk 12
- Findings support Ω3 as potentially beneficial for childhood depression. Risk: benefit ratio may be superior to that of traditional anti-depressants

Ω3 Treatment: Bipolar Disorder in Children

Wozniak et al, '07, European Neuropsychopharmacology, 17, 440-447

- 8-wk open-label trial of Ω3 fatty acids (7:1 EPA:DHA)
- Monotherapy (only exception: stimulants)
- 20 outpatients aged 6-17 with bipolar disorder
- 1.3 to 4.3g of Ω3 daily, 85% taking ≥2.0 g/day
- 16 participants completed the entire trial
  - Drop-outs were d/t lack of efficacy, not side effects

Ω3 Treatment of Bipolar Disorder in Children *Wozniak et al, '07, European Neuropsychopharmacology, 17, 440-447*

- Ω3 caused few, mild side effects, usually GI
- Manic symptoms: ↓ by 30% in 50%; ↓ by 50% in 35%
  - Participants on ≥2.0g Ω3 improved more than those on <2.0g
- Depressive symptoms: 40% rated much/very much improved

Nutrition & Mental Health

Iron	Produces ATP-brain energy, maintains oxygen levels in brain, binding of serotonin & dopamine in frontal cortex, neurotransmitter production
Copper	Neurotransmitter production, ratio to copper important-metabolic functioning
Zinc	Found in glial cells & neurons, protein synthesis & regulation of gene expression, involved in >200 enzymatic reactions-many in brain, central role in metabolism
B1	Neuronal health, deficiencies impact cardiovascular & PNS- Wernicke's encephalopathy
B6	Deficiencies may decrease serotonin & GABA in brain
B12	Essential to brain & CNS functioning maintains myelin sheaths, synthesis of monoamine neurotransmitters, alters folate levels
D	Deficiencies related to depression & abnormal brain development
E	Anti-oxidant, protects cell membranes potentially effecting brain functioning
Folate	Neurotransmitter synthesis, relationship btw tryptophan & serotonin, deficiencies related to dementia & mood d/o

(Hutto, 1997; Kaplan et al., 2007; McCarty, 2000; Meador et al., 1993; Takeda, 2001; Velez-Pardo et al., 1995)

Multi-Ingredient Supplements

Kaplan et al, 2007, Psych Bulletin, 133(5), 747-760

- Past nutritional research focused on individual vitamins and minerals
- To understand results of these studies, need to know potential mechanisms underlying the positive effects of nutrients on mood.

Multi-Ingredient Supplements: Theorized Mechanisms of Action

Kaplan et al, 2007, Psych Bulletin, 133(5), 747-760

- Mood dysregulation may result from innate metabolism malfunctions that ultimately affect brain functioning
- Mood instability may result from deficiencies in methylation of molecules responsible for completing DNA transcription, switching on genes, regulating protein generation, activating enzymes, and synthesizing neurotransmitters
- Nutrition deficiencies may alter gene expression and lead to mood instability
- Unstable mood may result from long-latency effects of nutrient deficiencies that alter brain development directly or by way of dysfunctional nutrient absorption

Impact of Diet & Nutrition on Brain Function

Benton, Eur J Nutr 47(3):25-37, 2008

- Diet and nutrition affect the structure and functioning of the brain
  - In adulthood, the brain contributes 20% of the human basal metabolic rate
  - In neonates, this number is as high as 44%
- Nutrition deficiencies, particularly in prenatal and neonatal stages, may contribute to long-term physical and behavioral detriments

Vitamin-Mineral Treatment of Anti-social Behavior in Children

Schoenthaler and Bier (2000) Journal of Alternative & Complementary Medicine, 6(1), 7-18

- 468 6--12 yr olds from two working class, primarily Hispanic elementary schools in the Southwestern US
- RCT— ½ placebo, ½ daily vitamin-mineral supplementation at 50% of the US recommended daily allowance (RDA) for 4 months
- Outcome variable: disciplinary infractions

Vitamin-Mineral Treatment of Anti-social Behavior in Children

Schoenthaler and Bier (2000) Journal of Alternative & Complementary Medicine, 6(1), 7-18

- Vitamin-Mineral group had, compared to the placebo group
  - 47% lower mean rating of antisocial behavior (1.0 vs. 1.9 disciplinary actions)
  - lower ratings for every type of recorded infraction: threats/fighting, vandalism, being disrespectful, disorderly conduct, assault/battery, defiance, obscenities, refusal to work or serve, endangering others, and nonspecified offenses

Ω3 & Vitamin-Mineral Treatment of Antisocial Behavior

Gesch et al 2002 British Journal of Psychiatry. 181: 22-28

Double-blind clinical trial—231 prisoners

- 142 days on recommended daily doses of two supplements
  - one capsule of Forceval, a 25-ingredient vitamin supplement
  - four capsules of Efamol Marine, containing 1260mg linoleic acid, 160mg gamma linolenic acid, 80mg EPA and 44mg DHA
- or placebo (identically appearing oil-based gelatin capsules)

Ω3 & Vitamin-Mineral Treatment of Antisocial Behavior

Gesch et al 2002 British Journal of Psychiatry. 181: 22-28

- Neither group reported notable side effects
- Supplement group experienced a 26% decrease in overall infringements resulting in disciplinary reports compared to placebo group ($p<.03$)

EMPower (EMP+)
www.truehope.com

- Contains 36 ingredients
- Vitamins:
  - A, C, D, E, B1, B2, B3, B5, B6, B9, B12, H (Biotin)
- Minerals:
  - Calcium, Phosphorus, Magnesium, Potassium, Iodine, Zinc, Selenium, Copper, Manganese, Chromium, Molybdenum, Iron, Nickel
- Other:
  - dl-Phenylalanine, Glutamine, Citrus Bioflavonoids, Grape Seed, Choline, Inositol, Ginkgo Biloba, Methionine, Germanium, Boron, Vanadium

EMP: Animal Data

Halliwell & Kolb (2003) Society for Neuroscience Abstracts, 29, 459.11., 29, 459.411

- Newborn rats received frontal or posterior parietal lesions on Day 3
- Subsequently fed either normal rat chow or rat chow enhanced with a rodent-appropriate dose of EMP+
- At Day 60, supplemented animals, compared to unsupplemented rats
  - exhibited deficit reversals (eg, performance on spatial learning tasks)
  - had significant regrowth of cortical tissue
  - were significantly calmer

EMP: Open Label Adult BPD Study

Kaplan et al, '01, J Clin Psychiatr, 62(12): 936-944

- 11 adults aged 19-46 yrs diagnosed w/ BPD and resistant to conventional treatments
- Treatment occurred for 6-21 months with no medication restrictions (i.e., participants could continue use of concurrent psychiatric medications under the supervision of their psychiatrist)
- Outcome variables:
  - Hamilton Depression Rating Scale (HAM-D: Hamilton, 1960)
  - Young Mania Rating Scale (YMRS: Young et al., 1978)
  - Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962)

EMP: Open Label Adult BPD Study

Kaplan et al, '01, J Clin Psychiatr, 62(12): 936-944

- Results indicated
  - 55-66% reduction in HAM-D, YMRS and BPRS scores
  - 50% decrease in need for psychotropic medications
  - only one mild side effect reported, infrequent/transitory nausea, which occurred most commonly when participants took their supplement without food
- Conclusion: more studies are needed

EMP: Child Bipolar Study

Popper, 2001, J Clin Psychiatr, 62(12): 933-935

- 10-year old boy with bipolar disorder
- ABACB design
  - A: 4 mos, daily severe temper tantrums for multiple hrs
  - B:
    - 2 days after full EMP dose, behavior improved significantly
    - by 5 days, tantrums/irritability ceased
  - A: After 14 days, EMP was discontinued
    - Within 2 days, tantrums resumed
  - C: different supplement used, resulting in (per parent and teacher reports) 60% of the benefit
  - B: EMP resumed, tantrums/irritability resolved

EMP: Open Label Bipolar Study

Popper, 2001, J Clin Psychiatr, 62(12): 933-935

- 22 patients with bipolar disorder
  - 10 adults, 9 adolescents and 3 children
- Mild side effects (eg, headache) common
- 19/22 (86%) responded positively
- 11/15 patients (73%) previously on psychiatric medications remained stable without resumption of these medications at both 6-month and 9-month follow-up assessments

EMP: Open-Label ABAB Trial

Kaplan et al, 2002, J Ch Adol Psychopharm, 12(3): 205-219

2 boys w/ irritability, mood lability, explosive rage

- 8-year old: atypical obsessive-compulsive disorder (OCD) and ADHD
- Course of treatment: ABAB
  - A: Baseline/EMP withdrawal: consistent explosive rage, irritability, obsessions-guns
  - B: On EMP: these behaviors almost completely dissipated. Obsessive thoughts ceased, frequency and duration of temper outbursts ↓ significantly, mood fluctuations minimized. After ≥ 2 years of treatment, the boy remained well and free of side-effects while taking 25% of his initial dose of EMP

EMP: Child Case Series

Kaplan et al, 2004, J Child Adol Psychopharm, 14(1), 115-122

- N=11 children aged 8—15, all with mood and/or behavioral problems
- Intake diagnoses: n=3, BPD (1+anxiety, 1+behavior); n=2, Asperger's+anxiety; n=5, ADHD+ anxiety +/or behavior disorders; and n=1, Praeder-Willi syndrome, ODD + anxiety
- 9/11 (82%) completed the open-label trial

EMP: Child Case Series

Kaplan et al, 2004, J Child Adol Psychopharm, 14(1), 115-122

- Intent-to-treat analyses indicated significantly ↓ scores from baseline to final visit on Youth Outcome Questionnaire (YOQ: $p<.001$) and Young Mania Rating Scale (YMRS: $p<.01$)
- For the 9 completers, improvement was significant on 7/8 (88%) Child Behavior Checklist scales, YOQ and YMRS (p values ranged from $<.05$ to $<.001$)
- Conclusion: need RCTs

OSU Case Study: EMP+

Frazier, Fristad & Arnold, 2009, J Ch Adol Psychopharm, 19(4): 453-460.

- Boy diagnosed at age 5 yrs, 11 mos with BP-NOS, rule-out generalized anxiety disorder (GAD)
  - severe mood cycling, sadness, irritability, self-harming behaviors, sleep disturbance, severe tantrums, elevated mood, poor peer relations, low frustration tolerance, flight of ideas, aggressive behavior, hyperactivity and impulsive negative behaviors

OSU Case Study: EMP+

- By age 8: diagnoses evolved into BP-I, enuresis, GAD, learning disorder-not otherwise specified (LD-NOS), communication disorder-not otherwise specified
  - impairing anxiety and worsening mood symptom intensity and cycling, increased destructive behavior, transient suicidal ideation, and increased global impairment

OSU Case Study: EMP+

By ages 10-11: developed psychotic features (auditory hallucinations), obsessions and compulsions

- increasingly disrespectful and aggressive behaviors. Intrusive, command hallucinations when anxious, told him to act on his compulsions, do things he did not want to do, and threatened him, ≤~ 100X/wk telling him, "If you don't do this you'll surely die." and "Don't listen to them [referring to parents and other adults]". In 2006, the voices told him he would die on the day John Glenn dies. Symptoms became impairing to the point that he was removed from his private school and was home schooled.

OSU Case Study: Conventional Treatment

- Medication+psychoeducational psychotherapy
- Many medication trials d/t intolerable side effects +/or inadequate treatment response
  - lithium citrate, risperidone, lithium carbonate, clonidine, flax seed, desmopressin, omega-3 fatty acids, trazodone, gabapentin, valproic acid, propranolol, quetiapine, aripiprazole, lorazepam, and lamotrigine
- No medication combination maintained symptom amelioration and adequate global functioning over an extended period of time

2008	1/21/08	1/22/08	1/29/08	1/31/08	2/1/08
Begin EMPower Plus (EMP+)	EMP+ 5 pills/day Lithobid Lamictal	EMP+ 10 pills/day, Lithobid Lamictal	EMP+ 15 pills/day, cut ¼ Lithobid & ¼ Lamictal	EMP+, cut Lithobid & Lamictal by ½	EMP+, cut Lithobid & Lamictal by ½
Taper off all psycho-tropic medica-tions between 12/07-2/08			slight headache, improve-ment in bowels	irritability after taking regular meds, "downer" after lunch, dizziness & extreme tiredness before bed	slight headache in AM-gone by lunch

2/2/08	2/3/08	2/4/08
EMP+, cut Lithobid & Lamictal by ½	EMP+ , cut Lithobid & Lamictal by ¼	EMP+, cut Lithobid & Lamictal by ¼ (no regular meds in AM)
slight irritability in early afternoon, very tired in PM after receiving regular meds	"felt, looked, & acted great", no irritability, no social issues tired & dizzy after receiving regular meds in PM	

2/10/08	3/6/08	5/2/08
EMP+ only	EMP+ only	EMP+ only
	focused & efficient in school, good peer relationships, calm & playful, sleeping well, regular BMs, irritable & angry if pushed around 3-4PM followed by genuine apology, "mouthy" at times, decreased fidgeting, some compulsions but are ignored, child feels "natural"	good peer interactions, enjoys school, active in sports, all symptoms stable no longer has dry skin

Additional Follow-Up

- May, '08: ↑ EMP+ dose from 15 to 18 capsules/day d/t ↑ irritability, ? mood cycling, and "odd" behavior
  - Mother and boy reported this relieved symptoms
- Summer, '08: ↓ EMP+ to 15 capsules/day
- Fall, '08: Started regular public school (for the first time), plays on a school soccer team, maintains friendships, parents report improvements in his functioning while taking EMP+ are greater than those he has made in the past on medications
- His only additional intervention has been drinking whey protein mixed in milk when very active. During sports seasons, he takes ½ cup of whey protein mixed with milk in the morning, which according to his mother, helps keep him "clear, slowed down, peaceful, settled and happy"
- Summer, '09: Continues to remain stable, a "normal" teenager Summer, '11: Needed to ↑ dose

Open Label Pilot Exploration of a Nutritional Supplement for Childhood Mood Dysregulation

Frazier, Fristad, Arnold, in press, J Comp Alt Med

- N=10, 2-month open label trial of EMP+
- Explore feasibility, provide preliminary efficacy data
- Participants had to remain off all psychotropics for 11 wks (3 wks prior to EMP+ and 8 wks of EMP+)
- Any other treatment could continue
- Seven assessments conducted
  - interviews with parent and child
  - brief physical exam
  - blood draws at the second and last visit

Participants

- 10 children age 6-12; *M* = 8.9, *SD* = 2.0
- 60% male
- 90% White, 10% Hispanic
- IQ estimate: *M* = 98.7, *SD* = 9.5
- Income: $20,000 to >$100,000
- 10% BP-I, 30% BP-NOS, 60% sub BP-NOS
  - Sub BP-NOS: 20% MDD & 10% Dysthymia
- 100% comorbid behavior d/o, 60% comorbid anxiety, 10% enuresis
- 70% completed full open-label study

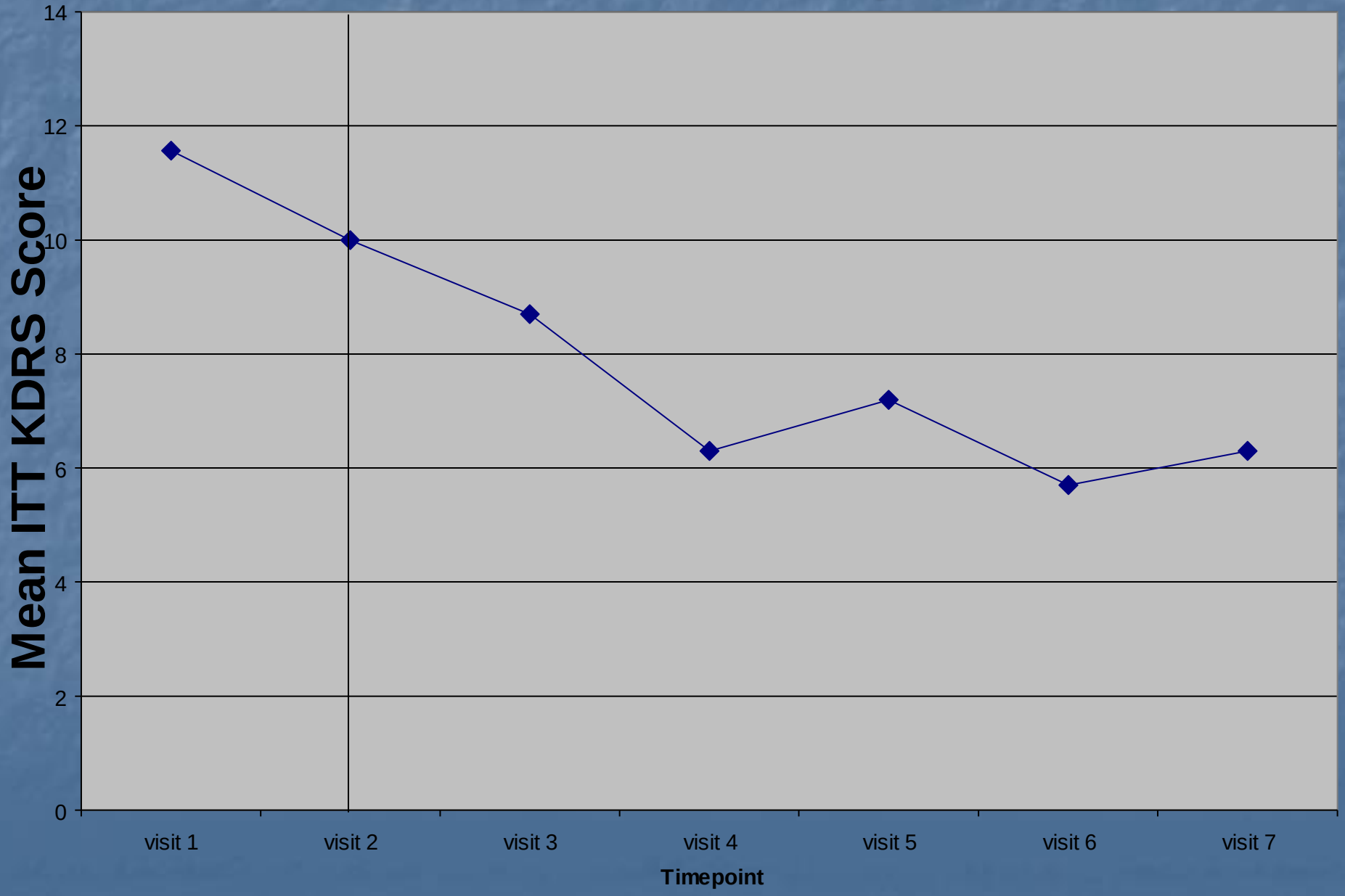
Dosage

- 1 capsule tid, increased up to a max of 5 capsules tid
- Average 46.4 days on EMP+ (SD = 23.3, median = 55)
- No concomitant psychotropics
  - N=3 on psychotropic medications at enrollment; completed ≥ 3-week washout
  - N=1 n-3 + melatonin
  - n-=1 n-3 fatty acids; Focalin 10mg added after Visit 5
  - N=10 continued pre-existing psychosocial services outside of study

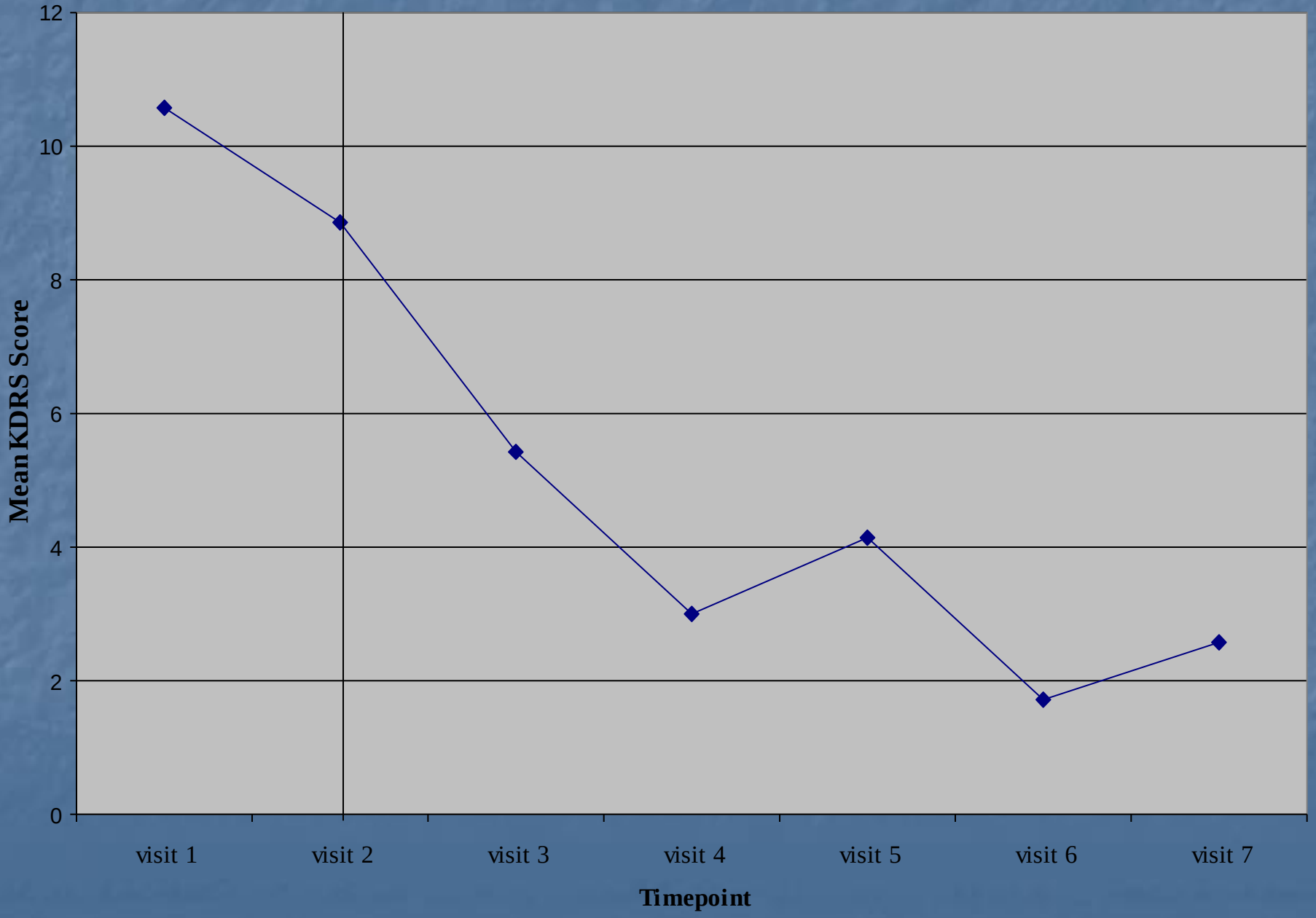
Side Effects

- 4 mild nausea w/o food 1x, 1 vomited 1x
- 3 mild initial insomnia 1x
- 1 mild ↑ appetite 1x
- 1 nocturnal enuresis 1x

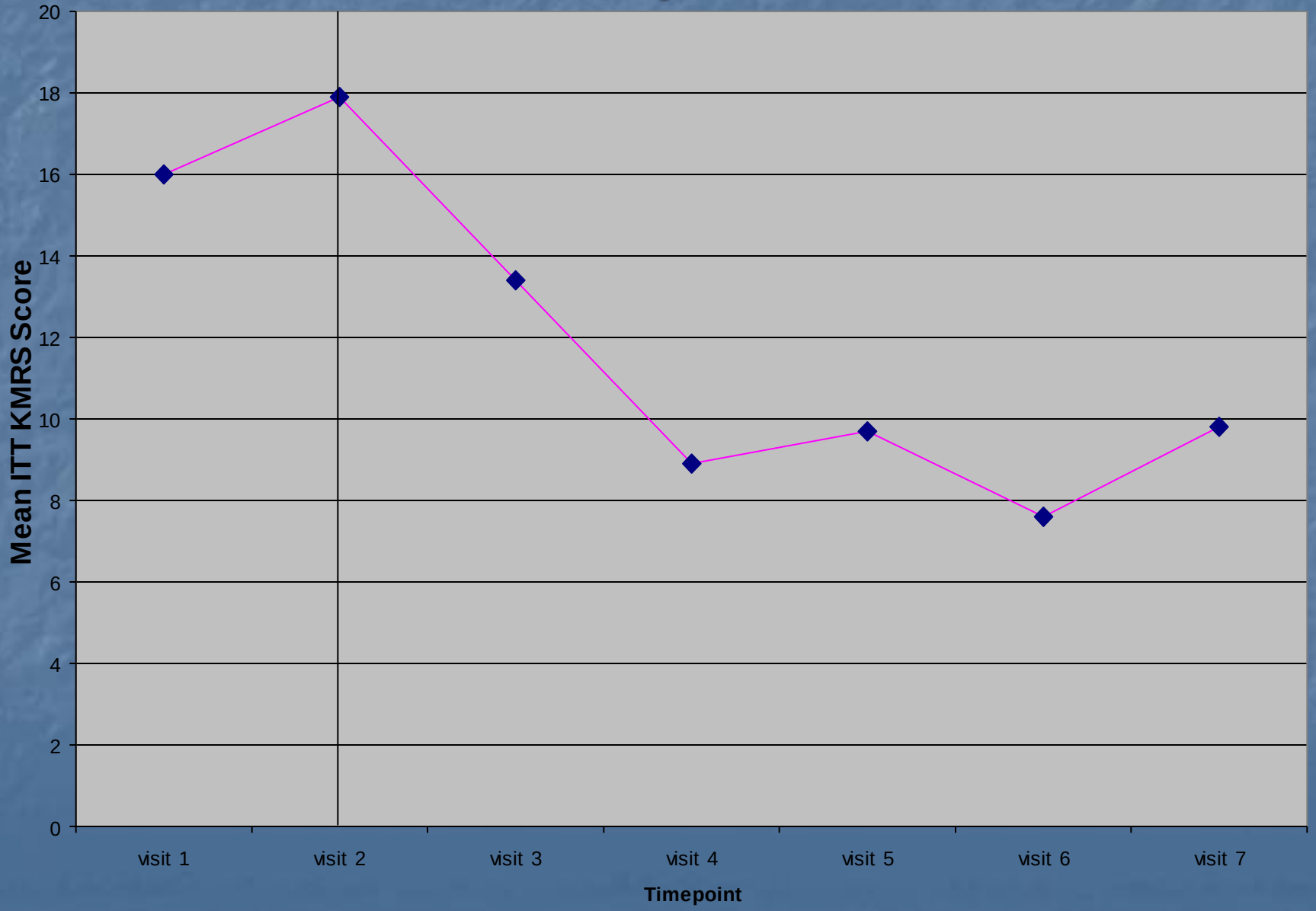
ITT (N=10) Depression Scores Over Time, p<.06



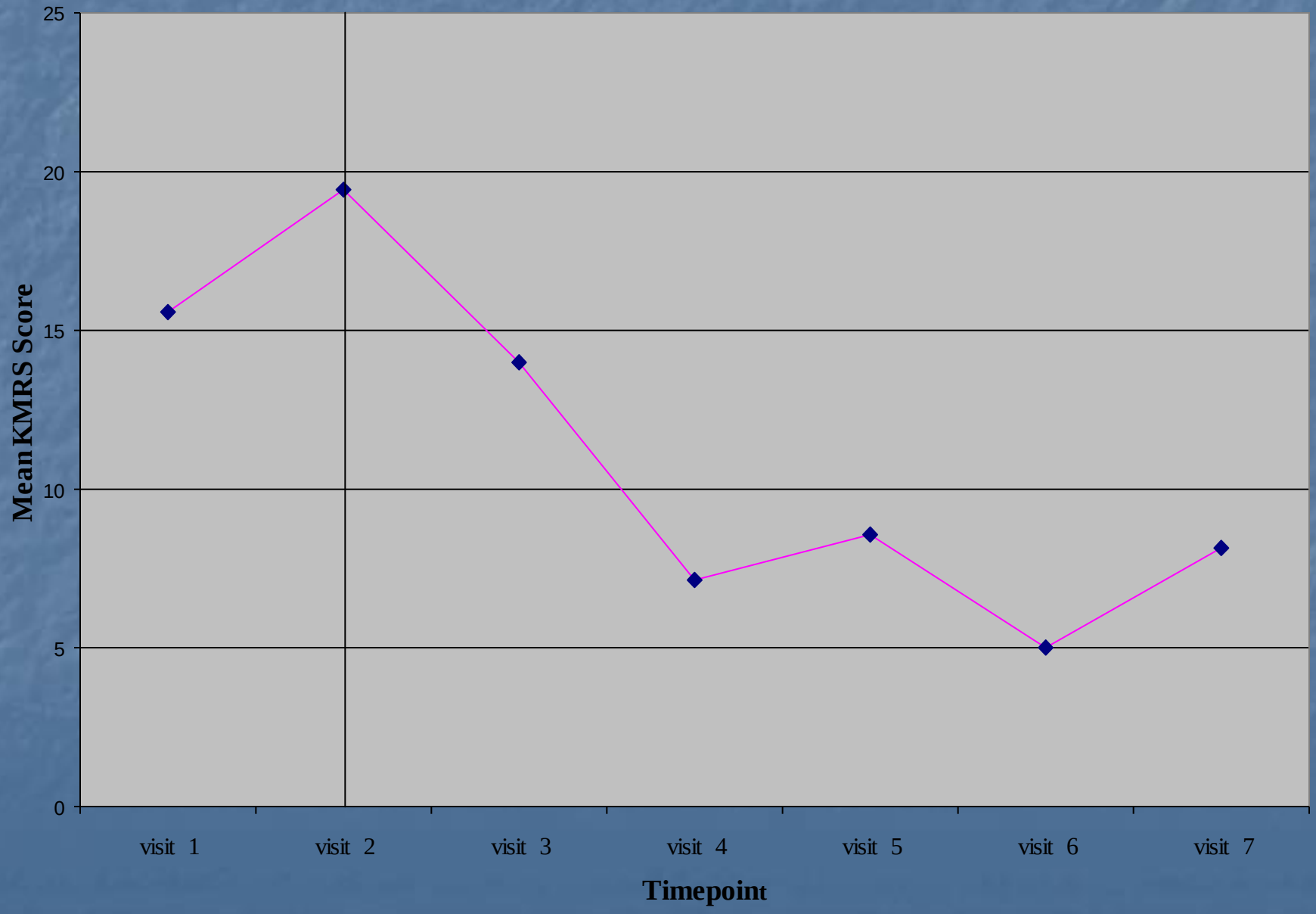
Mean Depression Scores Over Time (n=7) Study Completers, p<.05



ITT (n=10) Mania Scores Over Time, p<.01



Mean Mania Scores Over Time (n=7) Study Completers, p<.05



Discussion-Medication Compliance

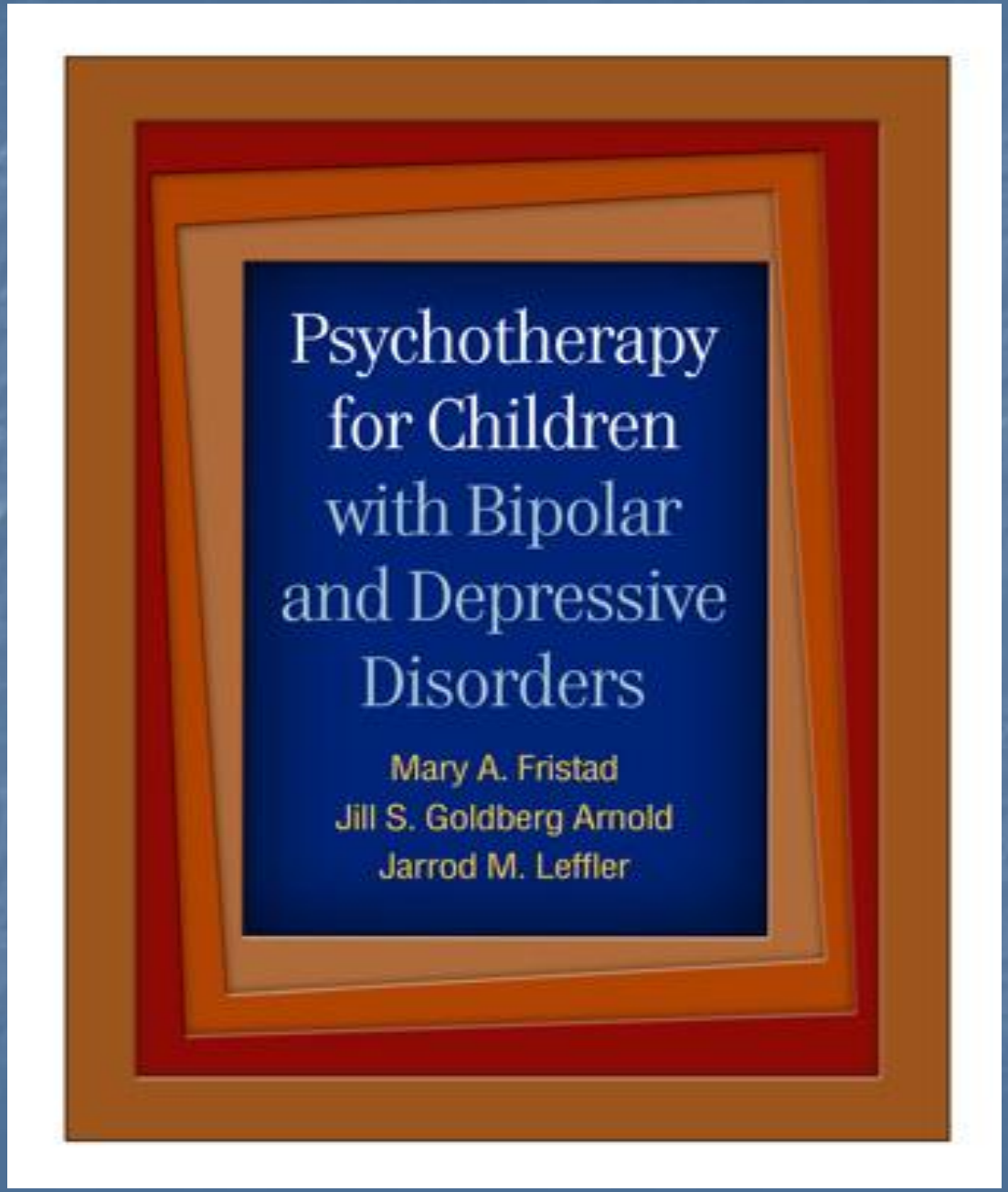
- 3 participants dropped out due to tolerability/palatability/compliance
- Of the 7 completers, all maintain high compliance
  - All maintained at least 93%
  - 2 maintained 100%
- Those who fit swallowing inclusion criterion displayed excellent treatment adherence

Treatment Response

- Suggest ↓ depression and mania symptoms over time
- Open-label design, interpret w/ caution
  - Placebo-effects, 18.7%-33.6% in review of adult BPD medication trials *(Smith, Cornelius, Warnock, Tacchi &Taylor, 2007)*
- Anecdotal follow-up
  - 4 continued on EMP+ post study completion
  - 2 were considering cost, unknown
  - 1 began mood stabilizer
  - 1 began antidepressant
  - 2 unknown
- Future, more scientifically rigorous placebo-controlled trials appear warranted

Workshop Goals

- Participants will learn:
  - How BPSD presents in children
  - Biological interventions
  - ***Psychosocial treatment for BPSD***
    - *Multi-family psychoeducational psychotherapy (MF-PEP)*
    - *Individual-family psychoeducational psychotherapy (IF-PEP)*


Psychotherapy for Children with Bipolar and Depressive Disorders
Mary A. Fristad
Jill S. Goldberg Arnold
Jarrod M. Leffler

The OSU Psychoeducational Psychotherapy (PEP) Program

- Orientation
  - Nonblaming/growth-oriented
  - Biopsychosocial—uses systems and cognitive-behavioral techniques
- Education + Support + Skill Building→ Better Understanding → Better Treatment + Less Family Conflict → Better Outcome
- Three formats
  - Multi-family psychoeducational psychotherapy (MF-PEP)
  - Individual family psychoeducational psychotherapy (IF-PEP)
  - workshops

How to Conceptualize Family-Based Intervention

- Historically, families
  - Have been blamed
  - Have not gotten useful information/support/skill building
- This can result in families being "skittish" or "defensive" about family-based intervention

Goals of Psychoeducation

- Teach parents and children about
  - The child's illness & its treatment
- Provide support
  - Peers ("I'm not the only one")
  - Professionals - understand the disorder
- Build skills
  - problem-solving
  - communication
  - symptom management

Psychoeducation: Treatment Goal

- *If you give a man a fish, he will eat for a day. If you teach a man to fish, he will eat for a lifetime.*

Pro's and Con's of MF-PEP

+Peer support- for children and parents

+In-vivo social skills training

+Parents and children learn from each other

-Can't tailor make treatment for specific needs of child/parent

-Need to consider attend to group dynamics when selecting members

-Schedule harder for families to accommodate

Therapist (3) Requirements: MF-PEP

- Parent & Lead Child Therapist: be familiar with
  - Mood disorders
  - Children/families
  - Group therapy
- Child Co-Therapist: be familiar with
  - Behavior management
  - Excellent role for trainee

Additional Features of MF-PEP

- Point system—accumulate at
  - Each session-for completed projects, participation
  - Review game (cash in after playing)
- Immediate reinforcers (eg, Starbursts)
- News of the Week
- Games (social skills, thematically linked)
- Think about group composition
  - Don't leave any member "stranded"
  - SES, gender, symptom severity
- Therapist workbook includes:
  - Keep in Mind, Leader Tip, Examples, Games, Posters+ prompts, Child Workbook page prompts

Pro's and Con's of IF-PEP

+Can flexibly administer treatment modules

+Includes Healthy Habits, siblings, school professional contact

+In-the-bank sessions allow for repeating and/or augmenting of treatment

+Easier to schedule for families

-Don't meet others struggling with unique issues of mood disorder

-Social skills training with peers not available in session

Therapist (1) Requirements: IF-PEP

- Be familiar with
  - Mood disorders
  - Children and families

Resources

OATS-Bipolar, 2011-2014, NIMH R34

- OATS=Omega3 and Therapy Study
- Kayden Healy, ***614-293-4908***
- N=60
- 12 week trial
- 8-14 years
- BP-NOS, cyclothymic disorder
- No meds/psychotherapy in previous month except stable stimulants, sleeping aids

	Omega3	Placebo	TOTAL
IF-PEP	15	15	30
Active Monitoring	15	15	30
TOTAL	30	30	60

Books for Children

- Brandon & the Bipolar Bear -- *T. Anglada*
- My Bipolar, Roller Coaster, Feelings Book & Workbook—*B. Hebert*
- The Storm in My Brain -- Child & Adolescent Bipolar Foundation (CABF): 1-847-256-8525, www.bpkids.org
- Kid Power Tactics for Dealing with Depression -- *N. & S. Dubuque*
- Matt, The Moody Hermit Crab -- *C. McGee*
- Anger Mountain—*B. Hebert*

Books for Adolescents

- When Nothing Matters Anymore: A Survival Guide for Depressed Teens -- *B. Cobain*
- Recovering from Depression: A Workbook for Teens -- *M. E. Copeland & S. Copans*
- Conquering the Beast Within: How I Fought Depression & Won…& How You Can, Too -- *C. Irwin*
- Mind Race: A Firsthand Account of One Teenager's Experience with Bipolar Disorder — *P.E. Jamieson & M.A. Rynn*

Children's Literature

- ***The Phoenix Dance***
  - Dia Calhoun, award winning author
  - Farrar, Straus & Giroux, NY, 2005

  - Based on the Grimms' Twelve Dancing Princesses
  - Explores the experience of bipolar disorder in an adolescent girl

Books for Parents

- Raising a Moody Child: How to Cope with Depression and Bipolar Disorder -- *M.A. Fristad & J.S. Goldberg-Arnold*
- New Hope for Children & Teens with Bipolar Disorder—*B. Birmaher*
- The Childhood Bipolar Disorder Answer Book– *T. Anglada & S.M. Hakala*
- The Bipolar Child --*D. & J. Papalos*
- A Parent's Survival Guide to Childhood Depression -- *S. Dubuque*

Books for Adults

- Out of the Darkened Room: Protecting the Children and Strengthening the Family When a Parent is Depressed -- *W. Beardslee*
- Living Without Depression & Manic Depression --*M. E. Copeland*
- An Unquiet Mind -- *K. Redfield Jamison*
- Thoughts & Feelings: Taking Control of Your Moods & Your Life --*M. McKay, M. Davis & P. Fannin*
- The Bipolar Survival Guide: What You and Your Family Need to Know --*D.J. Miklowitz*
- Winter Blues: Seasonal Affective Disorder- What it is and How to Overcome it -- *N.E. Rosenthal*

More Books to Read

- **General Parenting**
  - How to Talk So Kids Will Listen & Listen So Kids Will Talk -- *Faber & Mazlish*
  - The Explosive Child -- *R. Greene*
  - The Optimistic Child -- *M. Seligman*
- **Sibling Issues**
  - Siblings Without Rivalry -- *A. Faber & E. Mazlish*
  - Turbo Max: A Story For Siblings of Bipolar Children -- *T. Anglada*
- **Understanding Psychiatric Disorders**
  - It's Nobody's Fault --*H. Koplewicz*
- **Understanding Psychiatric Medications**
  - Straight Talk About Psychiatric Medications for Kids ---*T. Wilens*
- **Miscellaneous**
  - I Am Not Sick, I Don't Need a Help! -- *X. Amador & A.L Johanson*
  - The Thyroid Sourcebook --*M.S. Rosenthal*

Educational Websites

- **Information re: BPD for Parents, Children and Educators**
  - *www.bpchildren.com*
  - *www.schoolbehavior.com*
  - *www.bpkids.org*
  - *www.josselyn.org/Store.htm*
- **Special Education Advocacy** -- *www.wrightslaw.com*
- **National Association of Therapeutic Schools and Programs**—*www.natsap.org*
- **Internet Special Education Resources (ISER)**
  - *www.iser.com/index.shtml*

Groups/Websites – Adults, Families & Children

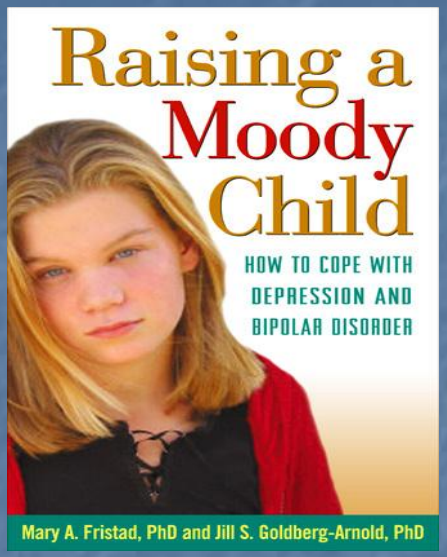
- National Alliance on Mental Illness (NAMI)
  - 1-800-950-6264 www.nami.org
- Mental Health America (NMHA)
  - 1-703-684-7722 www.nmha.org
- Depressive & Bipolar Support Alliance (DBSA)
  - 1-800-826-3632 www.dbsalliance.org
- Families for Depression Awareness (FFDA)
  - 1-718-890-0220 www.familyaware.org
- Child & Adolescent Bipolar Foundation (CABF)
  - 1-847-492-8519, www.bpkids.org
- Juvenile Bipolar Research Foundation (JBRF)
  - 1-866-333-5273, www.bpchildresearch.org
- BP Children
  - 1-732-909-9050 (fax) www.bpchildren.com

Additional Resources

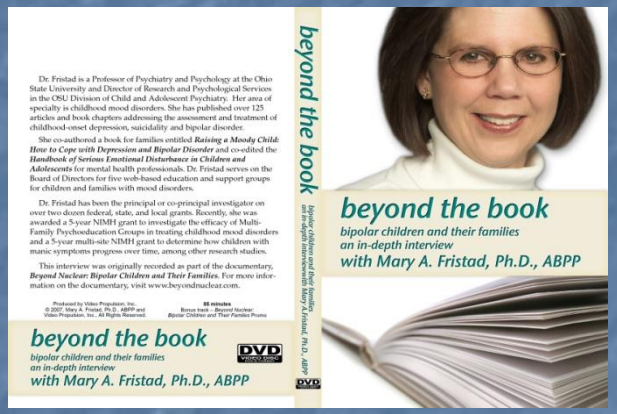
- **Light Therapy:**
  - Center for Environmental Therapeutics www.cet.org
- **Nutritional Intervention:**
  - EMpower Plus
    - 1-888-878-3467 www.truehope.com
  - Omega-Brite
    - 1-800 383 2030 www.omegabrite.com
- **Evidence-Based Treatments:**
  - **www.effectivechildtherapy.com**
- **PEP Workbooks**
  - **www.moodychildtherapy.com**

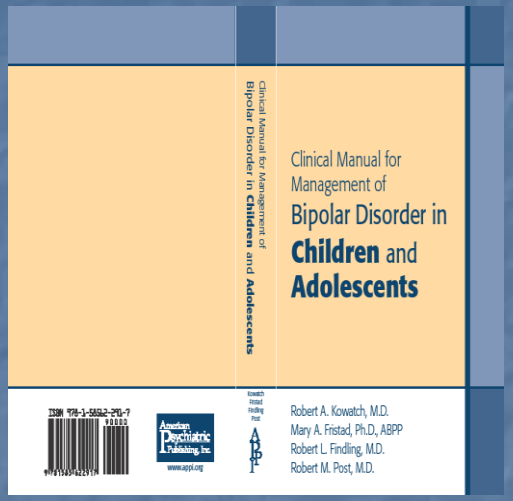
- Note that Parts 4-6 follow the PEP manuals.

PEP & MF-PEP Resources



Books & DVD for parents or therapists—order from www.amazon.com





Treatment Manual—2011, Guilford Press

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Home Study Course— *for professionals*

Taped 2 day seminar by Dr. Fristad
6 or 12 hours Continuing Education credit
$95 for CD or cassette
$65 for test scoring/reporting
www.jkseminars.com

www.moodychildtherapy.com

Child, Parent & Child Therapist MF-PEP Workbooks

Child & Parent PEP Workbooks

Thank You, The End

- mary.fristad@osumc.edu
- Clinic #: 614-293-9600
- 1670 Upham Drive Suite 460G
  Columbus, OH 43210-1250

For more information, please go to the main website and browse for more videos on this topic or check out our additional resources.

Additional Resources

Online resources:

1. Society of Clinical Child and Adolescent Psychology website: http://effectivechildtherapy.com
2. Psychoeducational Psychotherapy Workbooks: www.moodychildtherapy.com

Books:

1. Fristad, M.A., Goldberg Arnold, J.S. & Leffler, J. (2011). *Psychotherapy for Children with Bipolar and Depressive Disorders.* New York: Guilford Press.

Selected Peer-reviewed Journal Articles:

1. Fristad, M.A., Verducci, J.S., Walters, K. & Young, M.E. (2009). The impact of multi-family psychoeducational psychotherapy in treating children aged 8-12 with mood disorders. *Archives of General Psychiatry. 66*(9);1013-1021.
2. Kaplan, B.J., Crawford, S.G., Field, C, J., & Simpson, J.S. (2007). Vitamins, minerals, and mood. *Psychological Bulletin*, 133(5) 747-760.
3. Kowatch, R.A., Fristad, M.A., Birmaher, B., Wagner, K.D., Findling, R.L., Hellander, M., & the Child Psychiatric Workgroup on Bipolar Disorder (2005). Treatment guidelines for children and adolescents with bipolar disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 44, 213-235.
4. Lofthouse, N. and Fristad, M. (2004) Psychosocial interventions for children with bipolar disorder. *Clinical Child and Family Psychology Review*, 7, 71–88.
5. Youngstrom, E.A., Findling, R. L., Youngstrom, J. K., & Calabrese, J. R. (2005). Toward an evidence-based assessment of pediatric bipolar disorder. *Journal of Clinical Child & Adolescent Psychology*, 34, 433-448.

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