FIRST DAY HANDOUTS

Childhood Bipolar Disorder

Diagnosis and Treatment

Presented By

Mary A. Fristad, Ph.D., ABPP

MORNING AGENDA

8:15 a.m. Registration
(continental breakfast buffet)

9:00 Recognizing Symptoms of Depression and Mania

10:20 Break (coffee and tea)

10:35 **Differential Diagnoses & Co-Morbid Disorders**

Noon Lunch (on your own)

AFTERNOON AGENDA

1:30 **Biological Interventions**

2:45 Break (coffee, tea, soda, snack)

3:00 **Predictable Problems & Promising Possibilities**

- Building Therapeutic Teams
- Working with Families
- The 3 Ss: Spouse, Self & Sibling Issues

4:30 Adjournment (pick up one-day certificates)

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Childhood Bipolar Disorder: Assessment & Treatment

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Recognizing the Symptoms of Depression and Mania

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 (2005)

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

Workshop Overview: Learner Objectives

- ***Identify how symptoms of depression and mania appear in youth***
- Be aware of differential diagnoses and common comorbidites
- Learn about currently available biological interventions and their role in treatment
- Develop a conceptual basis for comprehensive care in the context of the child's family and school system
- Learn specific therapeutic techniques
- Identify resources that will assist families cope

Mood Myths

- It will go away (soon) on its own
- Everybody gets this way
- You ought to "just snap out of it!"
- Getting treatment is a sign of weakness
- People who talk about suicide are just trying to get attention
- Mood impaired kids are bad or lazy
- Teenagers are "just moody"

Depression Facts

- Among the most common of psychiatric disorders
  10-25% women (lifetime)
  5-12% men (lifetime)
  5% adolescents (current)
  2% children (current)
- Occurs among people of all ages, income levels, ethnic groups & cultures (even in animals!)
- only ¼ of 19 million Americans with depression seek help!

Bipolar Facts

- Difficult to diagnose in children
- Many misconceptions
  - Professionals: can take a long time to "get" the diagnosis
  - Public: often blame parents
  - Family/Friends: often blame parents

Why Don't People Get Help?

- You hope the problem will "go away"
- You don't recognize it as an illness
- You get confusing advice
- You've tried things that haven't worked and don't know what to do next
- Your child doesn't understand and so says "nothing's wrong!" when asked, and doesn't know how to solve the problem
- Treatment isn't available OR affordable

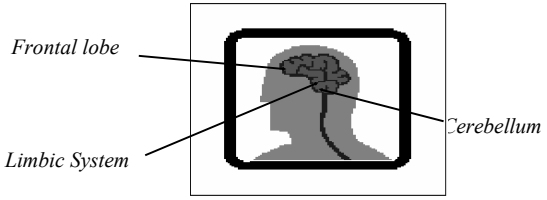
Why Do People Get Mood Disorders?

- 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%

A No Fault Brain Disorder

- You don't get to choose your genes or your child's genes!
- Brain structures + brain chemicals (send "messages" between structures) differ in bipolar disorder → behavior problems



- Medication changes brain chemicals ("messages") → behavior changes

More Facts

- The CAUSE of mood disorders is probably biological; the COURSE of illness is influenced by psychosocial events
- A realistic goal is to TREAT the symptoms, not CURE the illness
- We can't predict WHO will have another episode WHEN
- We can teach skills to manage the disorder

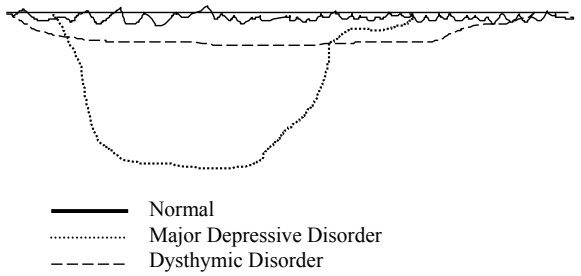
Our Motto

- It’s not your fault, but it’s your challenge!

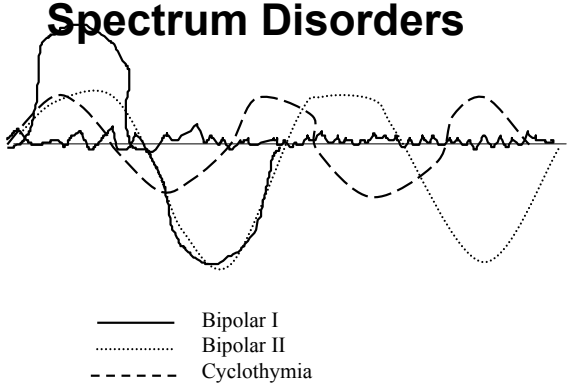
What Makes Diagnosing Mood Disorders Tricky with Children?

- 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?”

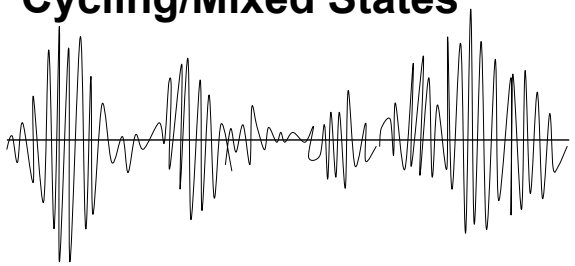
Tracking Mood Changes: Depressive Spectrum Disorders



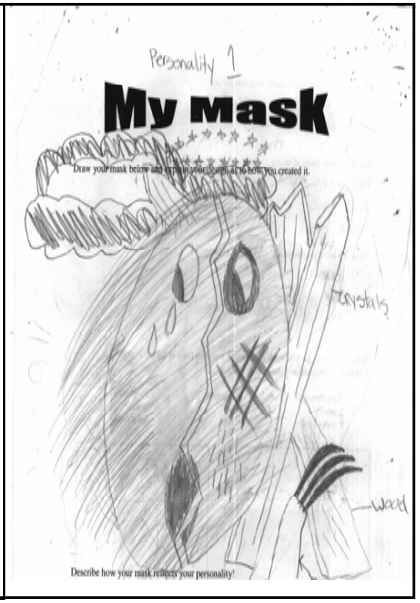
Tracking Mood Changes: Bipolar Spectrum Disorders



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 to 9 mos
- 90% get well by 1.5 to 2 years
- 6 to 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 PictureKovacs 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

Differential Diagnosis & Comorbidities

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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%
Distractability	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 Mania or ADHD?

Symptom	**ADHD**	**Bipolar**
Euphoric	*Can get silly—transitory, rarely impairing*	*Leads to outrageous behavior*
Grandiosity	*Can brag—usually trying to boost self-esteem*	*Truly believes at the time in outlandish ideas*
↓ Need for Sleep	*Some have never needed much sleep; medications can interfere with sleep*	*Sleeps ≥ 2 hours less than usual, fully rested*
↑ Speech	*Chronic, or when excited*	*Often loud, hard to interrupt, intrusive*

Is it Mania or ADHD? *(Cont'd)*

Symptom	**ADHD**	**Bipolar**
Racing thoughts	*Especially if low IQ or has LD, can be difficult to follow*	*Can be difficult to follow, cause interference*
↑ Goal directed activity	*Hyperactivity is less "focused"*	*Engage in elaborate schemes*

Is it Mania or ADHD? *(Cont'd)*

Symptom	ADHD	Bipolar
↑ **Involvement in pleasurable activities w/ potential for painful consequences**	*Quality here is "mouth and/or body engage before frontal lobe does"*	*Has a more planful quality and/or clearly deviates from social norms*

Is it Mania or ADHD? *(Cont'd)*

Symptom	ADHD	Bipolar
Inattentive	*Across settings and time*	*Variable, changes with mood*
Hyperactive	*Ditto*	*Ditto*
Impulsive	*Ditto*	*Ditto*
Irritable	*Often as medication is wearing off* *can develop secondary "demoralization"*	*Often pulsating, volatile, extreme; aggression toward self/others common*

Is it BPD or A/PTSD?

- Symptoms of BPD and A/PTSD overlap
- Symptoms can also co-occur
  - *Post 2006-Adults w/ hx of childhood abuse/neglect*
    - 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 anture
  - *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

Biological Interventions

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- Identify how symptoms of depression and mania appear in youth
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Types of Treatment

- ***Biological***
  - Medications
  - Lights
  - ECT
- ***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

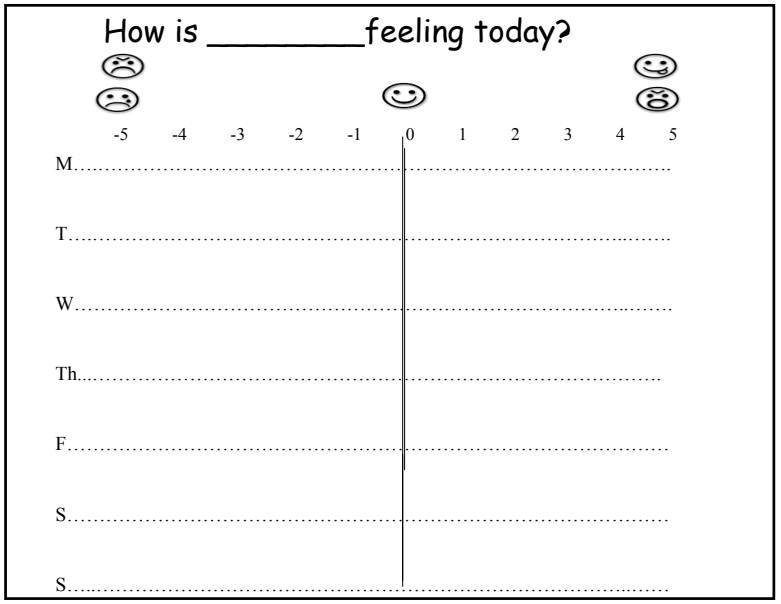
- Ask for fact sheets about medications
- Know common & serious side-effects (side effects often decrease as the body adjusts to new medicine)
- Know what to do if a serious side-effect occurs
- Know how to monitor the medication
- ALWAYS tell both the primary care doctor and psychiatrist about ALL medications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



What's the Evidence?

Kowatch et al, 2005, JAACAP

- Four levels of evidence
  - A: randomized, controlled trials in youth
  - B: randomized, controlled trials in adults
  - C: open trials and retrospective analyses
  - D: case reports and panel consensus
- Minimum requirement
  - 4-6 weeks at therapeutic blood levels and/or adequate dosage (lithium, 8 wks)

Medication	BP-I, Mixed or Manic, no Psychosis	BP-I, Mixed or Manic, w/ Psychosis	BP-I, Depressed
Lithium	A & B	A & B	B & C
Divalproex *Depakote*	B & C	B & C	C
Carbamazepine *Tegretol*	B	B	--
Oxcarbazepine *Trileptal*	D	D	--
Topirimate *Topomax*	C	C	--

Medication	BP-I, Mixed or Manic, no Psychosis	BP-I, Mixed or Manic, w/ Psychosis	BP-I, Depressed
Clozapine *Clozaril*	C	C	--
Risperidone *Risperdal*	B & C	B & C	--
Olanzapine *Zyprexa/Zydis*	B & C A?	B & C A?	B
Quetiapine *Seroquel*	B & C	B & C	B
Ziprasidone *Geodon*	B & C	B & C	--
Aripiprazole *Abilify*	B & C	B	--

Medication	BP-I, Mixed or Manic, no Psychosis	BP-I, Mixed or Manic, w/ Psychosis	BP-I, Depressed
SSRIs	N/A	N/A	C*
Bupropion	N/A	N/A	D
Lamotrigine	C	C	B & D
*May be mood destabilizing			

Newer Agents

Kowatch et al, 2005, JAACAP

- Gabapentin *(Neurontin)*
  - Associated with behavioral disinhibition
  - May help with comorbid anxiety AFTER mood is stable
- Lamotrigine *(Lamictal)*
  - Indicated for BP-D in adults
  - Black box warning for Stevens Johnson syndrome (1 in 10,000)
- Oxcarbazepine *(Trileptal)*, aripiprazole *(Abilify)*, omega-3 fatty acids– all have some good adult data, need child data
- Topirimate *(Topomax)*—not effective in adults, ?youth?
- Newer anticonvulsants (levetiracetam, zonisamide, tiagabine)—little adult data, no child data

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 to 90% of children and 30 to 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

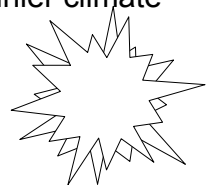
- Skin Sensitivity
  - Use sunscreen
  - Wear protective clothes
  - Avoid sunlight/sunlamps
- Impaired Sleep
  - Have routine sleep habits
  - Don't let the weekend disrupt this by > 1 hour
  - No exercise/caffeine in late evening
  - Wake at regular time EVEN IF TIRED!
  - Don't nap during the day

Nutritional Interventions

- Omega 3 Fatty Acids
- Vitamin/mineral complex

Treatment: Light Therapy

- Move to a warmer, sunnier climate



OR

- Sit for 30-40 minutes, 1-2X/day in front of a special lamp
- Circadian Solutions™
  - 1-800-545-9667 www.circadiansolutions.com

Predictable Problems & Promising Possibilities—

- ***Building Therapeutic Teams***
- Working with Families
- The 3 Ss: Spouse, Self & Sibling Issues

Workshop Overview: Learner Objectives

- Identify how symptoms of depression and mania appear in youth
- Be aware of differential diagnoses and common comorbidites
- Learn about currently available biological interventions and their role in treatment
- ***Develop a conceptual basis for comprehensive care in the context of the child's family and school system***
- Learn specific therapeutic techniques
- Identify resources that will assist families cope

Constructing a Mental Health Team

- **Parents** are ultimately the most important member of the child's mental health team!
- Help them construct a complete mental health and school team
  - Psychiatrist, psychologist, social worker, case manager, respite, other
  - Who is needed? Help them choose
- Help them become effective advocates
  - Keep Mood Logs
  - Participate in education: Websites, books, groups
  - Participate in treatment: bring notebook to sessions

Mental Health Services: The Players (Cont'd)

- **Respite providers**
- **Therapeutic summer camp**
  - Camp Nuhop www.nuhop.org
- **Adult mentor outside the home**
  - Big Brother/Big Sister
  - Neighbor, religious youth leader, family friend, etc.

Social Security Disability

(Adapted from CABF Website)

- The **Social Security Administration** (*SSA*) provides benefits for disabled children if they/their families have limited income and resources (*SSI*=**Supplemental Security Income**)
- Additional benefits
  - Children who qualify for SSI also qualify for Medicaid (a health program for people with low income and limited assets)

What's the Big Deal, Anyway?

- Children with "serious emotional disturbance" (SED) are ***4 TIMES*** more likely to drop out of high school than their peers
- 85% vs 21% high school completion rate (*US Dept of Education, 11/99*)

Impact of Illness on Learning

- "Primary" symptoms get in the way
  - mood disorder
  - comorbid disorders
- "Secondary" symptoms get in the way
  - eg, peer relations
- Cognitive disruption associated with mood disorders
- Medication side-effects

How Does Bipolar Disorder Translate to Problems in the Classroom? Anglada, 2002

- ↓ concentration
- ↓ focus
- disinhibited actions
- Doesn't remain in seat
- Disorganized
- Performs below potential
- Talks loudly
- Can't sit still/wait
- ↓ motivation
- ↓ task completion
- Sleepy/slowed down
- Cries
- Peer problems
- Anger outbursts
- Change is difficult
- Doesn't handle stress
- ↑ absent
- ↑ late
- ↑ physical complaints

Academic Functioning—Hospitalized Children w/ BPD Biederman et al, 1999

- 24%: repeated a grade
- 43%: previous/current Special Education placement
- 58%: tutoring
- 13%: learning disability

Academic Records Pre/Post BPD Onset in Adolescents *Quakenbush et al, 1996*

- Prior to illness onset
  - 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—leadership potential
  - 2/3 peer difficulties (loss of previous activities/friendships)
  - 38% of eligible H.S. seniors graduated (Canada)

Constructing a School Team

- Teachers (regular and special education)
- Principal
- School Nurse
- Guidance Counselor
- School Psychologist
- School Social Worker
- Special Education Coordinator
- Enrichment
- Speech/Language Pathologist
- Learning disabilities Tutor
- Occupational Therapist
- Physical Therapist
- Attendance Coordinator
- In-school Discipline Specialist
- Custodial and Clerical Staff

- Parents
- Child
- Prescribing physician
- Therapist
- Other adult support

Questions to Ask Anglada, 2002

1. Does the child have a co-occurring condition?
2. What side effects might occur?
3. What are specific stressors/triggers?
4. What helps the student stay calm/focused?
5. Does the student have a special talent?
6. What symptoms interfere with school?

Teacher Characteristics: The "Exponential Rule" Anglada, 2002

- Be empathic and compassionate
- Be willing to learn about BPD
- Convey a positive attitude toward child
- Avoid degrading or humiliating comments
- Focus on special gifts and talents
- Provide much encouragement and praise
- Don't blame the parents

Classroom Chacteristics:More of the Exponential Rule Anglada, 2002

- Quiet
- Not overcrowded
- Clear rules
- Consistent routine
- Flexible discipline (based on illness)

Free to Low Cost Interventions

- Educate the educators
- Seating choice
- Allow breaks (including naps)
- Use laptop computer (graphomotor issues)
- Adjusted schedule
- BE FLEXIBLE!
- MAINTAIN A SENSE OF HUMOR
- MAINTAIN A TEAM
- Test accommodations
- Grade adjustments
- Peer mentoring
- (Home schooling)
- GED
- Flexible attitude!

Moderate to High Cost Interventions

- Use
  - resource room
  - in-school tutor
  - home-based instruction (partial or full)
  - specialized part- or full-time staff
  - self-contained classroom
  - alternative school (if available)
- Enroll in specialized
  - day treatment program
  - residential school

Alternatives to Regular Classroom Placements

- Regular classroom + resource room support
- Self-contained classroom
- Therapeutic day school
- A hospital's day treatment program
- Residential treatment center
- Therapeutic boarding school (typically very expensive and not covered by insurance)

Educational Accommodations: Recent Severe Episode

- If the student is currently too anxious, depressed or unstable to manage the stresses of a full school day
  - Arrange for *temporary* homebound instruction followed by gradual transition back to school if needed OR
  - Arrange for partial days at school

Educational Accommodations: Medication Side Effects

(Adapted from CABF Website)

- General comments:
  - Provide privacy for taking medications
  - Inform school staff of all medications and their serious (rare) and nuisance (common) side effects
  - Provide an emergency contact person who can pick the child up if parents cannot
- ↑ thirst ↑ urination: (eg, lithium)
  - Allow unlimited access to fluids, restroom
- Drowsiness, Sluggishness
  - Consider nap opportunities
  - Modify schedule accordingly

Educational Accommodations: Episodes of Intense Emotion

- Identify a safe/private place for the child to go to regain control (eg, guidance office, resource room)
- Arrange for a Functional Behavior Assessment
  - Assess triggers/events that precede rages. If due to:
    - Boredom: provide enrichment
    - Hunger/low blood sugar: allow for snacks
    - Excessive academic challenges: reduce demands
- Develop a behavior plan to teach the child new ways to prevent or cope with stressors and frustrations

Educational Accommodations: Concentrating & Remembering Assignments

- Use a homework notebook signed by teacher(s) and parent(s)
- Establish an end-of-day reminder system for homework assignments (check in with a peer leader or teacher)
- Arrange for a second set of books for use at home
- Add a classroom aide
- Modify expectations and assignments based on the child's fluctuations in concentration

Educational Accommodations: Cognitive

- Difficulty reading/comprehending long passages of text
  - Provide recorded books or break reading assignments into manageable chunks
- Problems understanding complex, multi-step directions/assignments/questions
  - Break assignments into manageable steps
  - Have teacher/aide administer tests so questions can be clarified
- Problems completing written assignments within designated time frame
  - Arrange for extended time on tests and written assignments
- Difficulty writing (graphomotor dysfunction)
  - Provide a calculator and/or a word processor with a keyboard or dictation software, use graph paper to keep math columns straight

Educational Accommodations: Social-Emotional

- Conflicts with a particular student or group of students
  - Increase staff supervision to avert problems
  - Establish a "zero tolerance" policy in regard to bullying
  - Inform parents in case bullying persists outside of school
- Extreme anxiety about speaking in front of others
  - Provide alternatives to oral classroom presentations (eg, present to one or two supportive peers and the teacher, or just the teacher)
  - Arrange for practice and coaching to reduce anxiety
- Poor social skills (bossy, misinterprets jokes, very shy)
  - Provide individual or group school-based intervention (eg, Friendship Groups)

Tips for What to Say (Adapted from CABF Website)

- **Instead of "You're not trying hard enough"**
  "It looks like you're getting frustrated. Would you like some help?"
  "This seems hard for you right now but you're still doing a good job. I bet a break from this would help. When you come back to it, it may not be so hard."
- **Instead of "I know you're being lazy (not trying, not caring, etc) because I've seen you do better work."**
  You seem to be having a hard day. I can see that you're really trying, but things aren't working for you the way they usually do. Let's try (mention a high interest or creative activity that would be productive and enjoyable) instead.
- **Instead of "I know you did that on purpose and I will make sure you are punished"**
  "I'm concerned about what I just saw because (eg, it was dangerous). This would be a good time to use your behavior management plan."
- **Instead of "Why are you acting like that? You're acting crazy."**
  "It looks like you need to calm down. Would you like to go to your 'safe place'? Or would you like to draw or read here in the classroom?"
- **Instead of "Why did you just do that? You know better than that!"**
  "Shoes are not for throwing" or "Scissors are not for cutting your book."

Predictable Problems & Promising Possibilities—

- Building Therapeutic Teams
- ***Working with Families***
- The 3 Ss: Spouse, Self & Sibling Issues

Psychotherapy: Types & Goals

- Individual
  - Increase self-awareness
  - *Improve coping/symptom management*
- Family
  - Improve communication & problem solving
  - Identify & resolve family conflict
  - *Improve coping/symptom management*
- Group
  - Improve social skills
  - *Improve coping/symptom management*

Empirically Supported Psychosocial Adjunctive Treatments for Childhood Bipolar Disorder

- Fristad, Goldberg-Arnold & Gavazzi, 1999
  Bipolar Disorders
  -None
- Past 5 years
  - Pavuluri et al, youth aged 5-18
  - Miklowitz et al, adolescents, 13-18
  - Fristad et al, children aged 8-12
  - All have psychoeducation in common

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

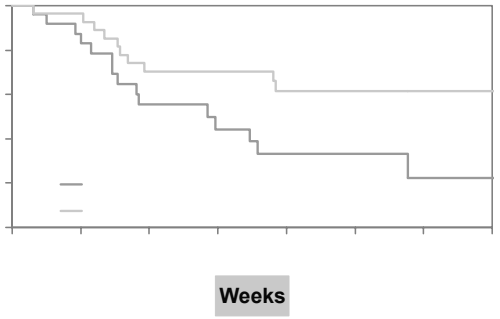
Psychoeducation: Adults w/ BPD

Miklowitz et al, Arch Gen Psychiat 2003

- Colorado study, *N*=101
  - Delays relapse: 74 vs 53 weeks
  - Reduces mood symptoms: gain begins at 6 mos, continue through 24 mos

Adults—BPD *Rea et al, JCCP, 2003*

- UCLA study, *N*=53: delays rehospitalization



Adolescents w/ BPD

Miklowitz et al, J Aff Disorders, 2004

- *N*=20, open trial
- Improved mood and behavior following treatment—ratings every 3 mos (0-12)
  - K-SADS Depression, 2.1→1.7
  - K-SADS Mania, 2.4→1.8
  - CBCL Behavior Problems, 86 →46
- Randomized trial planned

Children & Adolescents w/ BPD *Pavuluri et al, 2004, JAACAP*

- *N*=34, aged 5 to 18, nonrandomized trial
- Children on medication and in RAINBOW program had decreased scale scores for:
  - mania
  - depression
  - aggression

ODMH Study

Fristad, Goldberg-Arnold & Gavazzi, JMFT, 2003

- 35 children and their parents
  - 54% depressive; 46% bipolar disorders
  - M=3.6 comorbid diagnoses/child (range, 1-7)
  - C-GAS=51 at baseline
  - 29/35 (83%) on meds
  - 8-11 years old (average, 10.1 yrs)
  - 77% boys
- 6 month wait-list design
- 6 sessions, 75 minutes/session, manual-driven treatment

ODMH Findings

Fristad, Goldberg-Arnold & Gavazzi, JMFT, 2003

- Parents
  - *Increased* knowledge of mood disorders
  - *Increased* positive family interactions
  - *Increased* efficacy in seeking treatment
  - *Improved* coping skills
  - *Increased* social support
  - *Improved* attitude toward child/treatment
- Children
  - *Increased* social support from parents
  - *Increased* social support from peers (trend)

The OSU Psychoeducation 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
  - groups of families (MFPG)
  - single families (IFP)
  - workshops

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.*

MFPG Session Format

- Children aged 8-11 (any mood disorder)
- 8 sessions, 90 minutes each
  - Begin/end with parents/children together
  - Middle (largest) portion-separate groups
    - Children receive *in vivo* social skills training (in gym) after formal "lesson" is completed
  - Therapists: 1-parents; 2-children
  - Families receive projects to do between sessions

8 Session Outline--Parents

1. Welcome, symptoms & disorders
2. Medications
3. "Systems": school/treatment team
4. Negative family cycle, WRAP UP 1st ½
5. Problem solving
6. Communication
7. Symptom management
8. WRAP UP 2nd ½ of program & graduate

8 Session Outline--Children

1. Welcome, symptoms & disorders
2. Medications
3. "Tool kit" to manage emotions
4. Connection between thoughts, feelings and actions (responsibility/choices)
5. Problem solving
6. Nonverbal communication
7. Verbal communication
8. Review & GRADUATE!

Our Mottos

- The CAUSE of mood disorders is fundamentally *biological*, their COURSE can be greatly affected by *psychosocial events*
- We don't get to pick the genes we get or the genes we pass on
- "It's not your fault but it's your challenge"

Many Contributors…

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  - Kitty W. Soldano, PhD, LISW
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  - 693 Students
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  - Rita Kahng, MA
  - Becky Hazen, PhD
  - Kari Jibotian, MA
  - Lauren Ayr, MA
- ***165 Families***

*Consensus Conference Reviewer

NIMH Study Design, N=165

Group[a]	Time 1 Month 0	Time 2 Month 6	Time 3 Month 12	Time 4 Month 18
MFPG + TAU[b]	Baseline: Pre-treatment	Follow-up	Follow-up	Follow-up
WLC + TAU[c]	Baseline	Follow-up	Pre-treatment	Follow-up

[a]Families were enrolled in 11 sets of 15 (7-MFPG/8-WLC) = 165 families

[b]Multifamily Psychoeducation Group + Treatment As Usual

[c]Wait-List Control + Treatment As Usual

Study Sample - Family Characteristics

Variable	MFPG	
	MFPG+TAU (*n*=78)	WLC+TAU (*n*=87)
Family Structure		
Married bio par	46%	40%
Step-family	17%	23%
Married adop par	5%	7%
Single bio par	21%	17%
Single adop par	1%	1%
Other	10%	12%
Income	<20K to >100K M=40-59K	<20K to >100K M=40-59K

Demographics: MFPG Total Sample & BPD Sub-Sample

Variable	TOTAL *N*=165	BPD *N*=115
Comorbid D/O		
Anxiety	67%	70%
Behavior	97%	95%
ADHD	87%	80%
Two-parent families (includes step-families)	74%	65%
Average round trip	56 mi (range: 2-344)	70 mi (range: 14-344)

Demographics—Various Samples

Variable	All N=165	BPD n=115	Treated BPD n=89
Age	9.9	9.8	9.7
% Male	73	72	69
% White	91	91	94
% Fam Hx-Mania	50	53	55
% Fam Hx-Depression	76	73	72
% Fam Hx-Either	84	84	83

Outcome Measures

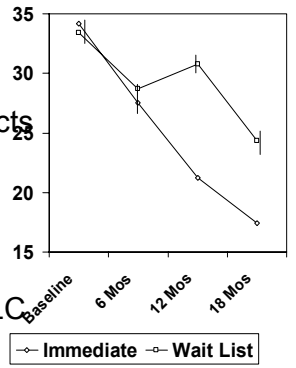
- MSI=Mood Severity Index
  - CDRS-R + MRS (equal contributions)
  - <10: minimal symptoms
  - 11-20: mild symptoms
  - 21-35: moderate symptoms
  - >35: severe symptoms

Outcome Measures

- Rage Index
  - MRS irritability + disruptive-aggressive items
  - <3: minimal symptoms
  - 4-8: mild symptoms
  - 9-12: moderate symptoms
  - 13-16: severe symptoms

Mood Severity Index (Parent, Current) MFPG BPD Sample

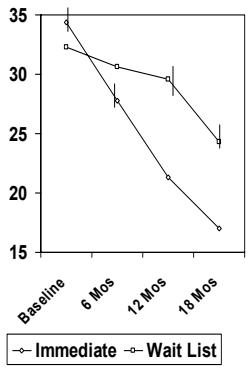
- N=115, all BPD
  - n=55 Immediate
  - n=60 Wait List
- Linear Mixed Effects Modeling
  - X^2=6.19, p<.02
  - Slope difference= -3.88/6 mos
- Pre-post Imm=WLC



Dr. Fristad--R01 MH61512

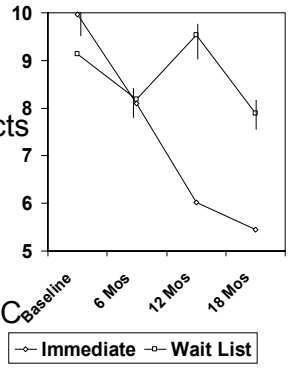
Mood Severity Index (Parent, Current) MFPG Treated BPD Sample

- N=89
  - n=54 Immediate
  - n=35 Wait List
- Linear Mixed Effects Modeling
  - X^2=5.91, p<.02
  - Slope difference= -3.98/6 mos
- Pre-Post Imm=WLC



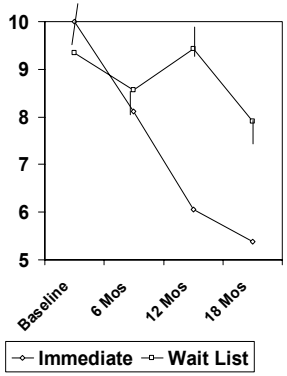
Rage Index (Parent, Current) MFPG BPD Sample

- N=115
  - n=55 Immediate
  - n=60 Wait List
- Linear Mixed Effects Modeling
  - X^2=13.21, p<.002
  - Slope difference= -1.95/6 mos
- Pre-post Imm=WLC



Rage Index (Parent, Current) MFPG Treated BPD Sample

- N=89
  - n=54 Immediate
  - n=35 Wait List
- Linear Mixed Effects Modeling
  - X^2=10.71, p<.0015
  - Slope difference= -1.50/6 mos
- Pre-post Imm=WLC



Anecdotal Evaluations--Parents

- *No matter how bad the situation is…there is hope and treatment. Don't give up. This program was an eye opener for me. I also was encouraged and relieved to find out that I was not alone.*
- *Listen to what they are saying. They can really help you. Learn what is going on with your child. Stay focused on what is going with your child and do not give up on your child.*

Anecdotal Evaluations--Children

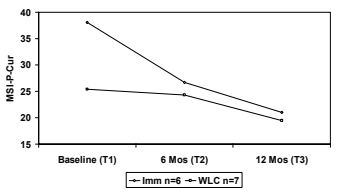
- *You get to meet new people you never knew before. They help you with your symptoms.*
- *They're nice and they're helpful. And you guys support us and give us snacks. You've been nice to us and treated us with respect.*
- *It really helps out if you let it.*

Individual-Family Psychoeducation (IFP) *OH Dept Mental Health, 2002-2004*

- N=20
- 16 sessions
  - Alternate child and parent with parent
  - Same content + Healthy Habits
    - diet, exercise, sleep
- Comparable design to MFPG

IFP Primary Outcome: MSI-Parent-Cur—Power Analyses

Variable	N per Condition	Effect Size
MSI-Parent-CUR T1-T2	64	.45
MSI-Parent-CUR T1-T3	36	.60



IFP: Parent Evaluations

- Anonymous evaluations completed after treatment
- Parents report (1-5 rating, overall 1.6)
  - ↑ knowledge re: symptoms, medication, accessing treatment
  - ↑ skills re: working with schools and treatment team, managing symptoms at home
  - Feeling supported/not blamed

IFP: Children's Evaluations

- 1-5 Rating Scale
  - Overall rating, 1.7
  - Item Range: 1.3 (therapist) to 2.2 (learned about medications)
- ↑ knowledge re: mood symptoms, medication
- ↑ ability to get along with family, friends and at school
- ↑ skill re: symptom management
- ↑ support/ ↓ isolated, "not the only one"
- parents' behavior toward them better

Predictable Problems & Promising Possibilities—

- Building Therapeutic Teams
- Working with Families
- ***The 3 Ss: Spouse, Self & Sibling Issues***

Causes of Caregiver Stress

Hellander, Sisson, Fristad, in Geller & DelBello, 2003

- Care of a high needs child
- Need to advocate in schools
- Worry about the future
- Exhaustion
- Physical illnesses
- Financial strain
- Isolation
- Stigma
- Guilt and blame

Impact of EOBPD on Family Functioning

- "…we were a functioning family until you turn in the mix and add Jason into our family; we become dysfunctional…"
- "…logic and education helps us to a point [parents are both college grads], but then again we are human beings and it is just really tough living with Jason. It affects our whole relationship. It affects our marriage…"
  Mother of a 11 year old boy with BPD-NOS

Relationships In and Out of the Family Suffer

- "I also find it very difficult to facilitate relationships within our household between the siblings and…neighbors or his teacher or other people. I feel like I'm always having to facilitate when his moods are switching very rapidly or he's highly anxious."
  Mother of an 11 yr old boy w/ BPD-Mixed

Siblings Suffer

- "My husband and I sometimes will argue over what to do with Maria, and the older child believes that she's not getting enough attention because Maria's sucking all of it up"
  Mother, 11 yr old girl w/ BPD-NOS

Workshop Overview: Learner Objectives

- Identify how symptoms of depression and mania appear in youth
- Be aware of differential diagnoses and common comorbidites
- Learn about currently available biological interventions and their role in treatment
- Develop a conceptual basis for comprehensive care in the context of the child's family and school system
- ***Learn specific therapeutic techniques***
- Identify resources that will assist families cope

Clinical Caveats

- Many core mood symptoms (eg, euphoric mood, pressured speech, delusional thinking) *do not* respond to behavioral management in a conventional manner
- Symptoms will wax and wane, so plans must be ***flexible***
- Comorbidities often *do* respond to behavioral management (eg, ADHD symptoms)
- This disorder humbles each & every person affected by it!
- We all need to stay on the same team, or we'll be defeated!

The Can’ts, Won’ts, and Combos

- **Learn what your child CAN’T do**
  (versus what he WON’T do)
- **This is not easy!**
- **Learn your child’s signs**

Cant’s	**Won’ts**
“That look in his eyes”	A naughty twinkle
“She’s gone”	He gets a nasty smile on his face

How Can Mood Disorders "Mess Up" Family Life?

- Results in problems getting along
  - reassurance doesn't help!
  - overly sensitive, preoccupied with self
  - negative behavior appears to be "on purpose"
  - expectations aren't met
  - need to be in control
  - fail with regular responsibilities
  - feel like the family needs to "walk on eggshells"

More Problems Caused by Mood Disorders...

- Unpredictable behavior
- Dangerous/violent outbursts
- Agitation
- Lack of "reasonability"
- Apparent lack of caring for others

Negative Family Cycles...

- Family tries to help by coaxing, reassuring, protecting
- Child doesn't respond + to this
- Family either tries even harder or withdraws
  - parents often attempt different solutions, then start quarreling with each other
- Child feels more alienated & family feels rejected, family either withdraws or gets angry or does BOTH

Negative Family Cycles (Cont'd)

- Family feels guilty, goes back to coaxing, etc.
- Child feels unworthy, hopeless, infantilized
- Family burns out over time but still feels guilty/angry
- End result: alienation &/or overprotection

How to Break the Negative Family Cycle

- First, "hold" and acknowledge the child's feelings
  - No one asks for lousy emotions
  - Empathy without blame is a salve
- Next, shift to communication and problem solving strategies to manage symptoms

Positive Parenting: The Exponential Rule

- **Be flexible and empathic**
  - Do a "mood check"
  - If too high or too low, let it go
- **Keep structured**
  - Schedule
  - Environment
- **Be prepared**
  - Listen when your child is ready to talk
- **Praise success**
  - Use the child's baseline
  - Be specific—helps to build skills
- **Speak with positives**
  - Replaces "don'ts" with "do's" (eg, "Don't hit your brother!" becomes "Please keep your hands and feet to yourself.")
- **Reduce stressors**
  - Maintaining a buffer of time and energy helps when disaster strikes

Managing Suicidal/Crisis Behavior

- Suicide threats & attempts
  - take suicidal talk /gestures seriously
  - remove available methods
- Hospitalization
  - use when child is at risk to self/others
  - is usually brief
  - should NOT be used for PUNISHMENT or RESPITE

Managing Mania

- Early stages:
  - recognize the need for treatment
  - don't get carried away with a "high" mood
  - avoid highly stimulating situations
  - take away dangerous items (knives, other items)
- Later stages:
  - don't argue
- After the episode:
  - don't remind your child of manic behavior UNLESS he or she doesn't admit there is a problem
  - go back to "business as usual!"

Safety Plan

- Create a safety plan
  - locks on doors
  - emergency phone numbers
  - therapeutic hold
  - know when/how to contact police
  - medication side effect information
  - emergency room

Workshop Overview: Learner Objectives

- Identify how symptoms of depression and mania appear in youth
- Be aware of differential diagnoses and common comorbidites
- Learn about currently available biological interventions and their role in treatment
- Develop a conceptual basis for comprehensive care in the context of the child's family and school system
- Learn specific therapeutic techniques
- ***Identify resources that will assist families cope***

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*
- Everything You Need to Know about Bipolar Disorder & Manic Depressive Illness -- *M. A. Summers*

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 Ups and Downs of Raising a Bipolar Child --*J. Lederman & C. Fink*
- If Your Child is Bipolar – The Parent-to-Parent Guide to Living with and Loving a Bipolar Child -- *C. Singer & S. Gurrentz*
- A Parent's Survival Guide to Childhood Depression -- *S. Dubuque*
- The Bipolar Child --*D. & J. Papalos*

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 for the Mentally Ill (NAMI)
  - 1-800-950-6264 www.nami.org
- National Mental Health Association (NMHA)
  - 1-703-684-7722 www.nmha.org
- Depressive & Bipolar Support Alliance (DBSA) 800-826-3632 www.dbsalliance.org
- Child & Adolescent Bipolar Foundation (CABF) www.bpkids.org
- Juvenile Bipolar Research Foundation (JBRF) www.bpchildresearch.org
- BP Children www.bpchildren.com
- Parenting Bipolars: A Survival Guide for Parents www.parentingbipolars.com

Additional Resources

- **Light Therapy:**
  - Circadian Solutions
    - 1-800-545-9667 www.circadiansolutions.com
- **Nutritional Intervention:**
  - EMpower Plus
    - 1-888-878-3467 www.truehope.com
  - Eat Wild – Provides nutritional information about food sources
    - www.eatwild.com
  - Omega-Brite
    - 1-800 383 2030 www.omegabrite.com

Thank You, The End

- Fristad.1@osu.edu
- Clinic #: 614-293-9600
- 1670 Upham Drive Suite 460G Columbus, OH 43210-1250

SECOND DAY HANDOUTS

Childhood Bipolar Disorder
Diagnosis and Treatment

Presented By

Mary A. Fristad, Ph.D., ABPP

AGENDA

Morning

7:30 a.m. Registration (continental breakfast buffet)

8:30 Therapeutic Exercises with Children

- Naming the Enemy
- Building a Tool Kit
- Thinking-Feeling-Doing

9:50 Break (coffee and tea)

10:05 **Exercises with Children (Continued)**

- Problem Solving
- Paying Attention to Feelings
- Let's Talk

11:30 Lunch (on your own)

Afternoon

12:45 **Therapeutic Exercises with Parents**

- Fix-It List
- Mood Logs

2:00 Break (coffee, tea, soda, snack)

2:15 **Exercises with Parents (Continued)**

- Treatment Teams, Managing Symptoms
- Out with the Old - In with the New

3:45 Adjournment (pick up certificates)

Dr. Mary A. Fristad
Fristad.1@osu.edu
Clinic: 614-293-9600
1670 Upham Dr. Ste 460G
Columbus, OH 43210-1250

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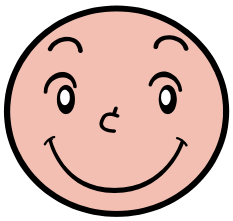
Children’s Therapeutic Exercises

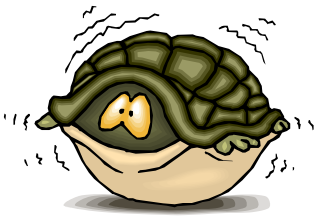
Feelings



Happy

Sad

Angry



Scared

Calm/
Relaxed

Bored

Proud

Stressed

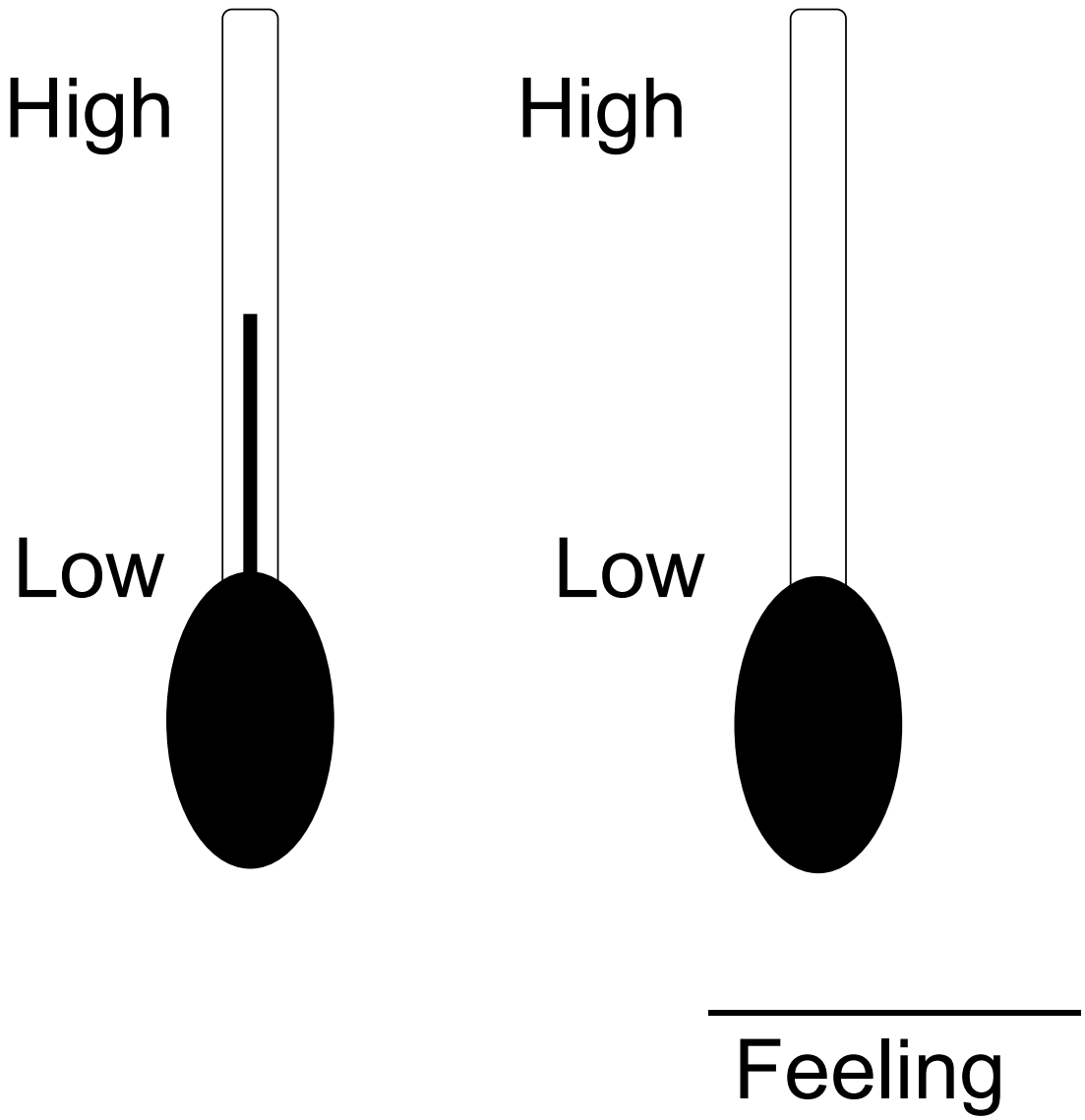
Jealous

Excited

Tired

Stubborn

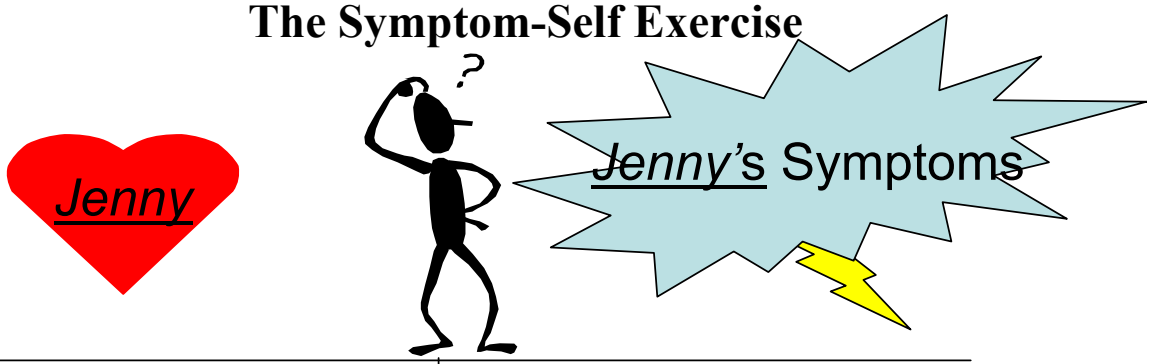
Strength of Feelings



Name _____

"Naming the Enemy"

The Symptom-Self Exercise

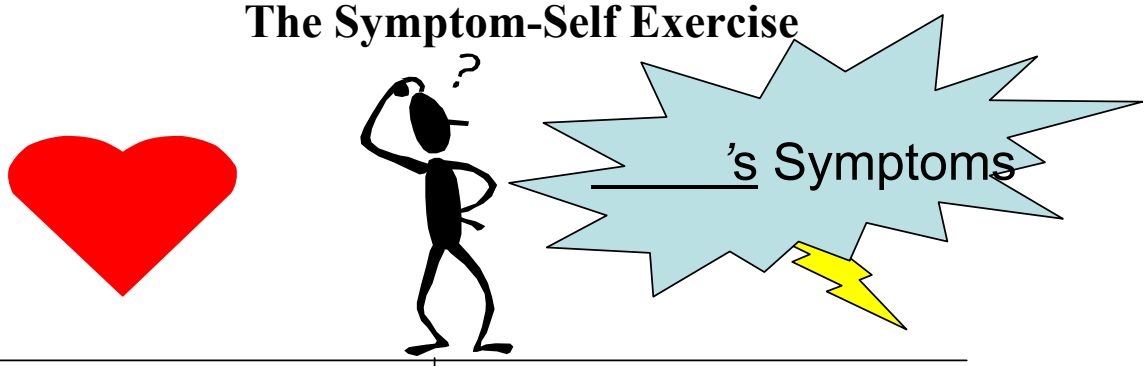


Caring	<u>Depression</u>
Good helper	Low energy
Good swimmer	Irritable, disrespectful
Very loving	Cries
Good student	Hate myself
Likes computers	<u>Mania</u>
Good at basketball	Talks too fast
Smart	Sleeps much less
Shares well with siblings and friends	Aggressive
	Acts wild, silly and inappropriately
	<u>Other</u>
	Hears voices

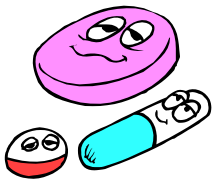
Name _____

"Naming the Enemy"

The Symptom-Self Exercise



My Medicine



	Name	How much/when	Reason
1			
2			
3			
4			
5			

Name _____

Taking Charge of the Mad, Bad, Sad Feelings

My Tool Kit

Creative

Coloring.

Drawing pictures

Social

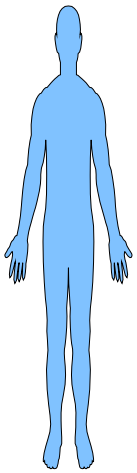
Going outside to play with friends. Talk to mom

Physical

Playing soccer. Do jumping jacks

R&R

Read a book in my room
Take a shower

I felt mad/sad/bad when. . . (triggers)	**My body felt…** (Signals)	**How I remembered to use my tool kit…**	**From my tool kit I used…**
When my sister took my toy without asking		Parent reminded me by.. Telling me to think of my tool kit or I remembered by…Putting it on my bedroom door	I did 10 jumping jacks to calm myself down

Name _____

Taking Charge of the Mad, Bad, Sad Feelings

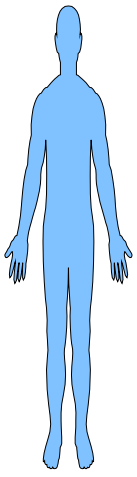
My Tool Kit

Creative

Social

Physical

R&R

I felt mad/sad/bad when. . . (triggers)	**My body felt…** (Signals)	**How I remembered to use my tool kit…**	**From my tool kit I used…**
		Parent reminded me by.. or I remembered by…	

Name _____

Thinking, Feeling, Doing

(+) *Helpful*

(-) *Hurtful*

THINKING

(+) "Even when I have a hard day things always get better", "Sometimes things do go my way", "I know that my parents love me"

(-) "I hate my life", "Nothing ever goes the way I want", "This isn't fair", "I'm a loser", "No one cares"

FEELING

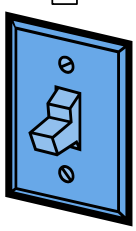
(+) Happy, Relaxed

(-) Sad, Angry

DOING

(+) Talk to someone about how I'm feeling, ride my bike, listen to music, take deep breaths

(-) Yell at my parents, kick my dog, throw things, stay by myself



SOMETHING HAPPENS!

The kids at school teased me!

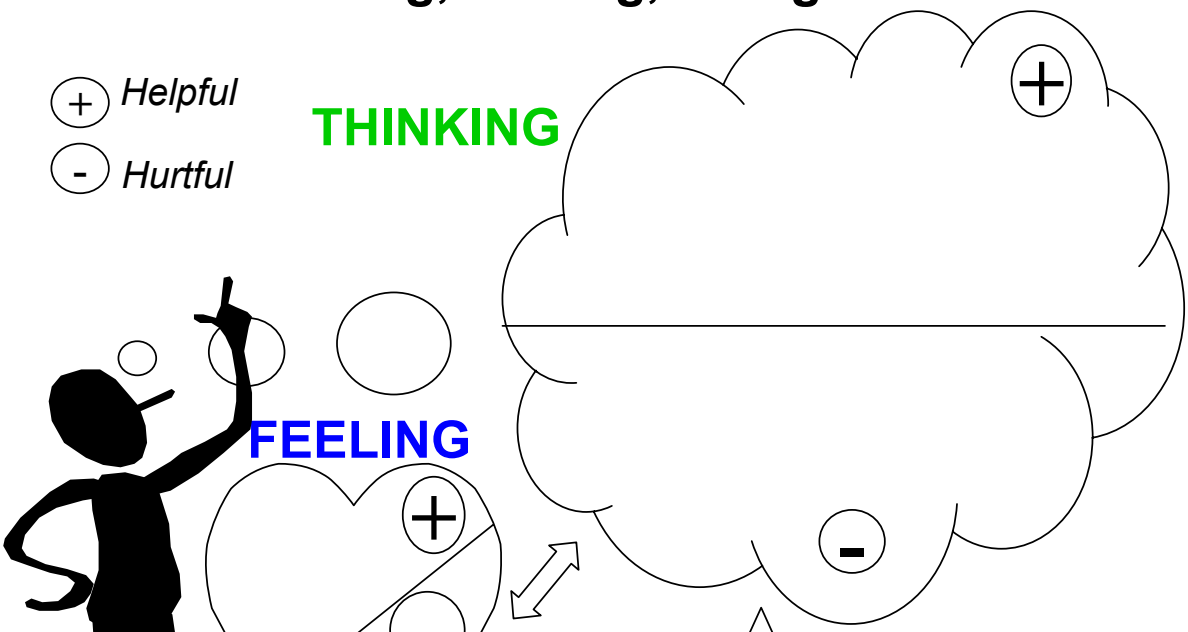
Name _____

Thinking, Feeling, Doing

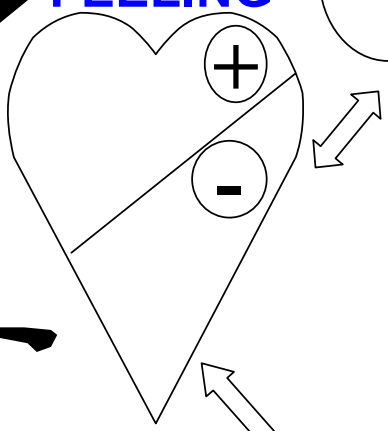
⊕ *Helpful*

⊖ *Hurtful*

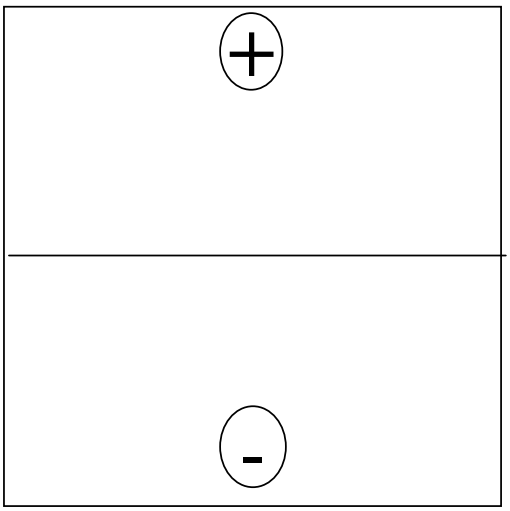
THINKING

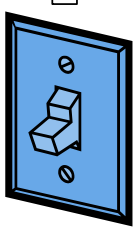


FEELING

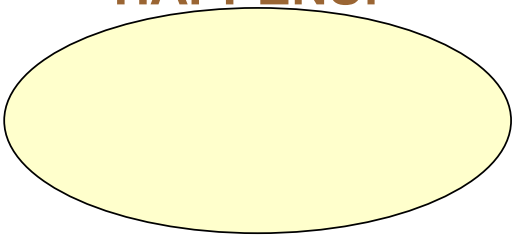


DOING



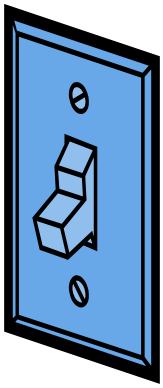


SOMETHING HAPPENS!



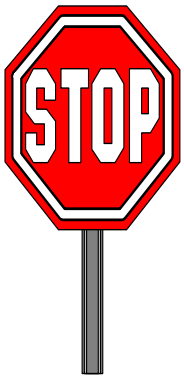
Name:_____

Problem Solving



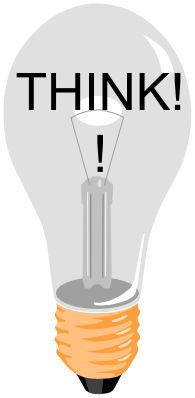
This is what happened:

I got angry ‘cause I don’t understand my homework!



I used this tool to calm down:

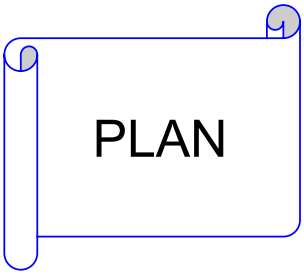
I took deep breaths



What can I do to solve

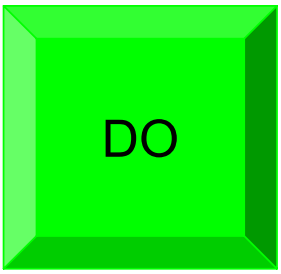
my problem?

1. Never do my homework!
2. Ask my mom for help
3. Ask the teacher for help
4. Copy friend’s homework



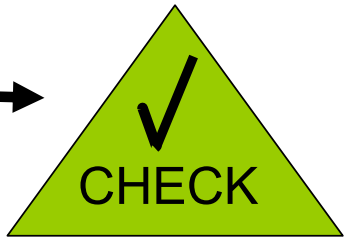
Which solution seems the best?

3



Do

3

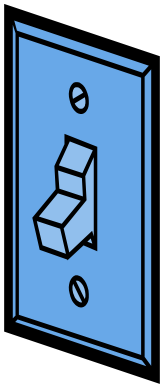


Did it work? Yes

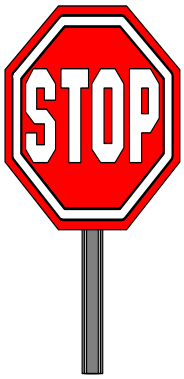
Next time I will Ask the teacher more often

Name:_____

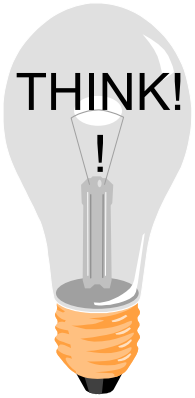
Problem Solving



This is what happened:

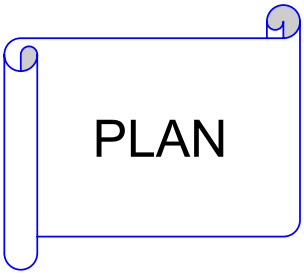


I used this tool to calm down:

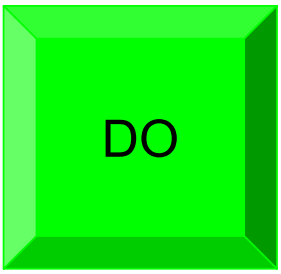


What can I do to solve

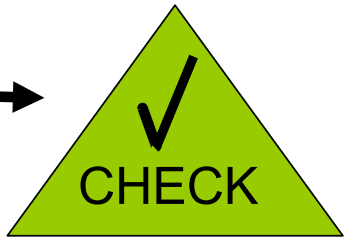
my problem?



Which solution seems the best?



Do



Did it work?

Next time I will

Communication

What is communication? _____

Why is it important? _____

Two Types of Communication:

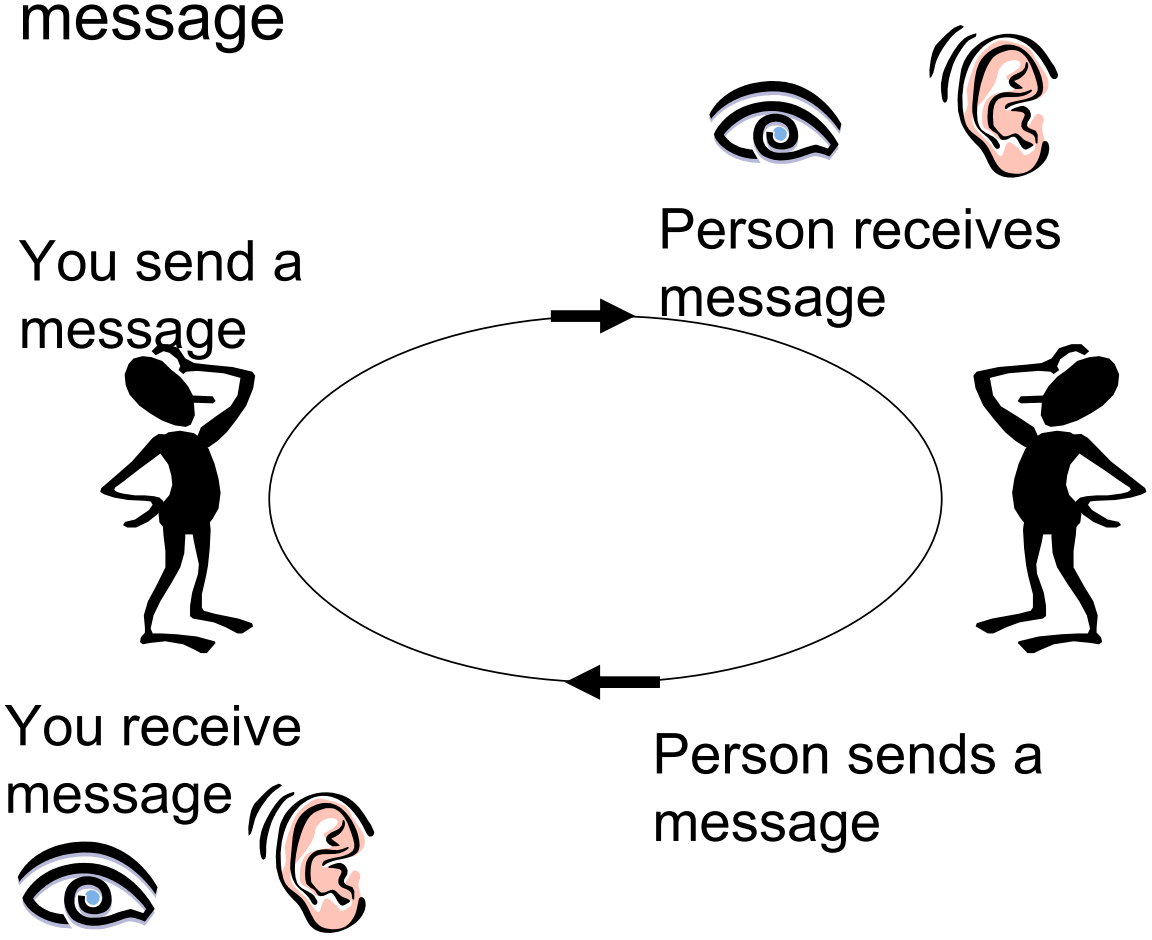
Nonverbal which includes

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

Verbal which includes _____

The Communication Cycle (Verbal and Nonverbal)

Verbal and nonverbal communication involves both sending and getting a message



Nonverbal Communication (Without Words)

Look  and listen  to your own and others' nonverbal clues

1. Facial Expression – happy, sad, scared, angry

2. Body Gestures – hands, shoulders, head nods

3. Body Posture – relaxed, stressed, angry, bored, attentive, tired

4. Tone of Voice – happy, sad, angry, excited, bored

5. Personal Space – too close, too far or arm's distance

Name _____

Paying Attention to Feelings

Feeling	Child Practices-- Can Adult Guess? ☺= yes ? = not sure	Adult Practices-- Can Child Guess? ☺= yes ? = not sure
Sad	☺	☺
Scared	?	?
Angry	?	☺
Confused	☺	☺
Stressed	☺	☺
Bored	☺	?
Focused	?	☺
Other: _____		

Name _____

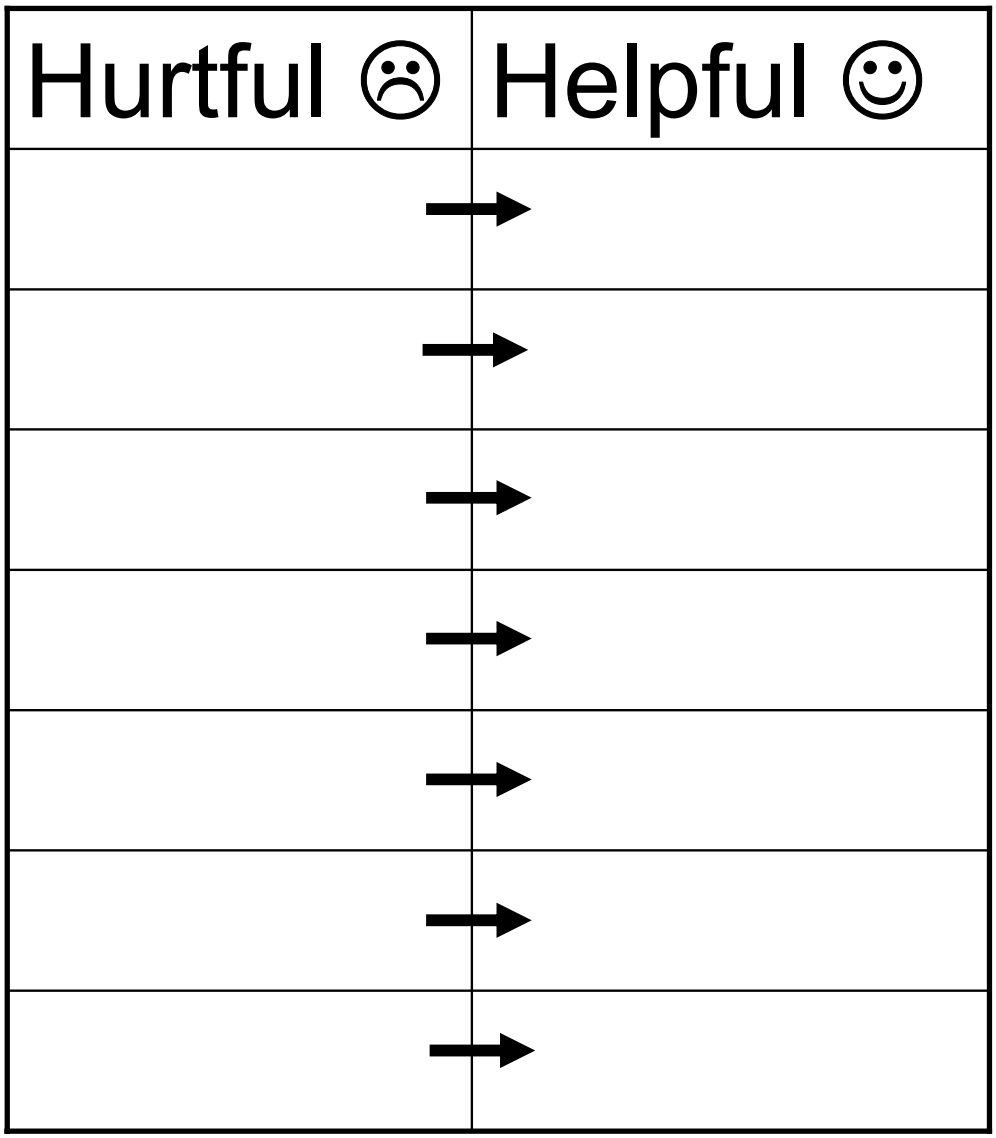
Paying Attention to Feelings

Feeling	Child Practices-- Can Adult Guess? ☺= yes ? = not sure	Adult Practices-- Can Child Guess? ☺= yes ? = not sure
Sad		
Scared		
Angry		
Confused		
Stressed		
Bored		
Focused		
Other: _____		

Verbal Communication

Hurtful ☹	Helpful ☺
You're stupid! →	Don't call me names!
I hate you! →	Please don't yell at me.
My teacher sucks! →	Math is really hard. Can you help me with it?
I just want to die! →	I am so frustrated!!!
→	
→	
→	

Verbal Communication



Name _____

Let's Talk!"

Kids did this

1. Look at me when I'm talking.
2. Don't interrupt me.
3. Don't raise your voice.

We could all communicate better if…

Adults did this

1. Not yell at me.
2. Let me talk too.
3. Not use mean words

Name _____

Let's Talk!

Kids did this

1.

2.

3.

We could all communicate better if…

Adults did this

1.

2.

3.

Parents' Therapeutic Exercises

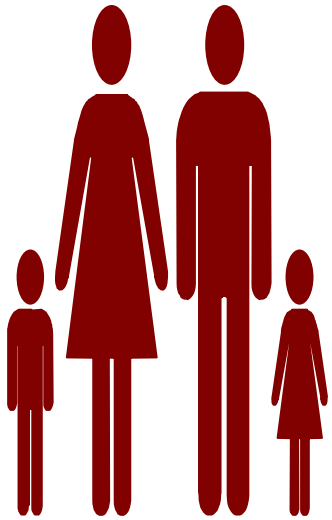
Goals of Family Psychoeducation

Education + Support + Skill Building➔

Better Understanding ➔

Better Treatment + Less Family Conflict ➔

Better Outcome



Bipolar Disorder (BPD) in Children: Quick Fact Sheet

- BPD in children differs in several key ways from bipolar disorder with adult onset
  - Children often have "mixed" depressed and manic symptoms rather than separate cycles of depression and mania
  - Children often have had problems from birth or early childhood

- How do you know if behaviors are "manic" or something else? (Manic symptoms can look like symptoms of ADHD, behavioral disorders, or post-traumatic stress disorder)
  - Associated symptoms (eg, racing thoughts, rapid speech, grandiosity, distractibility, increased energy, foolish/reckless behavior) MUST *co-occur* with altered mood state
  - Symptoms wax and wane, *often unrelated* to environmental triggers
  - Symptoms must reflect a significant *change* from baseline difficulties (eg, a child who has always had trouble concentrating would need to show a notable increase in this behavior co-occurring with mood fluctuations for it to be considered a manic symptom)
  - Symptoms must cause *significant impairment* in the child's life
  - Symptoms are not *developmentally appropriate*
    - eg, young children may try to "fly" three steps from the bottom of the landing in "typical" play, but they do not try to jump from a second story window to fly, hypersexual behavior might include inappropriate touching or kissing of adults, writing "dirty" notes to other children)
  - Having psychotic symptoms (eg, hearing voices) does not mean the child has schizophrenia – often these symptoms go away when the mood is stabilized

- Treatment
  - Misdiagnosis can lead to harmful treatment (ie, an unrecognized bipolar disorder can get worse if a child is prescribed a stimulant or an antidepressant without a mood stabilizer)
  - Medications
    - Mood stabilizers (eg, Lithium, Depakote, Tegretol)
    - Antipsychotics (eg, Zyprexa, Risperdal, Seroquel, Abilify)
    - Antidepressants (eg, Zoloft, Prozac) – after mood stabilizes to reduce depressive symptoms
    - Psychostimulants (eg, Adderall, Ritalin) – after mood stabilizes to treat ADHD symptoms
  - Nutritional interventions (eg, omega-3 fatty acids, vitamin-mineral complexes) – current research will inform us how useful these are
  - Therapy
    - Many issues may require intervention (family, peer, school functioning)
    - Intervention might include some combination of family therapy, individual therapy, parent guidance, group therapy, school-based intervention, home-based treatment, respite, out-of-home placement, web-based support
    - Research has shown that psychoeducational therapy is beneficial

Name _____

Family Fix It List

Child's "Fix It" List

1. I'll play fairly with my brother
2. If my brother is mean, I will quit playing with him
3. I'll invite someone to play with me

Parent's "Fix It" List

1. *I will stop yelling.*
2. *I will take 15 minutes/day for myself (e.g. walk around the neighborhood).*
3. *I will not get angry at my husband for "ignoring" me when he gets home from work and I want to fill him in on Jeffrey's day.*

Family's "Fix It" List

1. The kids will play fairly with each other or play alone.

2. We will all use "inside voices" and not yell.

3. All family members will get some "my" time (eg, Mom gets a 30 minute walk after dinner, Dad gets to unwind for 30 minutes when he comes home from work uninterrupted, Jeffrey gets 30 minutes after school for Play Station, Jessica gets 30 minutes on the computer after dinner) that everyone else in the family will honor.

Name _____

Family Fix It List

Child's "Fix It" List

1.

2.

3.

Parent's "Fix It" List

1.

2.

3.

Family's "Fix It" List

1.

2.

3.

Name _____

Understanding My Child's Medication

Medication & Dose	**Target Symptom**	**Side Effects**	**How to Manage Side Effects**	**Important Things to Remember**
1. Depakote 500mg	*Rage, mood swings*	*Eats too much*	*Provide healthy snacks. Increase exercise*	*Avoid aspirin.* *Blood tests (levels, liver)*
2. Concerta, 36 mg	*Inattention*	*Stomach ache*	*Give with food*	*Do not give near bedtime*
3.				
4.				
5.				
6.				

Name _____

Understanding My Child's Medication

Medication & Dose	Target Symptom	Side Effects	How to Manage Side Effects	Important Things to Remember
1.				
2.				
3.				
4.				
5.				
6.				

Mood-Medication-Coping Log

Child's Name *John Doe* Treatment Provider/Program: *Dr. Nice*

Medications (Type, Dose, Side Effects): *Depakote =625 mg, Prozac =10mg*

Month: *September*

Date	Overall rating (1=Great, 3=So-So, 5=Terrible)	Meds Taken? Yes No	Used Strategies (1=100%, 3=50%, 5=0%)	Comments (e.g., Life Event, Med Changes, Med Side Effects, Sleep/Appetite Changes, Other)
1	1 2 3 4 **5**	**Yes** No	1 2 3 4 **5**	Appetite loss, decrease in sleep, dry mouth, doesn't like meds, started school, coping-- yelled, "it's not my fault!" over and over
2	1 2 3 4 **5**	**Yes** No	1 2 3 4 **5**	
3	1 2 3 4 **5**	**Yes** No	1 2 3 4 **5**	
4	1 2 3 **4** 5	**Yes** No	1 2 3 4 **5**	
5	1 2 **3** 4 5	**Yes** No	1 2 3 4 **5**	
6	1 2 **3** 4 5	**Yes** No	1 2 3 4 **5**	
7	1 2 **3** 4 5	**Yes** No	1 2 3 4 **5**	
8	1 2 3 **4** 5	**Yes** No	1 2 3 4 **5**	Increase in tantrums at school and in the morning. John refused meds. Coping-- end of week he went to his room instead of tantrumming
9	1 2 3 4 **5**	**Yes** No	1 2 3 4 **5**	
10	1 2 3 4 **5**	Yes **No**	1 2 3 4 **5**	
11	1 2 3 4 **5**	Yes **No**	1 2 3 4 **5**	
12	1 2 3 4 **5**	Yes **No**	1 2 3 4 **5**	
13	1 2 3 **4** 5	**Yes** No	1 2 **3** 4 5	
14	1 2 3 **4** 5	**Yes** No	1 2 **3** 4 5	
15	1 2 3 **4** 5	**Yes** No	1 2 **3** 4 5	Increase in Depakote to 750 mg, decrease in tantrums. Sleeps better. Increase in depression and anxiety. Coping-- he's noticing his mood changes now
16	1 2 3 **4** 5	**Yes** No	1 2 3 **4** 5	
17	1 2 3 **4** 5	**Yes** No	1 2 **3** 4 5	
18	1 2 **3** 4 5	**Yes** No	1 2 3 **4** 5	
19	1 2 **3** 4 5	**Yes** No	1 **2** 3 4 5	
20	1 2 **3** 4 5	**Yes** No	1 2 **3** 4 5	
21	1 2 **3** 4 5	**Yes** No	1 2 3 **4** 5	
22	1 **2** 3 4 5	**Yes** No	1 2 **3** 4 5	Increase in Prozac to 20 mg, decrease in depression and anxiety. Coping-- better mornings and school days. Fewer tantrums. Solved a peer problem by himself.
23	1 **2** 3 4 5	**Yes** No	1 **2** 3 4 5	
24	1 **2** 3 4 5	**Yes** No	1 **2** 3 4 5	
25	1 2 **3** 4 5	**Yes** No	1 2 3 **4** 5	
26	1 **2** 3 4 5	**Yes** No	1 **2** 3 4 5	
27	1 2 **3** 4 5	**Yes** No	1 2 **3** 4 5	
28	1 2 **3** 4 5	**Yes** No	1 **2** 3 4 5	
29	1 **2** 3 4 5	**Yes** No	1 2 **3** 4 5	Made a new friend at school. Helped his brother to think positively
30	**1** 2 3 4 5	**Yes** No	1 2 **3** 4 5	
31	1 **2** 3 4 5	**Yes** No	1 **2** 3 4 5	

Mood-Medication-Coping Log

Child's Name _____ Treatment Provider/Program:_____

Medications (Type, Dose, Side Effects):_____

Month: _____

Date	Overall rating (1=Great, 3=So-So, 5=Terrible)	Meds Taken? Yes No	Used Strategies (1=100%, 3=50%, 5=0%)	Weekly Comments (e.g., Life Event, Med Change, Med Side Effects, Sleep/Appetite Changes, Other)
1	1 2 3 4 5	Yes No	1 2 3 4 5	
2	1 2 3 4 5	Yes No	1 2 3 4 5	
3	1 2 3 4 5	Yes No	1 2 3 4 5	
4	1 2 3 4 5	Yes No	1 2 3 4 5	
5	1 2 3 4 5	Yes No	1 2 3 4 5	
6	1 2 3 4 5	Yes No	1 2 3 4 5	
7	1 2 3 4 5	Yes No	1 2 3 4 5	
8	1 2 3 4 5	Yes No	1 2 3 4 5	
9	1 2 3 4 5	Yes No	1 2 3 4 5	
10	1 2 3 4 5	Yes No	1 2 3 4 5	
11	1 2 3 4 5	Yes No	1 2 3 4 5	
12	1 2 3 4 5	Yes No	1 2 3 4 5	
13	1 2 3 4 5	Yes No	1 2 3 4 5	
14	1 2 3 4 5	Yes No	1 2 3 4 5	
15	1 2 3 4 5	Yes No	1 2 3 4 5	
16	1 2 3 4 5	Yes No	1 2 3 4 5	
17	1 2 3 4 5	Yes No	1 2 3 4 5	
18	1 2 3 4 5	Yes No	1 2 3 4 5	
19	1 2 3 4 5	Yes No	1 2 3 4 5	
20	1 2 3 4 5	Yes No	1 2 3 4 5	
21	1 2 3 4 5	Yes No	1 2 3 4 5	
22	1 2 3 4 5	Yes No	1 2 3 4 5	
23	1 2 3 4 5	Yes No	1 2 3 4 5	
24	1 2 3 4 5	Yes No	1 2 3 4 5	
25	1 2 3 4 5	Yes No	1 2 3 4 5	
26	1 2 3 4 5	Yes No	1 2 3 4 5	
27	1 2 3 4 5	Yes No	1 2 3 4 5	
28	1 2 3 4 5	Yes No	1 2 3 4 5	
29	1 2 3 4 5	Yes No	1 2 3 4 5	
30	1 2 3 4 5	Yes No	1 2 3 4 5	
31	1 2 3 4 5	Yes No	1 2 3 4 5	

How is _____feeling today?

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

M…X……

T…..……X……..…

W……X……..…

Th...……X

F……X

S……X……

S…...……X……..…

How is _____feeling today?

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

M……

T……

W……

Th……

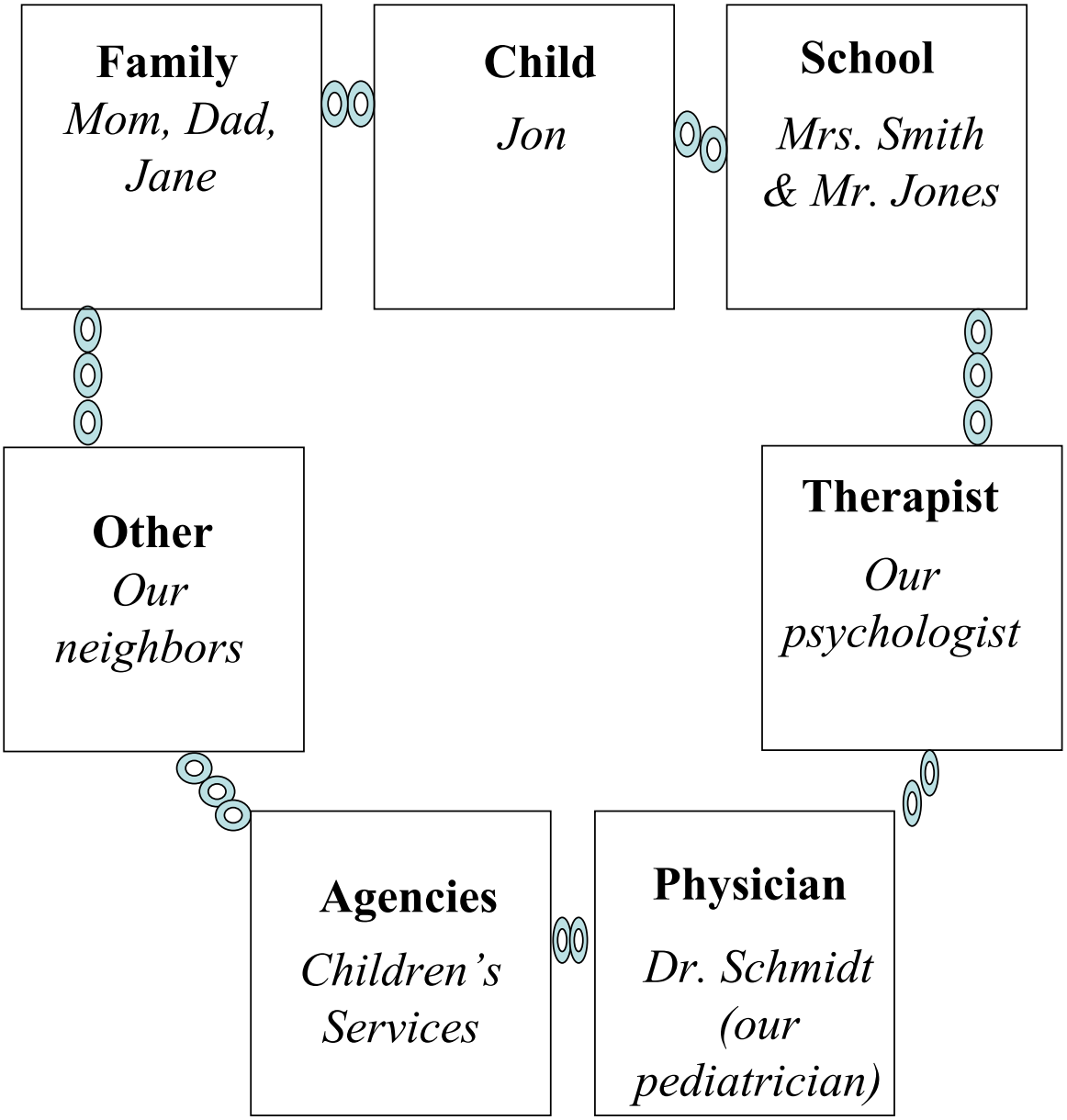
F……

S……

S……

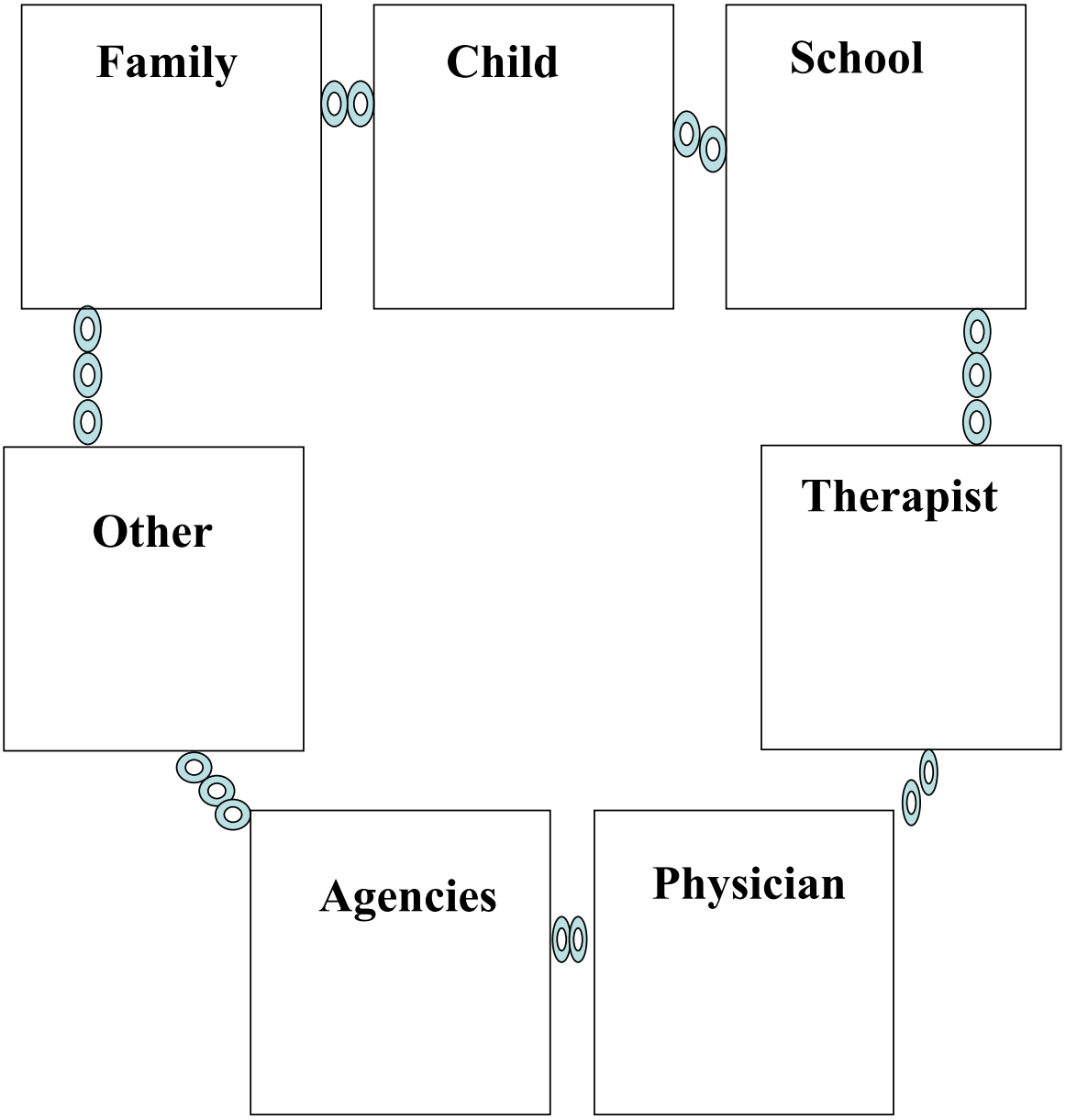
Name _____

My Child's Treatment Team



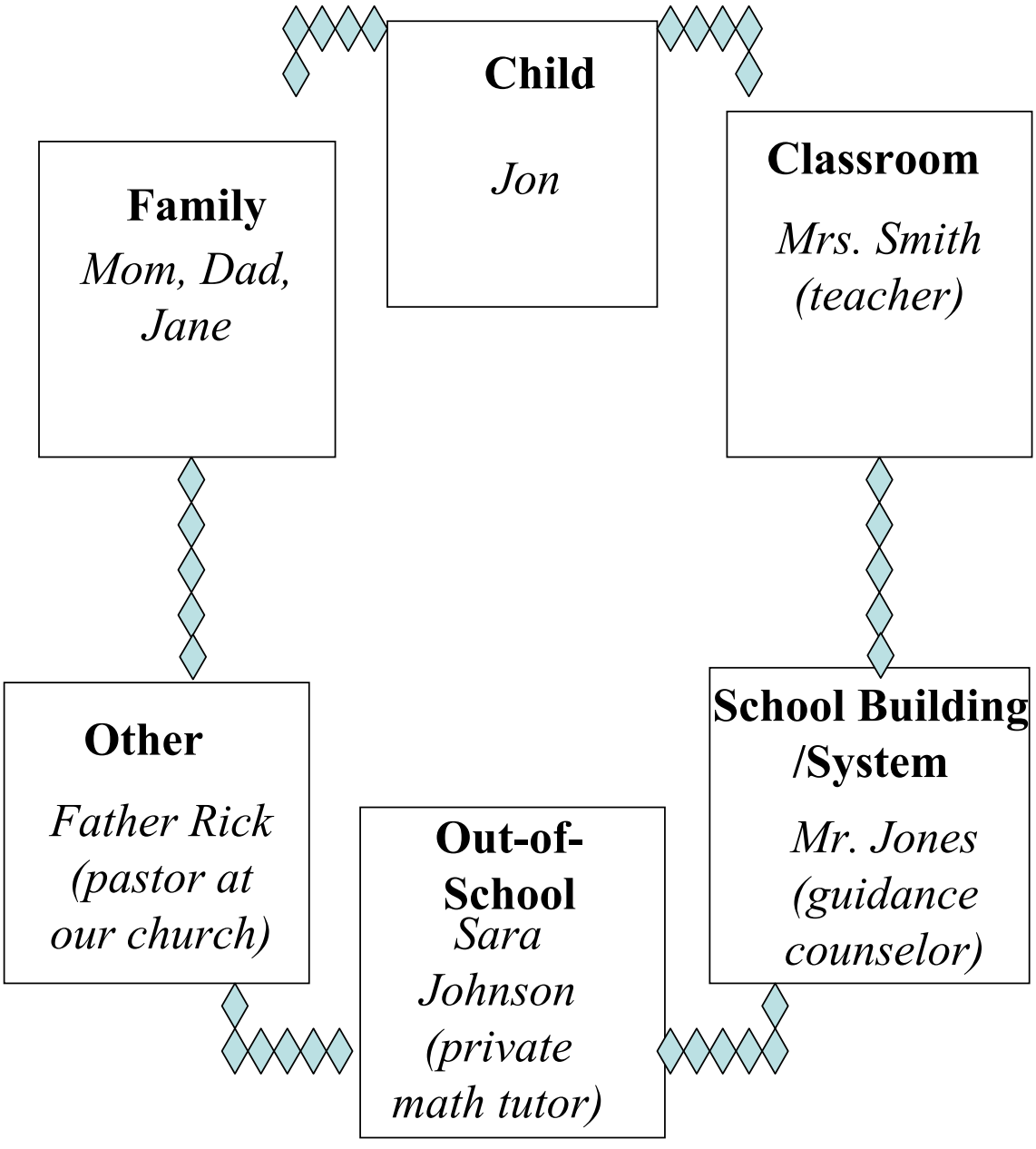
Name _____

My Child's Treatment Team



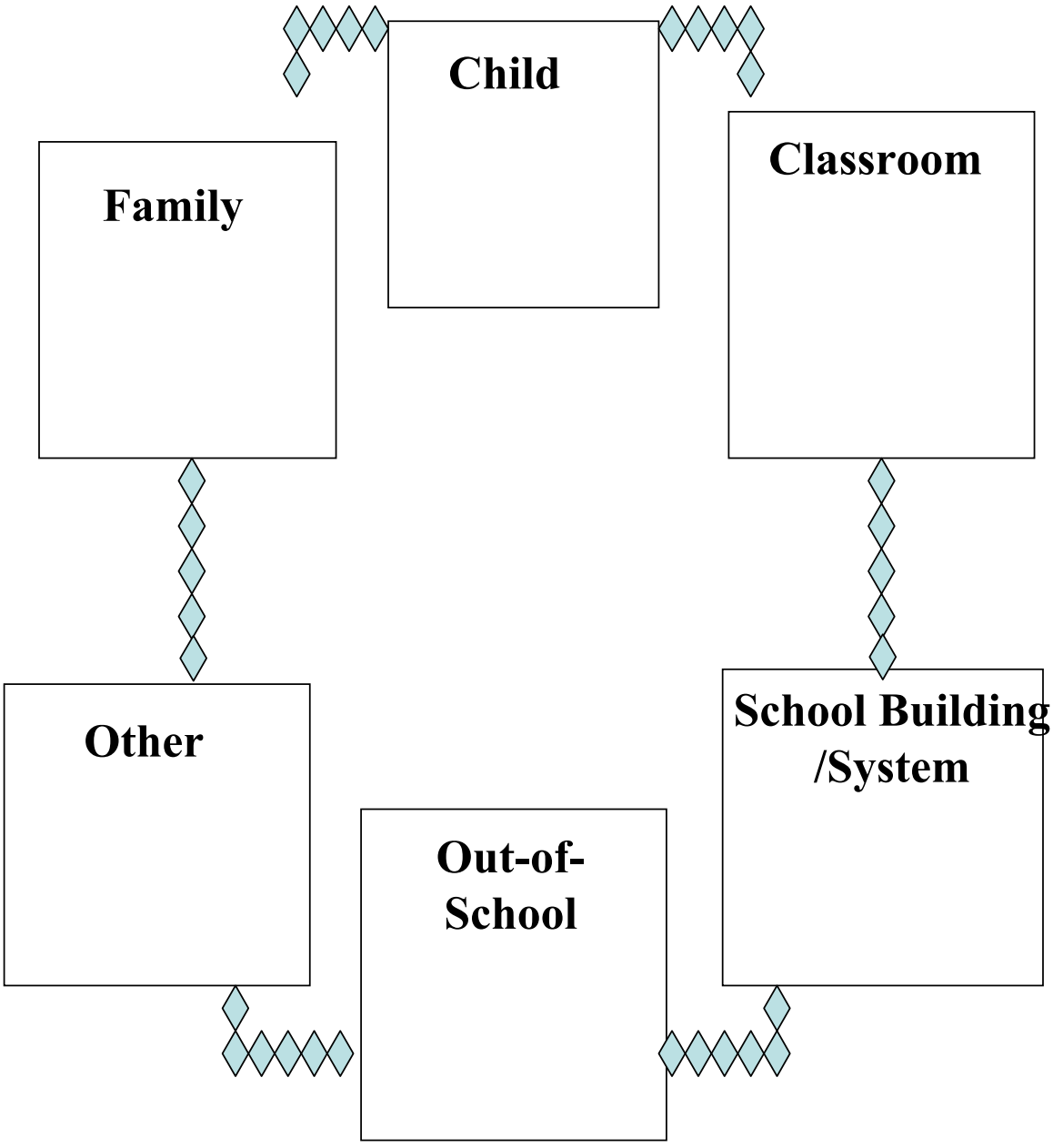
Name _____

My Child's Educational Team



Name _____

My Child's Education Team



Name _____

Managing Symptoms using Problem Solving

1. The problem is: ***Violence towards siblings***
2. ***Mom, John, and Sally*** talked about it.
3. Possible solutions (and their pros and cons) are…

Solution?	Pros	Cons
1. Making them play together more	*They would learn to get along better*	*They could also fight more*
2. Don't let them play together at all	*They won't be as likely to get into physical fights*	*They will get lonely; not develop good relationship*
3.Punish John every time he hits Sally	*He'll know hitting is not acceptable*	*Punishment doesn't really stop John's behavior*
4.Monitor their play more closely, separate as soon as John becomes angry	*They still get to play together* *Sally will be safe*	*Hard for me to get other things done if monitoring them so closely*

4. We'll try #: ***4***
5. This is how it worked: ***I limit their play time and have them play in the kitchen while I'm making dinner; I separate them as soon as John becomes angry***
6. Next time we will: ***Try this more***

Name _____

Managing Symptoms using Problem Solving

1. The problem is…
2. Here's who talked about
3. Possible solutions (and their pros and cons) are…

Solution?	Pros	Cons

4. We'll try #

5. This is how it worked:

6. Next time we will:

Name _____

"Out With the Old, in With the New!" Communication With Your Child

Day	"Old" (Hurtful Communication)	When Did I Catch Myself *	"New" (Helpful Communication)
1	"Stop that now or else!"	When I saw my child's reaction	Use a calmer voice and don't threaten
2	"You never listen to me"	The next day	Say "right now I feel that you aren't listening to me"
3	"Just snap out of it!"	As soon as I said it	"I can tell you are feeling bad right now and I'm also very frustrated" and then problem solve later
4	I don't remember – I just remember screaming at him	Once I calmed down	Wait until I'm calmer to talk to him about what's making me feel unhappy
5			
6			

*Right away? When I saw my child's reaction? An hour/day later?

Name _____

"Out With the Old, in With the New!" Communication With Your Child

Day	"Old" (Hurtful Communication)	When Did I Catch Myself *	"New" (Helpful Communication)
1			
2			
3			
4			
5			
6			

*Right away? When I saw my child's reaction? An hour/day later?