

Information about:

Bipolar Disorder

Revised September 2009



Vermont
Family
Network

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Introduction

Information About Bipolar Disorder is part of a series of information packets developed by the Vermont Family Network (VFN). Designed to provide basic information, the packet includes fact sheets, articles, advocacy tips, and resources for families of children with special needs and for the professionals working with them.

After reading the packet, we hope that you'll have a greater understanding of bipolar disorder and the ways in which parents and professionals can support children at home, in school, and in the community. We've selected information from a variety of sources, and many articles are on the Internet.

Thank you to BEST (Building Effective Strategies for Teaching), Vermont Department of Education, for making this publication possible. Thanks also go to the organizations and authors who gave us permission to use their articles and fact sheets. Use of any specific articles in this packet is meant for information purposes only and doesn't indicate any endorsement on the part of VFN of the views and opinions of the authors.

Because your comments are important to us, we've included a reader's response form at the end of the packet. Please take a few minutes to fill it out and return it to our office. Thank you.

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Bipolar Disorder

What is bipolar disorder?

Bipolar disorder, or manic depression, is a serious brain disorder that causes extreme shifts in mood, energy, and functioning. It affects 2.3 million adult Americans, or 1.2 percent of the population. Bipolar disorder is characterized by episodes of mania and depression that can last from days to months. Bipolar disorder is a chronic condition with recurring episodes that often begin in adolescence or early adulthood. It generally requires ongoing treatment.

What are the symptoms of mania?

Mania is the word that describes the activated phase of bipolar disorder. The symptoms of mania may include:

- either an elated, happy mood or an irritable, angry, unpleasant mood
- increased activity or energy
- more thoughts and faster thinking than normal
- increased talking, more rapid speech than normal
- ambitious, often grandiose, plans increased sexual interest and activity
- decreased sleep and decreased need for sleep

What are the symptoms of depression?

Depression is the other phase of bipolar disorder. The symptoms of depression may include:

- depressed or apathetic mood
- decreased activity and energy
- restlessness and irritability
- fewer thoughts than usual and slowed thinking
- less talking and slowed speech
- less interest or participation in, and less enjoyment of activities normally enjoyed
- decreased sexual interest and activity
- hopeless and helpless feelings
- feelings of guilt and worthlessness
- pessimistic outlook
- thoughts of suicide
- change in appetite
- change in sleep patterns

What is a "mixed" state?

A mixed state is when symptoms of mania and depression occur at the same time. During a mixed state depressed mood accompanies manic activation. The symptoms during a mixed state often include agitation, trouble sleeping, significant change in appetite, psychosis, and suicidal thinking.

What is rapid cycling?

Sometimes individuals may experience regularly alternating periods of mania and depression. When four or more episodes of illness occur within a 12-month period, the individual is said to have bipolar disorder with rapid cycling. Rapid cycling is more common in women.

What are the causes of bipolar disorder?

While the exact cause of bipolar disorder is not known, researchers believe it is the result of a chemical imbalance in the certain parts of the brain. Scientists have found evidence of a genetic predisposition to the illness. Bipolar disorder tends to run in families, and close relatives of someone with bipolar disorder are more likely to be affected by the disorder. Sometimes serious life events such as a serious loss, chronic illness, or financial problem, can trigger an episode in some individuals with a predisposition to the disorder. There are other possible "triggers" of bipolar episodes: the treatment of depression with an antidepressant medication may trigger a switch into mania, sleep deprivation may trigger mania, or hypothyroidism may produce depression or mood instability. It is important to note that bipolar episodes can also occur without an obvious trigger.

How is bipolar disorder treated?

While there is no cure for bipolar disorder it is a highly treatable and manageable illness. After an accurate diagnosis, most people (80 to 90 percent) can be successfully treated. Medication is an essential part of successful treatment for people with bipolar disorder. Maintenance treatment with a mood stabilizer substantially reduces the number and severity of episodes for most people, although episodes of mania or depression may occur and require a specific additional treatment. In addition, psychosocial therapies including, cognitive-behavioral therapy, interpersonal therapy, family therapy, and psychoeducation are important to help people understand the illness and cope with the stresses that can trigger episodes. Changes in medications or doses may be necessary, as well as changes in treatment plans during different stages of the illness.

Medications used to treat mania. Two medications commonly used to treat manic episodes of bipolar disorder are called mood stabilizers, and they include lithium (Eskalith or Lithobid) and divalproex sodium (Depakote).

Lithium has long been used as a first line treatment for acute mania in people with bipolar disorder. Lithium is effective for preventing episodes of mania from occurring and for treating an episode after it has begun. However, for some individuals, lithium is ineffective and for others, lithium has a variety of side effects that may make it an undesirable treatment option.

Depakote is an anticonvulsant that has been used to treat epilepsy since 1983, but it was approved as a treatment for manic episodes of bipolar disorder in 1995. Depakote seems to be as effective as lithium for treating mania and it has fewer side effects, although it may not be appropriate for people with a history of liver problems.

Other anticonvulsant medications have also been found to be effective treatments for mania, including carbamazepine (Tegretol), lamotrigine (Lamictal), gabapentin (Neurontin), and topiramate (Topamax). However, these four medications have not been officially approved by the FDA for the treatment of bipolar disorder and have their own side effects.

Mania may also be treated acutely with antipsychotic medications in addition to a mood stabilizer. More research is needed to test the safety and efficacy of atypical antipsychotics, which may prove to be alternatives in the long-term treatment of bipolar disorder.

Medications used to treat depression. During depressive episodes, people with bipolar disorder may need additional treatment with an antidepressant medication. Because of the risk of triggering mania, doctors often prescribe lithium or an anticonvulsant mood stabilizer with an antidepressant. Antidepressant medications relieve depression, elevate mood, and activate behavior, but it often takes three to four weeks to respond. Sometimes a variety of different antidepressants and doses will be tried before finding the medication that works best for a particular individual.

There are several different types of antidepressants used to treat depression including tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), selective serotonin reuptake inhibitors (SSRIs), or newer antidepressants that function in different ways.

Consumers and their families must be cautious during the early stages of treatment when energy levels and the ability to take action return before mood improves. At this time - when decisions are easier to make, but depression is still severe - the risk of suicide may temporarily increase.

What are the side effects of the medications used to treat bipolar disorder?

All medications have side effects. Different medications produce different side effects, and people differ in the amount and severity of side effects they experience. Side effects can often be treated by changing the dose of the medication, switching to a different medication, or treating the side effect directly with an additional medication.

Side effects of medications used to treat mania.

Lithium tends to have the most side effects of the mood stabilizers - including hand tremors, excessive thirst, excessive urination, and memory problems - but they often become less troublesome after a few weeks as the body adjusts to the medication.

Particularly bothersome tremors can be treated with additional medication. Low thyroid function can be treated with thyroid supplements. In very few people, long-term lithium treatment can interfere with kidney function.

The other anticonvulsant mood stabilizers tend to have fewer side effects than lithium. Common side effects include nausea, drowsiness, dizziness, and tremors. Some people taking anticonvulsant mood stabilizers may develop liver problems or problems with white blood cell count and blood platelets, which can be severe. Therefore, blood tests to monitor liver function and blood cells may be an important part of treatment with some of these medications.

Side effects of medications used to treat depression. About half of the people taking antidepressant medications have mild side effects during the first few weeks of treatment. Common side effects of tricyclic antidepressants (TCAs) include dry mouth, constipation, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, skin rash, or weight gain or loss.

Individuals taking monoamine oxidase inhibitors (MAOIs) may have to be careful about eating certain smoked, fermented, or pickled foods, drinking certain beverages, or taking some medications because they can cause severe high blood pressure in combination with the medication. MAOIs have other, less severe side effects as well.

The SSRIs and newer antidepressants tend to have fewer and different side effects, such as nausea, nervousness, insomnia, diarrhea, rash, agitation, or sexual problems.

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Bipolar Disorder (Manic Depressive Illness) in Teens

Publication Number 38

Teenagers with Bipolar Disorder may have an ongoing combination of extremely high (manic) and low (depressed) moods. Highs may alternate with lows, or the person may feel both extremes at the same time.

Bipolar Disorder usually starts in adult life. Although less common, it does occur in teenagers and even rarely in young children. This illness can affect anyone. However, if one or both parents have Bipolar Disorder, the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with Bipolar Disorder in teens.

Bipolar Disorder may begin either with manic or depressive symptoms.

The manic symptoms include:

- severe changes in mood compared to others of the same age and background - either unusually happy or silly, or very irritable, angry, agitated or aggressive
- unrealistic highs in self-esteem - for example, a teenager who feels all powerful or like a superhero with special powers
- great increase in energy and the ability to go with little or no sleep for days without feeling tired
- increase in talking - the adolescent talks too much, too fast, changes topics too quickly, and cannot be interrupted
- distractibility - the teen's attention moves constantly from one thing to the next
- repeated high risk-taking behavior; such as, abusing alcohol and drugs, reckless driving, or sexual promiscuity

The depressive symptoms include:

- irritability, depressed mood, persistent sadness, frequent crying
- thoughts of death or suicide
- loss of enjoyment in favorite activities
- frequent complaints of physical illnesses such as headaches or stomach aches
- low energy level, fatigue, poor concentration, complaints of boredom
- major change in eating or sleeping patterns, such as oversleeping or overeating

Some of these signs are similar to those that occur in teenagers with other problems such as drug abuse, delinquency, attention-deficit hyperactivity disorder, or even schizophrenia. The diagnosis can only be made with careful observation over an extended period of time. A thorough evaluation by a child and adolescent psychiatrist can be helpful in identifying the problems and starting specific treatment.

Teenagers with Bipolar Disorder can be effectively treated. Treatment for Bipolar Disorder usually includes education of the patient and the family about the illness, mood stabilizing medications such as lithium and valproic acid, and psychotherapy. Mood stabilizing medications often reduce the number and severity of manic episodes, and also help to prevent depression. Psychotherapy helps the teenager understand himself or herself, adapt to stresses, rebuild self-esteem and improve relationships.

For additional information see Facts for Families:

from www.aacap.org/cs/root/facts_for_families/facts_for_families_numerical_list

#3 Teens: Alcohol and Other Drugs

#4 The Depressed Child

#6 Children Who Can't Pay Attention (ADHD)

#33 Conduct Disorder, and

#52 Comprehensive Psychiatric Evaluation.

See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 6900 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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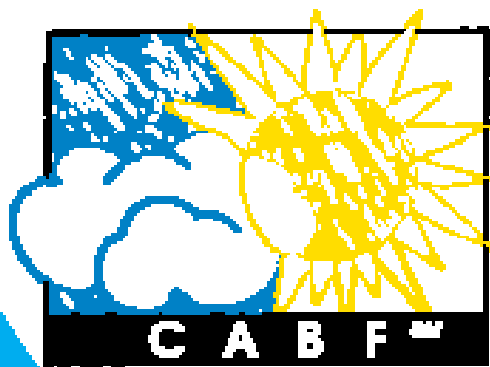
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CHILD & ADOLESCENT BIPOLAR FOUNDATION



EDUCATING THE CHILD WITH BIPOLAR DISORDER



Commonly Seen Behaviors

- crying for no apparent reason
- an expansive or irritable mood
- depression
- rapidly changing moods lasting a few minutes to a few days
- explosive, lengthy, and often destructive rages
- separation anxiety
- defiance of authority
- hyperactivity, agitation, and distractibility
- sleeping too little or too much
- night terrors
- strong and frequent
- cravings, often for carbohydrates and sweets
- excessive involvement in multiple projects and activities
- impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- dare devil behaviors
- inappropriate or precocious sexual behavior
- delusions and hallucinations
- grandiose belief in personal abilities that defy the laws of logic (ability to fly, knows more than the teacher or principal)
- extreme irritability

What is Pediatric Bipolar Disorder?

Bipolar disorder is a biological brain disorder causing severe fluctuations in mood, energy, thinking and behavior. It was previously known as manic depression, as it causes moods to shift between mania and depression. Children—whose symptoms present differently than those of adults—can experience severe and sudden mood changes many times a day. Symptoms of mania and depression can also occur simultaneously. Young people with this disorder are frequently anxious and have very low frustration tolerance.

At least one million American children and teenagers struggle with bipolar disorder, most of them undiagnosed and untreated. Children with bipolar disorder are at risk for school failure, substance abuse, and suicide. The lifetime mortality rate for bipolar disorder (from suicide) is higher than some childhood cancers. Yet children who are stable and have the right support can thrive in school and develop satisfying peer relationships.

Depressed children may not appear to be sad. Instead they may withdraw, not want to play, need more sleep than usual, display chronic irritability, or cry for no obvious reason. Children may also talk of wishing to die and may need to be hospitalized for harm to themselves or others.

Symptoms of mania may include elation, grandiose thinking, racing thoughts, pressured speech, hypersexuality, and decreased need for sleep. Since hyperactivity can be seen in both bipolar disorder and ADHD, a growing number of researchers believe that many children who are diagnosed with “severe ADHD” may actually have undiagnosed bipolar disorder.

Bipolar disorder is a chronic, lifetime condition that can be managed, but not cured, with medication and lifestyle changes. Because the symptoms wax and wane on their own, and children’s bodies change as they grow, managing medication to ensure continued stability is a complex and ongoing challenge.

How Bipolar Disorder Affects Cognition and Learning

Recent brain imaging studies show biological differences in patients with bipolar disorder. The disorder affects learning in a number of ways, ranging from difficulties with sleep, energy, school attendance, concentration, executive function, and cognition. Side effects from medications can affect the child's learning and energy. Moreover, while many of these children are uncommonly bright or creative, they often have co-occurring learning disabilities.

Even when moods are stable, the condition often causes cognitive deficits, including the ability to:

- Pay attention
- Remember and recall information
- Think critically, categorize, and organize information
- Employ problem-solving skills
- Quickly coordinate eye-hand movements

In addition, bipolar disorder can cause a child to be at times impulsive, talkative, distractible, withdrawn, unmotivated, or difficult to engage. Medications to manage the illness can cause cognitive dulling, sleepiness, slurring of speech, memory recall difficulties, and physical discomfort such as nausea and excessive thirst.

Despite all these challenges, a student with bipolar disorder can succeed in the classroom with the right supports and accommodations.



Strategies For Teaching a Child with Bipolar Disorder

The teaching skills that make a classroom teacher successful with typical students are essential when working with children who have bipolar disorder:

Flexibility to adapt assignments, curriculum and presentation style as needed.

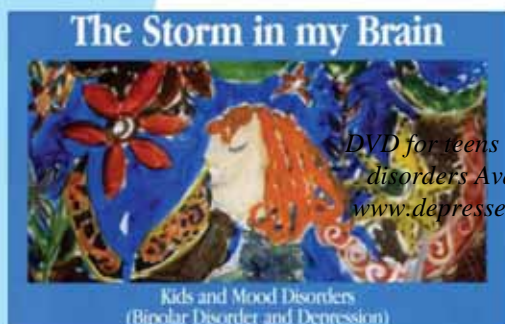
Patience to ignore minor negative behaviors, encourage positive behaviors, and provide positive behavioral choices. Most important is the ability to stay calm and be a model of desired behavior.

Good conflict management skills to resolve conflicts in a non-confrontational, non-combative, safe, and positive manner.

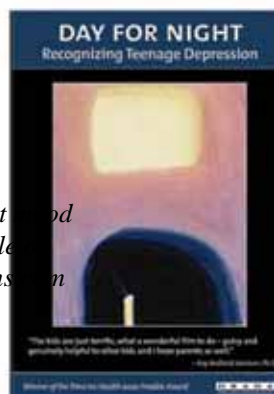
Receptivity to change and to working collaboratively with the child's parents, doctors, and other professionals to best meet the needs of the child.



The ability to laugh at oneself and at situations. Teachers who can laugh at their own mistakes, and bring fun and humor into the classroom reduce the level of stress that students feel.



Booklet for children describing how it feels to have a mood disorder. Available at www.bpkids.org



DVD for teens about mood disorders Available on www.depressedteens.com

Teaming Up to Help the Child

Since bipolar disorder affects all aspects of a child's life, it takes a well-coordinated team of concerned adults to give the child the best chance for a full and productive life. The team might include parents, teachers, special education specialists, a guidance counselor, an adjustment counselor or social worker, a school psychologist, an occupational therapist, a speech therapist, and the school nurse.

The school team should feel comfortable consulting with the child's psychiatrist and/or outside therapist.

It is critical to work closely with the child's family to understand the symptoms and course of the illness.

Parents should identify patterns in behavior that could signal a change in the illness, and help teachers brainstorm better ways of handling specific situations. Teachers and school personnel also need to know about changes in the child's home life or medication in order to work around them constructively at school.

At times of transition, the current or previous year's teacher needs to work closely with the new teacher or team to smooth the way—change is difficult for any child, but even more difficult for the child with a neurological disorder.

Suggested Accommodations

Students with bipolar disorder benefit enormously from stress-reducing accommodations such as:

- Consistent scheduling that includes planned and unplanned breaks
- Seating with few distractions, providing buffer space and model children
- Shortened assignments and homework focusing on quality, not quantity
- Prior notice of transitions or changes in routine— minimizing surprises
- A plan for unstructured time or lulls in the day
- Scheduling the student's most challenging tasks at a time of day when the child is best able to perform (allowing for medication-related tiredness, hunger, etc.)



Successful Teaching Strategies

Students with bipolar disorder face tough challenges navigating through the many pressures of a typical school day. Their neurologically-based mood disorder affects emotion, behavior, cognitive skills, and social interactions.

These students are very vulnerable to stress that can easily overwhelm their coping skills. Therefore, it is paramount to their success in the classroom to reduce exposure to stressors and help them build coping skills that they will need throughout their lives. More than anything else, these children need structure and predictability to frame the day, provided by supportive and flexible teachers who calmly help them stay in control when any difficulties develop.

The most important factor in these children's success is the way adults respond to and work with them. The teachers who work best with these students are resourceful, caring, and calm, and know how to work positively with children's shifting moods and cognitive weaknesses. Praise, encouragement, and key words elicit positive behaviors, while negativity helps the child spin out of control. Experts recommend some praise for all children at least once every 5 minutes, or 12 positive comments for every negative statement.

Good communication between home and school is essential.

Contact should be frequent, timely, and focused on facts and solving problems (rather than blame). The school needs to inform parents regularly about how the student is performing. This can be done via a notebook that goes back and forth to school with the child, or a daily chart or e-mail that records successes, progress, difficulties, and mood information. Parents can then reinforce and support the teacher and the child. Parents can also spot trends in the child's illness and respond before problems reach a crisis. They should inform teachers of any unusual stressors at home and changes in medication.

One of the challenges of working with these children is that even tried-and-true strategies may not work consistently due to the frequent mood shifts the students experience. Being prepared with a variety of approaches certainly increases a teacher's odds of dealing successfully with their students' challenges.



How to Handle Changing Moods

In a manic mood, children may exhibit distractibility, increased energy, grandiose thinking, rapid speech, and a strong goal orientation. Help them direct all that energy productively with hands-on projects and increased activity. The child will need help to set realistic goals. During lulls in the classroom, give the child an OT break, send the child on errands, or assign tasks involving motor activity, such as washing the board or moving items. Provide opportunities for the student to move around during class, work on computers, or use manipulatives and encourage him/her to get involved in other interactive activities. You might even set up games and intervention strategy that allow the children to become more conscious of and better able to control their need for movement.

When children are sad or depressed, exhibiting low energy, shorten their assignments and check in frequently to help them stay on track. Sometimes, simply asking what is wrong and how you can help is enough to get the child back on track. Children in a depressed state can find it extremely hard to wake up in time for school, particularly at certain times of the year. They should not be penalized for tardiness that is biologically based. Any talk of suicide must be taken seriously and reported to the child's parents.

You might not be able to discern clearly defined episodes

of mania or depression because children with bipolar disorder often experience both states at once, producing chronic agitation and irritability. Defiance and aggression are probably the most challenging moods to manage. The best strategy for addressing these behaviors is to not take it personally, keep your composure, and do not get involved in power struggles. Remain a positive model. Prompt children who are rude to rephrase statements politely and try again. Be firm and consistent, and give the child acceptable, positive choices. An ultimatum or threat can easily force the child to make poor choices.

At times all students are more demanding or just need a lot of attention. Greet them when they enter the classroom, seat them near where you teach, give them opportunities to work with other students, use their names in spelling sentences, math problems, etc, and acknowledge them when they stay on task. Try to ignore inappropriate, attention-getting behaviors as much as possible. Use "bossiness" to everyone's advantage by making the child a leader or teacher.

Using Social Stories to Rehearse New Situations

Like children with other neurologically-based disorders, children with bipolar disorder often have difficulty in novel situations and don't know how to behave appropriately. When given some sort of structure or script, however, they are far more successful. Social stories, which have been used by children with autism spectrum disorders, prepare the child in advance for a given situation so he can respond appropriately when that situation occurs.

Social stories can be simple, such as talking through and role-playing how to perceive that someone else doesn't want to be splashed. They can also be longer, such as a 20-page book on going to a new camp or school. It's important to not only give the child information on the situation, but also to reassure the child that he is capable of handling it. The story can also be a jumping off point for discussing "what if" scenarios, so the child has a chance to practice appropriate reactions for different outcomes. Involving the child in creating the story, either by coming up with what the child might say or by illustrating it, is a great way to capture the child's interest.



Carol Gray, noted expert on social stories, provides the following guidelines* for writing your own social stories:

- Picture the goal
- Gather information
- Tailor the text
- Teach with the title • *

Additional Resources

[www.thegraycenter.org/
socialstories.cfm](http://www.thegraycenter.org/socialstories.cfm)

[www.polyxo.com/
socialstories/introduction.
html#needforintervention](http://www.polyxo.com/socialstories/introduction.html#needforintervention)

Managing Challenging Behavior

Bipolar disorder affects the areas of the brain that regulate memory, speech, thought, emotions, personality, planning, anxiety, frustration, aggression, and impulse control. It's no surprise, then, that these children have difficulty behaving appropriately in all situations. Although medication helps the children control their behavior, they are highly influenced by their impulses and surroundings even when moods are stable.

Children with bipolar disorder need adults around them who are positive, calm, firm, patient, consistent, loving, and who encourage them to behave appropriately. Praise and key words elicit positive behaviors, while negativity helps the child spin out of control. In fact, experts recommend some praise at least once every 5 minutes, or 12 positive comments to every negative comment.

In addition, the child's team should have a behavior intervention plan. When a child is stable, the team needs to build the child's skills that lead to appropriate reactions and behavior, including emotion labeling, empathy, anger management, social rules, nonverbal communication,

and making amends. Those who work with the child need training in nonviolent crisis prevention, focusing on verbal de-escalation techniques, to avoid crises.

Reward positive behavior with praise and privileges but don't set up a reward system in advance. Programs that reward the child for positive behavior, while punishing negative behaviors set the child up for failure, raising stress. Punishing a child with bipolar disorder for a fit of anger is akin to punishing an asthmatic child for an asthma attack.



A child with bipolar disorder often feels overwhelmed by the intensity of their emotions

Experts recommend some praise at least once every 5 minutes, or 12 positive comments to every one negative comment.

Modifying the Physical Environment

Children with bipolar disorder generally need an environment that reduces distractions and improves their ability to focus and behave appropriately. They benefit from accommodations like those made for students with ADHD, and in fact many of these children have ADHD in addition to bipolar disorder. Preferential seating near model students, with few nearby distractions, is critical. Some students do better near the teacher so that the teacher can unobtrusively check in and keep them on task, while others need extra space to pace or move around.

Noise is an issue for some children with bipolar disorder, as sensory integration problems are not

uncommon. Ear plugs for loud events, headphones that screen out noise, or even calming music can help a child focus. If music is more distracting than helpful, try a tape with a background noise such as ocean sounds to filter out random classroom noises.

Discomfort from heat and light can be distracting. If you don't have control over the temperature in your classroom, suggest the child dress in layers to ensure comfort. Children who are tired or depressed may fall sleep if it's too dark in the room. Others, if they're sensitive to bright light, can be made more comfortable by sitting in carrels or away from bright sunlight.

Other Accommodations for Comfort

Students with bipolar disorder need an established "safe" person—an adult to go to when feeling overwhelmed—and a safe place. This safe place should be a private location used for regaining composure or collecting one's thoughts, away from peers or other staff. Sometimes the student simply needs to take a walk. Make arrangements in advance that do not call undue attention to the student, but also consider policies on safety.

Many children experience side effects from medication, including

sleepiness, thirst, frequent urination, or constant hunger. Work out a plan to keep these issues from affecting the child's success.

Some students, particularly younger ones, may need one-on-one adult supervision, not only in the classroom, but at times of transition or unstructured activities full of peer interaction, such as recess or lunch time.

Consider extending education about diversity to include learning differences and how individual minds can work differently. This information can increase peer acceptance and reduce stigma for these students.

Adjusting the Schedule

Many factors affect the way children with bipolar disorder experience time, including difficulties with sleep, concentration, memory, and moods, plus medication side effects and a tendency to hyper focus. Students with bipolar disorder may need several or all of the following schedule accommodations:

- permission to arrive later when necessary
- a shorter school day
- scheduling difficult tasks for a time of day when the student is best able to perform
- warnings before a change in activities
- more time for turning in homework or large projects
- extra time for tests
- breaking tests or assignments into shorter segments with breaks
- scheduling stimulating courses early in the day to get interest flowing
- periodic checks on progress during an assignment to ensure the student is on schedule

Optimizing Testing Situations

Brain imaging shows that people with bipolar disorder have differences in their brains in the areas that control memory. With help, however, such as the following testing accommodations, students with bipolar disorder can succeed in demonstrating their knowledge more effectively:

- modified time constraints
- altered or simpler instructions
- oral testing or the use of a scribe
- an altered environment (such as a room with few or no other students)
- multiple-choice or matching rather than open-ended questions
- tools such as a calculator or word bank
- offering an alternative type of assignment to reduce the stress of testing



Special Education Classification

When developing an IEP for a child with bipolar disorder, educators are sometimes unsure of the most appropriate way to classify the student's special education needs. CABF advocates the classification Other Health Impaired (OHI). This classification acknowledges the biological nature of the illness. An OHI classification recognizes that:

- Bipolar disorder impairs a child's ability to function effectively in school due to impairment in cognitive, emotional, and physical functioning.
- The behavioral and emotional problems of the student are symptoms of a biological brain disorder requiring pharmacological and psychosocial intervention, not primarily behavior modification.
- Behavioral outbursts, negative peer relationships, and an inability to interpret social situations are symptoms of neurological instability. These

symptoms are not always within the child's control, although proper medication can help.

- Repeated episodes of bipolar disorder cause deficits in social, vocational, and academic skills. Without proper accommodations within the academic program, these deficits lead to a high dropout and school failure rate.
- An OHI classification clearly defines the child's heightened levels of impulsivity, distractibility, sensory integration deficiencies, and poor decision-making skills as being due to this neurological disorder.

With appropriate program supports, pharmacological treatment, and environmental support, students with bipolar disorder are more likely to successfully complete school and become productive citizens.

The OHI classification is an essential building block of vital support that students with bipolar disorder need in order to succeed.

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Parenting a Bipolar Child – A Mother's Thoughts

by Sigrid

The light spring rain falling upon my garden reminds me that it's been a year since Rose's baffling tantrums, mood swings and annual winter sadness were finally given a name: bipolar disorder, a diagnosis made by Dr. William Bradbury of Chicago just after her ninth birthday. It's been a year of reading textbooks and medical journals, grappling with how this news impacts our family, and reaching out to other parents of similar "wild angels" for advice and support.

The lifechart of my daughter's moods [printed with published article] does not begin to convey the unique and wonderful person she is. Where can I note the lovely altar she made for her room? Where to indicate the delight she expressed with her new canopy bed, a curtained lair designed to soothe the onset of her fire-breathing moods? Where to record the eagerness with which she anticipates the weekly visits of Michael, a baby she adores, or the patience she displays while helping teach karate to disabled kids? Such a chart is useful in detecting and diagnosing symptom patterns and tracking medication response, but we must never forget that our kids are unique individuals with feelings, interests, and talents of their own.

Our challenge as parents, once we have processed the inevitable feelings of shock and grief upon diagnosis, is to seize these years as a window of opportunity in which to educate our kids in methods of self-awareness, self-control, and self-expression. One of the easiest, yet most important, contributions we can make in our collaboration with treatment professionals is to observe and record our child's moods, sleep habits, outbursts, troublesome encounters with others, and other behaviors of concern. A few notes made at the end of each day can capture valuable facts soon lost to memory. These notes are of immense value prior to diagnosis in discerning patterns, and later in deciding which medications to prescribe. Eventually, our children will be encouraged to do this monitoring themselves. Until then, attending to this task on a regular basis is something we can do when, at times, it seems there is little else we can do.

To help our kids with self-control, beyond the essential medications might be training in the martial arts, yoga, neurofeedback or meditation, with teachers who understand the special challenges faced by bipolar kids. All of the arts--writing, music, painting and drawing, ceramics and sculpture, dance--as well as sports offer means for expressing the passions and channeling the incredible energy that, at times, floods a bipolar child's whole being. It is essential to find flexible teachers; Rose's piano teacher, for example, gauges the length of her lesson each week by Rose's energy level that day; the lessons run anywhere from 15 minutes to over an hour.

Crucial coping strategies at our house and in the families I've met include a sense of humor, a tolerance for eccentricity, flexibility, and support from other parents. We call our angelic-looking little girl with the blonde hair and big brown eyes "Mountain Goat," for her facility at scaling the kitchen cupboards, and send her to a summer camp that offers climbing lessons where she can safely indulge her need for risk-taking. We have accepted that we must be prepared to leave any situation that Rose finds overwhelming, and don't mind cooking artichokes for breakfast at times. In a parent support group, we discover that all of our kids have, at one time or another, attempted to jump out of a moving car; we are not surprised to find that they share a deep affinity with animals, and an innate spirituality. Our kids often blame us for their rages, emotional hijackings in which their hair-trigger limbic systems perceive even the gentlest parental guidance as nuclear attack and react accordingly. So we dub ourselves honorary lifetime members of the Mean Moms Club, but when the dust has settled take our kids on our laps and point out the difference between thoughts, feelings, and actions, and teach ways they can make choices about those things.

"Parenting Rose must be really interesting," a friend said recently. It certainly is. Yet, many days I wonder how I'll survive the roller-coaster mood swings, the creativity utilized in devising yet another scheme to test my patience (the latest: photocopying our Siamese cat), and an intensity that can exhaust several adults in a day. It is heartbreaking to witness one's young child trash her room in a rage, then threaten to kill herself, sobbing "why do I have to cry all the time?" And to find her older sister silently weeping on the kitchen steps, after listening through her bedroom wall to my hour-long struggle to restrain Rose during a wall-kicking, ear-splitting tantrum.

In my stronger moments, I regard the challenge of parenting Rose as a gift; she blesses me with plenty of practice at staying present and in the moment. Her days of irritability that begin with a barrage of angry words and end with slammed doors are sometimes endured only with help of the deep breathing techniques I learned for childbirth. Her sunny moods, longer and more frequent since she began taking Depakote and Wellbutrin, are welcome oases of calm affection. On one of those precious days, she might wrap her arms around my neck and say, "I'm glad you're my mom, even though I don't always think so." Those days, I am grateful for all the things she's taught me about patience, and love, and how much we take for granted in life.

Published in Bipolar Network News (Stanley Foundation), Vol. 3, Issue 2 (July 1997 issue, devoted to childhood and adolescent-onset bipolar illness). To request copies, contact the Stanley Foundation Bipolar Network at (800) 518-7326.

Jerry's Story: Early-onset Bipolar – A Mother's Perspective

By Cheryl

It has only been recently (perhaps 15 years or so) that professionals in the psychiatric field have even begun considering that bipolar disorder (manic depression) may in fact have its onset prior to puberty. I believe it was a surprise even to them how many children were being affected by this disorder.

My son Jerry was diagnosed with bipolar disorder at age nine during a stay in a children's psychiatric unit. He was admitted following a period of behaviors I could neither understand nor control. I remember him being "different" (I now know he was manic) as far back as three years old. Jerry was diagnosed with ADHD at age six. The stimulant medications prescribed for him caused side effects such as facial tics, or they backfired and gave him a rebound effect. By age nine, he had begun lying, stealing, destroying property, setting fires, and hurting himself. He had no real friends at school, although he would say that wasn't true. He was filled with an anger I could not understand.

Most people who knew our family were saying it was my fault, implying that if I would just control him, he would be fine. Some claimed it was because his father was not around anymore. (I now believe his father is also bipolar, but undiagnosed). Some told me that if I wouldn't give in to his tantrums, he would stop having them. Actually, I never gave in to tantrums; they made me more determined he would not receive what he wanted. Had he logically explained why he felt he should be getting what it was he wanted, he might have gotten it.

Placing Jerry in the hospital at age nine was the hardest thing I have ever had to do. But it was also the best choice I could have made. It took the treatment team three weeks to diagnose him and find the correct medication combination that worked for him. The child who came home to me was smiling and loving; and he started remembering the things he had enjoyed like Nintendo, bike riding, and roller-blading. As time progressed he lost most of his anger and began to make friends at school and to cooperate at home.

My son is a rapid-cycler, which is defined by DSM-IV as having four episodes a year, but he might have that many in a single day. He can change without notice. The medication isn't a cure; it is an adjustment. We still have to continue with behavior modification, and he still cycles, but not to the severe degree that he did before hospitalization. I know that puberty is going to play havoc with his medication levels, but I am prepared for that (I think).

Last April, Jerry was rehospitalized. This was the first rehospitalization since he was diagnosed 17 months ago. I was told that 17 months is a long spell to be hospital-free at this stage in his disorder. Jerry had become increasingly depressed and angry. He began slipping away from me. His psychiatrist and I were starting to adjust his

medication-adding a new medication, Risperdal, to the lithium and Wellbutrin he was taking-but he had an adverse reaction to it.

Before we could try another medication, Jerry did something irreversible. He put our two cats in danger, and this resulted in the death of one of them. Jerry was so remorseful that he began planning his own death. (He loved the cats dearly. They were the best calmers we found when he was frustrated.)

I immediately called both his therapist and his child and adolescent psychiatrist. Everyone agreed that it was imperative to get him to the hospital and get him stabilized. He was only there for five days. I never thought that a short stay would be harder on me than the previous one of three weeks, when he was diagnosed, but it was.

I wasn't prepared to rush him into the hospital so quickly. Jerry cried and begged me not to punish him by putting him away. I was afraid he needed to see me more than I could be available while he was there. During his hospitalization, Zyprexa was added to his medication regimen. He got past the active suicidal ideation, but he still isn't through with the cycling. He isn't over the depression. After returning home, his school placement was altered. To relieve some of the stress he has been experiencing, he has moved to almost a full-day resource room at school. He participates with his classmates during activities such as homeroom, lunch, physical education, and art. He has one academic class with peers, social studies. I am still praying that we will get past his puberty with both of us intact.

While I am not a doctor or a mental health professional, as a parent searching for ways to help my child, I have discovered that if the diagnosis your child receives doesn't seem to fit, or the treatment prescribed just isn't working, don't stop searching for a better answer. A good doctor is willing to listen to you and to weigh any information you give him or her. If your doctor doesn't listen, find one who will.

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Editors note: *Jerry's mother, Cheryl, has started a support group in the Texarcana (TX) area where parents and caregivers can meet to talk about problems finding help, dealing with early-onset bipolar disorder and other brain disorders, and finding solutions together. If you would like information on the next support group meeting, Cheryl can be reached at camalot_cb@aol.com.*

Dr. Fassler is a Board Certified Child and Adolescent Psychiatrist practicing in Burlington, Vermont.

Advocating for Your Child: 25 Tips for Parents

by David Fassler, M.D.

According to the Surgeon General, 1 child in 5 will experience significant problems due to a psychiatric disorder. The good news is that we can help many, if not most, of these youngsters. The real tragedy is that so few, less than 1 in 3, are receiving the comprehensive treatment they really need.

Children and adolescents with emotional and behavioral problems deserve access to the best possible mental health care. Unfortunately, such services are often difficult to obtain. Parents can help by being informed, involved and persistent advocates on behalf of their children.

The following outline offers specific tips and suggestions which parents may find useful in such advocacy efforts:

1. Get a comprehensive evaluation. Child psychiatric disorders are complex and confusing. A full assessment will often involve several visits. Effective treatment depends on a careful and accurate diagnosis.
2. Insist on the best. Talk to physicians, therapists, guidance counselors and other parents. Find out who in your community has the most experience and expertise in evaluating and treating your child's particular condition. Check the clinician's credentials carefully. Are they appropriately licensed or certified in your state? If he or she is a physician, are they "Board Certified"? Push schools, insurance companies and state agencies to provide the most appropriate and best possible services, not merely services which are deemed sufficient or adequate.
3. Ask lots of questions about any diagnosis or proposed treatment. Encourage your child to ask any questions he or she may have, as well. Remember that no one has all the answers, and that there are few simple solutions for complex child psychiatric disorders. In addition, all treatments have both risks and benefits. Make sure you and your child understand the full range of treatment options available so you can make a truly informed decision.
4. Insist on care which is "family centered" and which builds on your child's strengths. Ask about specific goals and objectives. How will you know if treatment is helping? If your child's problems persist or worsen, what options and alternatives are available?
5. Ask about comprehensive "wrap around" or individualized services, geared specifically to the needs of your child and family. Are such services available in your state or community? If not, why not?

6. Be prepared. One of the most important things you can do to help your child is to keep all information, including past consultation and treatment reports, in an organized place. Insist on receiving your own copies of all evaluations. Records can easily be misplaced, delayed or even destroyed. Maintaining your own file with all relevant information can help avoid unnecessary duplication of previous treatment efforts.
7. Feel free to seek a second opinion. Any responsible mental health professional will be glad to help with referrals or by sharing information. If you have any questions at all about your child's diagnosis or the proposed course of treatment, by all means, arrange an independent consultation with another clinician.
8. Help your child learn about their condition. Use books, pamphlets and the Internet. Make sure the information is age-appropriate. Answer questions with honest, accurate and consistent information, but don't overload children with more detail than they need or want.
9. Learn the details of your insurance policy, and learn about the laws governing insurance in your state. For example, in some states, insurance companies must provide access to a specialist, such as a child and adolescent psychiatrist, within a certain distance from your home. If no such specialist is available as part of the company's "network", you may be able to receive treatment from a provider of your choice, with the insurance company responsible for full payment.
10. Work with the schools. Insist on access to appropriate mental health consultation services. Suggest inservice training programs to enhance awareness about child psychiatric disorders. Request copies of your child's educational records, including the results of any formal testing or other evaluations. Ask to be included in any and all school meetings held to discuss your child.
11. Learn about the reimbursement and funding systems in your state. The more you know, the better you can advocate on behalf of your child. How does Medicaid work? Which services are covered and which are excluded? Is there a "waiver program" which allows increased flexibility based on the specific needs of children and families? Is your child eligible? If not, why not? What other sources of funding are potentially available?
12. Get to know the state insurance commissioner and healthcare "ombudsperson" or consumer representative. Ask them to attend regular meetings with parent groups. Let them know about your experiences.
13. Use a lawyer, if necessary. Learn about the local legal resources. Find out which lawyers in your community are familiar with educational and mental health issues. Talk to your local Protection and Advocacy agency or American Civil Liberties Union for suggestions. Call the State Bar Association. Talk to other parents who are lawyers or who have used lawyers. Consider a legal consultation to make sure you are pursuing all appropriate avenues and options regarding services for your child.

14. Become politically active. Meet with state senators and representatives. Question candidates about their positions on access to necessary and appropriate mental health services for children and families. Testify at hearings on state legislation and budgets. Legislators are more likely to be influenced and persuaded by personal stories than by data, statistics or the opinions of professionals.
15. Build coalitions and work with local advocacy and parent organizations such as NAMI, NMHA and the Federation of Families. Develop and publicize a common "Agenda for Children's Mental Health".
16. Teach children about advocacy. Invite them to become involved in advocacy activities, where appropriate, but don't force them to participate.
17. Develop a legislative strategy. If your state does not yet have parity legislation, put this at the top of the agenda. Other "family protection" initiatives include:
 - access to an independent panel to review and potentially reverse insurance company denials
 - consumer representation on community mental health center boards
 - adequate network provisions, which mandate timely and appropriate access to specialists
 - adequate funding for school and community based mental health services.
18. Seek bipartisan support. Mental illness affects families of all political persuasions. Building a broad base of support has been a key to successful legislative initiatives, both at the State and Federal levels.
19. Fight stigma. Develop an ongoing local education campaign that reiterates the key messages:
 - child psychiatric disorders are very real illnesses
 - they effect lots of kids and adolescents
 - fortunately, they are also quite treatable, especially if treatment begins early and is individualized to the needs of each child and family.
20. Become involved with medical education. Meet with local medical students and residents. Sensitize them to the issues and challenges families face when caring for a child with emotional and behavioral problems.
21. Use the media. Write letters to the editor and/or op-ed pieces on child mental health issues. Meet with local reporters covering health care topics. Suggest story ideas to local TV stations.
22. Work with local professional organizations. Psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors are natural allies with a common advocacy agenda. Coordinate efforts on issues such as parity, funding for mental health services, managed care oversight, etc. Professional organizations may also have access to resources, including funds for lobbying and/or public education initiatives, from their national associations.

23. Talk to other parents. Seek out and join local parent support groups. If none exist, consider starting one. Develop an email "listserv" to facilitate communication. Circulate articles, information and suggestions about local resources.
24. Attend regional and national conferences of parent and advocacy organizations. Such meetings provide information, ideas, camaraderie and support. Sharing experiences with other parents is both helpful and empowering.
25. Don't give up. Aim for and celebrate incremental victories and accomplishments. Remember, advocacy is an ongoing process!

There's no right or wrong way to be an advocate for your child. Advocacy efforts and initiatives should be individualized to your state, community and the particular issues, circumstances and needs within your family. Advocacy is also hard work. Even when people want to help, and are willing to listen, it takes lots of time and energy to change the system. But when it works, and it often does, the outcome is clearly worthwhile. You really can make a difference, both for your own child, and ultimately for all children who need and deserve access to appropriate and effective mental health treatment services.

Resources

The following organizations are excellent resources regarding advocacy on behalf of children's mental health:

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
(202) 966-7300
www.aacap.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(703) 524-7600
www.nami.org

American Psychiatric Association
Division of Public Affairs
1400 K Street, NW
Washington, DC 20005
(202) 682-6140
www.psych.org

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
1-800-969-6642
www.nmha.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
Alexandria, VA 22314
(703) 684-7710
www.ffcmh.org

The Children's Defense Fund
25 E Street NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC 20005-5002
(202) 467-5730
www.bazelon.org

Continued on next page

Resources *(continued)*

Childhood and Adolescent Bipolar Foundation
1187 Wilmette Avenue
P.M.B. #331
Wilmette, IL 60091
(847) 256-8525
www.bpkids.org

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201,
Landover, MD 20785 CHADD
1-800-233-4050, (301) 306-7070
www.chadd.org

Juvenile Bipolar Research Foundation
49 S. Quaker Road
Pawling, NY 12564
(203) 226-2216
www.bpchildresearch.org

Depression and Bipolar Support Alliance (DBSA)
730 N. Franklin Street, Suite 501
Chicago, IL 60610
1-800-826-3632
(312) 642-0049
www.ndmda.org

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Resources

Books

- Anglada, T. and S. Hakala, M.D. (2008), *The Childhood Bipolar Answer Book: Practical Answers to the Top 300 Questions Parents Ask*
- Burns, D. (1999). *Feeling Good: The New Mood Therapy*.
- Copeland, M. (1994). *Living without Depression and Manic-Depression: A Workbook for Maintaining Mood Stability*.
- Dowling, C. (1993). *You Mean I Don't Have to Feel This Way?*
- Duke, P. and Hochman, G. (1998). *A Brilliant Madness*.
- Fawcett, J., Golden, B. and Rosenfeld. (2000). *New Hope for People with Bipolar Disorder*.
- Redfield Jamison, K. (1999). *Night Falls Fast: Understanding Suicide*.
- Fink, M. (1999). *Electroshock: Restoring the Mind*.
- Goodwin, F. and Redfield Jamison, K. (1990). *Manic-Depressive Illness*.
- Gorman, J. (1998). *Essential Guide to Psychiatric Drugs*.
- Redfield Jamison, K. (1997). *An Unquiet Mind: A Memoir of Moods and Madness*.
- Redfield Jamison, K. (1996). *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*.
- Klein, D. and Wender, P. (1994). *Understanding Depression: A Complete Guide to Its Diagnosis and Treatment*.
- McDonnell, Mary Ann, A.P.R.N., B.C., and Janet Wozniak, M.D. (2008) *Is Your Child Bipolar? The Definitive Resource on How to Identify, Treat, and Thrive with a Bipolar Child*
- Mondimore, F. (1999). *Bipolar Disorder: A Guide for Patients and Families*.
- Mondimore, F. (1993). *Depression: the Mood Disease*.
- Papoulos, Dimitris. F. and Papoulos, J. (1997). *Overcoming Depression*.
- Papoulos, Dimitris. F. and Papoulos, J. (1999). *The Bipolar Child*.
- Styron, W. (1992). *Darkness Visible: A Memoir of Madness*.

The following organizations can provide help, information and support:

National Depressive and Manic-Depressive Association (NDMDA). A national support and information-giving group for people with Depression and Manic-Depressive Illness and for their family members and friends. There are local meetings throughout the New York metropolitan area and across the country. For information, call NDMDA at 1-800-82-NDMDA or you can reach them online at <http://www.ndmda.org>.

National Alliance for the Mentally Ill (NAMI). An international support and information-giving organization for people with psychiatric illness and their family members. For information about NAMI membership and availability of local meetings, call 1-800-950-NAMI, or reach them online at <http://www.nami.org>.

New Concepts in Treating Bipolar Disorder

by Hussein Manji, M.D. Originally webcast February 11, 2003. Archived on UCLA's Neuropsychiatric Institute Bipolar Grand Rounds Web site.
<http://www.bipolargrandrounds.com/archived.html>

Science Friday: Bipolar Disorder in Children

In this hour of Science Friday, guest host Paul Raeburn and guests talk about bipolar disorder in children, why it's difficult to diagnose, and what is available to help treat the condition. Guests on this show include Ellen Liebenluft, M.D. and Mani Pavuluri, M.D. (October 11, 2002)

http://www.sciencefriday.com/pages/2002/Oct/hour1_101102.htm1

Child and Adolescents Bipolar Foundation

Expert presentations taped at the American Society of Adolescent Psychiatry annual meeting in Chicago, April 21-24, 2002. <http://www.bpkids.org/learning/reference/>

Mood Stabilizers in Children and Adolescents

by M. Kovacs, M. Pollock, *Journal of the American Academy of Child & Adolescent Psychiatry* June 1995;34(6):715-23.

<http://www.bpkids.org/learning/reference/articles/abstracts/001.htm>

N.B.: Many resources are available online at www.bpkids.org. Some may require membership to access.

Bipolar Disorder in Children: Misdiagnosis, Underdiagnosis, and Future Directions

(a White Paper commissioned by the National Institute of Mental Health) by Martha Hellander, Executive Director, Child & Adolescent Bipolar Foundation (May 2000)

<http://www.bpkids.org/learning/reference/articles/028.htm>

An excerpt from *Surviving Manic Depression: A Manual on Bipolar Disorder for Patients, Families and Providers* by E. Fuller Torrey, M.D. and Michael B. Knable, D.O. (Basic Books, 2002). <http://www.bpkids.org/learning/reference/articles/01-24-03.htm>



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