# Diagnosing Bipolar Disorder in Children

## *NCH-BH Primary Care Webinar, 1/11/2023*

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NATIONWIDE CHILDREN'S®
*When your child needs a hospital, everything matters.*

THE OHIO STATE UNIVERSITY
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# Conflicts of Interest

- *Royalties:*
  - Guilford Press
  - American Psychiatric Publishing
  - JK Seminars
- *Research:*
  - Janssen
- *Editorial Stipend & Travel:*
  - Society of Clinical Child and Adolescent Psychology

# Objectives

(1) Name the types of diagnoses included in bipolar spectrum disorder.

(2) State the prevalence of bipolar I and bipolar spectrum disorders in US youth.

(3) Name a diagnostic mnemonic and list its associated symptoms.

# Bipolar Spectrum Diagnoses

- Bipolar Disorder I (BP1): M (+ D)
- Bipolar Disorder II (BP2): m + D
- Cyclothymia (CYC): m + d
- Other Specified Bipolar and Related Disorder (OSBARD or BP-NOS): Define why
    - •Duration insufficient?
    - •One symptom short?
    - •Episodes not clearly defined?
    - •Informants sketchy, need to observe before finalizing diagnosis?

# Epidemiology

*Van Meter et al., 2019, J Clin Psychiatr, 80(3): 18r12180*

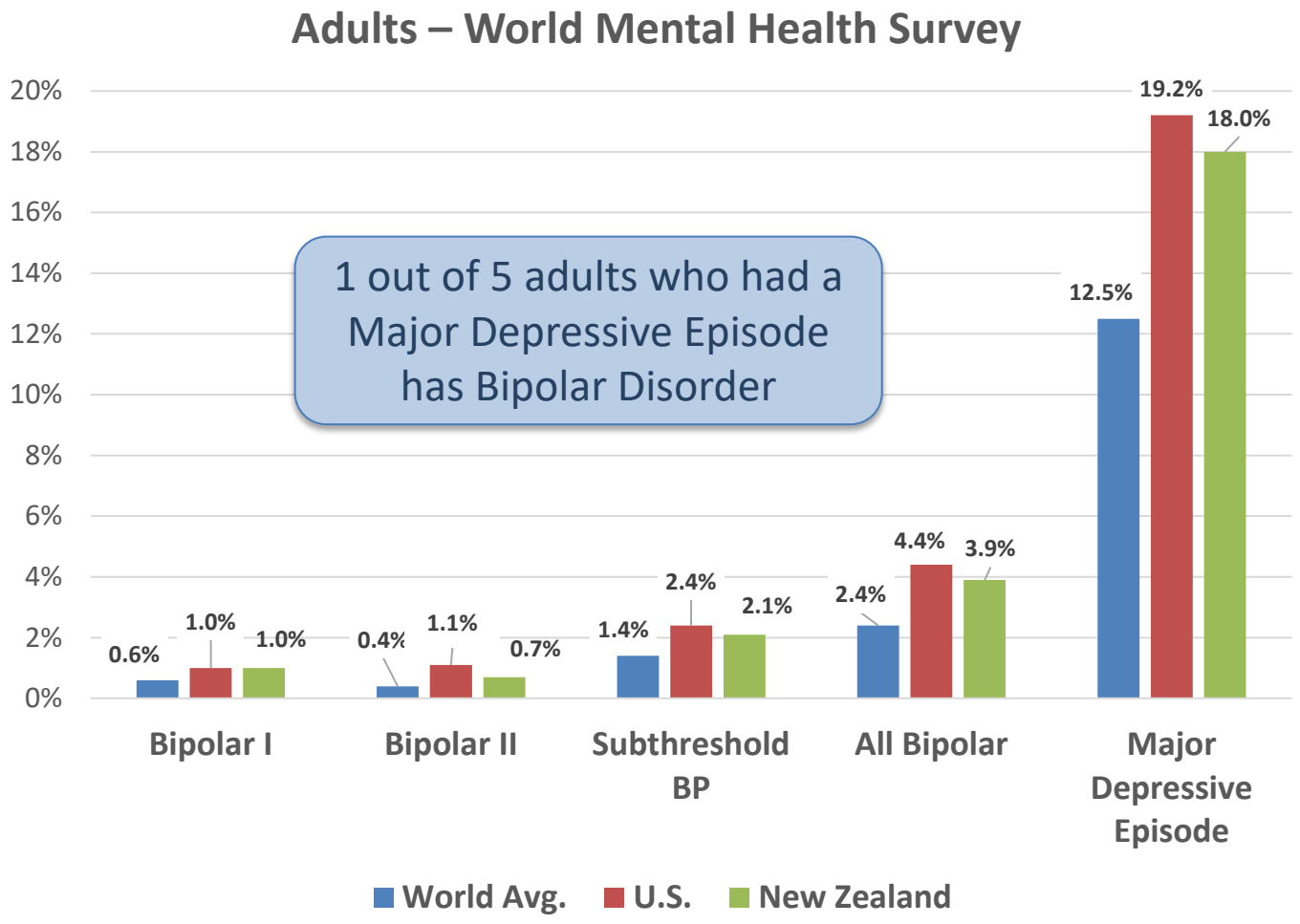
- 19 epidemiologic studies, N=56,103 (n=1,383 with bipolar disorder)
  - 7 from US, 12 from South America, Central America, or Europe

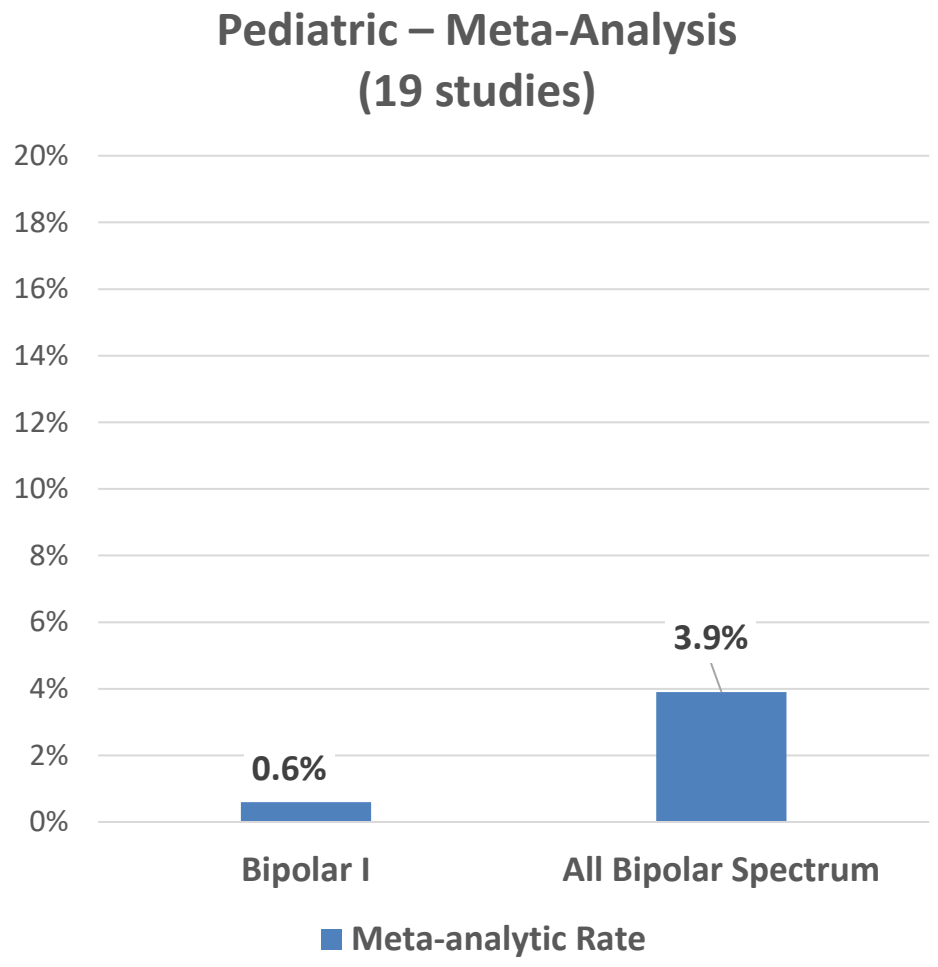
- 3.9%, Bipolar Spectrum Disorders
- 0.6% Bipolar Disorder- Type I

- Rates are *not* higher in the US than other countries
- Rates are *not* increasing over time (pre/post 2000)

- Need non-Western country data, consistent measurement, more data on young children

# Epidemiology of Bipolar Disorder




Merikangas KR et al., *Arch Gen Psychiatry* (2011)

Nationwide Children's — When your child needs a hospital, everything matters.

The Ohio State University College of Medicine

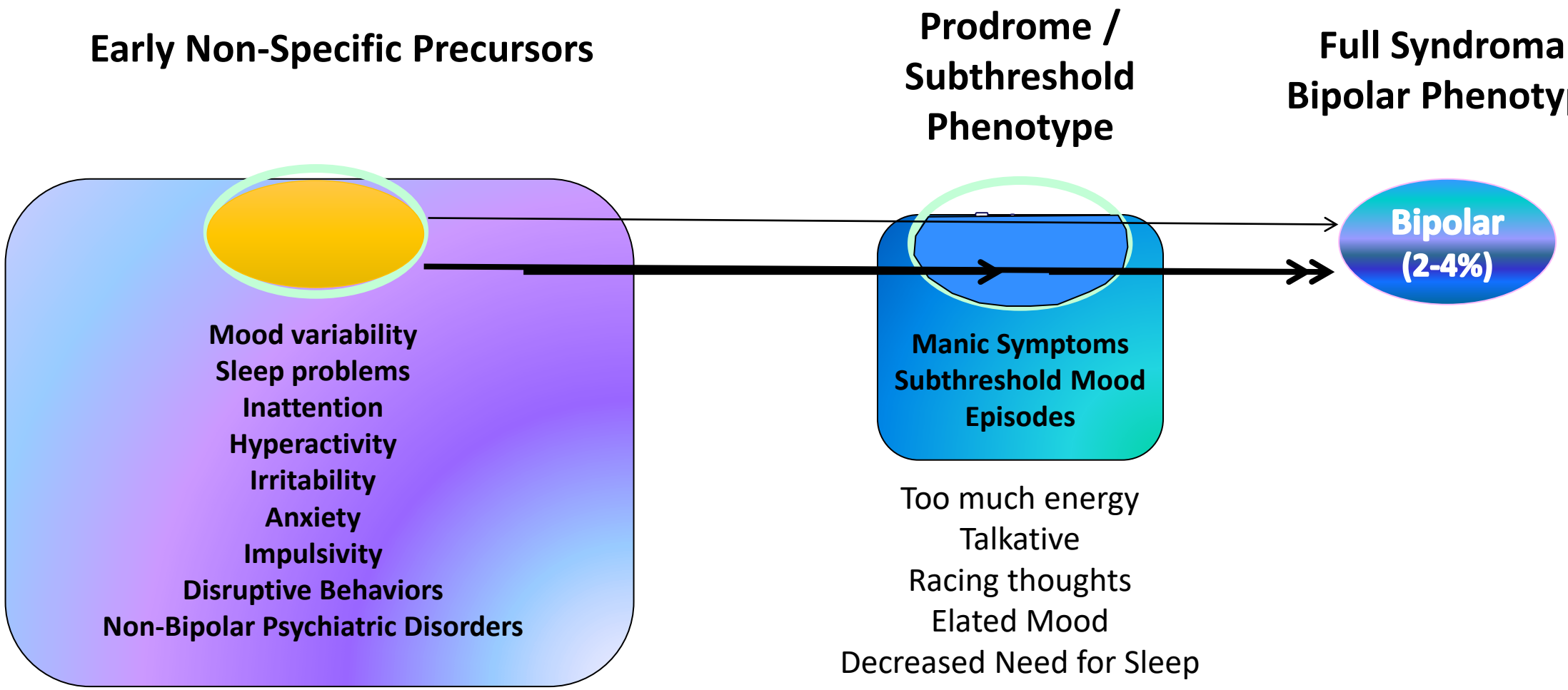
Van Meter AR et al., *J Clin Psychiatry* (2019)

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

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

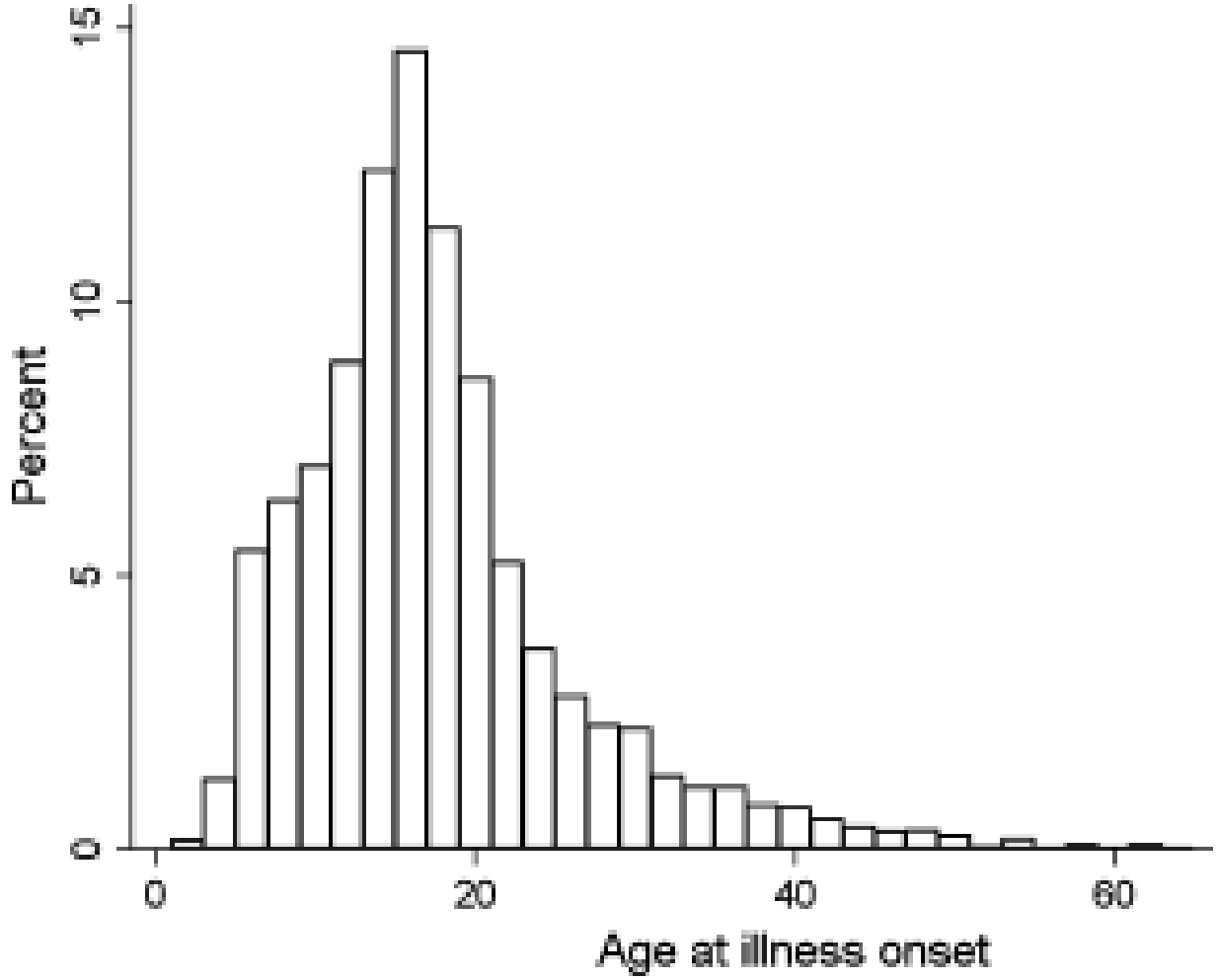
- Risk factors include:
  - symptoms of psychomotor retardation or psychosis
  - + family history-- bipolar disorder
  - ++ family history--mood disorder
  - Medication induced hypomania

# Developmental Progression of Bipolar Illness




Faedda GL et al., *Bipolar Disorders* (2019)
Van Meter AR et al., *J Am Acad Child Adol Psychiatry* (2016)

# Age of Bipolar illness onset




- N = 3,658
- 1st onset of cluster of manic or depressive symptoms
- 29% child onset
- 38% adolescent

Perlis et al., *Bipolar Disorders* (2009)

# *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) *Mendlewicz and Rainer, 1977*
- If 1 parent has a mood disorder, 27% offspring +
  If 2 parents have a mood disorder, 74% offspring + *Gershon et al., 1982*
- If one twin has a mood disorder– *Sullivan et al., 2000; Kieseppa et al., 2004*

| The Other Twin… | Identical | Non-identical |
|---|---|---|
| Depression | 43% | 28% |
| Bipolar Disorder | 75% | 11% |

# DIG FAST (Mania)

- Distractibility (must be a change from baseline-not ADHD)
- Indiscretion or excessive Involvement in pleasurable activities
- Grandiosity

- Flight of ideas
- Activity increase (see distractibility)
- Sleep deficit (but not tired)
- Talkativeness

# WHIPLASHED (Bipolar Depression; ≥5 symptoms)

*Ronald W. Pies, MD, Psychiatric Times, Vol 24 No 3*

- **Worse** or **"wired"** when taking antidepressants. Complaints of feeling "antsy," unable to sleep, or more agitated on conventional antidepressants. Numerous failed antidepressant trials; apparent "tolerance" to antidepressants not overcome with increased dosage (pseudotolerance); antidepressant-induced "switching" into mania or cycle acceleration may be reported.
- **Hypomania, hyperthymic** temperament (intense optimism, increased energy, reduced need for sleep, extroversion, overconfidence) or mood swings by history. Periods of elevated mood or energy often do not fit formal DSM-IV criteria for hypomania; eg, may last only a day or two. Mood lability in younger patients may be even more dramatic and poorly demarcated.
- **Irritable**, hostile, or showing mixed features during depression. May show one or more hypomanic features (eg, racing thoughts) even while depressed.
- **Psychomotor retardation** appears more common in bipolar I depression than unipolar major depression; **psychomotor agitation** more common in bipolar II than in unipolar major depression.
- **Loaded family history** for mood swings, bipolar disorder, or affective illness in general; also, comorbid mood disorder and alcoholism.
- **Abrupt onset and/or termination** of depressive bouts, or relatively brief depressive episodes (less than 2 to 3 months). May have **a brief burst** of increased energy or subthreshold hypomanic symptoms immediately before the onset of depression.
- **Seasonal** pattern of depression (depressed in fall/winter, hypomanic in spring).
- **Hyperphagia** and **hypersomnia**- more common in bipolar depression than in unipolar depression. Paradoxically, hypersomnia may coexist with psychomotor agitation in bipolar II patients ("sleepy speeders").
- **Early age** at depression onset (younger than 25 years), especially with psychotic features.
- **Delusions, hallucinations, or other psychotic features** appear to be more common in bipolar than in unipolar depression.

# Symptoms of Mania/Hypomania

Distinct period of abnormally and persistently elevated, expansive, or irritable mood and persistently increased goal-directed activity or energy, plus:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (feels rested with only 3 hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or racing thoughts
- Distractibility (attention too easily drawn to irrelevant stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments

# Manic / Hypomanic episodes in DSM-5

- At least 3 symptoms  (at least 4 if irritable mood only)
- Mood and symptoms present most of the day, nearly every day
  - 7 days for manic episode (any duration if hospitalized)
  - 4 days for hypomanic episode
- Episodes that emerge during antidepressant treatment and persist at full syndromal level after stopping treatment “count”
- Specifiers for manic, hypomanic and major depressive episodes
  - With anxious distress
  - With mixed features

# Bipolar and related disorders in DSM-5

- Bipolar I disorder: manic episode(s)
- Bipolar II disorder: hypomanic & major depressive episode(s)
- Cyclothymic disorder: numerous periods of subthreshold hypomania and depression over 2 years (1 year for kids)
- Substance/Medication-Induced or Due to Medical Condition
- Other Specified Bipolar and Related Disorder
  - Short (2-3 day) hypomanias + MDE's
  - Hypomanias with insufficient symptoms + MDE's
  - Hypomanic episodes with no prior MDE
  - Short-duration cyclothymia (? Minimum duration)
- Unspecified Bipolar and Related Disorder

# Subthreshold BP:  Bipolar Not Otherwise Specified (BP-NOS)

- Duration too short (episodes < 4 days) and/or 1 symptom short

- Distinct period of abnormally Elated Mood plus 2 symptoms or Irritable Mood plus 3 symptoms
- Mood must be clear change from usual and symptoms must be associated/intensify with mood change
- Change in functioning
- Not associated with medication
- At least 4 hours meeting above criteria in a 24-hour period to count as “one day” (persistence / to a significant degree)
- Lifetime of ≥ 4 days total of meeting criteria (e.g. 4 one-day episodes; 2 two-day episodes, etc.)

# *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 Psychopharm*

- 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 BPD or A/PTSD?*

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

# *Posttraumatic Stress Disorder*

- ***Traumatic event*** occurred

- The ***child's reaction*** involved intense fear, helplessness, or horror that might appear as disorganized or agitated behavior, with ***new*** and ***persistent*** examples of:

- ***Reexperiencing*** the trauma-- ≥ 1 of:
  - recurrent and intrusive distressing recollections (can be displayed as repetitive play)
  - recurrent distressing dreams (these may be frightening but w/o recognizable content)
  - acting or feeling like the traumatic event is recurring (this can include a sense of reliving the experience, illusions, hallucinations, and dissociative flashbacks)
  - intense psychological distress at exposure to internal or external reminders of the trauma
  - physiological reactivity on exposure to internal or external reminders

# *Posttraumatic Stress Disorder (cont'd)*

- ***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*

# Is It Tik Tok/You Tube?

*Christina Caron, Teens Turn to TikTok in Search of a Mental Health Diagnosis, NYTimes, 10-29-2022*

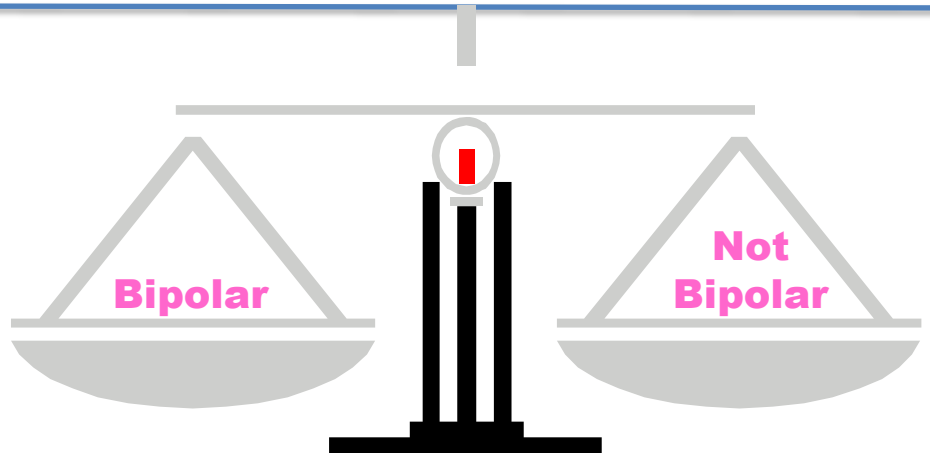
- Tourette, Dissociative Identity Disorder, Eating Disorders…Bipolar disorder
- Exacerbated by Covid and decreased face-to-face interactions
- A diagnosis "justifies" feeling "off"
- -: Can impede a careful diagnostic evaluation by a trained professional
- -: Can lead to erroneous treatment
- -: Can be seen as a "personality trait" not something to heal
- +: Can provide direction and path to appropriate treatment if accurate
- +: Can be a source of support

*"I could run a clinic full of these kids – oh wait, I think I am."* MAP Medical Director

# Diagnostic Difficulties

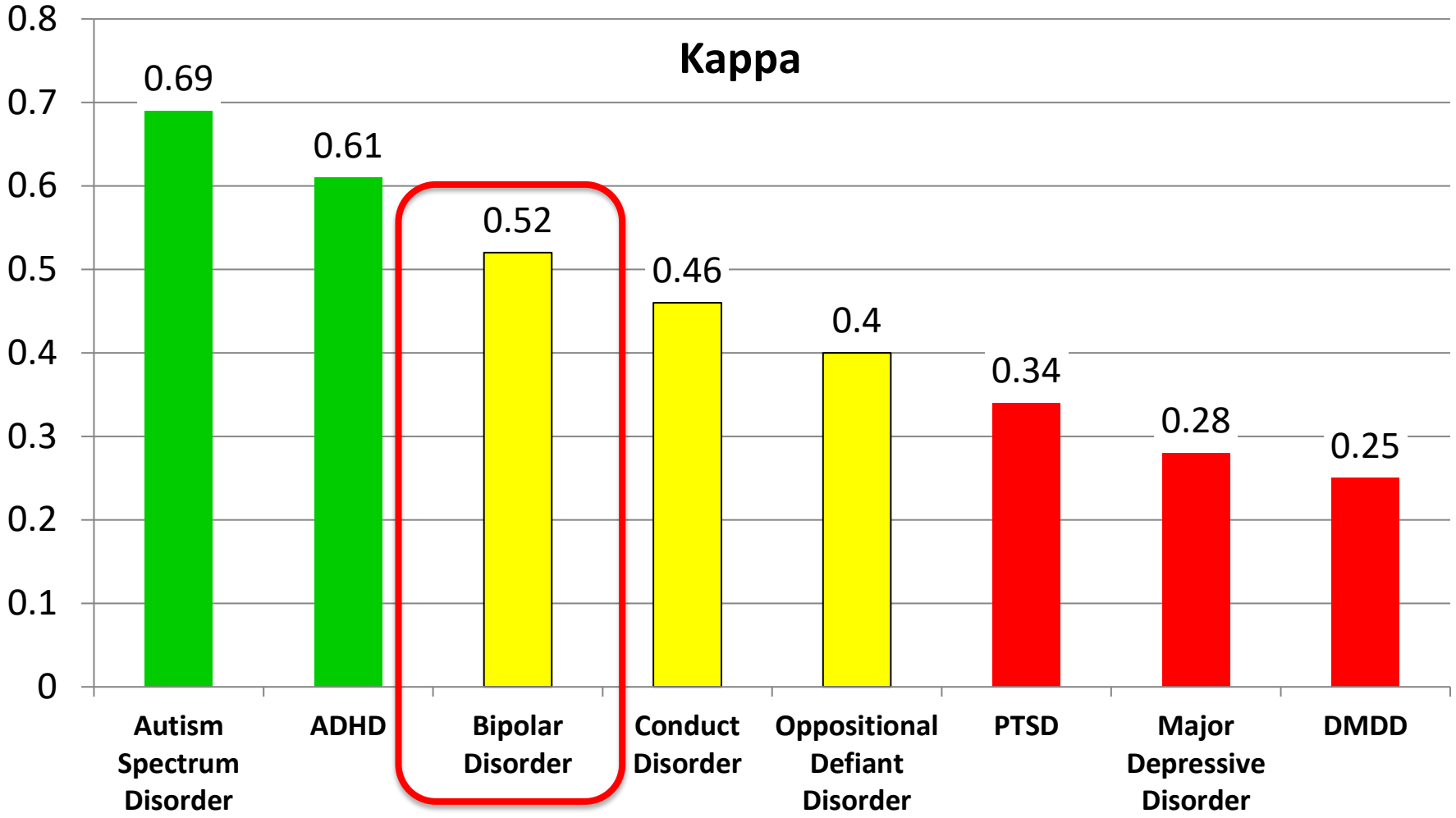
- Especially difficult to identify abnormally elevated mood, grandiosity
- Clear symptoms rarely observed in the office
- Lack of insight part of mania/hypomania – must ask parent / caregiver
- Broad differential diagnosis (remember can be comorbid with bipolar disorder)
  - Moody ADHD/DBD
  - Unipolar depression
  - Severe Anxiety disorders
  - Substance Use disorders
  - PTSD
  - Reactive Attachment Disorder / Trauma
  - High functioning autism spectrum
- Often need repeated visits, longitudinal follow-up, remain humble

# Pearls to help with diagnosis




- Change compared to baseline, compared to peers in similar situations
- Presence of elation/euphoria, decreased need for sleep, grandiosity
- Look at timeline of symptoms – not just current mental status
- Episodic worsening within chronic symptoms
- Family history (BP is highly heritable; Identical twin concordance ~ 30-70% vs. Fraternal ~ 10-20%)
- MDD: + psychosis, psychomotor retardation, childhood onset
- History of medication-induced manic symptoms

# Test-Retest Reliability of DSM-5 diagnosis in youth




Regier et al., *Am J Psychiatry* (2013)

# Research goal: Improve identification and accurate diagnosis of bipolar disorder in youth

- What are the clinical features of pediatric bipolar disorder?
- Do some children and adolescents with “subthreshold” presentations of mania/hypomania really have a bipolar illness?
- High-Risk Research Studies
  - Clinical High-Risk
    - Course and Outcome of Bipolar Youth (COBY)
  - Familial High-Risk
    - Pittsburgh Bipolar Offspring study (BIOS)

# Course & Outcome of Bipolar Youth (COBY) Study

- Longitudinal follow-up of youth with BP-spectrum illness
- Funded by NIMH
- Pittsburgh, Brown, UCLA
- Referred Sample (outpatient, inpatient, advertisements)
- Ages 7 – 17
- Strict application of DSM-IV criteria for BP - I (n=260) and BP – II (n=33)
- Operationalized criteria Subthreshold Bipolar Disorder / BP-NOS (n=153)

# Manic Symptoms in Pediatric Clinical Samples with BP-I

| | Mass General | WASH-U | Case Western | COBY BP-I |
|---|---|---|---|---|
| **Elated/Elevated Mood** | **25%** | **89%** | **86%** | **90%** |
| **Irritability** | **84%** | **98%** | **92%** | **84%** |
| Increased Energy | 79% | 100% | 81% | 90% |
| Grandiosity | 57% | 86% | 83% | 72% |
| Decreased Need for Sleep | 53% | 40% | 72% | 81% |
| Pressured Speech | 68% | 97% | 81% | 93% |
| Racing Thoughts | 71% | 50% | 88% | 74% |
| Distractibility | 93% | 94% | 84% | 89% |
| Motor Hyperactivity | 90% | 99% | 81% | 95% |
| Poor Judgment | 90% | 90% | 86% | 84% |
| Hypersexuality | 25% | 43% | 32% | 47% |

Axelson et al., *Arch Gen Psychiatry* (2006)

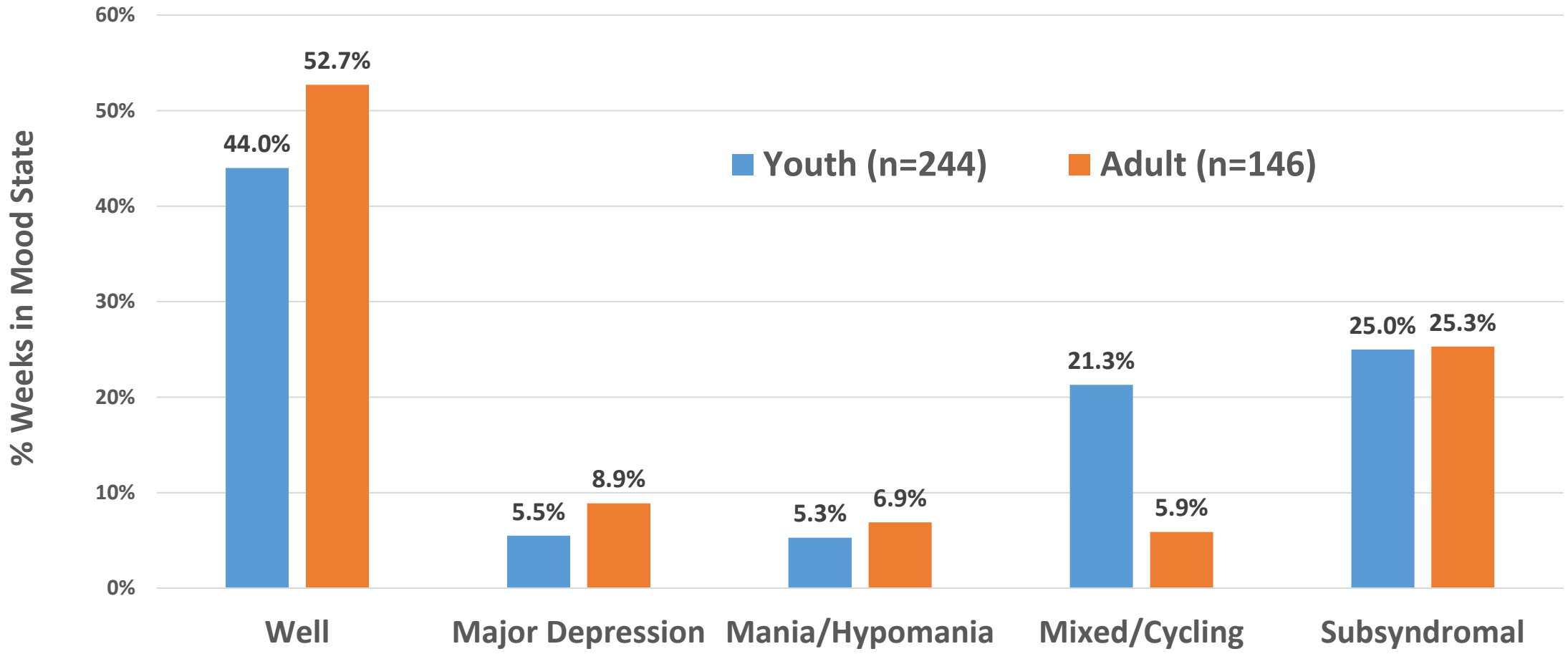
# Comorbid Disorders – Bipolar I Disorder

| | Mass General | WASH-U | Case Western | COBY Age Adjusted | World Mental Health Survey Adults |
|---|---|---|---|---|---|
| Attention-Deficit Hyperactivity D/O | 87% | 87% | 70% | 69 % | 28% |
| Oppositional Defiant D/O | 86% | 79% | 47% | 46% | 30% |
| Conduct D/O | 41% | 12% | 17% | 12% | 28% |
| Anxiety D/O | 54% | 23% | 14% | 37% | 76% |
| Substance Use D/O | 7% | 0% | 7% | 5% | 52% |

18% Panic D/O
58% Panic Attacks

Axelson et al., *Arch Gen Psychiatry* (2006)  Merikangas KR et al., *Arch Gen Psychiatry* (2011)

# Bipolar I Longitudinal Course: Youth vs. Adults




Judd et al., *Arch Gen Psychiatry*, 2002
Birmaher et al., *Am J Psychiatry,* 2009

# Subthreshold BP Disorder - progression

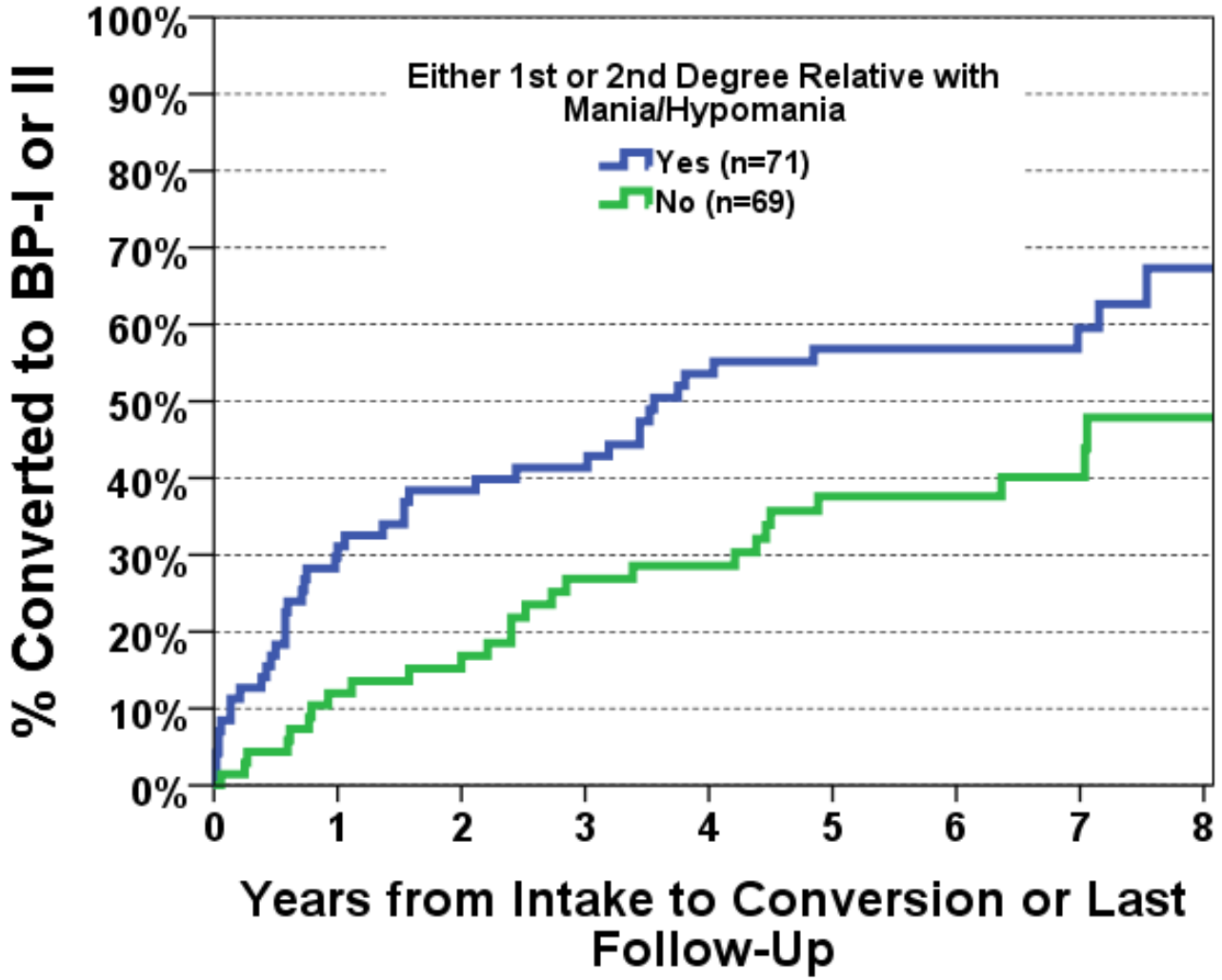
- COBY Intake:  15 year old female
- Age 9:  Panic attacks, frequent periods of anxiety
- Age 10:  First major depressive episode (5 in total, with 1 serious suicide attempt, 2 inpatient hospitalizations)
- Age 13: First onset of brief hypomanias
  - Duration 1-2 days, maximum 2 days; ~50 lifetime
  - Elevated mood, cooking, cleaning fits, sleeps 3 hours/night, rapid speech, physically restless and energized, mildly inflated self-esteem
  - Could occur in the midst of major depressive episode
- Heavy THC use in late adolescence
- Schizoaffective Disorder, Bipolar Type as a young adult

# COBY Intake: Subthreshold BP vs. "Full" BP-I

- Similarities
  - Types of symptoms & number to meet DSM-IV criteria
  - Comorbidity
  - Rates of prior Major Depressive Episode
  - Family History (inc. BP and depression)
  - Cross-sectional symptom severity & impairment at intake
- Differences
  - Duration of episodes (had many short episodes)
  - Lower severity of symptoms at most severe episode
  - Lower severity of impairment at most severe episode
  - Lower rates of severe features (psychosis, suicide attempts)

**Axelson et al., *Arch Gen Psychiatry* (2006)**

# Family History at Intake associated with progression to BP-I or II




**Log Rank (Mantel-Cox) $\chi^2 = 6.5$**
**p=.01**

**Median 6.9 years of follow-up**

**33 (24%) converted to BP-I**
**(9 initially converted to BP-II)**

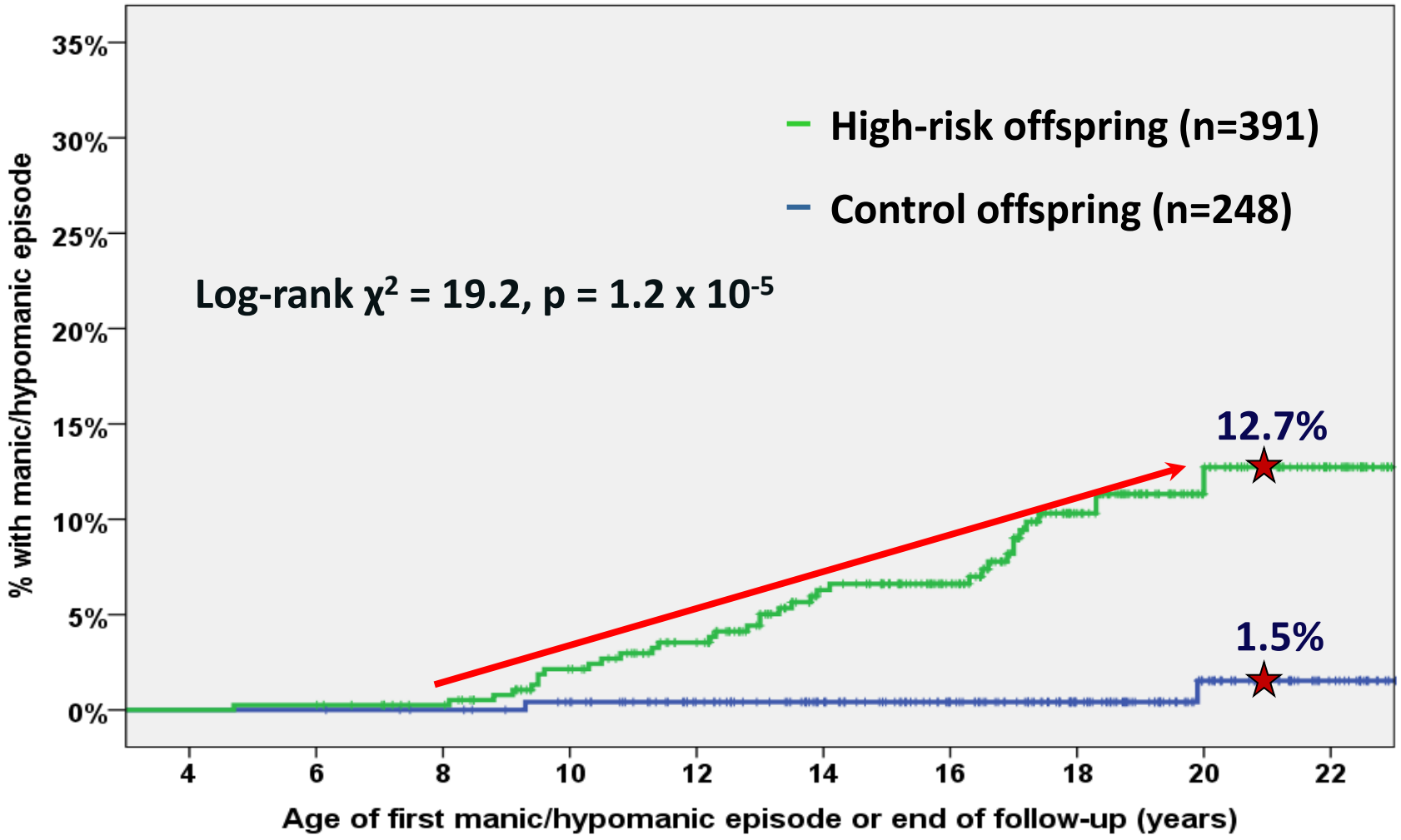
**35 (25%) converted to BP-II**

Axelson et al., *J Am Acad Child Adolesc Psychiatry* (2011)

# Pittsburgh Bipolar Offspring Study Design

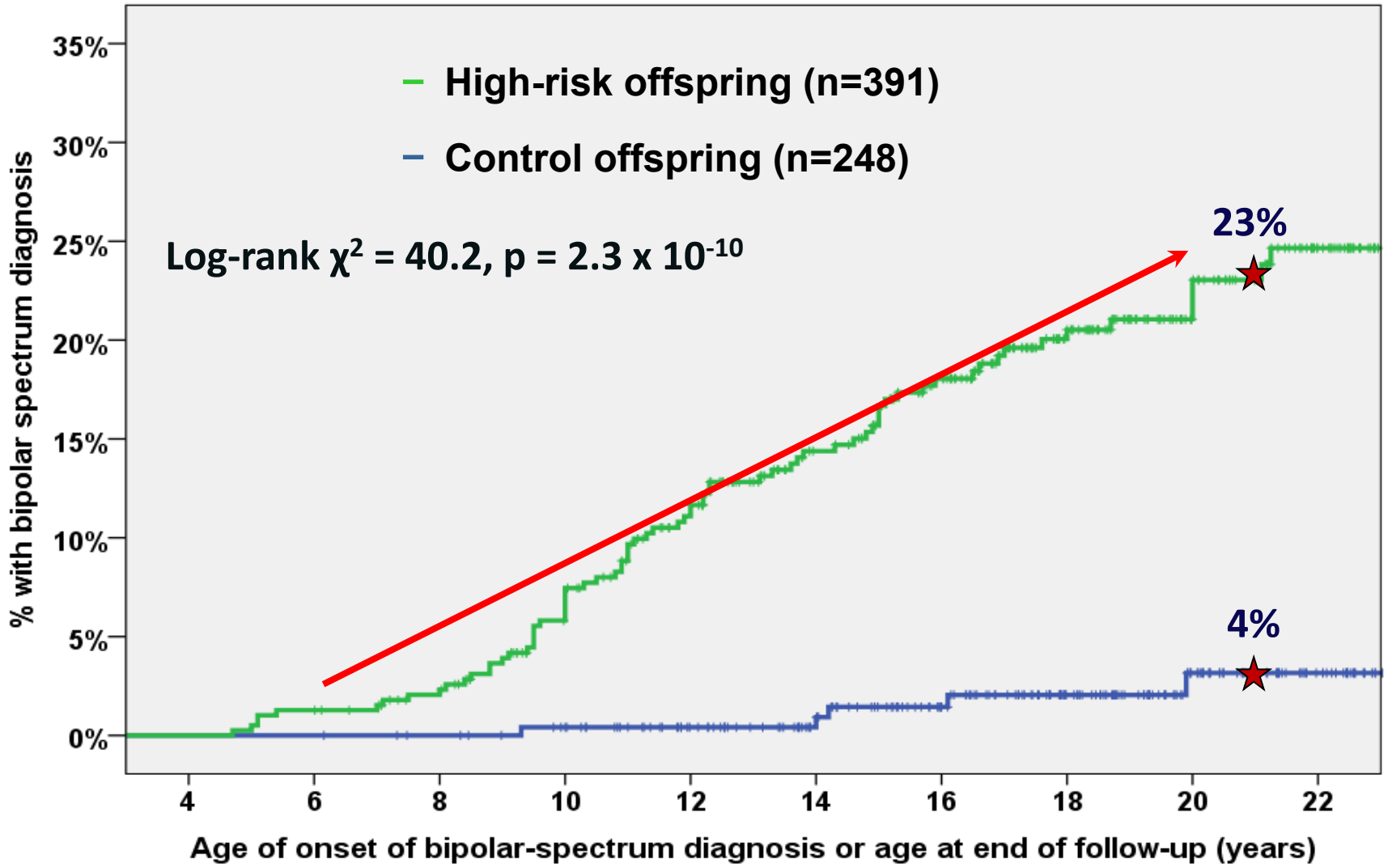
- Case-control high-risk study
- Recruit parents who have bipolar disorder and child/adolescent offspring
- Demographically match control parents with child/adolescent offspring
- Examine offspring (blind to parent diagnosis) every 2 years
- 91% had follow-up; average 2.7 follow-up assessments

# Age of Onset of 1st Manic / Hypomanic Episode

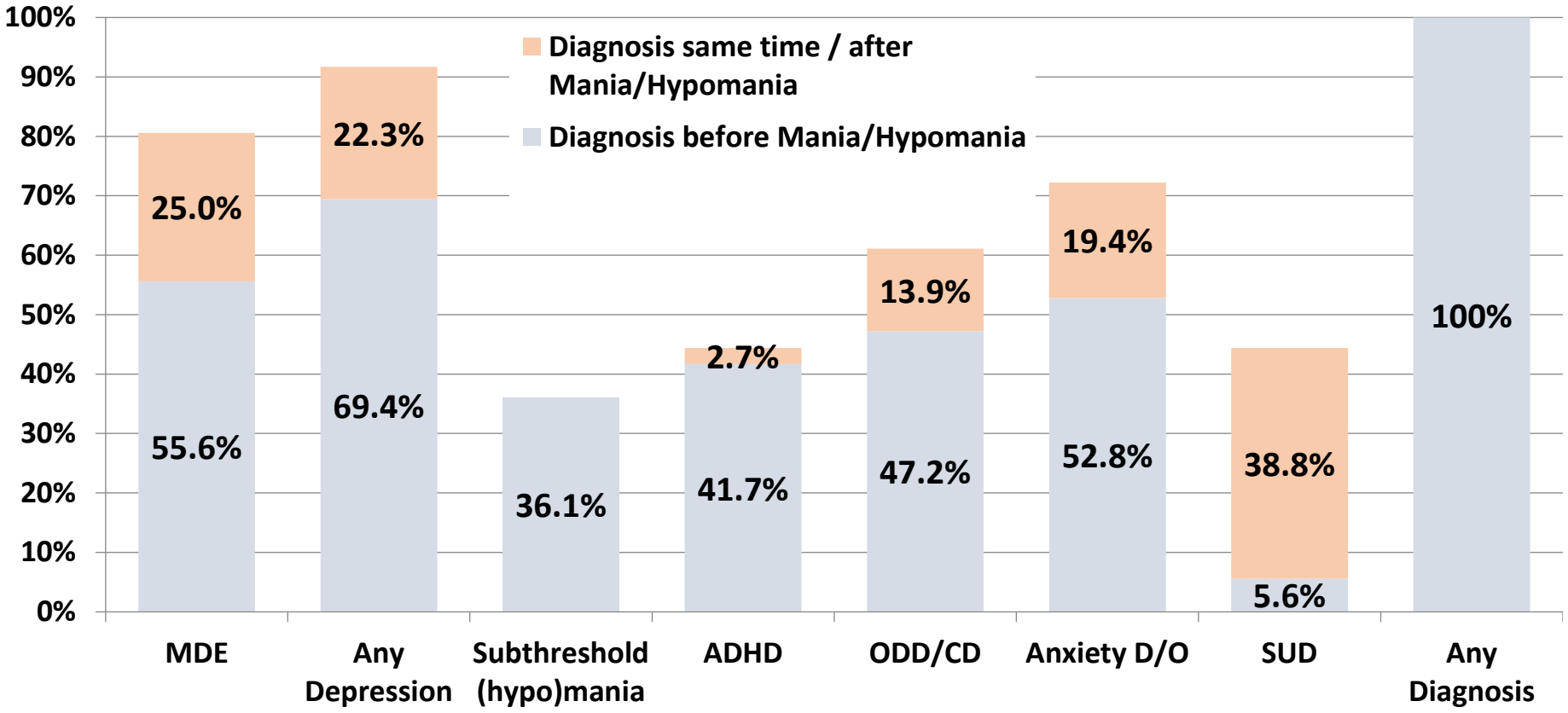



Axelson et al., *Am J Psychiatry* (2015)

# Age of onset of BP-spectrum disorder (includes subthreshold (hypo)mania)



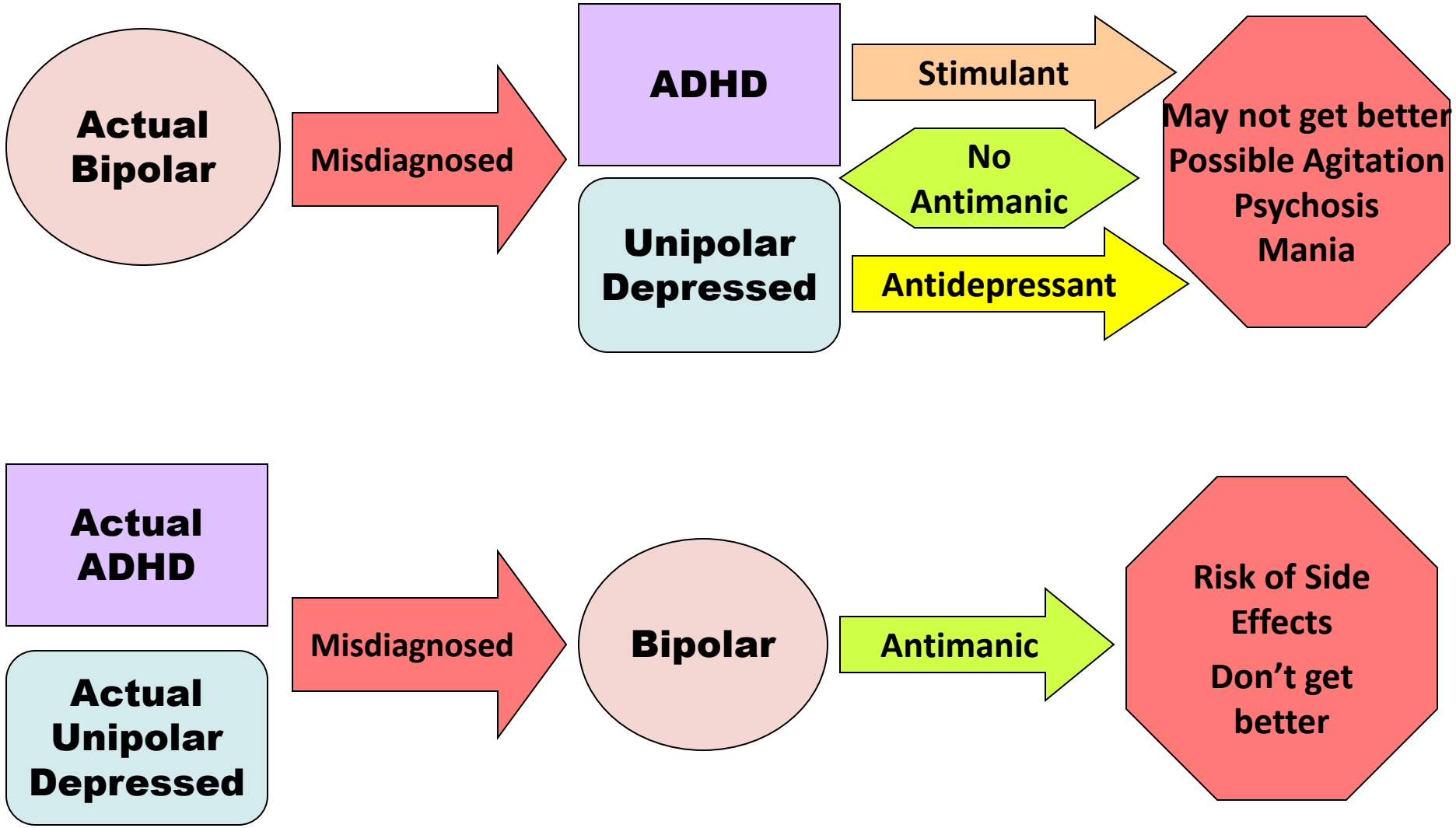
# Onset of depression and comorbid diagnoses relative to onset of 1st Manic/Hypomanic Episode (n=36)




**Onset established when full diagnostic criteria were met**

Axelson et al., *Am J Psychiatry* (2015)

# Diagnostic Implications for medication treatment



# Evidence-Based Psychotherapy for Bipolar Disorder

*Goldstein et al, 2017, Bipolar Disorders, 19(7): 524-543*

| Level of Evidence | Psychosocial Treatment | Citation |
|---|---|---|
| Well Established | Family Psychoeducation & Skill Building | Fristad et al, 2009<br>Miklowitz et al, 2008<br>West et al, 2014 |
| Probably Efficacious | -- | -- |
| Possibly Efficacious | Cognitive-Behavioral<br>*Dialectical Behavioral*<br>Interpersonal & Social Rhythm | Feeny et al,2006<br>*Goldstein et al, 2007*<br>Hlastala et al, 2010 |

# Four Common Ingredients of Psychotherapy

- psychoeducation
- family-based
- emotion regulation
- symptom management

# 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)*

Kid Power Tactics for Dealing with Depression -- *N. & S. Dubuque*

Matt, The Moody Hermit Crab -- *C. McGee*

Anger Mountain—*B. Hebert*

# Books for Adolescents

Mind Race: A Firsthand Account of One Teenager's Experience with Bipolar Disorder – *P.E. Jamieson & M.A. Rynn*

*****

When Nothing Matters Anymore:  A Survival Guide for Depressed Teens -- *B. Cobain*

Recovering from Depression: A Workbook for Teens -- *M. E. Copeland & S. Copans*

Monochrome Days: A First-Hand Account of One Teenager's Experience with Depression – *Irwin, Evans & Andrews*

# Children's Literature

## *The Phoenix Dance*

- Dia Calhoun, award winning author
- Farrar, Straus & Giroux, NY, 2005

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

# Books for Parents

Raising a Moody Child: How to Cope with Depression and Bipolar Disorder -- *M.A. Fristad & J.S. Goldberg-Arnold*

The Bipolar Teen: What You Can Do to Help Your Child and Your Family – *D.J. Miklowitz & E.L.George*

New Hope for Children & Teens with Bipolar Disorder—*B. Birmaher*

The Childhood Bipolar Disorder Answer Book– *T. Anglada & S.M. Hakala*

The Bipolar Child --*D. & J. Papalos*

# Books for Adults

Living Without Depression & Manic Depression --*M. E. Copeland*

An Unquiet Mind -- *K. Redfield Jamison*

Clinician's Guide to Bipolar Disorder – *Miklowitz & Gitlin*

The Bipolar Survival Guide: What You and Your Family Need to Know --*D.J. Miklowitz*

# Educational Websites

**Information re: BPD for Parents, Children and Educators**

- *www.bpchildren.com*
- *www.thebalancedmind.org (Depression and Bipolar Support Alliance)*

**Special Education Advocacy -- *www.wrightslaw.com***

**National Association of Therapeutic Schools and Programs—**
***www.natsap.org***

**Internet Special Education Resources (ISER)**

- *www.iser.com*

# Groups/Websites

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

# Conclusion

Bipolar spectrum disorders CAN be diagnosed in youth

- Take your time and be thorough

Treatment should be multi-modal

Therapy should include the child and family

# Thank you

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