



Hello!

Welcome to the first edition of our new digital newsletter! We are always looking for ways we can improve and appreciate your feedback. If you have any questions and/or comments, please let us know! We look forward to hearing from you.

Warmly,

Colleen Schneider

Upcoming Events

The 30th Annual CMHACY Conference

California Mental Health Advocates for Children and Youth

Shaping Our Future: Prevention, Integration, Innovation, Advocacy

Pre-Conference: May 4, 2010

Conference: May 5, 2010 - May 7, 2010

www.cmhacy.com

Public Policy Updates by Raphael Metzger

I am very pleased to be joining the team at United Advocates for Children and Families (UACF) as Director of Policy and Research. One of the nice things about coming into a new situation is being able to carry in certain external perspectives of the UACF organization. I thought I would share some of my initial impressions of UACF in this introductory article. These are:

California Specialists. Like many non-profit, charitable organizations UACF is the product of a grassroots movement by a special group of people who have experienced things as they are, and have had the courage to try and create what should be. What seems to distinguish UACF, however, is a conscious decision not to grow and expand for the sake of growth, but to return to a focus on California, the state of its birth.

Consistently Mission Driven. UACF was created by parents, and perhaps this is why I have yet to hear any major discussion or programs or operations that has not deferred to the question, *“what is right for California’s children and their families?”* or *“what do California children and families think about this?”*. “Subject matter territoriality” is noticeably, and refreshingly, absent.

Meaningful Participation. Participation is the essence of democracy, and UACF’s approach to policy is uniquely democratic. The UACF process for developing and adopting policy positions is specific, transparent, and designed to support the meaningful, substantive participation of families in the development of the public policies that affect them.

These are some of the reasons I am excited to have joined the UACF family. I am looking forward to serving the needs and interests of the children and families served by UACF, and to working with CEO Oscar Wright and the Board to support the advancement of child and family mental health in California.

Raphael Metzger
rmetzger@uacf4hope.org

Bipolar May Not Be the Right Diagnosis for Some Kids: According to a Panel of Experts with the American Psychiatric Association.

February 10, 2010

Since the mid-1990s, the number of children diagnosed with bipolar disorder has increased a staggering 4,000 percent. And that number has caused a lot of controversy in the world of child psychiatry.

Doctors faced with kids struggling with explosive moods felt the diagnosis was appropriate and said that the bipolar medications they gave to children worked. Research psychiatrists worried that the children were being given a label that wasn't right for them, and saddled with the sentence of a serious mental illness for the rest of their lives.

In a move that could potentially change mental health practice all over America, the American Psychiatric Association has announced that it intends to include a new diagnosis in its upcoming fifth edition of the Diagnostic and Statistical Manual — and hopes that new label will be used by clinicians instead of the bipolar label. The condition will be called temper dysregulation disorder, and it will be seen as a brain or biological dysfunction, but not as a necessarily lifelong condition like bipolar.

Definitions: Bipolar Disorder and Temper Dysregulation Disorder

The following are excerpts from the DSM on criteria used in making a diagnosis of bipolar disorder, or a newly proposed category, Temper Dysregulation Disorder. Doctors have been using the bipolar definition for adults to diagnose kids.

Bipolar: *Patients with bipolar have one or more manic episodes and often also experience major depressive episodes.*

Manic episodes are when a person experiences an unusually euphoric or irritable mood that lasts for at least a week. During a manic episode a person may:

- have an inflated self-esteem that can reach delusional proportions
- feel full of energy and be more talkative than usual even while not needing much sleep
- do pleasurable things to excess, often with painful consequences, such as engaging in unrestrained shopping sprees, sexual indiscretions, or foolish business involvements
- It's common during manic episodes for the person to alternate between euphoria and irritability.

Major depressive episodes are described as at least 2 weeks of depressed mood or loss of interest.

The patient also shows additional symptoms: trouble sleeping, lack of interest, feeling sad, hopeless or discouraged, decreased energy or sense of worthlessness and guilt, and difficulty concentrating.

Temper Dysregulation Disorder: *This proposed new disorder is seen as a brain or biological dysfunction, but not necessarily a lifelong condition. It can only be diagnosed in children over the age of 6, and onset must begin before a child is 10.*

The disorder is characterized by severe recurrent temper outbursts in response to common stressors. To have the disorder, the person has to have had these symptoms for at least 12 months, and cannot have been free of symptoms for more than three months at a time.

- temper outbursts involving yelling or physical aggression
- overreacting to common stressors
- temper outbursts occurring on average three or more times a week
- nearly every day the mood between temper outbursts is persistently negative.
- in the past year the patient has not had a period longer than a day of elevated or euphoric mood.

The DSM is the official dictionary of mental disorders recognized by the American Psychiatric Association. Doctors use the DSM to diagnose patients, and insurance companies use it to decide on reimbursement, so it's incredibly important in the profession of psychiatry.

By adding this new entry, the American Psychiatric Association is trying to use the considerable institutional power of the DSM to curb use of the pediatric bipolar label.

But it will take some time to determine whether psychiatrists and psychologists will actually change their ways. "I don't know what they'll do," said Dr. David Shaffer, one of the psychiatrists on the DSM 5 childhood committee that is behind this change. "Maybe the practitioners will be such firm believers in it that they'll continue to use [bipolar]. But, you know, I guess there are a lot of people that have been involved in reviewing this."

The Beginning of 'Bipolar' Children

The notion that children might suffer from bipolar disorder in large numbers is new, dating back only to the mid-1990s.

Dr. Janet Wozniak, an assistant professor of psychiatry at Harvard Medical School, was one of the people who first popularized this idea.

Wozniak says that when she was starting out, most psychiatrists placed the prevalence of bipolar disorder in children somewhere between "never" and "vanishingly rare."

"Papers about bipolar disorder in children would usually start out with the phrase, 'Here's a disorder that's so rare maybe you'll see one or two in your entire lifetime in practice,' " Wozniak says.

Wozniak herself only started thinking about pediatric bipolar disorder when she got a job as a researcher in the clinic of a famous Harvard child psychiatrist named Dr. Joseph Biederman. Biederman was studying kids with attention deficit hyperactivity disorder and felt that there was a portion of the kids in his clinic whose problems with anger seemed to go way beyond normal ADHD. So he asked Wozniak to look into it.

She did. And what she found were kids who continued to struggle with intense, uncontrollable outbursts of anger — violent hitting and screaming and kicking — even after they passed through the preschool years.

She felt these outbursts were substantively different from the kind of outbursts you saw among ADHD kids, who often had problems regulating their impulses. Then one day, she says she had an insight.

"This child that I was thinking of as having really difficult-to-treat ADHD and a lot of parent-child interaction problems, I really was ignoring the serious mood component of their problem." In other words, it wasn't that the kids just had problems with their impulse control; there was a more serious problem of mood. These kids were bipolar.

Redefining a Defining Characteristic

Wozniak wrote all this up in a now famous paper proposing that some of the kids characterized as having ADHD were actually bipolar.

The paper won awards. Clinicians began to approach Wozniak at meetings saying her insights made intuitive sense. She had helped transformed their practice.

But Shaffer says that to see these children as bipolar, Wozniak and her co-author, Joseph Biederman, had to change one critical component of the traditional definition of bipolar disorder. "The defining feature of manic-depression was that it was episodic," says Shaffer. "You had episodes of depression and episodes of mania and episodes of normal mood, and that was really, its defining characteristic."

But the kids Wozniak described rarely, if ever, had these kind of discrete weeklong or month-long episodes. So to make them fit the traditional concept of bipolar disorder, Shaffer says, she and Biederman made the argument that in children, episodes presented themselves in a radically different way.

"They said maybe in childhood the episodes would be very brief and very frequent," says Shaffer. "These are called 'ultra diem,' you know, 'many times a day.' If you regarded every time children changed their mood, every time they lost their temper or became overexcited, as a mood episode, then they were really being misdiagnosed and were really cases of bipolar disorder."

Critics countered that bipolar should look the same in kids and adults, that there wasn't good evidence that these kids grew up to be bipolar, and that if you looked backward at bipolar adults, they didn't necessarily have these uncontrolled anger issues when they were young, Shaffer says.

Nevertheless, pediatric bipolar disorder took off. Today, it's estimated that at least 1 million children in the United States have been diagnosed with the disease. Wozniak is convinced that she knows why. "The diagnosis took off because it made clinical sense," she says. "Because we opened our eyes."

A Second Look at Bipolar Diagnoses

Gabrielle Carlson, a child psychiatrist at Stony Brook University, doesn't agree that the bipolar label took off simply because the diagnosis allowed clinicians to finally categorize children in a way that made sense. She points to a host of other reasons.

Reworking the Book of Mental Disorders

When clinicians see a patient with mental health issues, part of their job is to determine if the patient is experiencing temporary emotional struggles or if the patient has an illness. To do this, doctors rely on the bible of psychiatry, a book called the Diagnostic and Statistical Manual of Mental Disorders. The DSM lists all the mental disorders recognized by the American Psychiatric Association.

The book is also used by insurance companies to decide which treatments they'll pay for, and by courts to help determine insanity or other mental conditions.

The APA is releasing a new draft of the DSM Wednesday, the first major revision since 1994. This latest version of the book, the **DSM 5**, proposes some significant changes to the following disorders:

Asperger's Syndrome

Binge Eating

"Cutting"

For example, she says many of the kids now categorized as bipolar were, once upon a time, diagnosed as having conduct disorder. Kids with conduct disorder are seen as very combative, aggressive, and prone to destructive behavior. But the treatments for conduct disorder are woefully limited, says Carlson. "Mostly prayer and fasting," she says. "We don't have good treatments for it. We've got parent-training kinds of treatment, very strict behavioral modification kinds of things, but the evidence that therapy makes a big difference is not wonderful."

Which is why when every day psychiatrists were told that they could now think of this set behaviors as manic-depression, not as conduct disorder, they got so excited, says Carlson. "They thought, 'Heck, if that's what it is, we have a bunch of medicines that are supposed to be helpful for mania — maybe I can make it better,' " she says. This has deep appeal to doctors face to face with parents who are heartbroken over the difficult time their child is having.

Another advantage to the bipolar label, Carlson points out, is that the insurance industry saw bipolar as a biological or medical problem, while conduct disorder was seen more as a parenting problem, so insurance companies were reluctant to reimburse for it.

"If you've got something that says it's not a medical problem," says Carlson, insurance is not going to pay for it. "Conduct disorder is bad parenting, lousy environment, poor supervision, you're a bad seed. It ain't a medical problem. Bipolar they'll pay for."

Finally, Carlson argues, parents themselves were relieved on some level. Because this set of behaviors was no longer seen as conduct disorder, the psychiatrist sitting across the desk from them was no longer blaming them for the terrible things that were happening to their child.

"Part of the acceptance of the bipolar if you're a parent is, 'Hey I'm off the hook on this one. It's not 'cause I'm a bad parent, I've just got this kid with a genetic problem. It's not my fault,' " says Carlson. "You know, there's some pros and cons to that, but the fact remains many people found that liberating."

A Lifelong Label

So clearly there are some real advantages to using the bipolar label. The problem, says Carlson, is that because bipolar disorder is understood as a chronic lifelong problem, you really want to be very careful about how you apply it.

"If you have a child who's got this behavior but you're not sure how it's going to evolve, to say to somebody, 'You've got to be on this medication for the rest of your life' is sentencing someone to something that's premature. And in the case of some of these medications, where we're not sure of some of the metabolic side effects; you may be exposing them to a risk that they don't need to have."

In fact, the problems with medication was foremost in the mind of the people put in charge of the childhood disorder section of the manual, says Shaffer. Particularly, Shaffer says, atypical, anti-psychotic medications, which, he says, "we think have quite profound effects on important mechanisms on the brain that may influence growth and development of the nervous system."

So, Shaffer and his DSM colleagues set out to create a new diagnosis — temper dysregulation disorder — that they hope clinicians will use instead of the bipolar label, he says. "We were trying to find a way to adequately describe the really quite serious behaviors that many of the children who've been given [the bipolar label] have. So what we thought would be valuable would be to carve out a group with the most severe reactions: [children] who when they do lose their temper, do so with great force, and who are having [tantrums] frequently — two or three times a week — and between the big episodes, have an abnormal mood."

Getting the Diagnosis Right

Of course there is no way to predict what practical effects creating the TDD category might have. For instance, Carlson points out that even if they are successful at changing the label that clinicians use, it could be that the kids all get the same medications as before. "They may get many of the same. Absolutely," she says. "But the difference is going to be that you won't have to take this for the rest of your life."

Carlson doesn't necessarily see this as a bad thing. She emphasizes that these children have very serious problems, and though there's been trouble naming it, there's clearly some sort of dysfunction in their brain. Shaffer agrees. "I don't think anyone is arguing that these are perfectly normal children that get the label [bipolar] — far from it," he says. "We're saying these kids are very sick. But they probably don't have bipolar disorder. And they probably do deserve a name that adequately describes what they're doing."

<http://www.npr.org/templates/story/story.php?storyId=123544191&ft=1&f=100>

Strategies for Teaching Children to Make Good Choices-from the folks at Sandbox Learning Company

Choice is a big part of people's lives. We decide daily what to wear, what to do, and how to treat people. Teaching children how to make good choices is critical for independence and self-control. This article focuses on a variety of strategies for teaching choice making.

1. Allow Children to Make Choices - Often it is easier to choose for children than allow them to decide for themselves. Unfortunately, lessons learned by making good and bad choices help children become responsible, independent adults. Choice also gives children a sense of ownership in activities. Take time to offer choices, create situations for choice, and reinforce the importance of good choices in your day.

2. Limit Choices - Keep the number and types of choices within reasonable limits. For example, if you let a child pick a snack, give them two or three healthy choices. By providing only allowable choices you reduce opportunities for conflict and create a situation where they succeed at making a good choice.

3. Discuss Options – When faced with decisions, think through and discuss the options to help children understand why one choice is better than another. Discuss possible choices, consequences, and why one option is better. For example, when leaving the house look outside and discuss the weather. Is it cold? Is it raining? Which coat is the better choice? What happens if you pick the light cotton coat and it rains? By guiding children through choices you teach them how to make decisions for themselves.

4. Consider Other People – When decisions involve other people, discuss the implications of the choice for the other people. For example, if a child wants to use the swing for the duration of recess discuss: Have other people asked to use the swing? Are other children waiting for the swing? How would you feel if you didn't have a chance to use the swing? Are there other places you can play for part of recess? This helps children realize their choices affect people other than themselves.

5. Use Past Choices as Opportunities – When a child makes a bad choice such as cutting in line, saying something hurtful, or playing rather than finishing homework, use the opportunity to discuss why the choice was bad, consequences, and better choices for the future. Ask the child what other choices they could have made and what may have happened. Additionally, use past decisions and consequences as reminders. For example, "Noah, remember how you played video games rather than clean your room yesterday and had to miss your favorite show and clean up? What do you think you should do today?"

6. Praise Good Choices – When children make good decisions let them know what they did and why it was a good choice. For example, "Jason, I like the way you moved over to make room for Ella on the bus. It was nice of you to share your seat. That was a very good choice."

7. State When There Is No Choice – Some situations such as safety and schedules have no choices. Holding hands crossing the street, participating in fire drills, and leaving on time for school are examples of times when there is no choice. Explain why these situations do not have choices and why all people must follow certain rules and schedules. Let children know if there is an aspect of the event that is their

choice. For example, "We have to leave now for the bus, but you can carry your blue or red book bag."

For more great ideas, please go to: sandbox-learning.com