What Lies Beneath: Pediatric Bipolar Disorder in the Context of the Rural School

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Sarah's teachers have begun to notice unusual behavior in Sarah early in her sophomore year of high school. These "changes of personality" seem to occur spontaneously. Instead of talking only when called on, she speaks up and interrupts her teachers, even after losing points for doing so. Sarah also appears to be unable to stay seated. Teachers have come to expect disruptive behavior in other students, but it is out of the ordinary for Sarah, who is normally a shy introvert. Laughing loudly 1 min, she becomes irritable the next minute and lashes out in frustration when requested to quiet down or leave the classroom. All of her teachers complain that Sarah talks incessantly, jumps from topic to topic, and cannot seem to stay on the subject at hand. Some students remark that she has begun skipping classes. When she's in one of her "moods," she fails exams or quizzes and neglects to turn in homework. Just when her parents are notified of Sarah's behavior, she shows up to school acting just like her old self. However, now she seems down and apathetic towards class activities, even in science, her favorite subject.

Bipolar disorder among children and adolescents lacks the acknowledgment by school personnel that more commonly diagnosed disorders receive (Angst, 2006). Within the classroom, the manic symptoms of bipolar disorder will most likely present as irritability, frustration, and aggression, with grandiosity and elation (Craney & Geller, 2003; Kowatch, Youngstrom, Danielyan, & Findling, 2005). The disruptive behaviors of this disorder include excessive speech, inappropriate behavior, and aggressive outbursts and are more noticeable to educators than the depressive symptoms of the mood disorder. These symptoms often go undetected, but are equally detrimental to grades and overall functioning (Hammen & Rudolph, 2003). To educators, the labile behavior of this profile is more likely to be classified as a discipline issue, not a psychological one, further obstructing appropriate referral for assessment and care while the disorder progresses.

What is Bipolar Disorder?

Bipolar disorder is a serious and debilitating disease that often runs a recurrent lifetime course. The risk of suicide is 15 times higher for

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individuals diagnosed with bipolar disorder than for those without the diagnosis (American Psychiatric Association (APA), 2013). In fact, the diagnosis may account for 25% of all completed suicides (APA, 2013). Bipolar disorder observed in children and adolescents has been termed pediatric bipolar disorder (PBD) within the literature. PBD is different from the regular ups and downs seen in children or the mercurial angst witnessed in teenagers. Children and adolescents with PBD report significantly more functional impairment in all aspects of daily living compared to other youths that seek out pediatric services (Freeman et al., 2009), and they often exhibit disruptive behavior and other disorders within and outside of the school environment (Lewinsohn, Klein, & Seeley, 1995). Two thirds of adults with bipolar disorder begin to show signs during adolescence, and one third of youth with serious mood problems follow a bipolar course into adulthood (Angst, 2006). Therefore, early detection could protect against the risks of bipolar disorder: high school dropout, lower socioeconomic status, unemployment, repeated hospitalizations, overutilization of medical resources, suicide attempts, and death by suicide (APA, 2013; Miklowitz & Chang, 2008).

The newest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) recognizes four major types of bipolar disorder: bipolar I, bipolar II, cyclothymia, and other specific bipolar and related disorders (APA, 2013). These diagnoses require substantial evidence of impairments across areas of functioning, including home, work, or school environments. Recently, bipolar disorder has been conceptualized as a spectrum disorder, acknowledging that many individuals, including adolescents, experience difficulty and negative consequences (e.g., school suspensions) from subthreshold symptoms of mania and depression (Angst et al., 2003; Lewinsohn et al., 1995). The newest edition of the *DSM-5* accounts for more of the subthreshold cases of mixed episodes with a diagnostic umbrella of "Other Specified Bipolar and Related Disorders" (OS-BRD), adding "brief cyclothymic disorder" to the other prototypes of bipolar "Not Otherwise Specified" (NOS) from the *DSM-IV* (APA, 2013).

Bipolar I disorder has been conceptualized as the classic presentation of bipolar, requiring only a full episode of mania, i.e., manic symptoms present much of the day, most days, for a week, or symptoms so severe the individual requires psychiatric hospitalization (APA, 2013). However, bipolar I presents in a variable fashion. An individual with bipolar I may experience mania only once in a lifetime or several times and may exhibit depressive episodes frequently or not at all (Youngstrom & Algorta, 2014). In contrast, the diagnosis of bipolar II disorder requires both a full major depressive episode and a hypomanic episode, i.e., milder manic symptoms lasting at least 4 days. Contrary to popular belief, the risk for suicide is equal between types I and II partly because of the dysfunction and impairment associated with the depression in type II (Merikangas & Lamers, 2012; Novick, Swartz, & Frank, 2010). The severity in problems that result from either mania or hypomania has not been found to differ significantly either; therefore, a child experiencing any bipolar type across the range of the spectrum should be treated with equal caution and immediacy of care (Merikangas & Lamers, 2012).

Cyclothymic disorder is defined by a mixture of hypomanic and depressive symptoms lasting for a period of 2 or more years (1 year for people 18 years or younger; APA, 2013). Although the mood symptoms may cause impairment, they do not develop fully into a major depressive episode or mania, and the individual does not experience a period of 2 months or more without mood symptoms during the defining mood episode (APA, 2013). Careful monitoring of these subthreshold symptoms is imperative, and the lack of unbiased documentation often causes this disorder type hard to identify diagnostically. Nonetheless, cyclothymic disorder has been found to cause substantial impairment (Van Meter, Youngstrom, Demeter, & Findling, 2012; Van Meter, Youngstrom, & Findling, 2012; Van Meter, Youngstrom, Youngstrom, Feeny, & Findling, 2011). Lastly, the OS-BRD subtype is the category for residual cases that do not meet the diagnostic criteria of the first three subtypes of bipolar. Often these are cases that could be cat-

egorized as bipolar II, but lack one symptom or duration criteria (e.g., hypomania without depressive symptoms *or* hypomanic symptoms for 2 days instead of four), so therefore fall into OS-BRD (Youngstrom & Algorta, 2014). A diagnosis of OS-BRD requires significant impairment in at least one setting (APA, 2013).

Within community samples, the lifetime prevalence of any bipolar disorder, or PBD, among adolescents is approximately 1–2.4% (Kozloff et al., 2010; Lewinsohn et al., 1995; Van Meter, Moreira, & Youngstrom, 2011). Approximately 5.6% of adolescents report some symptoms of significantly elevated or irritable and expansive moods lasting for isolated periods of time that do not meet full criteria for a bipolar diagnosis (Lewinsohn et al., 1995). For the presence of the full bipolar II subtype in adolescents, the lifetime prevalence rate has been found to be greater (3–4%; Merikangas & Lamers, 2012).

Who Should be Assessed for PBD in the School?

Before making a decision on how to treat or contain PBD in the school, a student must be assessed thoroughly in order to clarify the diagnostic picture. Most students with "manic" symptoms will, in fact, not have a bipolar disorder, given the low prevalence rates compared to other more common diagnoses (e.g., attention deficit hyperactivity disorder [ADHD]; Arnold et al., 2011). Even though the probability estimate is low, there will be a small subpopulation of adolescents present within the school who are experiencing one of the disorders on the bipolar spectrum. Unfortunately, there is not a prototype for PBD; meaning no "poster child" by which to compare the diagnostic picture of potential cases, nor is there one specific symptom that is exclusive to all youth with PBD (Kowatch et al., 2005). However, a set of well-supported commonalities and risk factors has been reported in the literature (Biederman, 1998; Van Meter, Burke, Kowatch, Findling, & Youngstrom, 2016). As part of an evidence-based assessment approach, adolescents with the following features or circumstances could be referred credibly to consider the possibility of a PBD diagnosis.

Family History of a Bipolar Disorder

Bipolar disorders are one of the most heritable conditions and also strongly predicted by the interaction of genetic and environmental factors (Hodgins, Faucher, Zarac, & Ellenbogen, 2002). For children and adolescents, having a first-degree relative with a bipolar disorder increases the risk by five times. A second-degree relative poses at least twice an increase for the risk of developing PBD (Youngstrom, Findling, Youngstrom, & Calabrese, 2005). In addition, the presence of any mood disorder among parents increases the risk of developing PBD, with the probability further increasing when both parents have experienced a major depressive episode (Findling et al., 2001). For an adult, the risk of developing a bipolar disorder is ten times more likely compared to an individual without such a familial background (Gottesman, Laursen, Bertelsen, & Mortensen, 2010).

Adolescent Depression

Approximately 14% of adolescents will meet full criteria for a major depressive episode at any given time, a point prevalence rate roughly three times higher than the prevalence rates for PBD (Merikangas, He, Burstein et al., 2010). Of all cases of adolescent depression, one third will evolve into a bipolar spectrum disorder when followed longitudinally (Angst et al., 2003). Most children who suffer from a depressive episode will not develop the manic symptoms of PBD, but many children who later meet criteria for PBD will experience depression or subthreshold symptoms of depression before the onset of mania (Egeland et al., 2012; Mesman, Nolen, Reichart, Wals, & Hillegers, 2013). Because it is rare for only mania to be present in a case of PBD (Hammen & Rudolph, 2003), it is important for educators to know that the probability of PBD increases among the subpopulation of adolescents

who have a history or are in the midst of a major depressive episode, especially for teens who present with mixed mood features.

Adolescent Substance Abuse

Substance use and dependence is higher among adolescents who experience symptoms of PBD compared to those who do not (Goldstein et al., 2013; Lewinsohn et al., 1995). The use or abuse of substances, including illegally obtained prescription drugs, exacerbates the symptoms and course of PBD (Goldstein et al., 2013). Among children and adolescents who have presented for treatment for PBD, 12% met criteria for a substance use disorder (SUD) at that time of presentation (Kowatch et al., 2005). This may be an underestimate, since few studies have examined substance use, and those that did contained participants who were less impaired than the majority of adolescents with PBD (Kowatch et al., 2005). According to one estimate, approximately half of adolescents with a bipolar spectrum disorder will meet criteria for a SUD by adulthood (Goldstein et al., 2013).

During a manic or hypomanic state, adolescents may abuse alcohol or sleeping medications in order to fall asleep, potentially leading to dependence and further substance experimentation (Goldstein et al., 2013). They may also try substances due to impulsivity or heightened sensation seeking at these times (Youngstrom & Algorta, 2014). In a longitudinal study ($N = 167$) of adolescents and young adults diagnosed with PBD, 32% experienced the onset of a SUD by age 18 (Goldstein et al., 2013). The majority of these participants reported first use of a substance by 15 years old, with the most common substance being cannabis followed by alcohol. More than three quarters of the subsample reported eventually becoming poly-substance users.

It is important that educators are aware of the negative consequences of PBD alone, but also know that PBD increases the risk for the substance abuse problems later on. Although it is commonly believed that experimentation with alcohol is a normative process for a teenager, there is a strong link between first experimentation and the development of a SUD an average of 2 years later if that child has been struggling with symptoms of PBD (Goldstein et al., 2013). The potential for a SUD and PBD duo is heightened with the presence of the additional diagnoses of oppositional defiant disorder (ODD) or panic disorder (PD), a family history of a SUD, or low cohesiveness among family members (Goldstein et al., 2013).

Adolescent Psychosis

Another warning sign for school personnel is if a child reports significant delusions or hallucinations (Tillman et al., 2008). Although PBD is uncommon, schizophrenia is even more rare in childhood. If a youth reports psychosis bound to an isolated period of time, it is more likely for the diagnosis to be a mood disorder (i.e., depression with psychotic features or a bipolar disorder), instead of a delusional disorder (Tillman et al., 2008). Approximately 20–40% of children and adolescents will experience psychotic symptoms during the course of a manic episode (Kowatch et al., 2005).

Adolescents with Sleep Disturbances

A complaint that often differentiates more common childhood disorders from PBD is episodic problems with sleep. More than two thirds of youths with PBD have periods where the need for sleep substantially decreases (Kowatch et al., 2005). Adolescents with PBD may report sleeping only for a few hours that previous night, but that they feel unaffected and rested (Murray & Harvey, 2010). These episodes of needing less sleep most often coincide with increased energy and emotional excitability (Van Meter et al., 2016). Along with decreased need for sleep, heightened mood or euphoria is commonly reported as well as grandiosity in thinking during these times (Kowatch et al., 2005; Van Meter et al., 2016). This behavior would only be of concern if these episodes of lessened sleep differ

from the child's baseline number of hours needed to feel rested. Distractibility often presents along with these symptoms, and in the classroom, this could look like ADHD to an educator. Herein another common mistake often made and why assessment of sleep is important to ascertain the most accurate clinical picture.

What PBD Looks Like in the Classroom

The majority of PBD cases observed in the classroom are three to five times more likely to meet criteria for bipolar II, cyclothymia, or NOS/OS-BRD, rather than the classic bipolar I presentation (Lewinsohn et al., 1995; Merikangas & Lamers, 2012; Mesman et al., 2013). However, the appearance of depression, hypomania, and mania in the classroom are not likely to be separated into neat episodes, but more likely to present intermittently with mixed symptoms (Geller & Luby, 1997; Youngstrom & Algorta, 2014). A mixed state is defined as experiencing symptoms of hypomania and depression during the same episode, a presentation that could be best described as "agitated depression" (Youngstrom & Algorta, 2014). In general, males are more likely to exhibit manic symptoms than female students, who more often experience the depressive symptoms associated with PBD (Duax, Youngstrom, Calabrese, & Findling, 2007).

PBD has been found to present differently in younger children in comparison to adolescents (Youngstrom & Algorta, 2014). Higher rates of manic symptoms are reported in younger children, partly due to their developmental maturity and the high comorbidity rates with ADHD. Adolescents with PBD are more likely to experience greater depressive symptoms than those with ADHD (Youngstrom & Algorta, 2014). In one rural setting, a set of features that characterized children who later developed PBD in adolescence included poor attention, hyper alertness, extreme excitability, somatic complaints, labile mood changes, and patterns of low energy or excessive tiredness (Egeland et al., 2012). For this distinctive sample, symptoms became more episodic and pronounced as the children reached adolescence (Egeland et al., 2012).

While increased energy and hyperactivity are the symptoms first noticed by an adolescent when entering a manic or hypomanic state, irritability and distractibility are most likely the first symptoms to be noticed by a caregiver (Freeman, Youngstrom, Freeman, Youngstrom, & Findling, 2011). Other common manic-specific symptoms include episodes of excessive energy, pressured speech, and racing thoughts (Kowatch et al., 2005; Van Meter et al., 2016). During a manic or hypomanic episode, youths with PBD compared to other children are more likely to show greater mood lability and episodic aggression (Kowatch et al., 2005). Grandiosity that looks like narcissism is an important feature that differentiates PBD from other more commonly diagnosed disorders in childhood such as ODD or ADHD (Freeman et al., 2011). Periods of focused goal-directed activity, which may look like an adolescent initiating projects and/or large plans without follow-up or follow through, are common (Van Meter et al., 2016). More than likely, youths with manic symptoms will exhibit more behavioral problems (e.g., class disruptions) and face more discipline referrals associated with poor judgment than other students (Youngstrom & Algorta, 2014).

Aggressive behavior is the most debilitating feature for children and adolescents experiencing PBD (Youngstrom, Freeman, & Jenkins, 2009), because it can lead to consequences that directly impact academic outcomes (e. g. suspensions, expulsions). Irritability may stem from the cognitive impairments that youths with PBD experience. Youths diagnosed with ADHD only experience greater broad executive functioning impairment, but those with PBD also have difficulty suppressing their responses to distractions or unimportant background stimuli (Walshaw, Alloy, & Sabb, 2010), in addition to having trouble thinking in flexible ways when faced with a complex problem (Jiménez, Ballabriga, Martin, & Arrufat, 2015). Such cognitive deficits can lead to frustration and aggression. Compared to the inattention and hyperactivity associated with ADHD, deficits in problem-solving and inhibiting

emotional reactions are more pronounced in cases with bipolar diagnoses (Jiménez et al., 2015; Walshaw et al., 2010).

The Evidence-Based Framework for the Assessment and Treatment of PBD Optimized for the Rural School Setting

Evidence-Based Assessment

Establish Reasonable Base Rates

Before referring a student for the possibility of a PBD diagnosis, one must consider the base rate for bipolar disorder in that particular setting (Youngstrom & Duax, 2005). A base rate gives school personnel or clinicians in the school a percentage to start from when examining the likelihood of the diagnosis. In one high school sample, a prevalence estimate was found to be 0.6% for a full criteria bipolar disorder (Lewinsohn, Klein, & Seeley, 2000). As estimated from a community sample, 5–6% of a high school population could be dealing with subthreshold symptoms or full criteria PBD (Lewinsohn et al., 1995). Therefore, mental health clinicians working within any school system could begin with a benchmark of 6% before taking other risk factors (e.g., family history) into account (Youngstrom & Duax, 2005).

Begin Collecting Measurement Data

Although family history is a robust and well-replicated risk factor, it does not necessarily confirm a bipolar diagnosis. Most youths with a relative with bipolar disorder will not have the disorder themselves. After determining base rate and family history, a broad-scale assessment tool can assess the general emotional, behavioral, and adaptive functioning of the student. Well-established screening tools include the Behavioral Assessment for Children, Second Edition (BASC-2; Reynolds & Kamphaus, 2004), the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000), or the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001).

A child with PBD will likely show multiple elevations on a broadband questionnaire, but the Externalizing subscale on the CBCL or BASC-2 provides the most information on adjusting the true diagnosis probability (Youngstrom et al., 2004). For example, if Sarah (from the opening vignette) scored above the *T*-score cutoff of 70 on the Externalizing subscale, the likelihood of PBD would increase moderately (Youngstrom et al., 2004). If Sarah also had a first-degree biological relative with bipolar disorder, the probability percentage would increase to approximately 50% (Youngstrom & Youngstrom, 2005). On the other hand, if Sarah scored low or in the insignificant range on the Externalizing scale of a broad-scale measure, the probability percentage would lower dramatically, and PBD could likely be ruled out as a diagnostic possibility (Youngstrom et al., 2004).

Many clinicians may hastily assign the PBD diagnosis when working with a child with a positive family history and an elevated Externalizing score. However, in a school-based setting, there remains an equal chance that this child does not have the diagnosis (approximately 50%). The next step would be to administer brief screening instruments that target manic symptoms, ideally obtaining ratings from the parent or adult most familiar with the youth's behavior. Some manic symptoms are more specific to PBD than aggression and irritability: elated mood, grandiosity, unstable self-esteem, goal-directed activity, and increased energy (i.e., decreased need for sleep) (Van Meter et al., 2016; Youngstrom, Joseph, & Greene, 2008). Examples of valid mania-specific tools are the Parent version of the Mood Disorder Questionnaire (Wagner et al., 2006), the Child Mania Rating Scale (Pavuluri, Henry, Devineni, Carbray, & Birmaher, 2006), and the Parent General Behavior Inventory (Youngstrom, Findling, Danielson, & Calabrese, 2001; Youngstrom, Frazier, Demeter, Calabrese, & Findling, 2008). An elevated score on a brief checklist measure increases evidence for ruling the diagnosis in, and low scores decisively rule the diagnosis out.

Administer Confirmatory Measurement Tools

All the measurement tools so far have been relatively brief and inexpensive, using checklists and rapid screening for risk factors. This process is sufficient to rule out bipolar disorder in many cases, though it does not yield enough information to make a positive diagnosis of bipolar disorder. In order to confirm a diagnosis, the collection of additional information on daily functioning and administration of a semi-structured interview is clinically indicated (Youngstrom & Youngstrom, 2005). Further assessment can include administration of a full semi-structured interview or only the mood modules (Youngstrom, Jenkins, Jenson-Doss, & Youngstrom, 2012). Administering a full semi-structured interview is time-intensive but effective in determining additional diagnoses as either competing hypotheses or potential comorbidities. Lastly, life-charting or mood-monitoring techniques are helpful in pulling apart patterns associated with PBD (Denicoff et al., 2000). As PBD is ruled out through the evidence-based practice framework, another diagnosis will almost always be ruled in via this diagnostic process. After the appropriate diagnosis is established, the treatment phase begins.

Additional Considerations

The CBCL Parent report consistently shows higher diagnostic validity than the Teacher or Self-report forms for discriminating bipolar from other disorders (Youngstrom et al., 2004). In fact, parent report on any measure specific to mania has been found to be more accurate for the purpose of detecting PBD (Wagner et al., 2006; Youngstrom, Genzlinger, Egerton, & Van Meter, 2015; Youngstrom et al., 2004). This may be due to the fact that lack of self-awareness is woven into the presentation of mania and hypomania, and the consequences to others from mania or hypomania may not be noticed by the child (Dell'Osso et al., 2002). It is important to note that a parent's credibility should not be hindered by a personal history of a mood disorder or current stress level. A clinician is encouraged to use personal judgment based on other information (e.g., validity scales on questionnaires) when determining the credibility of a parent or caretaker's report, instead of sweeping or intuitive judgments (e.g., "Dad's not a legitimate source because he was diagnosed with bipolar two years prior;" Youngstrom et al., 2011; Youngstrom et al., 2015).

Although it might be counterintuitive that a parent's report is more accurate than a teacher's report, the teacher is often not well-positioned to observe the hallmark features of mania (e.g., decreased need for sleep). Also, teachers are likely to attribute many of the disruptive features of PBD to ADHD or deliberately oppositional behavior (Youngstrom, Joseph et al., 2008). Many teachers have been trained or have had more experience in detecting the signs of a learning disability, but few have had equal amounts of training or time dedicated to learning about students with PBD. Given the overlap in symptoms, it is understandable that behavior associated with PBD is more likely to be classified and treated as ADHD (Arnold et al., 2011).

Approximately 60% of children with PBD-seeking services will also meet criteria for ADHD (Geller & Luby, 1997; Kowatch et al., 2005; Youngstrom, Meyers, Youngstrom, Calabrese, & Findling, 2006). Individuals with comorbid PBD and ADHD are more likely to be male and younger (Craney & Geller, 2003). Also, those with PBD often have a diagnosis of oppositional defiant disorder. Externalizing features of ADHD like impulsivity and hyperactivity tend to present before the symptoms specific to PBD such as excessive elation and grandiosity (Geller & Luby, 1997; Kowatch et al., 2005; Van Meter et al., 2016). Older adolescents are likely to be diagnosed with conduct disorder once they become more impaired by the aggressive and impulsive symptoms of the comorbidity (Kowatch et al., 2005).

Evidence-Based Treatment and Maintenance of Gains

Working within a rural setting presents additional barriers to quality assessment and treatment for any psychiatric disorder. Rural areas tend to have

a larger number of individuals who are older, live in poverty, have difficulty accessing medication and mental healthcare, and have higher rates of stigma towards mental maladies and help-seeking behavior (Slama, 2004). Clinicians in rural areas must adapt to suboptimal circumstances and adjust the way traditional service delivery has been accomplished in the past (Owens, Watabe, & Michael, 2013). Instead of working within the "four-wall therapy" format, clinicians are encouraged to embed themselves within the culture of the child's school, home, and community (Owens et al., 2013). Clinicians in rural areas must approach high-risk clients proactively, diligently planning for worst-case scenarios before they happen. For example, a safety plan of action tailored to each individual case should be established early in treatment. Potential considerations include risk-management plans surrounding issues such as access to guns and crisis-intervention plans for areas in which the closest psychiatric hospital is a day's drive away.

Pharmacological Treatment

Clinicians who work with students with PBD are charged with the arduous task of treating not only the externalizing symptoms of mania, but the internalizing symptoms of the disorder as well. Currently, the most efficacious treatment for reducing the acute clinical symptoms of bipolar disorder is pharmacological treatment (Swartz & Thase, 2011). Ideally, a psychiatrist who specializes in child and adolescent disorders would be treating the symptoms. This will be difficult to obtain in rural settings as 70% of the Appalachian region, for example, has been labeled as a mental health clinician shortage area, and 95% of rural counties with populations below 20,000 do not have a child psychiatrist physically present within the area (Gamm, Stone, & Pittman, 2008). But without pharmacological treatment, the disorder can rapidly exacerbate over time and reoccur episodically (Kanba, Kato, Terao, & Yamada, 2013). Further complicating matters, even when a child is in a depressive episode of PBD, the symptoms are often resistant to antidepressants (Kanba et al., 2013; Pacchiarotti et al., 2013).

One way to meet the current and poor status of medication providers in rural areas is the clinician taking on the role as a case-manager for high-risk individuals (Owens et al., 2013). A case-management approach may be necessary, with the primary task of helping families make connections and access available resources (e.g., substance abuse treatment groups, parent support groups) within the community. Chances are communication among these entities will be insubstantial; therefore, the clinician working within a school and rural setting could be increasingly valuable as a liaison in addition to his or her vocation for assessment and treatment. In addition, the parent or caregiver is encouraged to monitor the child's response to new medications, which could include taking notes to inform the prescribing doctor at the next scheduled appointment.

Psychosocial Treatment

Psychosocial intervention combined with medication further helps to prevent or delay relapse into a manic or depressive episode (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Kanba et al., 2013; Miklowitz et al., 2011). Cognitive behavioral therapy has been found to be effective in targeting the depressive symptoms of PBD, but is not as robust when used as a stand-alone treatment for mania (Hofmann et al., 2012). Environmental stress is one of the strongest predictors of relapse (Kanba et al., 2013); therefore, the most effective treatments include family members. Treatment should include clear rationales for therapeutic techniques, mood-monitoring, communication training, psychoeducation, and problem-solving skills building to enhance the possibility of transfer outside of therapy (Fristad & MacPherson, 2014; Miklowitz & Scott, 2009; Miklowitz et al., 2011).

Poor family functioning and communication are directly linked to earlier onset of the disorder and lackluster treatment response (McClellan, Kowatch, & Findling, 2007). Engaging family members in treatment not only reduces the stigma associated with the diagnosis, but also creates a supportive network for the youth. Family-focused psychoeducational treatment for bipolar adoles-

cents (FFT-A) is a promising intervention that significantly reduces PBD symptoms and improves daily functioning (Fristad & MacPherson, 2014; Miklowitz et al., 2011). FFT-A is structured and comprises three treatment modules: family psychoeducation, communication enhancement training, and problem-solving skills training. Specific treatment components for both the youth and family include recognizing prodromal features of an episode, learning the difference between mood dysregulation and appropriate emotional reactivity, determining stressors that trigger episodes through mood-charting, and changing the communication styles of all family members (Miklowitz et al., 2011). Increasing family's knowledge of the disorder has been found to significantly increase the families' perceptions of support and coping ability, as well as increase positive attitudes associated with treatment (Fristad, Goldberg-Arnold, & Gavazzi, 2002; Fristad & MacPherson, 2014). Broadly, the main focus of FFT-A is to detangle and correct the negative communication styles among family members that involve excessive criticism, hostility, and overbearing protective behavior (Miklowitz et al., 2011). Families should be encouraged to continue using communication-management techniques learned in therapy, even after symptoms of PBD have diminished (Miklowitz & Scott, 2009).

Assessment During Treatment

Whether the child is receiving treatment in or outside of school, brief symptom checklists should be used periodically to measure progress (Youngstrom et al., 2009). Something as small and simple as a numbering system (e.g., 1–10) can effectively measure mood change (Youngstrom et al., 2009). At mid-point of treatment, a lengthier tool, such as the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) Mania scale, can be used to better determine if gains have been made (Axelson et al., 2003). Given the labile nature of PBD, it is important to assess for suicidal ideation and intent at the beginning of every session (Novick et al., 2010).

Life-charting is not only helpful for initial assessment, but for tracking treatment response as well (Post et al., 2011). Also called mood-monitoring, this is a technique that can be taught in session and then completed at home where the individual documents a numerical value to each day on a mood scale. One commonly used instrument, the *Life Chart Method* (Denicoff et al., 2000),[1] provides check boxes that range from −3 to +3 and includes anxiety and irritability ratings for each day. The tool can help detect medication side effects, events that trigger high emotional arousal, and sleep patterns associated with mood.

In order to obtain a comprehensive picture, it is important to include parent's report in addition to the student's report when assessing treatment response. Shorter parent checklists are equally as sensitive to treatment outcomes when compared to full length measures (Youngstrom et al., 2012). In addition to collecting objective data, it is recommended that information about social functioning and daily living be gathered on a regular basis. Although teacher report devices are not as useful as parent report for initial assessment purposes, data collected from teachers and school personnel are helpful when designing or redesigning interventions and monitoring classroom performance.

The Rural School Setting

Bipolar disorders are roughly twice as common as autism, but a third as common as depression or ADHD (Merikangas, He, Burstein et al., 2010), yet there is a grave lack of research examining outcomes of evidence-based assessment and treatment for those with PBD within the rural school setting. Evidence-based psychotherapy delivered within the school has been found to be effective in the past for treating adolescent depression and increasing academic performance (Reynolds & Coats, 1986; Sander, Everts, & Johnson, 2011). Even if treatment does not explicitly target disruptive behaviors, it can yield

[1]The Life Chart Method instrument can be found for free at http://www.cqaimh.org/pdf/tool_edu_moodchart.pdf.

moderate to large effect sizes overall (Baskin et al., 2010). Although past studies have examined children with a wide array of functional difficulties, similar outcomes could be expected for individuals struggling with PBD in the school.

Challenges associated with rurality can be discouraging, but accurate assessment and effective treatment for PBD within a rural school setting are feasible. Preliminary studies that examined the impact of mental health services delivered by clinicians embedded within the rural high school setting have found significant clinical symptom improvement (Albright et al., 2013; Michael et al., 2013, 2016). Two small subsamples within these studies included adolescents with mixed mood symptoms, and individual evidence-based treatment improved symptoms and some academic outcomes for these students (Michael et al., 2013, 2016). Most cases stabilized in terms of grade point average, attendance, and discipline referrals (Michael et al., 2013).

Next Steps: What Educators and Clinicians Can Do Right Now

Next steps for educators and clinicians are separated into specific responsibilities for each (see Tables 13.1 and 13.2). The first step in Tables 13.1 and 13.2 seems simple but can be the most difficult in practice. Educators and clinicians are encouraged to be open to working with individuals with a bipolar diagnosis and the associated behaviors. This involves working together to distinguish behaviors that are categorized as psychological in nature from those that solely deserve disciplinary consequences. School personnel are not encouraged to be permissive when rules are broken. Instead, the first step represents a school personnel's willingness to coordinate with parents and treatment providers to form decisions that benefit a student's long-term success.

The optimal time to intervene upon a child with a bipolar disorder is before age 15 (Goldstein et al., 2013). Therefore, an immense amount of responsibility is charged to educators to help detect and bring this child to care before a negative trajectory is paved. Educators hold a vast amount of knowledge and experience that could inform treatment greatly. In turn, astute clinicians have the tools and training necessary to follow through with evidence-based assessment and treatment. After permissions are obtained, both clinicians and educators are encouraged to communicate with greater frequency than what may

Table 13.1 Next steps for educators working with youth with mood disorders

1	Be open to working with children with a bipolar diagnosis
2	Know the four types of bipolar defined in the *DSM-5*, and know what they can look like in the classroom
3	Know how common bipolar disorders are in your area—know the base rates!
4	Work to involve and motivate parents in the assessment and treatment process
5	Keep the line of communication open with clinician
6	Request and frequently refer to list of recommendations from clinician to help support emotional and behavioral regulatory growth of the child, as well as social and educational success in the school

Table 13.2 Steps for clinicians working in collaboration with educators

1	Be open to working with school personnel for the benefit of the child. Have a plan to respect confidentiality while providing appropriate updates to other stakeholders
2	Know the four types of bipolar defined in the *DSM-5*, and know what they can look like in the classroom and in the clinical interview (see Youngstrom & Algorta, 2014 for review)
3	Know the base rates for mood disorders and similar conditions in school, rural, and/or outpatient settings
4	Have checklists available that are bipolar-specific—some of the best are free!
5	Know what checklist scores mean in terms of changing probability of bipolar diagnosis for individual cases
6	Work with educators to help involve and motivate parents in the assessment and treatment process
7	Keep the line of communication open with clinician throughout assessment and treatment
8	Provide a list of recommendations to educator that pertains to emotional, behavioral, social, and academic functioning of the student

be or feel typical, while continuing to involve parents throughout all phases of assessment and treatment. A strong collaboration between schools and mental health clinicians is imperative to keeping children with pediatric bipolar in school, safeguarding them from the detrimental consequences of severe mental illness.

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