Assessment and Intervention for Bipolar Disorder:
Best Practices for School Psychologists

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SACRAMENTO STATE

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Acknowledgements

- Adapted from…

Hart, S. R., Jeltova, I., & Brock, S. E. (in preparation). *Assessing, identifying, and treating bipolar disorder at school.* New York: Springer.

Hart, S. R. (2006, December 8). *Bipolar disorder: The school psychologists role.* Workshop presented at the CASP Winter Conference, San Jose, CA.

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Presentation Outline

- Diagnosis
- Course
- Co-existing Disabilities
- Associated Impairments
- Etiology, Prevalence & Prognosis
- Treatment
- Best Practices for School Psychologists

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Workshop Goals

Attendees will…

1. gain an overview of bipolar disorder.
2. acquire a sense of what is like to have bipolar disorder.
3. learn what to look for and what questions to ask when screening for bipolar disorder.
4. understand important special education issues, including the psycho-educational evaluation of a student with a known or suspected bipolar disorder.

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It is as if my life were magically run by two electric currents: joyous positive and despairing negative - whichever is running at the moment dominates my life, floods it.

Sylvia Plath (2000)
The Unabridged Journals of Sylvia Plath, 1950-1962
New York: Anchor Books

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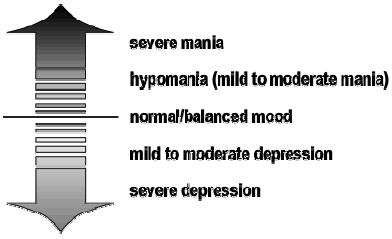
Diagnosis



NIMH (2007) 7

DSM-IV-TR Diagnosis

1. Importance of early diagnosis
2. Pediatric bipolar disorder is especially challenging to identify.
   - Characterized by severe affect dysregulation, high levels of agitation, aggression.
   - Relative to adults, children have a mixed presentation, a chronic course, poor response to mood stabilizers, high co-morbidity with ADHD
3. Symptoms similar to other disorders.
   - For example, ADHD, depression, Oppositional Defiant Disorder, Obsessive Compulsive Disorder, and Separation Anxiety Disorder.
4. Treatments differ significantly.
5. The school psychologist may be the first mental health professional to see bipolar.

Faraon et al. (2003) 8

DSM-IV-TR Diagnosis

- Diagnostic Classifications
  - Bipolar I Disorder
    - One or more Manic Episode or Mixed Manic Episode
    - Minor or Major Depressive Episodes often present
    - May have psychotic symptoms
  - Bipolar II Disorder
    - One or more Major Depressive Episode
    - One or more Hypomanic Episode
    - No full Manic or Mixed Manic Episodes

APA (2000) 9

DSM-IV-TR Diagnosis

- Diagnostic Classifications
  - Cyclothymia
    - Numerous periods with hypomanic and depressive symptoms
    - No full Manic, Major Depressive, or Mixed Episodes
  - Bipolar Disorder Not Otherwise Specified
    - Bipolar features that do not meet criteria for any specific bipolar disorder.

APA (2000) 10

DSM-IV-TR Diagnosis

- Manic Episode Criteria
  - A distinct period of abnormally and persistently elevated, expansive, or irritable mood.
  - Lasting at least 1 week.
  - Three or more (four if the mood is only irritable) of the following symptoms:
    1. Inflated self-esteem or grandiosity
    2. Decreased need for sleep
    3. Pressured speech or more talkative than usual
    4. Flight of ideas or racing thoughts
    5. Distractibility
    6. Psychomotor agitation or increase in goal-directed activity
    7. Hedonistic interests

APA (2000) 11

DSM-IV-TR Diagnosis

- Manic Episode Criteria (cont.)
  - Causes marked impairment in occupational functioning in usual social activities or relationships, **or**
  - Necessitates hospitalization to prevent harm to self or others, **or**
  - Has psychotic features
  - Not due to substance use or abuse (e.g., drug abuse, medication, other treatment), or a general medial condition (e.g., hyperthyroidism).

APA (2000) 12

Diagnosis: Manic Symptoms at School

Symptom/Definition	Example
Euphoria: Elevated (too happy, silly, giddy) and expansive (about everything) mood, "out of the blue" or as an inappropriate reaction to external events for an extended period of time.	A child laughs hysterically for 30 minutes after a mildly funny comment by a peer and despite other students staring at him.
Irritability: Energized, angry, raging, or intensely irritable mood, "out of the blue" or as an inappropriate reaction to external events for an extended period of time.	In reaction to meeting a substitute teacher, a child flies into a violent 20-minute rage.
Inflated Self-Esteem or Grandiosity: Believing, talking or acting as if he is considerably better at something or has special powers or abilities despite clear evidence to the contrary	A child believes and tells others she is able to fly from the top of the school building.

From Lofthouse & Fristad (2006, p. 215)

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Diagnosis: Manic Symptoms at School

Symptom/Definition	Example
Decreased Need for Sleep: Unable to fall or stay asleep or waking up too early because of increased energy, leading to a significant reduction in sleep yet feeling well rested.	Despite only sleeping 3 hours the night before, a child is still energized throughout the day
Increased Speech: Dramatically amplified volume, uninterruptible rate, or pressure to keep talking.	A child suddenly begins to talk extremely loudly, more rapidly, and cannot be interrupted by the teacher
Flight of Ideas or Racing Thoughts: Report or observation (via speech/writing) of speeded-up, tangential or circumstantial thoughts	A teacher cannot follow a child's rambling speech that is out of character for the child (i.e., not related to any cognitive or language impairment the child might have)

From Lofthouse & Fristad (2006, p. 215)

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Diagnosis: Manic Symptoms at School

Symptom/Definition	Example
Distractibility: Increased inattentiveness beyond child's baseline attentional capacity.	A child is distracted by sounds in the hallway, which would typically not bother her.
Increase in Goal-Directed Activity or Psychomotor Agitation: Hyper-focused on making friends, engaging in multiple school projects or hobbies or in sexual encounters, or a striking increase in and duration of energy..	A child starts to rearrange the school library or clean everyone's desks, or plan to build an elaborate fort in the playground, but never finishes any of these projects.
Excessive Involvement in Pleasurable or Dangerous Activities: Sudden unrestrained participation in an action that is likely to lead to painful or very negative consequences.	A previously mild-mannered child may write dirty notes to the children in class or attempt to jump out of a moving school bus.

From Lofthouse & Fristad (2006, p. 215)

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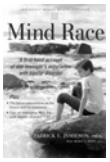
Life feels like it is supercharged with possibility… Ordinary activities are extraordinary!" "I become the Energizer Bunny on a supercharger. 'Why does everybody else need so much sleep?' I wonder…. Hours pass like minutes, minutes like seconds. If I sleep it is briefly, and I awake refreshed, thinking, 'This is going to be the best day of my life!'



Patrick E. Jamieson & Moira A. Rynn (2006)
Mind Race:
A Firsthand Account of One Teenager's Experience with Bipolar Disorder.
New York: Oxford University Press

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DSM-IV-TR Diagnosis

- Hypomanic Criteria
  - Similarities with Manic Episode
    - Same symptoms
  - Differences from Manic Episode
    - Length of time
    - Impairment not as severe
    - May not be viewed by the individual as pathological
      - However, others may be troubled by erratic behavior

APA (2000)

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DSM-IV-TR Diagnosis

- Major Depressive Episode Criteria
  - A period of depressed mood or loss of interest or pleasure in nearly all activities
    - In children and adolescents, the mood may be irritable rather than sad.
  - Lasting consistently for at least 2 weeks.
  - Represents a significant change from previous functioning.

APA (2000)

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DSM-IV-TR Diagnosis

- Major Depressive Episode Criteria (cont.)
  - Five or more of the following symptoms (at least one of which is either (1) or (2):
    1) Depressed mood
    2) Diminished interest in activities
    3) Significant weight loss or gain
    4) Insomnia or hypersomnia
    5) Psychomotor agitation or retardation
    6) Fatigue/loss of energy
    7) Feelings of worthlessness/inappropriate guilt
    8) Diminished ability to think or concentrate/indecisiveness
    9) Suicidal ideation or suicide attempt

APA (2000)

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DSM-IV-TR Diagnosis

- Major Depressive Episode Criteria (cont.)
  - Causes marked impairment in occupational functioning or in usual social activities or relationships
  - Not due to substance use or abuse, or a .general medial condition
  - Not better accounted for by Bereavement
    - After the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation

APA (2000)

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Diagnosis: Major Depressive Symptoms at School

Symptom/Definition	Example
Depressed Mood: Feels or looks sad or irritable (low energy) for an extended period of time.	A child appears down or flat or is cranky or grouchy in class and on the playground.
Markedly Diminished Interest or Pleasure in All Activities: Complains of feeling bored or finding nothing fun anymore.	A child reports feeling empty or bored and shows no interest in previously enjoyable school or peer activities.
Significant Weight Lost/Gain or Appetite Increase/Decrease: Weight change of >5% in 1 month or significant change in appetite.	A child looks much thinner and drawn or a great deal heavier, or has no appetite or an exce3sive appetite at lunch time.

From Lofthouse & Fristad (2006, p. 216)

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Diagnosis: Major Depressive Symptoms at School

Symptom/Definition	Example
Insomnia or Hypersomnia: Difficulty falling asleep, staying asleep, waking up too early or sleeping longer and still feeling tired.	A child looks worn out, is often groggy or tardy, or reports sleeping through alarm despite getting 12 hours of sleep.
Psychomotor Agitation/Retardation: Looks restless or slowed down.	A child is extremely fidgety or can't say seated. His speech or movement is sluggish or he avoids physical activities.
Fatigue or Loss of Energy: Complains of feeling tired all the time	Child looks or complains of constantly feeling tired even with adequate sleep.

From Lofthouse & Fristad (2006, p. 216)

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Diagnosis: Major Depressive Symptoms at School

Symptom/Definition	Example
Low Self-Esteem, Feelings of Worthlessness or Excessive Guilt: Thinking and saying more negative than positive things about self or feeling extremely bad about things one has done or not done.	A child frequently tells herself or others "I'm no good, I hate myself, no one likes me, I can't do anything." She feels bad about and dwells on accidentally bumping into someone in the corridor or having not said hello to a friend.
Diminished Ability to Think or Concentrate, or Indecisiveness: Increase inattentiveness, beyond child's baseline attentional capacity; difficulty stringing thoughts together or making choices.	A child can't seem to focus in class, complete work, or choose unstructured class activities.

From Lofthouse & Fristad (2006, p. 216)

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Diagnosis: Major Depressive Symptoms at School

Symptom/Definition	Example
Hopelessness: Negative thoughts or statements about the future.	A child frequently thinks or says "nothing will change or will ever be good for me."
Recurrent Thoughts of Death or Suicidality: Obsession with morbid thoughts or events, or suicidal ideation, planning, or attempts to kill self	A child talks or draws pictures about death, war casualties, natural disasters, or famine. He reports wanting to be dead, not wanting to live anymore, wishing he'd never been born; he draws pictures of someone shooting or stabbing him, writes a suicide note, gives possessions away or tires to kill self.

From Lofthouse & Fristad (2006, p. 216)

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DSM-IV-TR Diagnosis

- Mixed Episode Criteria
  - Both Manic and Major Depressive Episode criteria are met nearly every day for a least a 1 week period.
  - Rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic and Depressive episode.
  - Causes marked impairment in occupational functioning or in usual social activities or relationships, **or**
  - Necessitates hospitalization to prevent harm to self or others, **or**
  - Has psychotic features
  - Not due to substance use or abuse, or a general medial condition

APA (2000)

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DSM-IV-TR Diagnosis

- Rapid-Cycling Specifier
  - Can be applied to Bipolar I or II
  - Four or more mood episodes (i.e., Major Depressive, Manic, Mixed, or Hypomanic) per 12 months
  - May occur in any order or combination
  - Must be demarcated by …
    - a period of full remission, **or**
    - a switch to an episode of the opposite polarity
      - Manic, Hypomanic, and Mixed are on the same pole
  - NOTE: This definition is different from that used in some literature, where in cycling refers to mood changes within an episode (Geller et al., 2004).

APA (2000)

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Diagnosis: Juvenile Bipolar Disorder

- Terms used to define juvenile bipolar disorder.
  - Ultrarapid cycling = 5 to 364 episodes/year
    - Brief frequent manic episodes lasting hours to days, but less than the 4-days required under Hypomania criteria (10%).
  - Ultradian cycling = >365 episodes/year
    - Repeated brief cycles lasting minutes to hours (77%).
    - Chronic baseline mania (Wozniak et al., 1995).
    - Ultradian is Latin for "many times per day."

AACAP (2007); Geller et al. (2000)

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Diagnosis: Juvenile Bipolar Disorder

- Adults
  - Discrete episodes of mania or depression lasting to 2 to 9 months.
  - Clear onset and offset.
  - Significant departures from baseline functioning.
- Juveniles
  - Longer duration of episodes
  - Higher rates or rapid cycling.
  - Lower rates of inter-episode recovery.
    - Chronic and continuous.

AACAP (2007); NIMH (2001)

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Diagnosis: Juvenile Bipolar Disorder

- Adults
  - Mania includes marked euphoria, grandiosity, and irritability
    - Racing thoughts, increased psychomotor activity, and mood lability.
- Adolescents
  - Mania is frequently associated with psychosis, mood lability, and depression.
    - Tends to be more chronic and difficult to treat than adult BPD.
    - Prognosis similar to worse than adult BPD
- Prepubertal Children
  - Mania involves markedly labile/erratic changes in mood, energy levels, and behavior.
    - Predominant mood is VERY severe irritability (often associated with violence) rather than euphoria.
    - Irritability, anger, belligerence, depression, and mixed features are more common .
  - Mania is commonly mixed with depression.

AACAP (2007); NIMH (2001); Wozniak et al. (1995)

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Diagnosis: Juvenile Bipolar Disorder

- Unique Features of Pediatric Bipolar Disorder
  - Chronic with long episodes
  - Predominantly mixed episodes (20% to 84%) and/or rapid cycling (46% to 87%)
  - Prominent irritability (77% to 98%)
  - High rate of comorbid ADHD (75% to 98%) and anxiety disorders (5% to 50%)

Pavuluri et al. (2005)

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Diagnosis: Juvenile Bipolar Disorder

- Bipolar Disorder in childhood and adolescence appear to be the same clinical entity.
- However, there are significant developmental variations in illness expression.

	Bipolar Disorder Onset	
	Childhood	Adolescent
Male Gender	67.5%	48.2%
Chronic Course	57.5%	23.3%
Episodic Course	42.5%	76.8%
Attention-deficit/Hyperactivity Disorder	38.7%	8.9%
Oppositional Defiant Disorder	35.9%	10.7%

Masi et al. (2006)

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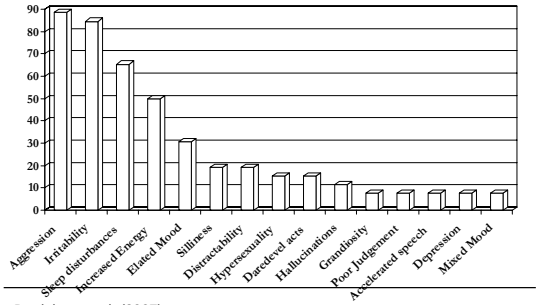
Diagnosis: Juvenile Bipolar Disorder

- The most frequent presenting symptoms among outpatient clinic referred 3 to 7 year olds with mood and behavioral symptoms



Danielyan et al. (2007)

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Diagnosis: Juvenile Bipolar Disorder

- NIMH Roundtable
  - Bipolar disorder exists among prepubertal children.
    - Narrow Phenotype
      - Meet full DSM-IV criteria
      - More common in adolescent-onset BPD
    - Broad Phenotype
      - Don't meet full DSM-IV criteria, but have BPD symptoms that are severely impairing.
      - More common in childhood-onset BPD
      - Suggested use of the BPD NOS category to children who did not fit the narrow definition of the disorder.

NIMH (2001)

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Diagnosis: Juvenile Bipolar Disorder

1. Sleep/Wake Cycle Disturbances
2. ADHD-like symptoms
3. Aggression/Poor Frustration Tolerance
4. Intense Affective Rages
5. Bossy and overbearing, extremely oppositional
6. Fear of Harm or social phobia
7. Hypersexuality
8. Laughing hysterically/acting infectiously happy
9. Deep depression
10. Sensory Sensitivities
11. Carbohydrate Cravings
12. Somatic Complaints

- *24: A Day in the Life*

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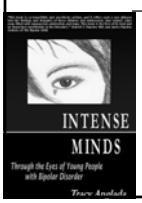
I felt like I was a very old woman who was ready to die. She had suffered enough living.
--- Abbey



Tracy Anglada
Intense Minds: Through the Eyes of Young People with Bipolar Disorder (2006)
Victoria, BC: Trafford Publishing

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Presentation Outline

- Diagnosis
- Course
- Co-existing Disabilities
- Associated Impairments
- Etiology, Prevalence & Prognosis
- Treatment
- Best Practices for School Psychologists

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Course: Pediatric Bipolar Disorder

- Remission
  - 2 to 7 weeks without meeting DSM criteria
- Recovery
  - 8 weeks without meeting DSM criteria
  - 40% to 100% will recovery in a period of 1 to 2 years
- Relapse
  - 2 weeks meeting DSM criteria
  - 60% to 70% of those that recover relapse on average between 10 to 12 months
- Chronic
  - Failure to recover for a period of at least 2 years

Pavuluri et al. (2005)

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  - Special Education & Programming Issues
  - School-Based Interventions

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Co-existing Disabilities

- Attention-deficit/Hyperactivity Disorder (AD/HD)
  - Rates range between 11% and 75%
- Oppositional Defiant Disorder
  - Rates range between 46.4% and 75%
- Conduct Disorder
  - Rates range between 5.6 and 37%
- Anxiety Disorders
  - Rates range betwee12.5% and 56%
- Substance Abuse Disorders
  - 0 to 40%

Pavuluri et al. (2005)

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Co-existing Disabilities

AD/HD Criteria Comparison

Bipolar Disorder (mania)		AD/HD
1. More talkative than usual, or pressure to keep talking	⇒	1. Often talks excessively
2. Distractibility	⇒	2. Is often easily distracted by extraneous stimuli
3. Increase in goal directed activity or *psychomotor agitation*	⇒	3. Is often "on the go" or often acts as if "driven by a motor"

Differentiation = irritable and/or elated mood, grandiosity, decreased need for sleep, hypersexuality, and age of symptom onset (Geller et al., 1998).

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Co-existing Disabilities

- Developmental Differences
  - Children have higher rates of ADHD than do adolescents
  - Adolescents have higher rates of substance abuse
    - Risk of substance abuse 8.8 times higher in adolescent-onset bipolar disorder than childhood-onset bipolar disorder
  - Children have higher rates of pervasive developmental disorder (particularly Asperger's Disorder, 11%)
- Unipolar Depression?
- Schizophrenia?

Pavuluri et al. (2005)

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Associated Impairments

Suicidal Behaviors

- Prevalence of suicide attempts
  - 40-45%
- Age of first attempt
- Multiple attempts
- Severity of attempts
- Suicidal ideation

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Associated Impairments

Cognitive Deficits

- Executive Functions
- Attention
- Memory
- Sensory-Motor Integration
- Nonverbal Problem-Solving
- Academic Deficits
  - Mathematics

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Associated Impairments

Psychosocial Deficits

- Relationships
  - Peers
  - Family members
- Recognition and Regulation of Emotion
- Social Problem-Solving
- Self-Esteem
- Impulse Control

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Etiology

- *Although the etiology of* [early onset bipolar spectrum disorder] *is not known, substantial evidence in the adult literature and more recent research with children and adolescents suggest a biological basis involving genetics, various neurochemicals, and certain affected brain regions.*
- *It is distinctly possible that the differing clinical presentations of pediatric BD are not unitary entities but diverse in etiology and pathophysiology.*

Lofthouse & Fristad (2006, p. 212); Pavuluri et al. (2005, p. 853)

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Etiology

- Genetics
  1. Family Studies
  2. Twin Studies
     - DZ = .67; MZ = .20 concordance
  3. Adoption Studies
  4. Genetic Epidemiology
     - Early onset BD = confers greater risk to relatives
  5. Molecular genetic
- Aggregates among family members
- Appears highly heritable
- Environment = a minority of disease risk

Baum et al. (2007); Faraone et al. (2003); Pavuluri et al. (2005)

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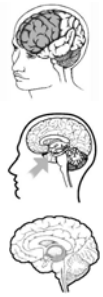
Etiology

- Neuroanatomical differences
  - White matter hyperintensities.
    - Small abnormal areas in the white matter of the brain (especially in the frontal lobe).
  - Smaller amygdala
  - Decreased hipocampal volume



Hajek et al. (2005); Pavuluri et al. (2005)

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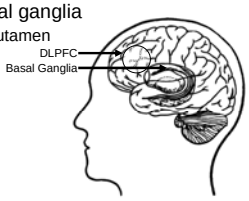
Etiology

- Neuroanatomical differences
  - Reduced gray matter volume in the dorsolateral prefrontal cortex (DLPFC)
  - Bilaterally larger basal ganglia
    - Specifically larger putamen



Hajek et al. (2005); Pavuluri et al. (2005)

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Prevalence & Epidemiology

- No data on the prevalence of preadolescent bipolar disorder
- Lifetime prevalence among 14 to 18 year olds, 1%
  - Subsyndromal symptoms, 5.7%
- Mean age of onset, 10 to 12 years
- First episode usually depression

Pavuluri et al. (2005)

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Prognosis

- *With respect to prognosis …,* [early onset bipolar spectrum disorder] *may include a prolonged and highly relapsing course; significant impairments in home, school, and peer functioning; legal difficulties; multiple hospitalizations and increased rates of substance abuse and suicide*
- *In short, children with* [early onset bipolar spectrum disorder] *have a chronic brain disorder that is biopsychosocial in nature and, at this current time, cannot be cured or grown out of*

Lofthouse & Fristad (2006, p. 213-214)

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Prognosis

Outcome by subtype (research with adults)

- Bipolar Disorder I
  - More severe; tend to experience more cycling & mixed episodes; experience more substance abuse; tend to recover to premorbid level of functioning between episodes.
- Bipolar Disorder II
  - More chronic; more episodes with shorter inter-episode intervals; more major depressive episodes; typically present with less intense and often unrecognized manic phases; tend to experience more anxiety.
- Cyclothymia
  - Can be impairing; often unrecognized; many develop more severe form of Bipolar illness.
- Bipolar Disorder Not Otherwise Specified (NOS)
  - Largest group of individuals

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Treatment

Psychopharmacological

DEPRESSION

- Mood Stabilizers
  - Lamictal
- Anti-Obsessional
  - Paxil
- Anti-Depressant
  - Wellbutrin
- Atypical Antipsychotics
  - Zyprexa

MANIA

- Mood Stabillizers
  - Lithium, Depakote, Depacon, Tegretol
- Atypical Antipsychotics
  - Zyprexa, Seroquel, Risperdal, Geodon, Abilify
- Anti-Anxiety
  - Benzodiazepines
    - Klonopin, Ativan

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Treatment

Psychopharmacology Cont.

- Lithium:
  - History
  - Side effects/drawbacks
    - Blood levels drawn frequently
    - Weight gain
    - Increased thirst, increased urination, water retention
    - Nausea, diarrhea
    - Tremor
    - Cognitive dulling (mental sluggishness)
    - Dermatologic conditions
    - Hypothyroidism
    - Birth defects
  - Benefits & protective qualities
    - Brain-Derived Neurotropic Factor (BDNF) & Apoptosis
    - Suicide

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Treatment

- Therapy
  - Psycho-Education
  - Family Interventions
  - Multifamily Psycho-education Groups (MFPG)
  - Cognitive-Behavioral Therapy (CBT)
  - RAINBOW Program
  - Interpersonal and Social Rhythm Therapy (IPSRT)
  - Schema-focused Therapy

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Treatment

- Alternative Treatments
  - Light Therapy
  - Electro-Convulsive Therapy (ECT) & Repeated Transcranial Magnetic Stimulation (r-TMS)
  - Circadian Rhythm
    - Melatonin
  - Nutritional Approaches
    - Omega-3 Fatty Acids

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  - Recognize Educational Implications
  - Psycho-Educational Assessment
  - Special Education & Programming Issues
  - School-Based Interventions

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Recognize Educational Implications

- Grade retention
- Learning disabilities
- Special Education
- Required tutoring
- Adolescent onset = significant disruptions
  - Before onset
    - 71% good to excellent work effort
    - 58% specific academic strengths
    - 83% college prep classes
  - After onset
    - 67% significant difficulties in math
    - 38% graduated from high school

Lofthouse & Fristad (2006)

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Psycho-Educational Assessment

- Identification and Evaluation
  - Recognize warning signs
  - Develop the Psycho-Educational Assessment Plan
  - Conduct the Assessment

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Psycho-Educational Assessment

- Testing Considerations
- Who are the involved parties?
  - Student
  - Teachers
  - Parents
  - Others?
    - Release of Information
- Referral Question
  - Understand the focus of the assessment
  - Eligibility Category?

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Psycho-Educational Assessment

- Special Education Eligibility Categories
  - Emotionally Disturbed (ED)
  - Other Health Impaired (OHI)

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Psycho-Educational Assessment

- ED Criteria
  - An inability to learn that cannot be explained by other factors.
  - An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
  - Inappropriate types of behavior or feelings under normal circumstances.
  - A general pervasive mood of unhappiness or depression.
  - A tendency to develop physical symptoms or fears associated with personal or school problems.

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Psycho-Educational Assessment

- OHI Criteria
  - Having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that:
    - is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and
    - adversely affects a child's educational performance.

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Psycho-Educational Assessment

ED	OHI
▪ Likely more opportunity to access special programs.	▪ Label less stigmatizing.
▪ Can be an accurate representation.	▪ Also an accurate representation.
▪ Draws attention to mood issues.	▪ Implies a medical condition that is outside of the student's control.
▪ Represents the **presentation** of the disorder.	▪ Represents the **origin** of the disorder.

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Psycho-Educational Assessment

- Health & Development
  - Family History
  - Health History
  - Medical History

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Psycho-Educational Assessment

- Current Medical Status
  - Vision/Hearing
  - Any medical conditions that may be impacting presentation?
  - Medications

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Psycho-Educational Assessment

- Observations
  - What do you want to know?
  - Where do you want to see the child?
  - What type of information will you be collecting?
- Interviews
  - Who?
  - Questionnaires, phone calls, or face-to-face?

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Psycho-Educational Assessment

- Socio-Emotional Functioning
  - Rating Scales
    - General
      - *Child-Behavior Checklist* (CBCL)
      - *Behavior Assessment System for Children* (BASC-II)
      - *Devereux Scales of Mental Disorders* (DSMD)
    - Mania
      - *Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia* (WASH-U KSADS)
      - *Young Mania Rating Scale*
      - *General Behavior Inventory* (GBI)
    - Depression
      - *Beck Depression Inventory* (BDI)
      - *Hamilton Rating Scale for Depression*
      - *Reynolds Adolescent Depression Scale* (RADS-2)

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Psycho-Educational Assessment

- Socio-Emotional Functioning, cont.
  - Rating Scales
    - Comorbid conditions
      - Attention
        - *Conners' Rating Scales*
        - *Brown Attention-Deficit Disorder Scales for Children and Adolescents*
      - Conduct
        - *Scale for Assessing Emotional Disturbance* (SAED)
      - Anxiety
        - *Revised Children's Manifest Anxiety Scale* (RCMAS)
  - Informal Measures
    - Sentence Completions
    - Guess Why Game?

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Psycho-Educational Assessment

- Cognitive Assessment
  - *Woodcock-Johnson Tests of Cognitive Abilities* (WJ-III)
  - *Wechsler Intelligence Scale for Children* (WISC-IV)
  - *Developmental Neuropsychological Assessment* (NEPSY)
  - *Kaufman Assessment Battery for Children* (KABC-2)
  - *Differential Ability Scales* (DAS-2)

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Psycho-Educational Assessment

- Psychological Processing Areas
  - Memory
    - *Wide Range Assessment of Memory & Learning* (WRAML-2)
  - Auditory
    - *Comprehensive Test of Phonological Processing* (CTOPP)
    - *Tests of Auditory Processing* (TAPS-3)
  - Visual
    - *Motor-Free Visual Perception Test* (MVPT-3)
  - Visual-Motor Integration
    - *Beery Buktenica Developmental Test of Visual Motor-Integration* (VMI)
    - *Bender Visual-Motor Gestalt Test* (Bender-Gestalt II)

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Psycho-Educational Assessment

- Executive Functions
  - Rating Scales
    - *Behavior Rating Inventory of Executive Functions* (BRIEF)
    - *Comprehensive Behavior Rating Scale for Children*
  - Assessment Tools
    - *NEPSY*
    - *Delis-Kaplan Executive Function Scale*
    - *Cognitive Assessment System* (CAS)
    - *Conners Continuous Performance Test*
    - *Wisconsin Card Sorting Test*
    - *Trailmaking Tests*

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Psycho-Educational Assessment

- The Report…
  - Who is the intended audience?
  - What is included?
    - Referral Question
    - Background (e.g., developmental, health, family, educational)
    - Socio-Emotional Functioning (including rating scales, observations, interviews, and narrative descriptions)
    - Cognitive Functioning (including Executive Functions & Processing Areas)
    - Academic Achievement
    - Summary
    - Recommendations
    - Eligibility Statement
- Delivery of information

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Special Education & Programming Issues

- Special Education or 504?

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Special Education & Programming Issues

- Consider referral options
  - Mental Health
  - Medi-Cal/Access to mental health services
  - SSI

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Special Education & Programming Issues

- Developing a Plan
  - IEP
  - 504

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Special Education & Programming Issues

- Questions to ask when developing a plan:
  - What are the student's strengths?
  - What are the student's particular challenges?
  - What does the student need in order to get through his/her day successfully?
  - Accommodations/Considerations
  - Is student's behavior impeding access to his/her education?
    - Behavior Support Plan (BSP) needed?

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School-Based Interventions

- Counseling
  - Individual or group?
    - Will it be part of the IEP as a Designated Instructional Service (DIS)?
      - Goal(s)…
  - Crisis Intervention
    - Will it be written into the BSP?

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School-Based Interventions

- Possible elements of a counseling program
  - Education
  - Coping skills
  - Social skills
  - Suicidal ideation/behaviors
  - Substance use

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School-Based Interventions

- Specific Recommendations
  1. Build, maintain, and educate the school-based team.
  2. Prioritize IEP goals.
  3. Provide a predictable, positive, and flexible classroom environment.
  4. Be aware of and manage medication side effects.
  5. Develop social skills.
  6. Be prepared for episodes of intense emotion.
  7. Consider alternatives to regular classroom.

Lofthouse & Fristad (2006, pp. 220-221)

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