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Article 9

Effectiveness of a Psychosocial Treatment Program for Pediatric Bipolar Disorder in Improving Self-Esteem and Reducing Problematic Behaviors

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Bipolar disorder is a brain disorder that causes extreme shifts in mood, energy, and ability to function (National Institute of Mental health [NIMH], 2008). Abnormalities in brain biochemistry, and in the structure and activity of certain brain circuits, are responsible for the extreme changes in mood ranging from severe depression to mania (NIMH, 2001). This disorder affects how a person thinks, feels, and acts.

Bipolar disorder has been traditionally viewed as a disorder of late adolescence or adulthood. Epidemiological studies carried out over the past few years have provided new information substantiating that both depression and manic symptoms afflict both children and adolescents (Weckerly, 2002). Experts estimate that one million children in the United States may suffer from the early stages of bipolar disorder. The American Academy of Child and Adolescent Psychiatry reports that up to one third of the 3.4 million children and adolescents with depression in the United States may actually be suffering from the onset of bipolar disorder (Wilkinson, Taylor, & Holt, 2002).

In an overview of pediatric bipolar disorder, Weckerly (2002) stated that the timely treatment of pediatric mania might also have broader social consequences. In her research, she stated that recent epidemiological studies have confirmed that the consequences of mental illness resulted in the greatest societal costs of any class of disease. She also stated that psychiatric disorders beginning in childhood might have an even greater impact on social development and educational attainment. Consistent with Weckerly's (2002) findings, a study by Muller-Oerlinghausen, Berghofer, and Bauer (2002) indicated that the mortality rate of bipolar disorder is two to three times higher than that of the general population. Between 10–20 percent of children with bipolar disorder take their own lives and one third admit to at least one suicide attempt. Longitudinal outcome studies have shown that the effects of aggressive drug treatment are not achieved in all patients.

Epidemiological studies have confirmed that mental illness produces the greatest societal costs of any class of disease and that psychiatric disorders beginning in childhood have a significant impact on social development and educational attainment (Weckerly, 2002). Children suffering from psychiatric disorders are often

developmentally behind in achieving certain cognitive, emotional, and social milestones. When studying children diagnosed with pediatric bipolar disorder, it is important to keep in mind the social, emotional, and cognitive level at which they are functioning (Holmbeck, Greenley, & Franks, 2003). A recent study by. Pavuluri et al. (2006) states that children diagnosed with bipolar disorder must learn to handle persistent depression, difficulty sleeping, as well as a natural tendency towards aggressive behavior. Children also lack the ability to age-appropriately problem solve. This is due to neuro-cognitive deficits in sustained attention, working memory, verbal memory and executive function (Pavuluri et al., 2006). Some of these problems may be addressed by intervening at the children's current developmental level and teaching them the skills needed to reach an age appropriate developmental level (Holmbeck et al., 2003).

Childhood behavior problems such as school failure, fighting, dangerous play, and inappropriate sexualized activity are more apt to be seen in a child with bipolar disorder. Often a child will experience a worsening of disruptive behavior, moodiness, difficulty sleeping at night, impulsivity, hyperactivity, and an inability to concentrate. These children have been described as having episodic short attention span, low frustration tolerance, explosive anger followed by guilt, sulkiness, depression, and poor school performance (Weller, Weller, & Fristad, 1995). Geller, Bolhofner, and Craney (2000) reported that more than half of those diagnosed with pediatric bipolar disorder had no friends, were teased by other children, and had poor social skills. They also had poor relationships with siblings and high-tension relationships with their parents. There was also a high degree of hostility and low warmth in maternal-child relationships, poor agreement between parents on child-rearing, and minimal problem-solving skills (Geller et al., 2000).

Geller et al. (2000) found that there is a high degree of hostility in familial relationships when a child is diagnosed with bipolar disorder. Papolos and Papolos (1999) stated that most children with bipolar disorder tend to be inflexible and oppositional as well as being extraordinarily irritable with periods of explosive rage. These children have been known to have tantrums for hours and to kick holes in doors and walls. Just about every member of a family, including the pets, can be threatened or hurt (Papolos & Papolos, 1999). Family life is filled with feelings of guilt, powerlessness, denial, anger, anxiety, fear, uncertainty, confusion, blame, and shame. Over time, these emotions lead to hostility, arguments, and fractured parent-child relationships. These types of psychosocial issues affect the child, family, school, and community in a very negative way. If these issues are not treated, then waves of destruction will continue to affect the child's life. This will not only impact the child's ability to have academic success, but it will also affect the child's ability to have a successful relationship with their family.

Purpose of the Study

The focus of this study was to design and test a comprehensive treatment program for children affected by pediatric bipolar disorder. The program incorporated a number of treatment modalities, was eight sessions in length, and used a psycho-educational design. During these eight sessions, participants learned:

1. To recognize the causes of their thoughts, feelings, and actions.
2. To adapt the belief, "I am a good child with difficult symptoms" rather than "I am a bad child."
3. To gain a sense of control over the problems related to their disorder which includes: awareness of mood changes, awareness of what triggers those changes, and awareness of their misperceptions of other people.

The goal of the treatment program was to decrease the symptoms of disruptive behavior, to decrease the symptoms of irritability, and to increase their feelings of positive self-image.

Significance of the Study

This study was designed to evaluate a treatment program for children affected with pediatric bipolar disorder and the issues they deal with every day. The program dealt with the psychosocial problems associated with pediatric bipolar disorder and focused on the situations that children have to deal with on a daily basis.

The children were given permission to accept themselves as human beings and to understand that they were no different from any other child. Then they could start to accept the fact that how they think, feel, and behave is due to a disorder and not the result of something they had done. With that as a foundation, they could begin to disengage from feelings of blame, shame, and embarrassment. The children no longer had to buy into the belief that they were, by nature, a *bad* child. By accepting the fact that they had a disorder, the children could then begin to learn how to use techniques and strategies that would lessen the negative effects of their differences and put them in a position to learn socially acceptable behaviors.

Research Design

This was a descriptive, causal-comparative, quasi-experimental research design. The study was designed to examine symptom changes as well as changes in each child's self-concept. Evaluations were conducted both before and after participation in the treatment program.

Participants

The 26 participants in the treatment program were public school children ages 6-14 (M=10.23, SD=2.405) currently placed in emotionally disabled (ED) classrooms. The age range was evenly split at 50% being between 6–10 years old and 50% being between 11–14 years old. Within these ranges, 77% were between 7–9 years old and 85% were between 11–13 years old. Of the children that participated in this study, 77% (n=20) were male and 23% (n=6) were female. Of the 26 participants, 18 (69.2%) were currently on a psychiatric medication and 8 (30.7%) were non-medicated. The families were from diverse ethnicities but were acculturated into the community. The ethnicity was primarily Caucasian (n=16, 61.5%), then Hispanic (n=8, 30.7%), with Native American and Black each representing 3.8% (n=1) of the group.

All the participants had diagnoses of a mood disorder, not otherwise specified, or bipolar disorder and 69% had Attention Deficit Hyperactivity Disorder (ADHD) symptoms as well. Most of the children were medicated for their disorders (69.2%).

Instrumentation

Three separate instruments were used in this study. A demographic information questionnaire consisted of questions on age, grade, current family constellation and stability. An interview protocol was used to obtain a mental health history as well as current issues that the families and child participants were dealing with. Information regarding current medication was listed in the initial screening and in the final interview. Changes in medication were noted as a potential factor in how far the child participant progressed in the study. This information was used to gain an understanding of the participant's mental health circumstances. The Child Behavioral Checklist (CBCL) for parents and the Teacher Report Form (TRF) for teachers was used to measure behavioral changes following the eight group sessions. The Beck Youth Inventory was used as a pre and post measure of mood and self-perception.

Method

The children participated in a series of eight psycho-educational group sessions over the course of eight weeks. Each session was 45 minutes in length, and each had a specific goal to be achieved during that time. Each session was taught using child appropriate and developmentally appropriate language. Each participant was assigned a code. That code was then used on participants' copies of the pre- and post- CBCL, TRF, and Beck Youth Inventory. For the two research questions, a repeated measure multiple analyses of variance (MANOVA) was conducted to examine: (a) if there were positive changes in participants' self-esteem after participating in the eight-session treatment program, and (b) if there were negative changes in social problems, attention problems, rule-breaking behavior, and aggressive behavior, following the eight group sessions.

Self-Concept

A MANOVA was conducted with self-esteem as the criterion variable, treatment program as the with-subject independent variable, and medication treatment as the between-subject variable. Results of the repeated measures MANOVA indicated that the treatment program was significant in regard to changes in participants self-esteem scores, *Wilks' Lambda* $\lambda = .31$, $F_{(1, 24)} = 54.18$, $p < .000$. In addition, there were no interaction effects between the medication treatment and the eight-session psychosocial treatment program, *Wilks' Lambda* $\lambda = .98$, $F_{(1, 24)} = .51$, $p > .05$. The effects of the medication were not significant $F_{(1, 24)} = .542$, $p = .469$. This suggests that participants in the psychosocial program showed significant improvements in their self-esteem. This was independent from the medication treatment received for their bipolar disorder.

Disruptive Behavior

Disruptive behavior in children typically refers to a variety of behaviors that interfere with personal, social, or educational development. This study examined four

specific areas, including social problems, attention problems, rule-breaking behavior, and aggressive behavior.

Social problems. A MANOVA was conducted with social problems as the criterion variable, treatment program as the with-subject independent variable, and medication treatment as the between-subject variable. Results of the repeated measures MANOVA indicated that the treatment program was significant in regard to changes in participants social problem scores, *Wilks' Lambda* $\lambda = .75$, $F_{(1, 24)} = 8.21$, $p < .01$. In addition, there were interaction effects between the medication treatment and the eight-session psychosocial treatment program, *Wilks' Lambda* $\lambda = .85$, $F_{(1, 24)} = 4.37$, $p < .05$. The effects of the medication were not significant, $F_{(1, 24)} = .021$, $p = .885$. This suggests that participants in the psychosocial program showed a significant decrease in their social problems. Those taking medication for their bipolar symptoms showed a greater decrease in social problems.

Attention problems. A MANOVA was conducted with attention problems as the criterion variable, treatment program as the with-subject independent variable, and medication treatment as the between-subject variable. Results of the repeated measures MANOVA indicated that the treatment program was significant in regard to changes in participants attention problem scores, Wilks' Lambda $\lambda = .77$ $F_{(1, 24)} = 7.17$, $p < .05$ In addition, there were no interaction effects between the medication treatment and the eight-session psychosocial treatment program, Wilks' Lambda $\lambda = .96$, $F_{(1, 24)} = 1.05$, $p > .05$. The effects of the medication were not significant, $F_{(1, 24)} = 1.012$, $p = .324$. This suggests that the participants in the psychosocial program showed a significant decrease in their attention problems. This was independent from the medication treatment received for their bipolar disorder.

Rule-breaking behavior. A MANOVA was conducted with rule-breaking behavior as the criterion variable, treatment program as the with-subject independent variable, and medication treatment as the between-subject variable. Results of the repeated measures MANOVA indicated that the treatment program was not significant in regard to changes in participants rule-breaking behavior scores, Wilks' Lambda $\lambda = .99$ $F_{(1, 24)} = .24$, $p > .05$ In addition, there were no interaction effects between the medication treatment and the eight-session psychosocial treatment program, Wilks' Lambda $\lambda = .96$, $F_{(1, 24)} = .76$, $p > .05$. The effects of the medication were not significant, $F_{(1, 24)} = .066$, $p = .799$. This suggests that the participants in the psychosocial program showed no significant decrease in their rule-breaking behavior whether or not they were on medication.

Aggressive behavior. A MANOVA was conducted with aggressive behavior as the criterion variable, treatment program as the with-subject independent variable, and medication treatment as the between-subject variable. Results of the repeated measures MANOVA indicated that the treatment program was not significant in regard to changes in participants aggressive scores, Wilks' Lambda $\lambda = .92$ $F_{(1, 24)} = 2.24$, $p > .05$. However, there were interaction effects between the medication treatment and the eight-session psychosocial treatment program, Wilks' Lambda $\lambda = .81$, $F_{(1, 24)} = 5.71$, $p < .05$. The effects of the medication were not significant, $F_{(1, 24)} = .183$, $p = .672$. This suggests that the participants in the psychosocial program did show a significant decrease in their aggressive behavior, and that this was dependent on the medication treatment for their bipolar disorder. Those who were on medication treatment demonstrated a significant

decrease in their aggressive behaviors, while those who were not on medication actually demonstrated an increase in their aggressive behaviors.

Discussion of Results

There were two major goals of the psychosocial treatment program. One was to increase self-esteem in children with bipolar disorder. The second goal was to decrease negative behavioral symptoms in these children, specifically in the areas of social problems, attention problems, rule-breaking behaviors, and aggressive behaviors. From a behavioral perspective, these four areas are the prime areas of concern.

Self-Esteem

The positive effects of the psychosocial treatment program on self-esteem were independent from the effects of medication treatment. The result of the increased self-esteem indicates that these child participants were able to cognitively change their thought processes and accept new information independent of medication.

This suggests that once a child's mood is stable enough, they will be able to learn and process new ideas and beliefs about themselves. When given this information in a strategic format, and when this information was reinforced on a consistent basis over a two-month period of time, these children accepted and believed it. During the course of the two-month program, there was an emphasis on positivity. Each week every participant was welcomed warmly and given many opportunities to receive verbal praise. The increase in the self-esteem score may be largely due to the consistent positive force that the participant's experienced each week from this researcher. The program's activities were geared toward building self-esteem, but the researcher's attitude toward each participant was also consistently warm, embracing, and uplifting. This common factor of everyone being accepted and embraced during this program may have been enough to increase their self-esteem.

In a 2002 study by Geller et al., low maternal warmth predicted relapse of manic symptoms in bipolar children. Those children with low maternal warmth were four times more likely to relapse within a two year period of time (Geller et al., 2002). In a study done in 2008 by Schenkel et al., the mother-child relationship was again reviewed. The study indicated that the mother-child relationships were characterized by less warmth and intimacy. Mothers reported that they found it more difficult to establish a warm and loving relationship with their child diagnosed with pediatric bipolar disorder (Schenkel et al., 2008). If these children are experiencing less accepting and warm relationships at home, then having the increased experience of warmth and acceptance in the program may have had a significant impact on their self-esteem. This treatment program specifically targeted negative thinking and gave participants an opportunity to build a new belief system. These participants were able to create an improved self-image and lessen their negative thoughts. This improved self-esteem helps build confidence, which in turn promotes better interactions with peers and family members.

Disruptive Behavior

Disruptive behavior is typically broken down into social problems, attention problems, rule-breaking behavior, and aggressive behavior. Children with this diagnosis

usually display behavior that is oppositional, hostile to others, mean, and aggressive. Not attending to tasks, being distracted, and having poor follow through are typical behaviors of children diagnosed with bipolar disorder as well as those dually diagnosed with ADHD (Papolos & Papolos, 2002). Each area is reviewed separately.

Social problems. The psychosocial treatment program was effective in reducing social problems. There was an interaction effect between the psychosocial treatment program and the medication treatment. The findings revealed that participants treated with medication had an even greater reduction in behaviors associated with this area. This finding is significant because poor social interaction is a significant problem for children with this diagnosis. A survey by Papolos and Papolos (2002) indicated that 77% of parents reported that their children had "tremendous problems maintaining peer relationships" (p. 18). Improving social interaction and increasing positive social support enhances a child's ability to cope in stressful circumstances (Schwartz, Dorer, Beardslee, Lavori & Keller, 2008). The positive social effect of the psychosocial program indicates that these children will have an easier time navigating some of the typical stressors associated with daily life which may have proven overwhelming in the past.

The decrease in social problems indicates that children gained acceptance from their peers. The increased self-esteem may also be a part of the decrease in social problems. Once children feel more positive about themselves, they begin to feel more positive about those around them. The reduction of social problems may have been a direct result of learning new ways to express themselves. It may also have been a function of working in a group, dealing with emotional and behavioral problems that they all have in common. This produces a level of comfort amongst the members of the group. The participants worked cooperatively and collectively to recognize and disengage from situations that caused increased emotional and behavioral outbursts. The group dynamic also increased their understanding of peer's behavior. The decrease in problematic interactions can also be seen in families, where there tends to be a higher degree of negative parent-child and sibling interaction.

Decreased social problems within an emotionally disabled classroom are significant in the area of learning. With fewer social problems erupting between students, a greater focus on the academic needs of the class can take place. The primary reason for a child to be placed in an emotionally disabled classroom is the child's inability to behave in a socially appropriate manner. Improved social skills and a decrease in social problems allow these children to be placed in a less restrictive environment.

Although the findings indicated that participants reduced their social problems as a result of the psychosocial treatment program, those currently being treated with medication showed greater improvement. There are two primary purposes for medication treatment in pediatric bipolar disorder. The first is for mood stabilization and the second is to reduce impulsive and aggressive behavior (Pavuluri & Bishop, 2007). Aggression towards family and peers, impulsive negative behaviors, poor frustration tolerance, and verbal attacks negatively affect relationships and cause social problems. Those participants that were treated with medication may have been able to reduce the impulsive tendencies to respond negatively and aggressively to emotionally charged social situations. As a result, they were in a better position to learn socially acceptable behaviors and be more tolerant of their peer's behaviors.

Attention problems. Results of this study found that participant's attention problems improved after participating in the psychosocial program independent of medication treatment. Medications prescribed for pediatric bipolar disorder are primarily for mood stabilization and not for attention problems (Pavuluri & Bishop, 2007). There is a high degree of symptom overlap between ADHD and pediatric bipolar disorder with an estimated 80% of children with bipolar disorder having at least five major symptoms of ADHD. Medication typically given to reduce ADHD symptoms can end up aggravating bipolar symptoms (Faust, Walker, & Sands, 2006). It is likely that participants' medication treatment was not prescribed for issues of inattention or distractibility.

The American Academy of Child and Adolescent Psychiatry recommends medication be the primary treatment option except in cases of comorbidity with mood disorders. In these cases, medication selection and use must be heavily monitored for treatment-emergent side effects. The use of psychosocial treatment in conjunction with mood stabilizing medications may be more effective (Leonard, 2007). Psychosocial interventions designed to target peer relationships and improve social problem solving are considered efficacious treatments for ADHD in children (Daly, Creed, Xanthopoulos, & Brown, 2006). The psychosocial treatment program developed for this study targeted peer relationships and emphasized the teaching of personal routines, calming exercises, and problem solving techniques. Participants learned how routines can improve concentration and attention to the task at hand. They learned how calming exercises help gain control over situations and increase response process time. Participants also identified typical situations where inappropriate responses were used and, together with the group, developed and role-played new responses. This gave them some practice in using these new options.

The identification and development of personal routines for use at home and school was done to help reduce feelings of confusion when faced with multiple tasks or projects. The correlation between symptoms of ADHD and pediatric bipolar disorder include neurological deficits in the areas of executive functions. Executive functions are used for planning, organizing, reasoning, strategizing, problem solving, and self-control (Papolos & Papolos, 2002). Targeting these areas of deficit with specific strategies has been the most effective psychosocial treatment in regard to academic and school success (Daly et al., 2006). The development of classroom management routines, coupled with recognition of physical signs of intensifying emotion, and the use of calming exercises, resulted in a decrease in attention problems by the participants of this study. These results suggest that students with attention deficit problems who are unable to tolerate first line medications could improve their classroom behavior if they are provided with specific interventions that target deficit areas.

Rule-breaking behavior. The results show that there wasn't a significant change in behavior after completion of the program, regardless of the student's medication use. For the purpose of this study, rule-breaking behavior is specifically defined as lying, cheating, stealing, swearing, and not showing feelings of remorse or guilt. Neither the use of medication nor the participation in the program reduced behaviors in this area. The program did not have a specific intervention that targeted these specific behaviors. The participants needed to develop new techniques by applying what they had learned from other areas. The participants most likely were unable to do that. As mentioned earlier,

these children have executive function deficits, which are symptoms of bipolar disorder and ADHD.

Executive function deficits include the inability to generalize or shift what is known to another problem area. There is an inherent inflexibility in the thinking and learning processes of a child with bipolar disorder (Papolos & Papolos, 2002; Greene, 2001). Because of this inflexibility, it is unlikely these students would have been able to apply new information to an area not directly related to it.

This is a significant finding in this study because it indicates that an intervention program must address each specific area of need directly and not indirectly. To reduce rule-breaking behaviors, students will need specific instruction on problem solving daily situations that lead to breaking rules.

Aggressive behavior. The results of this study indicate that students treated with medication significantly lowered their aggressive behavior following participation in the psychosocial treatment program. There was actually an increase in the aggressive behaviors of students who were not being treated with medication. As indicated earlier, medication for pediatric bipolar disorder is primarily used for two purposes, mood stabilization and reduction of impulsive and aggressive behavior (Pavuluri & Bishop, 2007). Without the help of medication, students were unable to change their behaviors despite having interventions designed specifically to reduce aggressiveness. However, without the psychosocial program, the medication alone did not reduce the aggressive behavior either.

It is not known why aggressive behaviors increased following the program. It is possible that something within the classroom increased the frustration level in the non-medicated participants and therefore they reacted with aggressive behaviors. It is also possible that some participants had become more social and that this increased interaction between participants led to aggressive behavior. Another possibility is that participants began feeling more confident in their feelings and emotions. Perhaps given a longer span of time, these same participants would have learned the replacement behaviors and been able to use them more effectively. There is a phenomenon in behavioral therapy that negative behaviors often increase prior to decreasing. This could be what happened with the non-medicated population since they were less able to control their escalation to rage due to a lack of medication treatment.

Interventions used to lower aggressiveness are similar to those that were used to improve social behavior and attentiveness. A psycho-educational approach was used to show biological reasons why aggression is inherent to pediatric bipolar disorder. However, this does not teach the child a new behavior. As indicated with rule-breaking behavior, poor executive functioning does not allow the child to cognitively make correlations between understanding cause and finding an alternate behavior. Children will need direct instruction on what behavior is considered aggressive and what alternate behavior is considered appropriate. In the psychosocial program, participants were asked to recall a situation where they reacted in an aggressive manner. They were then given a series of choices of alternate behaviors that would be acceptable. The participants would then re-enact the situation using the less aggressive behavior.

This approach is similar to what is used with children who suffer from autism spectrum disorder. Children with autism spectrum disorder also have executive function deficits and are unable to problem solve when placed in stressful situations. They react

impulsively and often aggressively when faced with a peer interaction problem. Social stories are useful since they describe for the child the situation, the problem, and the acceptable solution. The child is then able to recall the lessons from this story and apply them when confronted by a stressful peer situation. This has produced positive results for children suffering from autism spectrum disorder (Spencer, Simpson, & Lynch, 2008). The psychosocial treatment program has a similar approach. It gives participants a situation, a problem, and an acceptable behavior to use.

Conclusion

This study was completed in a self-contained classroom with children diagnosed with bipolar disorders and there was success in that environment. The program can easily be expanded into a variety of settings and used for any type of mood disorder. The program could be run in a group format at a school outside of the classroom as well. The program is versatile and a community mental health center could use this program to effectively work with families. Used in a group format, the center would be able to run simultaneous groups for the children and for family members. Each group could follow the same format. The child group would be set up to mirror what was done in this study. The family group would focus on the psycho-education aspect and continue to use behavioral change techniques at home. The combined use of the program for the child and the family would increase the probability of long lasting positive effects and a reduction in symptoms. Much like the family focused therapies facilitated by Fristad, Gavazzi, and Mackinaw-Koons (2003), the goal of this program would be to increase knowledge and skill, and decrease expressed emotion in the family.

The findings from this study imply that more than just medication is needed to reduce the long-term effects of pediatric bipolar disorder on both the child and the family. Successful building of self-esteem and the reduction of negative behaviors would allow children affected by bipolar disorder to engage more effectively with their peers and families. These children would also be better equipped to achieve academically and socially in the school setting. The results of children having higher levels of success socially, emotionally, and academically would lead to happier and healthier families and communities.

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