

HEALING HANDS



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Which Is It: ADHD, Bipolar Disorder, or PTSD?

Across the spectrum of mental health care, Anxiety Disorders, Attention Deficit Hyperactivity Disorders, and Mood Disorders often appear to overlap, as well as co-occur with substance abuse. Learning to differentiate between ADHD, bipolar disorder, and PTSD is crucial for HCH clinicians as they move toward integrated primary and behavioral health care models to serve homeless clients. The primary focus of this issue is differential diagnosis. Readers interested in more detailed clinical information about etiology, treatment, and other interventions are referred to a number of helpful resources listed on page 6.

HOMELESS PEOPLE & BEHAVIORAL HEALTH Close to a quarter of the estimated 200,000 people who experience long-term, chronic homelessness each year in the U.S. suffer from serious mental illness and as many as 40 percent have substance use disorders, often with other co-occurring health problems. Although the majority of people experiencing homelessness are able to access resources through their extended family and community allowing them to rebound more quickly, those who are chronically homeless have few support mechanisms and more problems accessing care that is necessary to help stabilize their conditions. Ongoing federal programs and leadership through the Interagency Council on Homelessness help, but need continues to exceed the availability and accessibility of services. Of note, results continue to show that even homeless individuals with the most serious mental illness can be helped and with support reenter a housed community.¹

Behavioral health disorders account for 69 percent of hospitalizations among homeless adults.² Mental health professionals and federal agencies work to identify and document effective approaches to care. Nevertheless, many mental disorders are undiagnosed in primary care settings, where clinicians vary in their ability to recognize, diagnose, and treat behavioral health disorders.¹ This is where the promise and challenge of integrated primary and behavioral health care intersect. Urban centers may have more resources—along with more clients—while outlying areas may not have enough trained and experienced clinicians to fully integrate care.

CHICKEN & EGG QUANDARY Care providers interviewed for this issue of *Healing Hands* all acknowledged the classic chicken and egg quandary involved in making accurate mental health diagnoses, confounded by the manifestations of co-occurring substance use disorders. Indeed, there are significant similarities in the signs and

symptoms exhibited by clients with ADHD, bipolar disorder, or PTSD that make definitive diagnosis formidable. The second causative issue is how clients' illnesses affect their homelessness. Understanding that clinical and research scientists and social workers continually try to tease out the impact of living circumstances and comorbidities, we recognize the importance of causal issues but set them aside to concentrate primarily on how to achieve accurate diagnoses in a challenging care environment.

USING PROVEN ASSESSMENT MODELS Two decades of HCH practice has confirmed what clinicians continue to reaffirm—there are important principles of care to which each clinical practitioner is advised to adhere:³

- Integrated treatment
- Individualized treatment planning
- Assertiveness (outreach and engagement)
- Close monitoring
- Longitudinal perspective
- Harm reduction
- Stages of change
- Stable living situation
- Cultural competency and consumer centeredness
- Optimism

Recognizing that use of alcohol or other psychoactive substances may mimic and mask deep-seated mental health issues such as ADHD, bipolar disorder, or PTSD, clinicians concur that addressing substance use first is optimal, though often not feasible. Indeed, homelessness research over the last 20 years demonstrates that integrated treatment of dual disorders is associated with better outcomes than either sequential or parallel treatment.³

When a client is agitated, disoriented, and out of control, don't assume anything. "Observe, question, and listen," advises **Erin Cobb, MSW, LISW-CP**, a social worker with the Homeless Veteran Program, Ralph H. Johnson VA Medical Center in Charleston, SC. "If it's substance abuse, you'll most likely smell alcohol, see bloodshot eyes, or notice burned lips from crack pipes." And that opens a specific line of questioning that can lead to referrals for necessary resources. Having spent over six years working at a private homeless clinic with HCH connections, Cobb knows the value of a detailed medical history. "Veterans are really wonderful about responding to questions," she says. "They know from their military regimentation that you have to answer the questions before moving to the next step."

The VA Access to Care program strives to smooth the pathways to care and provides a 28-day substance use treatment program as a starting point. "But there is no cookie cutter mold to use in diagnosis and care," says Cobb. "Clinicians who work with homeless individuals must redefine their notion of success with every client. You absolutely must work with the individual, where that person is at that moment."

Claudio Cabrejos, MD, MPH, a psychiatrist with Family Health Centers of San Diego, works with clients in the Depression Project, Homeless Clinic, HIV Clinic, and Family Clinic. "The signs and symptoms of ADHD, bipolar disorder, and PTSD differ but often overlap—particularly a lack of concentration and poor memory," he says. "We use a walk-in clinic system because even though clients have scheduled appointments, many only come back after 2 to 3 weeks when they are running out of meds. Ongoing follow-up varies from patient to patient. Some seek help and come back readily, but with all you have to develop rapport."

Realizing that a comprehensive diagnosis of mood and anxiety disorders is challenging in the best of circumstances, "the clinician must always look for patterns and clues" according to **Karen Swartz, MD**, a psychiatrist in the Affective Disorders Consultation Clinic at The Johns Hopkins Hospital. "There are no 'a-ha' moments. Clinical psychotherapy has no tests to rule out one diagnosis over another. You must use observation and history on a continuing basis. It is important to establish a longitudinal relationship with the client so you can revise care based on new information."

Clinical practice standards such as these continue to set parameters for quality care in a primary care setting. The following sections review symptomology and clinical research specific to establishing differential diagnoses for ADHD, bipolar disorder, and PTSD.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD is generally described as a chronic biological disorder of brain physiology manifesting with neurobehavioral symptoms including hyperactivity, inattention, and impulsivity. Incidence ranges from 3 to 5 percent of school-aged children. Research tracking close relatives and studies of twins supports a genetic tendency from one generation to another. Symptoms manifest early and are recognized in children by the age of 6 or 7, though there are numerous clinical reports of ADHD in preschoolers. In addition, the basic ADHD symptomology

SIGNS & SYMPTOMS OF ADHD

Hyperactivity

- Can't stay seated—up and down a lot
- Fidgets and squirms
- Can't play quietly
- Climbs; runs around constantly
- Talks all the time

Impulsivity

- Can't wait turn
- Blurts out comments
- Interrupts

Inattention

- Easily distracted
- Can't follow instructions
- Makes careless mistakes
- Doesn't pay attention to details
- Moves from task to task without finishing
- Loses or forgets important items
- Distracted; daydreams

Environmental Exacerbations

- Stress
- Change
- Lack of schedule
- Unorganized living conditions

Comorbidities

- Anxiety and depression
- Sudden life changes (deaths, divorce, job loss)
- Seizures
- Learning disabilities
- Hearing problems

does not present in the same ways in all individuals but may be seen in a variety of combinations: hyperactivity, hyperactivity-impulsivity, impulsivity, or inattention. Because these responses are not unique to ADHD and can be affected by daily life, developmental age, and environmental stressors, diagnosis further requires that the symptoms interrupt normal function and are inappropriate to the patient's age.

As if these parameters weren't complicated enough, children, youth, and adults diagnosed with ADHD are at extreme and continuing risk of serious comorbidity. Disorders that may accompany ADHD include anxiety and depression, bipolar disorder, learning disabilities, neurological tic disorders, oppositional defiant disorder, conduct disorder, and substance use disorder. Such co-occurring disorders make treatment more complex and may call for caution when using stimulant medications.

Today, parents and teachers readily apply an ADHD label to children who exhibit hyperactivity and impulsivity along with signs of inattention. Youngsters who are primarily inattentive—more often girls—may be overlooked because their behavior is not so obviously problematic. Ongoing prospective follow-up studies of girls and young men by respected groups on both coasts support the need for early diagnosis and treatment. Hinshaw and colleagues at UC Berkeley have followed 200 girls over five years (ADHD, N = 140; matched comparison group, N = 88).⁴ While symptoms may differ from those seen in boys, the risks are high for functional impairments (math achievement in particular lagged behind the comparison group) and comorbidity (mild depression 30 percent in ADHD group; 10 percent in control group).

Biederman and associates at Massachusetts General Hospital similarly found that “by young adulthood, ADHD youth were at high risk for a wide range of adverse psychiatric outcomes including markedly elevated rates of antisocial, addictive, mood, and anxiety disorder . . . , [again pointing] to high morbidity associated with ADHD across the life cycle.”⁵

Wilens, Biederman, and Spencer, treating patients with ADHD and comorbid substance use and bipolar disorders at Mass General and Harvard, reported ADHD as often chronic into adulthood and requiring pharmacotherapy including stimulants, antidepressants, and antihypertensives across the life span.⁶ Kessler and associates have shown that adult ADHD symptoms tend to be more varied and often coexist with mental, emotional, and substance use disorders.⁷ Pliszka’s group recently substantiated difficulty with response inhibition through neuroimaging research conducted with individuals with ADHD who were treatment-naïve and healthy comparison subjects.⁸

Not all clinicians, however, are convinced that ADHD is so pervasive. Dr. Cabrejos in San Diego thinks ADHD is over diagnosed in adults. A review article by Lydia Furman, MD, at Case Western Reserve University School of Medicine systematically questions the validity of an ADHD diagnosis as either a disease or a neurobehavioral condition.⁹ In her summary, she calls ADHD “a collection of symptoms . . . without a diagnostic test to confirm diagnosis” and cites the “extraordinary societal and financial pressures that lead to the diagnosis.” She is particularly concerned with the therapeutic trials of stimulant medications for ADHD in general and for toddlers in particular. Of interest to the primary care provider, she says: “. . . symptoms of hyperactivity, inattention, and impulsivity might represent a final common pathway for a gamut of emotional, psychologic, and/or learning problems. Clinical experience and case studies reveal that other problems—for example, occult mental retardation, hypervigilance owing to fear or stress, and ongoing or past abuse—can masquerade as ADHD.”

Or perhaps this is a question of semantics. **Susan Montauk, MD**, professor of Clinical Family Medicine at the University of Cincinnati and medical director of The Affinity Center for ten years, has focused on ADHD in private practice, homeless clinics, and work and resident training in the homeless van program. She says, “the literature tells us—based on the current DSM, which is close to 10 years old—that the overlap for ADHD and bipolar is 60 to 90 percent. Today the diagnostic criteria for bipolar are much broader, so the overlap is undoubtedly much greater. . . . [ADHD, bipolar disorder, and PTSD] should all be labeled neuropsychiatric medical disorders.”

Medications have been used for decades to treat ADHD. The American Academy of Pediatrics suggests the following guidelines for treatment of children meeting diagnostic criteria:¹⁰

- Set specific, appropriate target goals to guide therapy.
- Start medication and/or behavior therapy.
- Evaluate the original diagnosis if treatment does not meet target goals.
- Consider other possible conditions and how well the treatment plan has been implemented.

- Implement follow-up to regularly reassess target goals, results, and any side effects of medications.
- Gather information from parents, teachers, and the child.

Behavioral interventions generally focus on organization skills that include setting a schedule with the same daily routine from wake-up time to bedtime with intervals for homework, playtime, and outdoor recreation. A place for everyday items such as clothing, backpacks, and school supplies should be established. The use of notebook organizers, writing down assignments, and bringing home books necessary for homework should be stressed. In addition, children with ADHD need consistent rules along with praise and rewards when they succeed. Psychotherapy and social skills training to help the child improve behaviors are also recommended interventions.

Teens and adults will benefit from these same interventions. Symptoms of ADHD can be especially difficult during the teen years when the intersection of impulsivity with peer pressure and the need to think through and make good choices become more important (i.e., wearing seat belts when driving, not exceeding the speed limit).

BIPOLAR DISORDER

The National Institute of Mental Health estimates 2 million adults (1 percent of the population, age 18 and older) as having bipolar disorder.¹¹ Characterized by dramatic mood swings, bipolar disorder produces severe changes in energy level and behavior. People with this disorder cycle through episodes of mania and depression. Symptoms range from severe depression at one end of the spectrum to severe mania on the other end, with mild to moderate levels of each of these conditions in between. In some instances, individuals experience a mixed bipolar state when symptoms of depression and mania occur together.

Generally, a manic episode is diagnosed when an elevated mood is present for over one week with three or more symptoms throughout each day. If the mood is irritable, four or more symptoms should be present. A depressive episode is diagnosed when five or more symptoms occur daily over a two-week period. Typically these episodes recur across the life span. Most people with bipolar disorder are free of symptoms between episodes; however, up to a third of patients may have residual symptoms, and a small percentage experience intractable symptoms despite treatment.¹¹

Sometimes individuals with bipolar disorder appear to have symptoms outside the classic diagnostic categories (bipolar I, bipolar II, and cyclothymia), such as impulsive behavior or substance use disorders. Hirschfeld and colleagues describe these patients as having bipolar disorder “not otherwise specified.” When this group is added to those meeting classic diagnostic criteria, the incidence of the combined bipolar spectrum disorder rises to between 2.6 and 6.5 percent of the population. Because the variety of symptoms seen in bipolar spectrum disorder often lead to misdiagnosis, these authors developed and validated a brief and easy-to-use screening tool: the Mood Disorder Questionnaire¹² (see source article or contact Eli Lilly and Co. for a free clinician’s poster in Spanish and English).

Dr. Montauk recommends this questionnaire as a great starting place for patient assessment. Clients can answer questions in 10 minutes and then discuss them with a clinician. It is available on the health van and used as a teaching tool with residents. Clear but careful communication with clients is key. “When you change the terms it sometimes takes away the fear and stigma—bipolar still has the manic/depressive psychosis image and that means CRAZY.”

“For instance, sleep almost always plays a major role in all three disorders—ADHD, bipolar, and PTSD,” adds Montauk. “Listen to what bothers these folks. Sleep differences can tell us a bunch. Ask ‘What was the longest time you were ever up (awake) without sleep and not on drugs?’ Then get the client to elaborate and talk about it. If being up for days has been a problem, you are often hearing about hypomania or mania. With PTSD, nightmares promote a fear of going to sleep, which is much different than being unable to get to sleep because your thoughts are racing. Those with anxiety-induced racing thoughts dwell on things that worry them while those with ADHD may find themselves unable to stop thinking about all sorts of things, positive and negative. Often, the racing thoughts of bipolar insomnia seem to layer on top of each other.”

In general, Dr. Montauk finds that “if you can help the patient get sleep, their disorders improve a lot and become part of the cure, even in mood disorders. Insomnia can be the trigger that sets an episode off. But safety is very important here because a homeless patient must be able to wake up in a dangerous situation.” When respite care sites are available and clients are willing to use them, the sleeplessness cycle is more readily broken.

As with most neurobiological conditions, science can offer only partial answers to the causative riddle. While the condition clearly runs in families, specific genes for bipolar disorder have not been confirmed. Studies of adult monozygotic twins show a 60 percent variance in bipolar disorder attributable to genetic factors and research in pediatric-onset points to a stronger association with prevalence among relatives.¹³ Neuroimaging remains an investigative rather than a diagnostic tool here as in ADHD, but recent preliminary evidence from longitudinal analysis supports the presence of decreased amygdala volumes in adolescent and young adult patients with bipolar disorder.¹⁴

Because complex pharmacotherapy is the mainstay of care, both the literature and clinicians interviewed emphasized the importance of referring ongoing medical treatment to practitioners skilled in the management of bipolar disorder. Often monotherapy is insufficient, and the cycling from mania to depression along with other comorbid conditions may disrupt the care plan.

Responding to the need for evidence-based treatment guidelines for children and adolescents, the Child and Adolescent Bipolar Foundation sponsored Kowatch and colleagues at the Department of Psychiatry, Cincinnati Children’s Hospital, to develop recommended practices drawn from clinical studies of children and adults, published case reports, and expert consensus opinion.¹⁵ Their findings and treatment suggestions include:

- Episodes of mood lability and irritability are more frequent in children than adults.

SIGNS & SYMPTOMS OF BIPOLAR DISORDER

Mania

- Restlessness; increased energy and activity
- Euphoric or overly good mood
- Extreme irritability
- Racing thoughts; talks very fast, jumps from one thought to another
- Can’t concentrate; distractible
- Needs little sleep
- Grandiose beliefs about abilities; power
- Poor judgment; spending sprees
- Substance abuse (cocaine, alcohol, sleeping meds)
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

Depression

- Empty mood with lasting sad and anxious feelings
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in activities once enjoyed, including sex
- Decreased energy; fatigue
- Difficulty concentrating, making decisions, remembering
- Restlessness, irritability
- Sleep problems—too much or none at all
- Change in appetite (weight loss or gain)
- Chronic pain not caused by illness or injury
- Thoughts of death or suicide; suicide attempts

Environmental Exacerbations

- Stress
- Change
- Lack of schedule
- Unorganized living conditions

Comorbidities

- Abnormal thyroid function
- Substance use disorders
- Anxiety disorders; PTSD
- ADHD
- Conduct disorder

- Make sure symptoms are frequent and severe enough to cause disruption in daily living.
- Some symptoms such as irritability are common to a number of disorders.
- Include multiple sources of information (child, parent, school) when formulating diagnosis.
- Always assess for risk of suicide.
- Stabilize bipolar disorder first before treating comorbid disorders.
- When bipolar disorder is stabilized, begin psychoeducation and skill-building exercises to promote continued success in treatment.

POST TRAUMATIC STRESS DISORDER

Anxiety disorders are recognized as the most common mental illness in America, affecting more than 19 million adults each year. PTSD, which is thought to affect over 4 percent of people with anxiety disorders, develops after exposure to any number of violent or traumatic events and is reinforced with each continued exposure. Whether terrorist incidents, natural disasters, combat, serious accidents, or violent personal assaults such as child abuse or rape, individuals who have experienced such stressful events often feel estranged from their environment and support systems and suffer flashbacks and nightmares that interfere with sleep and concentration.¹⁶ In fact, it is not unusual for symptoms of PTSD to appear months or years after the event.

Recognizing the prevalence of PTSD, the PATH Program produced a national teleconference in 2003 on “Working with Trauma Survivors Who Are Homeless.” Dr. Maxine Harris and Lori Beyer, nationally recognized trauma experts from Community Connections in Washington, DC, provided clear and useful information for clinicians about impact, signs and symptoms, medical treatment, strategies for shelter and street programs, and work with children (see online resources).¹⁷

Social workers **Chris Fowley, LCSW**, Rape Crisis Program, and **Lillian Engelson, LCSW**, SRO/Homeless Program, work within the Department of Community Medicine at St. Vincent’s Hospital-Manhattan in New York. Chris says, “We see two kinds of trauma: Simple and Complex PTSD. The response to one-time trauma, no matter how horrific, is different from the response to ongoing, day-after-day trauma. Ongoing trauma, particularly in childhood when perpetrated by a parent or caregiver, often causes overwhelming damage to the child. Almost all clients seen in the SRO/Homeless program have histories of severe and ongoing trauma.”

In working with adult homeless women in particular, “a key to beginning treatment is for the primary care provider who first sees the client to understand how sexual and physical trauma are interwoven with other health conditions the client may have,” add Fowley and Engelson. “Awareness of how trauma manifests and sensitivity to a client’s discomfort disrobing and being touched are as important as hearing and acknowledging what the client says by saying it back to them—for example, ‘It’s hard to be abused as a kid. How that history affects you today may have something to do with why you are here.’”

Research on interpersonal trauma experienced by severely mentally ill populations continues to show a strong association between trauma, homelessness, and PTSD. Mueser and associates found that homeless women and men with mental illness are at continued risk for trauma; and because PTSD correlates to both mental illness and physical health problems, the authors posit that accurate detection and treatment of PTSD may be critical to reducing distress and improving overall health in such patients.¹⁸

“While homelessness puts a family and children at higher risk of exposure to dangerous and lethal circumstances, PTSD has more to do with the child’s personal experience than with homelessness per se” according to **Cynthia King, MD**, a psychiatrist affiliated with the University of New Mexico and its Young Children’s Health Center in Albuquerque. Dr. King specializes in PTSD in children and youth. “ADHD, trauma, and severe anxiety often mimic one another and share many common symptoms,” adds King. “With PTSD you have a marker—all was going along well and then BOOM, all is troubled.” Dr. King notes that “a child’s self-report is very important. Children will generally talk about the trauma if a parent is not involved. The mother’s ability to cope is important, as are strong family ties; but children are also individuals and very resilient. The personality a child starts out with can be improved upon or diminished by parents or environmental factors.”

The seminal work of Garmezny and Masten on the resilience of children in poverty despite risk and negative life events¹⁹ led to ongoing research

SIGNS & SYMPTOMS OF PTSD

Adults

- Reliving the trauma through nightmares and flashbacks
- Sleep problems
- Depression
- Anger; rage
- Intense fear
- Feeling detached or numb
- Exaggerated startle response
- Irritable; distracted
- Paranoia
- Hypervigilance
- Difficulty concentrating

Children

- Disorganized; agitated behavior
- Acting out; aggressiveness
- Learning problems
- Withdrawal; decreased social competencies
- Feelings of guilt, worthlessness, helplessness

Environmental Exacerbations

- Stress
- Confrontation

Comorbidities

- Depression
- Bipolar disorder
- ADHD
- Obsessive compulsive behaviors
- Substance use disorders
- Conduct disorder
- Heart disease, high blood pressure, migraine
- Ongoing chronic disease: cancer, diabetes

by Caspi and Moffitt demonstrating genetic-environmental interactions that help explain differences in individual responses to trauma. Kaufman and colleagues carried this work further by exploring the effect of mitigating factors in abused children’s lives.²⁰

Veterans are another group that is greatly affected by PTSD. Erin Cobb at the Homeless VA Program in Charleston works mainly with veterans seeking treatment for substance abuse, which may mask PTSD. The majority of clients she sees are from past conflicts, roughly 70 percent from the Vietnam era. There aren’t many vets of current wars in Cobb’s program, probably because the VA is actively reaching out to returning soldiers in new ways to make sure they have a successful transition back into civilian life.

Research in 2004 by Hoge and colleagues at the Walter Reed Army Institute reports that Army and Marine Corps in Iraq and Afghanistan have been at significant risk of mental health problems and on return found barriers to receiving mental health services.²¹ In a recent report to Congress, the Government Accountability Office tracked treatment and referrals as well as new, post-deployment health assessments—particularly for PTSD—administered 90 and 180 days after return from combat.¹⁶

For more information about PTSD and the other behavioral health disorders discussed in this article, readers are encouraged to consult the resources listed below and the National Guideline Clearinghouse, where a number of clinical practice guidelines are available: <http://www.guideline.gov> ■

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