Bipolar Disorder in Children and Adolescents: A Manual for Educators

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By

Elizabeth DeBord
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ABSTRACT

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The first four sections of this manual will provide educators with in-depth knowledge regarding childhood bipolar disorder. The first section is a general introduction of the disorder and provides information on diagnosis and treatment plans for children who have the disorder. The second section describes the emotional states that children with bipolar disorder may experience during different mood episodes. These emotional states often manifest with many interrelated symptoms. The third section discusses the effects that childhood bipolar disorder has on the social competence of the child. Because mental illness is a social construction, children with the disorder not only face the symptoms of the disorder but also society’s view of the disorder and how that reflects upon them. The fourth section describes how academic success can be hindered by childhood bipolar disorder. The fifth and final section gives educators, ranging from teacher to counselor to coach, real-world application techniques to take what they have learned in the previous chapters and provide better environments for their students who have been diagnosed with childhood bipolar disorder.
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By Elizabeth DeBord

Approved by:

Kathy McMahon-Klosterman, Advisor
Dr. Kathy McMahon-Klosterman

Jennifer Green, Reader
Dr. Jennifer Green

Brooke Spangler, Reader
Dr. Brooke Spangler

Accepted by:

Carolyn Haynes
Director University Honors Program
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Chapter 1: Introduction

Bipolar disorder is an emotional disorder that can be debilitating for those who are suffering from its symptoms. The disorder affects anywhere from two to four percent of the U.S. population (Miklowitz & Johnson, 2009). Emotional disorders like bipolar disorder affect mood and emotional stability. Specifically, this disorder affects cycles of moods. People often suffer from drastic changes in energy levels, trouble with peer and family relationships, and difficulty with academic performance. While some people do not develop the disorder until later in life, over half of the cases show symptom manifestation before the age of 25 (NIMH, 2010a). Bipolar disorder is typically associated with adolescence and early adulthood. However, there are a growing number of cases being diagnosed in childhood and early adolescence. As a result, it is incredibly important as an educator to understand the various symptoms and stigmas associated with childhood bipolar disorder. Symptoms differ between childhood bipolar disorder and adult bipolar disorder.

Symptoms

Symptoms of childhood bipolar disorder range from moderate to severe depending on the level. According to the Diagnostic and Statistical Manual of Mental
Disorders (APA, 2000), there are four different types of bipolar disorder, but with all cases there is some transition from mania symptoms to depressive symptoms and back. These levels will be described later in the diagnosis section.

Mania symptoms of childhood bipolar disorder may resemble those of attention deficit and hyperactivity disorder (ADHD) in children. As many as 80% of children may be misdiagnosed with ADHD or go undiagnosed completely for up to ten years (Singh, 2008). Mania symptoms in children are often similar to behavioral problems associated with parenting styles, bad temperament, and ADHD. These similarities are contributing factors to the misdiagnosis of bipolar disorder in children.

Mania cycles are described as two or more weeks of a “high” feeling. A person usually experiences increased levels of energy, needs less sleep, and may be irritable or agitated (NIMH, 2010a). In children, mania episodes may not last the two full weeks, and symptoms for children include sleeping less than four hours per night and impulsivity. Children with the disorder are also often easily distracted, and report that they are “unable to shut off their brain” (Senokossoff & Stoddard, 2009, p. 92). This differs from adult bipolar disorder in which mania is associated with “binges” such as extended and
excessive cleaning or spending periods. Hypomania characteristics are mild versions of the above symptoms and may be present before full mania symptoms are manifested.

Depressive cycles of childhood bipolar disorder are similar to that of clinical depression. Feelings of emptiness or worthlessness may accompany behavioral changes like difficulty with memory or concentration (NIMH, 2010a). Another symptom that is similar to symptoms of clinical depression is loss of interest in activities that were once enjoyed and overall flat affect. One important symptom that educators must be on the look out for is consideration of or attempt at suicide (Cleaver, 2009).

Depressive and manic cycles can range from mild to severe. In the severe stages of the cycles, psychotic symptoms may present themselves. Delusions of being famous or paranoia are two examples of these psychotic symptoms. Delusions such as these, accompanied by hallucinations, are also symptomatic of schizophrenia and can lead to a misdiagnosis of patients with childhood bipolar disorder (NIMH, 2010a).

<table>
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<th>Depressive Symptoms</th>
<th>Manic Symptoms</th>
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<tr>
<td>▪ Feelings of emptiness or worthlessness</td>
<td>▪ Increased levels of energy, hyperactivity</td>
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<td>▪ Flat affect</td>
<td>▪ Decreased need for sleep</td>
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<td>▪ Difficulty concentrating</td>
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Diagnosis

The four different categories of bipolar disorder are as follows: Bipolar I, Bipolar II, Bipolar Disorder Not Otherwise Specified, and Cyclothymia (NIMH, 2010a). Bipolar I is characterized by severe manic episodes, with at least one major depressive episode.

Bipolar II is manifested as primarily depressive but with some short cycles of hypomania, although full-blown manic symptoms may never manifest. Patients diagnosed with Bipolar Not Otherwise Specified may exemplify symptoms from both cycles, but certain criteria such as length of cycles are not met. The last level of bipolar disorder is Cyclothymic Disorder. Patients with Cyclothymia exhibit mild depression and hypomania symptoms for at least two years but do not meet other criteria for the other
levels. In the case of all four levels of bipolar disorder, the behavior and mood changes must be outside of the normal range for the person (NIMH, 2010a).

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<th>Types of Bipolar Disorder</th>
<th>Manic Cycles</th>
<th>Depressive Cycles</th>
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<td>Bipolar I</td>
<td>Full-blown, intense manic cycles</td>
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<td>Bipolar II</td>
<td>Short hypomanic cycles</td>
<td>Major depressive episodes characterized by intense mood declines</td>
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<tr>
<td>Bipolar Disorder (Not Otherwise Specified)</td>
<td>Some symptoms, but certain criteria not met</td>
<td>Some symptoms but certain criteria not met</td>
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<td>Cyclothymic Disorder</td>
<td>Hypomanic symptoms for at least two years, but do not meet criteria for other levels</td>
<td>Mild depressive symptoms for at least two years, but do not meet criteria for other two levels</td>
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Diagnosis can be difficult with childhood bipolar disorder, and misdiagnosis is common because of the range of symptoms and their overlap with disorders. The symptoms overlap with other common childhood and adolescent disorders such as ADHD. It is believed that on average it takes ten years for a child or adolescent to be properly diagnosed with bipolar disorder (Singh, 2008). Children are more likely to be misdiagnosed because they typically experience cycles lasting less than the required two weeks of the Diagnostic and Statistical Manual for Disorders (American Psychological
Association (APA), 2000). Over 70% of children with bipolar disorder can go through several cycles in one day (Singh, 2008). No tests or neural images are available to diagnose bipolar disorder. However, there are careful steps that parents and educators can take to ensure proper diagnosis.

First, careful logs of the child’s or adolescent’s behavior must be kept. These descriptions of behavior should include: frequency, intensity, number, and duration of problem behaviors (Singh, 2008). Educators and parents should look specifically for “extreme difficulty in regulating emotion” (Cleaver, 2009, p. 62). Interviews of both the parents and child can give insight into different viewpoints of the mood swings. It is also important to have a detailed medical history. If only one parent was diagnosed with childhood bipolar disorder, the chances of the child also having the disorder are increased by about 15 to 30% (Singh, 2008).

Since 1993, diagnosis of bipolar disorder in children and adolescents has increased 40-fold and is strongly correlated with the decreasing bias against its diagnosis for that age group (Cleaver, 2009). Some criticism still arises from those who believe that it is misdiagnosis for young people because they have not fully matured. It is true that children and adolescents have not developed fully both in the cognitive and emotional
areas (Singh, 2008). However, it is important to recognize that full development or not, these children suffer from a debilitating mood disorder and need proper treatment.

*Treatment*

Treatment for childhood bipolar disorder is difficult. Psychotherapy and psychiatric medications are typically the only two options that patients and their parents have. The primary medications used to treat bipolar disorder are mood stabilizers, which are designed to limit the expressed mania and depressive symptoms of bipolar disorder. Lithium is the most common mood stabilizer prescribed to patients with bipolar disorder (NIMH, 2010b).

Other drugs that are combined with mood stabilizers are atypical antipsychotics for the mania cycles and antidepressants for the depressive cycles (NIMH, 2010b). These drugs like most medications have serious side effects and especially in the case of childhood and adolescent bipolar disorder should be considered carefully. Psychotropic drugs can have significant beneficial effects as well. Educators can help monitor drug effects and interactions by keeping track of behavior and mood changes at school (Senokossoff & Stoddard, 2009). Instead of a drug only regimen, some psychiatrists are
encouraging a “multimodal” treatment that includes medications, psychotherapy, and emotional regulation training (Senokossoff & Stoddard, 2009).

Psychotherapy is an additional option for children and adolescents with bipolar disorder. Simply put, psychotherapy is talking with a professional who is trained to listen and provide help (Depression and Bipolar Support Alliance, 2006). Therapists may suggest that the patient enter group therapy sessions or that parents or other family members join in on individual sessions. These kinds of sessions can be helpful, especially for children and adolescents, because they provide a stable support network that the patient can trust (Depression and Bipolar Support Alliance, 2006). Educators can have an important role in this trust network by being a reliable adult that a child can talk to at school.

Often psychotherapy comes with some form of emotional regulation training. This training is designed to help children and adolescents learn techniques to control mood swings that may still occur even when on medications (Senokossoff & Stoddard, 2009). An appropriate mixture of this training, psychotherapy, and medications will provide children with some semblance of normalcy and help the child adapt to their situation and succeed in various areas of life. It is worthy to note however that
accommodations must be made for children with bipolar disorder. It is a disability, and while there are methods for the child and family to control some symptoms of the disorder, it is the responsibility of the educator to help that child succeed in the classroom.

**Purpose**

This manual will serve as a tool for educators to gather in-depth information about bipolar disorder and gain important skills in helping their students cope with and overcome the negative effects of the illness. The manual will cover three important areas of the child’s psychological health that are affected by the disorder. First, the emotional development of the child will be discussed. Because childhood bipolar disorder is an affective disorder, many of its most prominent symptoms have a direct effect on emotional well-being. In the second section, the manual will focus on social relationships with discussion of both peer and family relationships. Social relationships deeply affect psychological health, especially in children and adolescents. Next, as educators, it is important to understand how childhood bipolar disorder may affect academic and intellectual performance. Academic and intellectual performance is not just affected by the social and emotional capacities of the child, but also the disorder itself. The last
section of the manual will provide effective application tools for educators to use with their own students who have bipolar disorder. The application tools will help educators integrate and assist their students with bipolar disorder in the classroom and help them achieve success in the various areas of school life.

In recent years, there has been some controversy over whether or not these symptoms and diagnosis for childhood bipolar disorder fit the DSM characteristics. In the near future, the American Psychological Association may change the name of childhood bipolar disorder. However, the symptoms manifested by children with the disorder remain the same. The consequences that arise for those children are not linked to the name of the disorder, but rather to the symptoms that are present. As a result, the techniques discussed in the last section of this thesis will still be relevant for educators and others working with children who have bipolar disorder.
Chapter 2: Emotional Health

Emotion and Mood

Emotion and mood are two different concepts that need to be addressed before discussing the difficulties children and adolescents face with this area of development. Mood is a description of a long-term feeling that is often difficult to express. Particular objects or events trigger emotions, which are described as temporary feelings.

Childhood bipolar disorder affects both emotions and moods. In the short-term, emotions can feel much stronger and more difficult to control for children suffering from the disorder. It could lead to emotional outbursts or impulsivity. Overall mood will have a greater effect on the behavior of adolescents with childhood bipolar disorder, such as sleep patterns, eating habits, and other general behaviors.

Emotional Well-Being

Children with bipolar disorder are more likely than their peers to experience chronic emotional instability. While emotional regulation techniques and capacities are being formed during this developmental period, children with bipolar disorder often find it difficult to employ these strategies or are incapable of developing them (Carlson & Meyer, 2006). Emotional regulation techniques include learning to alleviate extreme
negative emotions as well as lessen extreme positive emotions. The emotions that children with bipolar disorder experience are so severe that these techniques are unsuccessful and the emotions either worsen or remain the same.

A notable difference between childhood bipolar disorder and adult bipolar disorder is that children less often fit neatly into the DSM-IV for symptom manifestation. Instead of experiencing cycles of four or more weeks, children and adolescents will typically experience cycles for a few days or shorter (NIMH, 2008). While every child experiences ups and downs throughout the course of the day and week, children with bipolar disorder are on the extreme side of both continuums. In addition to the shorter cycles, children suffering from the disorder may experience mixed episodes with symptoms of both mania and depression. Children may also experience intense cycles of mania with less intense depression phases and vice versa (Kearney, 2010). As an educator it is important to realize that the child may be experiencing a manic episode during one day of class and the following day be in a depressive state.

Mania

One emotional state of mania is severe impulsivity. This inclination to act on passing thoughts is a symptom that should be of concern to educators as well as families.
Because of increased impulsivity in children with bipolar disorder, they are more at risk to experiment with drugs and alcohol (NIMH, 2008). Impulsive behavior can range from mild deviant behavior to more significant criminal activity. These behaviors can include reckless driving, excessive sexual activity, destruction of property and theft, and spontaneous spending (Markarian, 2008.) In the classroom, impulsive behavior can lead to cheating and other negative behavior such as aggression. Acts of aggression or violence are common in children and adolescents with bipolar disorder (Kearney, 2010). Educators should be aware that these behaviors are more likely to occur in children with bipolar disorder because of the increased impulsivity and also a lack of emotional regulation to control impulsive feelings. In the last section, ways that educators can attempt to prevent this behavior and help the child control the impulsive thoughts are discussed.

Children with bipolar disorder experience an increase in feelings of invulnerability. Combined with impulsiveness, this can lead to extremely risky behavior. Adolescents without bipolar disorder typically have this attitude as well, but with bipolar disorder this attitude of invulnerability can be heightened to dangerous levels. One reason that bipolar disorder may go unnoticed in adolescents is because this age period is seen as
a time of poor decision making in typical courses of development (Singh, 2008).

However, impulsivity and invulnerability in children and adolescents with bipolar disorder is much more severe than in their typically developing peers. A contributing factor to the attitude of invulnerability may be heightened self-esteem. According to Kearney (2010), this increase in self-esteem during manic phases could lead children and adolescents to believe that they are superior and immortal. Thought processes such as these contribute to their invulnerable behavior.

Irritability can be symptomatic of mania in children with bipolar disorder (Markarian, 2008). Irritability results in shorter tempers and increased aggressive behavior. Children and adolescents in a manic phase may exhibit this aggressive behavior through yelling or violence. Irritability could be a result of a “flurry of thoughts” that seem uncontrollable and prevent the child from being able to focus. Mania also increases energy that will often lead to a lack of sleep (Markarian, 2008, p. 2). Insomnia can negatively affect emotion as well. Regular sleep is necessary for proper functioning. Without regular sleep patterns, irritability in children with bipolar disorder can increase significantly. One example of child whose irritability symptom was affected by his sleep patterns is a child named Dustin (Kearney, 2010). Dustin would often awake during the
middle of the night, sit in his front yard, and rock back and forth until the morning (Kearney, 2010). His psychiatric therapist noticed that this behavior seemed normal during the manic phase of Dustin’s bipolar disorder and found that his irritability on days after these episodes increased significantly (Kearney, 2010). The agitation and “wired” feelings that accompany phases of mania contribute to irritability as well (Torpy, 2009).

As some of the aspects of mania are associated with positive feelings for the individual and taking medication reduces these positive feelings, individuals on these medications may choose to stop their regimen in order to experience the manic phase. This of course is detrimental to the individual because manic phases often progress into worse feelings and more risky behaviors the longer they go on.

Depression

The depression phase of childhood bipolar disorder could manifest slowly over several days or occur more quickly over night (Liebenluft, 2010). Several emotional states can accompany the depressive phase. The most common symptom of the depression stage is lack of interest or lack of enjoyment in life activities (Senokossoff & Stoddard, 2008). Children with bipolar disorder in the depressive cycle may stop hanging out with their friends, cease participation in games both structured and on the playground,
and exhibit a general lack of fatigue (Senokossoff & Stoddard, 2008). These behaviors are at a stark contrast to the manic symptoms. Often children who are experiencing this lack of interest become apathetic towards schoolwork as well.

Irritability is also a common symptom of the depressive phase of childhood bipolar disorder (Kearney, 2010). The case study of the child Dustin provided researchers with two sides to irritability, the manic side discussed above and the depressive representation. Dustin during the manic phase was verbally aggressive when irritated. However, during his depressive cycles, Dustin desired only to be alone when he was irritable (Kearney, 2010). He would beg for his foster parents to leave him by himself.

Children in this phase of bipolar disorder can also experience intense feelings surrounding a perceived loss of control over their environment. Feelings of worthlessness and shame because of past behavior contribute significantly to the perceived loss of control (Senokossoff & Stoddard, 2008). Parents and teachers must be especially concerned during this phase because of the increased risk for suicide. Children with bipolar disorder are more likely to commit suicide than children with other mental health disorders (Senokossoff & Stoddard, 2008). Because of the increased severity of childhood bipolar disorder due to its early manifestation, research estimates that around
one-third of all children diagnosed with bipolar disorder will attempt suicide by age eighteen (Senokossoff & Stoddard, 2008). In addition to suicide, children diagnosed with the disorder are also more likely to participate in self-injurious behaviors or activities during the depressive cycle (von Hahn, 2004).

Controlling Emotions

Treatments designed to stabilize the mood swings of bipolar disorder are important for children who have been diagnosed with the disorder (Senokossoff & Stoddard, 2008). Mood stabilizers have been often used for adult bipolar disorder as the sole treatment method. However, medications alone have not been shown to be effective when used for children (Senokossoff & Stoddard, 2008). Psychopharmacology must be paired with educational training and long-term monitoring of medicinal doses.
Chapter 3: Social Competence

Social Construction of Mental Illness

In today’s society there is a certain stigma against mental illness. Often people in the community are scared of the violent behavior associated with mental illness, including bipolar disorder (Pollack, Cramer, & Varner, 2000). Children with bipolar disorder can be victims of this stigma as well because aggression can be a symptom of the disorder. In addition to the stigma of violence, children with bipolar disorder can experience situations in which their emotions are ignored or rebuffed. Because bipolar disorder is a known disorder in society, members outside of the child’s immediate social environment, as well as family members, may not understand that there are real emotions and moods associated with the child’s behavior (Senokossoff & Stoddard, 2008).

Medications are also a source of stigmatization in society. As with other disabilities and mental illnesses, medication is often a necessary aspect of treatment for childhood bipolar disorder (Senokossoff & Stoddard, 2008). However, when medication must be taken in front of others, it draws attention to the fact that there may be a problem or illness. It will bring up biases in some audiences.
In general, through the diagnosis of bipolar disorder, the child becomes separated from other “typical” children. This separation can lead to shunning by the child’s peers and increase the intensity of symptoms such as low self-esteem and sense of hopelessness during depressive phases. As a result, peer and familial relationships that are affected by this stigmatization can actually make the cycles of bipolar disorder more severe.

Familial Factors

Familial factors in the prognosis of the disorder can include: familial support, structure of the family, and the education of the family regarding childhood bipolar disorder (Miklowitz & Johnson, 2009). Research indicates that negative life events that occur within the family can negatively affect the child’s ability to develop social relationships because of an increased severity in the disorder (Miklowitz & Johnson, 2009). As a result of the stressful family situation, children with bipolar disorder may experience decreased emotional support. The emotional support provided by the family is necessary to prevent relapse and when the child loses that support, the risk of relapse into manic or depressive phases increases significantly (Miklowitz & Johnson, 2009). While in the middle of a mood cycle, it becomes much more difficult for the child to maintain and develop social relationships. The various emotional symptoms of manic phases such
as invulnerability, irritability, and unusually high self-esteem can negatively affect current social relationships and drive away possible future relationships (Miklowitz & Johnson, 2009).

Family structure involves the support provided by the family, but more importantly, the routine of the family unit. Miklowitz and Johnson (2009) have found that stable daily routines can decrease the severity of mood cycles and deter relapse. Social rhythm irregularities can be detrimental to stabilized children with bipolar disorder. Shen, Alloy, Abramson, & Sylvia (2008) found that children and adolescents with bipolar disorder are particularly sensitive to even the slightest of changes in weekly routines. In addition, research indicated that those children and adolescents who maintained regular social activities had better outcomes than their peers without regular activities (Shen, Alloy, Abramson, & Sylvia, 2008). Families that promote specific wake-sleep cycles, meal times, and other consistent practices throughout the day help their children gain control over their bipolar disorder. Parents can also help the child gain control over the disorder by providing authoritative parenting in which there are clear rewards and punishments for behavior (Senokossoff & Stoddard, 2008). This type of parenting can
help the child develop emotional regulation skills that allow the child to begin to regulate some of the symptoms of their mood cycles.

One aspect of treatment that is often used for children with bipolar disorder is psychoeducation for the family members. This type of education allows the parents to gain greater understanding of the distress that is caused by the disorder for the child (Steinkuller & Rheineck, 2009). Typically psychoeducational programs separate the family and the child so that family members may ask difficult questions and find the support they need to provide the best environment for their child (Steinkuller & Rheineck, 2009). Psychoeducation is also combined with family therapy. Family therapy is another source of education and understanding for the family. Research indicates that it is the most effective treatment for childhood bipolar disorder when combined with medications (Steinkuller & Rheineck, 2009). It is suggested that when families attend therapy together there is an increased level of support for the child, both socially and emotionally, as well as an understanding of the importance of medication compliance. These combined factors lead to decreased relapse for children whose families complete the program (Steinkuller & Rheineck, 2009).

Peer Factors
Children and adolescents with bipolar disorder are at an increased risk for substance abuse disorders. In fact children and adolescents who had diagnoses of both bipolar disorder and a substance abuse disorder fared far worse on measures of psychosocial functioning than children and adolescents who did not have a co-morbid substance abuse disorder (Pollack, Cramer, & Varner, 2000). As a result, peer relationships can have an important effect on the severity of mood swings as well. When peer groups who partake in substance abuse activities surround children and adolescents with bipolar disorder, their chances of developing a co-morbid disorder increase significantly (Pollack, Cramer, & Varner, 2000). Children whose parents monitor their friend groups will have a better chance at a positive outcome.

Due to the mood swings and intense emotional states experienced by children with bipolar disorder, social relationships can be difficult to develop and maintain (Senokossoff & Stoddard, 2008). In fact, a recent study has shown that almost half of all children with bipolar disorder state that they have no friends (Senokossoff & Stoddard, 2008). The increased stress from lack of social relationships and support can actually cause mood swings to be more severe creating a vicious circle where the children have even more difficulties making friends (Senokossoff & Stoddard, 2008).
Peers of children with bipolar disorder may experience difficulties befriending their distressed classmate for several reasons. First the social stigma of illness is present even at the young ages of childhood (Senokossoff & Stoddard, 2008). Also children with bipolar disorder may be more aggressive than others due to lack of emotional regulation and may unintentionally push possible friends away. Many children with the disorder experience social shunning or are made fun of by their peers for their frenetic behaviors (Senokossoff & Stoddard, 2008). For female adolescents with bipolar disorder there is also an increased risk for hypersexuality that can lead to unhealthy social relationships or ostracism from same sex peers (Senokossoff & Stoddard, 2008).

Children with bipolar disorder also have a difficult time interpreting facial expressions and social cues. There may be brain abnormalities that contribute to this phenomenon. Dickstein, Rich, Roberson-Nay, Berghorst, Vinton, Pine, and Leibenluft (2007) performed fMRI observations of neural circuits in the brains of children with bipolar disorder and typical controls. These fMRI data were collected while the children observed angry and happy faces. These expressions are characteristic of the positive and negative emotions that children should be able to code properly (Dickstein et al., 2007). Happy faces have also been shown to be a positive reward for behavior for typically
developing children. As such, reward pathways are activated during observation of happy faces.

In addition to angry and happy faces the researchers also included fearful faces because children with major depressive episodes have been shown to have a specific difficulty coding fearful expressions (Dickstein et al., 2007). During the second half of the study the authors looked at possible memory deficits following the exposure to the faces in the children with bipolar disorder compared to their typical controls. Memory deficits would be significant because the recall of social experiences, both positive and negative, allows children to develop social skills and different coping methods for relating to others (Dickstein et al., 2007).

The results of the research experiment described above showed that children with bipolar disorder do show altered neural responses to happy expressions. The reward pathways were not activated. Thus, the children with bipolar disorder did not register any reward from the observation of a happy expression as opposed to the typical children whose reward pathways were activated (Dickstein et al., 2007). Data also indicated that children with bipolar disorder had a more difficult time recalling the expressions of the faces observed when compared with the typical controls. The difference between the two
groups was most significant for the recollection of fearful faces (Dickstein et al., 2007).

These memory deficits are unique to childhood bipolar disorder and not found in either childhood anxiety disorders or ADHD.

Other symptoms of childhood bipolar disorder can lead to misinterpretation of social cues by children diagnosed with the disorder. Specifically, irrationality during a manic episode can lead to paranoia and delusions (Pavuluri, Herbener, & Sweeney, 2003). The social implications of these symptoms are reduced ability to interact with peers appropriately and decreased understanding of proper social behaviors. As a result, the children may experience a decreased ability to maintain positive peer relationships (Pavuluri, Herbener, & Sweeney, 2003).
Chapter 4: Academic Achievement

Intellectual Functioning

There is no evidence that childhood bipolar disorder directly affects the intellectual functioning of the individual. However, there are certain brain structures necessary for learning that are affected by the disorder. First, the amygdala of children with bipolar disorder differs significantly from children without the disorder (Cleaver, 2009). This brain structure is necessary for emotional learning and some aspects of memory. In children with the disorder, research has shown that the amygdala is not as mature when compared to typically developing children (Cleaver, 2009). A second brain structure associated with contextual learning and specific aspects of memory is the hippocampus. In children with bipolar disorder there seems to be some abnormal development in this structure (Cleaver, 2009). These abnormalities can lead to decreased verbal and performance IQ scores (Cleaver, 2009). However, it is important to consider that there are other types of intelligence that are not measured by the academic achievement tests. Children with bipolar disorder may exhibit other types of intelligence such as linguistic, musical, or spatial intelligences that require more creativity.
Neurobiological research indicates that childhood bipolar disorder does have negative effects on the functioning of the prefrontal cortex (Child and Adolescent Bipolar Foundation (CABF), 2010). The prefrontal cortex plays a key role in decision-making. Children with the disorder may experience impulsive behavior and illogical thought processes as result of the effects on the prefrontal cortex (CABF, 2010).

Other neurological conditions that may affect the academic performance of children with bipolar disorder are chemical imbalances. Fluctuating levels of several neurotransmitters can affect the behaviors and thought processes of children with the disorder and result in reduced academic competence (CABF, 2010). First, the neurotransmitter monoamine oxidase affects the activity levels of other neurotransmitters such as serotonin, dopamine, and norepinephrine. These particular neurotransmitters play significant roles in mood episodes for children with bipolar disorder (CABF, 2010). In children with the disorder, monoamine oxidase oscillates from levels that are too low to levels that are too high (CABF, 2010). When levels of monoamine oxidase are too low, children with bipolar disorder often experience symptoms of depressive episodes. When the levels of monoamine oxidase are too high, they experience manic symptoms (CABF, 2010).
Symptom Manifestation

Symptom manifestation during both depressive and manic episodes can have significant negative effects on children with bipolar disorder. Poor concentration is a symptom that manifests both during depressive and manic episodes (Cleaver, 2009). As a result, children experiencing either episode can have difficulties maintaining attention during classroom lecture and completing homework assignments. The lack of ability to concentrate could result in decreased academic competence due to the child’s inability to recall class material (Cleaver, 2009). A child experiencing this symptom may appear fidgety and easily distractible and be diagnosed as having ADHD. During depressive episodes, fatigue and lack of confidence could contribute to the child’s poor concentration (Senokossoff & Stoddard, 2009). Poor concentration during manic episodes may be reflected through inappropriate goal-directed behaviors, such as an in-depth drawing that is unrelated to class material (Senokossoff & Stoddard, 2009).

The symptom known as flurry of thoughts also contributes to lack of concentration during a manic episode. Children with bipolar disorder describe this experience as an inability to process or control thoughts that are entering their consciousness so quickly they cannot keep up (Liebenluft, 2010). According to one child
with bipolar disorder the experience can be disorienting (Liebenluft, 2010). Flurry of thoughts can negatively affect academic competence because children are unable to maintain control over their thought processes. It can be distracting. In addition, it can make it difficult for the child to retain new information (Senokossoff & Stoddard, 2009). Children experiencing flurry of thoughts may not be able to articulate their ideas or they may produce writing that is incoherent (Cleaver, 2009).

Irritability in children with bipolar disorder can also lead to academic problems. Due to emotional regulation difficulties, irritability can lead to aggressive episodes in the classroom if the child is dealing with difficult academic or social situations (Cleaver, 2009). Behavior problems due to irritability and aggression can result in the child being removed from the classroom. The time spent out of the classroom is the loss of precious learning opportunities (Senokossoff & Stoddard, 2009). Irritability can also lead to the child’s inability to continue with tasks that are seemingly difficult. As a result, homework may not be turned in or turned in unfinished resulting in decreased grades and academic success (Cleaver, 2009). These symptoms are similar to those manifested in children with ADHD. However, children with bipolar disorder experience mood fluctuations that
children with ADHD do not. Specifically, children with bipolar disorder have much more
difficulty regulating their emotions than children with ADHD (Cleaver, 2009).

Fluctuating levels of self-esteem can also contribute to decreased academic
competence for children with bipolar disorder. During a depressive episode, low self-
estem and feelings of worthlessness may result in a decreased desire to complete
schoolwork for fear of failure (Cleaver, 2009). Children with bipolar disorder are
especially susceptible to fear of rejection and feedback on school assignments can be
terrifying. As a result, the child may not want to do the assignments required of him or
her (Cleaver, 2009). During manic episodes, children with bipolar disorder may
experience false, elevated levels of self-esteem in which they believe they are more
knowledgeable than the teacher. In this scenario, children with the disorder may interrupt
the teacher regularly, questioning his or her expertise on the subject (Cleaver, 2009).

They may not complete assignments or feel the need to participate in class because it is
“below them” (Cleaver, 2009).

*Environmental Factors*

Environmental factors can enhance the negative effects of bipolar disorder on the
child’s academic success. Disorganized classroom structure and routines are two ways in
which the classroom may contribute to the child’s difficulties (Cleaver, 2009). In the following chapter, applications of the information presented above will be provided so that educators can provide the best environment possible for their students with bipolar disorder.

The social construction of bipolar disorder as an uncontrollable, dangerous disorder may contribute to a negative environment for the child. If the child is to succeed in the classroom, negative perceptions of the disorder must be dismissed.
Chapter 5: Application for Educators

As educators it is important to recognize the importance of all domains of development. There are bidirectional relationships between emotional stability, academic success, and social competence (Papalia, Olds, & Feldman, 2008). Low self-esteem as a result of difficult social relationships can in turn affect academic competence and emotional stability. The inability to regulate emotions could negatively affect academic success and social relationships. Childhood bipolar disorder can make each of these interactions more stressful. While children without the disorder have typically found different coping methods for the stress of school and social lives, children with bipolar disorder are often at a disadvantage. Because the disorder negatively affects their emotional regulation skills, they must spend more time learning to control their emotions.

Educators have the responsibility to assist children with bipolar disorder with everyday situations that could initiate a mood swing.

In order to help students with bipolar disorder, educators must have a thorough understanding of how the disorder affects the child and recognize that the disorder is separate from the child. The first four sections of this manual were designed to give
educators the information they needed to be familiar with childhood bipolar disorder and its symptoms.

Cooperation with the family is the next step in ensuring a better environment for a student with bipolar disorder. There is some evidence that children with bipolar disorder are capable of controlling their symptoms at school (Cleaver, 2009). For the child, the amount of effort required to control these symptoms could be an emotional and physical battle. While the child is not acting out, their emotional health, social relationships, and academic competency could suffer (Cleaver, 2009). Understanding the child’s behavior at home and the triggers that could occur in the school environment will give the educator the ability to remove such triggers, and thus, relieve some stress for the child (Cleaver, 2009). Parents and family members can also provide valuable insight for educators as to how they can recognize the warning signs of an impending mood episode (Cleaver, 2009). Parents can also provide calming methods used at home when an uncontrollable emotional state strikes. Educators also have the responsibility to reciprocate on this informational pathway. If they recognize increased emotional episodes or increased behavioral difficulties, they should let the parents know immediately (Cleaver, 2009).
This will allow the parents to check medication and therapy regimens to ensure they are still effective.

Educators should also have knowledge of the treatment plan for the child. There may be some cases where a child with bipolar disorder needs to take medication at school (CABF, 2010). Educators need to be aware of the medication schedules and make sure that the child takes their medication at the appropriate time. Structure and routine for medication are important to keeping the child stable and out of manic or depressive episodes (Shen et al., 2008). However, knowledge of medication and other treatment procedures is privileged information that is protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As such, any information that is provided to the teacher must be protected so that no other individual may access the information (Centers for Disease Control (CDC), 2003).

In addition to knowledge about medications, educators’ knowledge of family and lifestyle therapy can be helpful as well. Commonly during counseling and therapy sessions, the child’s attending clinician can give the family strategies on how to increase family cohesion, gain the trust of the child, and provide coping methods for how to regulate mood swings (Steinkuller & Rheineck, 2009). If educators have knowledge of
these strategies they can implement them at school as well in order to provide consistent care for the child. This consistency will provide the child with feelings of security.

Therefore, the prognosis of the child will be greatly improved (Steinkuller & Rheineck, 2009).

Educators can also promote social competency for their students with bipolar disorder. First and foremost, educators must create an accepting and tolerant environment (Child and Adolescent Bipolar Foundation, 2010). Because significant stresses can initiate a mood episode, educators need to encourage a positive social environment at school for the child (Steinkuller & Rheineck, 2009). It is not necessary to separate the child from typically developing classmates nor is it necessary to tell other students that the child has a mental illness. However, if the parents and child feel that it would be the most beneficial for the child if the classmates had some understanding of the disorder then it is up to the educator, in cooperation with the family, to develop a method of informing classmates appropriately. Again, securing the family’s permission for any information that may be given out is essential according to HIPAA regulations (CDC, 2003). Answering questions that other children may have honestly and openly will help to encourage acceptance (Cleaver, 2009).
It is also important to emphasize the safety of the child. Children with bipolar disorder may misinterpret social cues. These misinterpretations can lead to fear of harm or betrayal (Pavuluri, Herbener, & Sweeney, 2003). Safety includes general physical safety but also safety from bullying or embarrassment (Cleaver, 2009). Providing students with bipolar disorder with a sense of security can improve academic success because they are more likely to feel comfortable in the classroom. As a result they are able to better process classroom material and participate in activities (Cleaver, 2009). The Ohio Department of Education provides curriculum guidelines for teachers who wish to incorporate conflict-resolution skills into classroom activities and material. Such activities would provide all students in the classroom with better stress management skills and create a more positive classroom environment.

In addition to promoting a tolerant school environment, educators can provide a rewards-based system for positive social interactions. According to the Child and Adolescent Bipolar Foundation (2010), providing rewards for the child for good behavior can help the student have more success socially and increase appropriate social interactions. These reward-based systems can mimic those used with children who have ADHD. Similar systems have been tested and shown to be effective with both
demographics (Cleaver, 2009). However, given the tendency for children with bipolar disorder to misinterpret social cues, rewards-based systems must be clearly explained to the child prior to implementation. The systems are most beneficial if they are used both at home and at school, and if the child is involved in the creation of the rewards. It is unrealistic to suppose that the child will always interpret expressions correctly. As a result, positive rewards should be tangible objects or activities that the child desires and can understand.

Teachers can play an important role in increasing academic success in the classroom. First, as discussed in previous sections, children with bipolar disorder are susceptible to changes in social rhythm. Teachers should provide a structured classroom. This structure should include consistency in the daily schedule, format of assignments, alternative or shorter homework assignments where necessary, and clear expectations (CABF, 2010). Any changes to the daily routine should be explained thoroughly to the child, and he or she should be given the opportunity to ask questions and process the changes (Cleaver, 2009). Although these specifics may seem impossible to incorporate into the classroom, establishing Universal Design for Learning (UDL) can help. UDL requires that information be presented in multiple forms so that any type of learner can
benefit from the material (National Center on Universal Design for Learning (NCUDL, 2011). UDL will reduce stigmatization because the child with bipolar disorder will not be separated from his or her classmates based on his or her academic needs. In addition, UDL benefits all of the children in a classroom, not just students with bipolar disorder. Many of the suggestions listed here for classroom activities and assignments can meet UDL guidelines.

Providing safety also allows the teacher to form a bond of trust with the student. Having a person they can trust in the school environment is absolutely necessary for children with bipolar disorder (CABF, 2010). Focusing on positive behaviors and characteristics will encourage the child to take new risks academically and grow as an individual. However, the child will need an unconditional support system to make these adjustments (Cleaver, 2009). Another important way that teachers can develop trust and rapport with the child is by using direct and open communication with the child.

Teachers should also help provide earlier recognition of relapse for children who have the symptoms of the disorder under control. Early recognition can allow parents and families to seek immediate treatment from a counselor (Steinkuller & Rheineck, 2009). The earlier that parents can seek treatment for their child, the better the prognosis will be.
Teachers can then also change teaching strategies based on the current mood episode. By providing more rest breaks, shortening assignments, extending deadlines for homework, and being generally accommodating, teachers can provide the child with the flexibility he or she needs to succeed in the classroom while staying well (CABF, 2010).

Other authority figures in the education setting can also help children with bipolar disorder succeed in the areas of development. School counselors and sports coaches also play vital roles in the lives of students with bipolar disorder. In particular, school counselors should have an in-depth understanding of the child’s Individual Education Plan as set forth by the school. If counselors can serve as mediator for the teacher and child in cases of conflict it can reduce the stress on the child. Any stress reduction is beneficial for the child because it reduces their risk of relapse (Steinkuller & Rheineck, 2009). Counselors can also provide additional educational and counseling resources for the child outside of the classroom. These resources are important because it allows the child to leave the classroom where pressure to be composed can be high.

Students with bipolar disorder can also benefit from participation in athletic events (CABF, 2010). Coaches who have players with bipolar disorder should follow a structured practice routine. Just as teachers inform their students with bipolar disorder of
changes to the schedule, coaches should give their players the practice schedule for the day and any alterations that are made to the routine.

Coaches can also work with the family as well. Knowing medication regimens, calming methods, and the reward-based system used at home can be beneficial, and coaches can implement these assets at sports events as well. In addition, coaches need to be sensitive to the athlete’s needs regarding social interactions. If coaches can provide a caring, safe environment for the play to take place in, athletes with childhood bipolar disorder will be much more successful. Any time the coach can eliminate major stressors will help reduce possible relapse for the child.

Overall, children with bipolar disorder experience obstacles in their lives that other children do not. Symptom manifestation and neurobiological changes as a result of the disorder can make certain life activities more difficult. However, with the right support system and with proper treatment, children with bipolar disorder can be successful in many ways. Even though their test scores may not be typical, children with bipolar disorder are creative and intelligent in other ways. As educators, it is important to keep these details in mind. Every child deserves the utmost effort from their school to provide for them a positive and accommodating environment.
References


# Appendix

## Quick Reference Suggestion Guide for Educators

<table>
<thead>
<tr>
<th>In the Classroom</th>
<th>Benefits</th>
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<tbody>
<tr>
<td>▪ Create a structured routine</td>
<td>Helps maintain the child’s social rhythm and reduce chances of relapse</td>
</tr>
<tr>
<td>▪ Offer alternative assignments, based more on creativity</td>
<td>Caters to the child’s other forms of intelligence, also benefits all students and allows for different types of learning</td>
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<tr>
<td>▪ Provide a “safe zone” where the child can express emotion outside of the classroom</td>
<td>Increases trust and rapport with the child by not requiring them to suppress all emotion, but rather providing a safe place to express it</td>
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<tr>
<td>▪ Use clear, direct communication</td>
<td>Protects the child from possibly misinterpreting social cues within language and expressions, increases trust</td>
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## Cooperating with the Family

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<tr>
<td>▪ Know the child’s medication routine</td>
<td>Helps prevent relapse for the child by maintaining the routine</td>
</tr>
<tr>
<td>▪ Cooperate with psychologist or therapist, if given permission from</td>
<td>Provides the child with consistent information, reducing stress and</td>
</tr>
<tr>
<td>Parents</td>
<td>Chances of mood episode triggers</td>
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<td>---------------------------------</td>
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| ▪ Learn the child’s coping methods  
and encourage the use of those methods in the classroom | Gives the child a sense of security by using the same techniques in both locations, increases rapport |
| ▪ Implement a rewards-based system  
that may be used at home and school | Consistent rewards provide a sense of stability for the child (Keep in mind that rewards must be direct and tangible so that the child does not misinterpret cues) |