Bipolar Disorder: Educational Implications for Secondary Students

Handling the symptoms of childhood bipolar disorder appropriately is vital to students' ability to learn.

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Bipolar disorder (BD) is a neurobiological disorder with cycling periods of mania and depression that was historically recognized as occurring only in adulthood but can now be diagnosed in children. Although controversy continues regarding the definition and diagnosis of BD in children, it is chronic and can cause major disruption in schooling for children and adolescents.

Widely accepted estimates of the prevalence of BD in adults range from 1%–2% (American Psychiatric Association [APA], 2000), and incidence is similar in adolescents (Wolf & Wagner, 2003). BD is considered one of the most heritable mental illnesses: children of parents with BD are more likely to develop a mood disorder. Other risk factors include rapid onset of depressive symptoms with psychotic features (e.g., delusions), family history of mood disorders, and history of manic or hypomanic symptoms following antidepressant treatment (Faedda, Baldessarini, Glovinsky, & Austin, 2004). In addition, research has shown that children treated with stimulants may experience early onset manic symptoms (Giedd, 2000).

Manic and depressive episodes of BD disturb mood, behavior, energy, and sleep. During a manic episode, a student may show a period of abnormally elevated, expansive, or irritable mood (APA, 2000) that is significantly different from his or her typical behavior. In class, for example, the student might be excessively happy and cause disruption by laughing hysterically for no reason. When with friends, a student with mania may be grossly irritable, short-tempered, and frustrated when not given his or her way. Minutes later, the student may become hyperverbal while expressing a flight of ideas or a desire to engage in risk-taking behavior.

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A depressive episode consists of loss of interest in activities or a low mood. A student having a depressive episode may no longer be interested in a favorite subject and may show a significant loss of energy. He or she may be anxious, argumentative, or aggressive with teachers or friends. Feelings of worthlessness or guilt and persistent thoughts of death or suicide resulting in an inability to concentrate also may be present (APA, 2000).

Criteria for the length of manic and depressive episodes in adults are specific (APA, 2000); the duration in children and adolescents, however, is not clear. Adolescents who have BD may vacillate between depressive and manic symptoms on a weekly, daily, or hourly basis. This rapid cycling is a hallmark symptom of BD in children and adolescents (Wolf & Wagner, 2003).

Mixed episodes cause extreme dysregulation of mood and energy. The student might appear enraged, anxious, and upset all at once. Frequent mood changes may produce severe irritability, serious temper outbursts, rage reactions, and behavior that is difficult to manage. Because of the cyclical nature of the disorder, students have periods of calm during which their problems seem miniscule and may not be apparent in the classroom. It is important to note patterns in students' behavior to better predict when erratic behavior may occur.

Coexisting Disorders

BD commonly overlaps with other psychiatric disorders. Biederman, Mick, and Faraone (2004) found that 87% of children with BD also had attention deficit/hyperactivity disorder (ADHD), although only 20% of children with ADHD met criteria for BD. Symptoms of grandiosity, elevated mood, flight of ideas, and decreased need for sleep distinguish BD from ADHD (Pavuluri, Birmaher, & Naylor, 2005). The combination of ADHD with BD often results in severe impairment with increased psychotic symptoms, need for hospitalization, and school failure (Wolf & Wagner, 2003) in addition to increased impulsivity that may lead youth to act in lethal ways, such as suicide (Biederman et al.). Children and adolescents with BD often meet criteria for oppositional defiant, conduct, anxiety, and learning disorders. Accurate diagnosis of BD is complicated by the complexity of symptoms and frequent co-occurrence with other disorders.

Treatment and Intervention

Because of the novel recognition of pediatric BD, treatment in children has been an extension of adult treatment. Only recently has intervention literature focused on treatment options that are specifically for children and adolescents with BD. To stabilize the severe behaviors often seen in pediatric BD, psychotropic medications are commonly used as first-line treatment. Without mood stabilization through medication, students may not adequately benefit from other interventions (McIntosh & Trotter, 2006).

Current psychosocial treatment guidelines for childhood BD are largely based on clinical experience, with scant empirical research establishing their effectiveness. Cognitive-behavioral therapy strategies and family psychoeducation approaches are highlighted as the most effective treatments (Kowatch et al., 2005; McIntosh & Trotter, 2006). Interventions are delivered at the individual or family level and include cognitive restructuring for depressive symptoms, problem-solving strategies to intervene with emotional dysregulation, and behavior management techniques to establish routine and consistency (e.g., Pavuluri et al., 2004). Family psychoeducation—providing information and guidance to families in a teaching format—has also proven to decrease symptom expression and increase parental knowledge and positive family interactions (Fristad, Goldberg-Arnold & Gavazzi, 2003; Pavuluri et al., 2004).

Schools' Response

Each student with BD has a unique symptom pattern, which makes the development and use of intervention plans in the school setting challenging. A collaborative approach that uses problem-solving strategies and includes families, school staff members, and medical and mental health providers is necessary to provide appropriate school intervention for students with BD. School-based interventions for these students can include different levels of special education services, specific classroom modifications, and direct services provided by school counselors and psychologists. Students diagnosed with BD can be served in general education or special education classrooms or a combination of both.

Students who have less-severe symptoms but who show limited academic progress because of BD may benefit from a Section 504 plan, which might include specific classroom accommodations and school-based counseling. An IEP is often created under the "Emotional Disability" or "Other Health Impaired" (OHI) category of disability, but for students to qualify for these services, their symptoms must adversely affect learning.

Case Study

Rylan is an eighth-grade student with early onset bipolar disorder (BD), attention deficit/hyperactivity disorder (ADHD), oppositional tendencies, social problems, and writing difficulties. Rylan's behavior results in classroom disruptions, peer conflicts, teacher frustration, and poor academic performance. Rylan's educators are struggling with how to best support his needs.

The assistant principal who deals with Rylan's misbehavior has noticed escalating concerns since earlier this school year. Rylan has only recently been sent to the office because of his short temper, refusal to write in most classes, argumentative interactions with teachers, and fights with peers. Upon reviewing Rylan's record and discovering his diagnoses, the assistant principal immediately puts a plan together to support Rylan.

The assistant principal created a plan of action for Rylan when problems first began. A proactive meeting was held with his parents and teachers. Medical providers were contacted immediately for consultation. School counseling efforts began while medication changes were being completed. Learning issues were assessed and teachers were given support to deal with Rylan in the classroom via the development and implementation of a 504 plan. These collaborative prevention measures allowed the assistant principal to manage the situation and support Rylan and his teachers.

Symptoms and Expression of Depressive and Manic Episodes in Children and Adolescents

Depressive Episode	
1. Depressed Mood and/or 2. Loss of Interest and	
Four Other Symptoms	**Possible Expression in Children and Adolescents**
3. Weight loss/gain	Uninterested in eating and/or overeats.
4. Insomnia or hypersomnia	Difficulty falling and staying asleep. Sleeps more than usual.
5. Psychomotor agitation or retardation	Hyperactive, difficulty sitting still, and/or impulsive. Less active and interactive.
6. Fatigue or loss of energy	Needs more rest, complains when pushed to do activities, and/or pretends to be sick.
7. Feelings of worthlessness or inappropriate guilt	Makes negative self-comments, such as “I am stupid” and “No one likes me.”
8. Diminished ability to think or concentrate	Has poor concentration, is disorganized, and/or distractible.
9. Recurrent thoughts of death, suicidal ideation/attempt.	Talks about dying or has themes of death in conversation, play, or artwork.
Manic Episode	
1. Elevated and/or expansive mood and/or 2. Irritable mood and	
Three (four if mood is *only* irritable) Other Symptoms:	**Possible Expression in Children and Adolescents**
3. Inflated self-esteem or grandiosity	Demands to be center of attention or overcommits to projects/activities. Has hallucinations (e.g., hears/sees things) or tells eccentric stories.
4. Decreased need for sleep	Full of energy and requires little sleep (e.g., wanders around house nightly looking for things to do). Gets very little sleep but is full of energy next day with no tiredness.
5. More talkative than usual	Talks rapidly, loudly, and incessantly without allowing others to enter conversation.
6. Flight of ideas/racing thoughts	In absence of language problems, does not make sense when they talk. Comments they can’t get things done because their thoughts are interrupting them.
7. Distractibility	More than typical, has difficulty paying attention and/or is disorganized.
8. Psychomotor agitation/increase in goal directed activity	Overly active, spends more time playing and completing a specific activity than usual, and/or displays impulsive behaviors.
9. Excessive involvement in pleasurable activities that have high potential for painful consequences (i.e., poor judgment).	Shows hypersexual behaviors (in the absence of sexual abuse) or makes inappropriate displays of affection. Engages in risk-taking behaviors and takes dares easily from others.

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Certain symptoms of BD lend themselves to specific interventions. Papolos, Hatton, Norelli, Garcia, and Smith (2002) suggest such strategies as adjusting the student's academic schedule to accomodate a disturbed sleep-wake cycle, allowing a "safe zone" for students who experience significant irritability or rage episodes, and allowing verbal or typed responses on schoolwork for students who exhibit perfectionistic tendencies. Students who have attention problems may benefit from preferential seating, frequent breaks, and organizational aids.

School staff members should become familiar with the potential side effects of the psychotropic medications that are used to treat BD. Any change in school performance, energy level, behavior, social interactions, or mood should be shared with parents and medical staff members immediately.

A key role for school administrators is consulting with other members of the student's treatment team on an ongoing basis. This treatment team typically consists of a mental health provider, a physician, a school nurse, at least one teacher, and at least one parent. Consultation may involve discussing situations that are difficult for the student and problem behaviors, developing intervention and crisis plans, and offering suggestions as a contributing member in a multidisciplinary team meeting.

Consultation with family members of students with BD involves supporting the family and providing information regarding school services for the student. School leaders also can forge positive relationships with community mental health and medical professionals by supporting regular contact with these providers or allotting time and resources for staff members to do so.

Resources

Web sites

Child and Adolescent Bipolar Foundation: www.bpkids.org
Depression and Bipolar Support Alliance: www.dbsalliance.org
Juvenile Bipolar Research Foundation: www.bpchildresearch.org

Books for Educators

Understanding and Educating Children and Adolescents With Bipolar Disorder: A Guide for Educators. 2003. M. Andersen, J. Boyd-Kubisak, R. Field, & S. Vogelstein. Northfield, IL: The Josselyn Center.

The Life of a Bipolar Child: What Every Parent and Professional Needs to Know. 2000. T. Carlson. Duluth, MN: Benline Press.

Books for Parents

Raising a Moody Child: How to Cope With Depression and Bipolar Disorder. 2004. M. A. Fristad & J. S. Goldberg-Arnold. New York: Guilford Press.

The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder (3rd ed.). 2006. D. Papolos & J. Papolos. New York: Broadway Books.

Conclusion

Early-onset BD severely impairs all areas of the student's life. Administrators have a unique opportunity to provide guidance to various staff members who work directly with students with BD to support their schooling. To provide this support, administrators should continue to seek information about BD, help and support teachers and other school staff members in identifying and devising appropriate intervention techniques for problem behaviors, consult with parents to support their needs in dealing with educational issues of students with BD, work with school staff members and community providers to de-stigmatize mental health problems and treatment, and forge positive relationships and model productive interactions with the student's entire treatment team. PL

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