UNDERSTANDING THE EFFECTS OF PEDIATRIC BIPOLAR DISORDER IN THE CLASSROOM

Catherine A. Cale-Thompson
B.A., California State University, Sacramento, 2001
M.A., California State University, Sacramento, 2010

Joanna T. Pastor
B.A., California State University, Sacramento, 2007
M.A., California State University, Sacramento, 2010

PROJECT

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Catherine A. Cale-Thompson
Students: Joanna T. Pastor

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___________________________, Graduate Coordinator
Bruce A. Ostertag, Ph.D. Date

Department of Special Education, Rehabilitation, School Psychology, and Deaf Studies
Abstract

of

UNDERSTANDING THE EFFECTS OF PEDIATRIC BIPOLAR DISORDER IN THE CLASSROOM

by

Catherine A. Cale-Thompson

Joanna T. Pastor

The authors collaborated and shared equal responsibility in all aspects of the development of this project, which reviews current research on pediatric bipolar disorder and how it presents in the school setting. The motivating force for creating this workshop was observations from working with school psychologists, behavior specialists, and teachers working in public schools who struggle with understanding students that have symptoms consistent with or have been diagnosed with pediatric bipolar disorder. Teachers, administrators, and practicing school psychologists lack resources when faced with the challenges of helping to manage the symptoms of the disorder in the school setting. The goal of this project is to help teachers, administrators, and school psychologists to first, understand and recognize how pediatric bipolar disorder presents in the classroom and secondly, to understand the need for a team approach in order to develop the best appropriate educational environment for these students to be successful both academically and emotionally.

The prepared project is a six-hour training workshop with a presenter’s manual, slides, presenter notes, and a reference handout. Any school psychologist can train a
target audience of teachers, administrators, and school psychologists working in schools. Workshop participants will actively participate through discussions and activities to further their understanding of working with this complex population of students.

____________________. Committee Chair
Stephen E. Brock, Ph.D.

____________________
Date
ACKNOWLEDGMENTS

We especially appreciate the contribution of our committee chair, Dr. Stephen E. Brock. Dr. Brock motivated us to reach our full potential during the process of completing this project. We cannot thank him enough for the time and devotion he spent collaborating with us on this project. We also wish to thank Dr. Leslie A. Cooley, Dr. Catherine Christo, and Dr. Melissa Holland who have greatly contributed to the development of our skills as school psychologists. Finally, words alone cannot express the thanks we owe to our families for their encouragement and support throughout the creation of this project.
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Chapter 1

INTRODUCTION

In the United States, at least one million children and teenagers struggle with bipolar disorder (Child and Adolescent Bipolar Foundation [CABF], 2007). In recent years, there has been a significant increase in the number of diagnoses of bipolar disorder in children, with nearly a 4,000 percent increase since the 1990’s (Moreno et al., 2007). With the rise of the identification of bipolar disorder in children comes an increased need for better understanding by teachers and school professionals of the symptoms associated with pediatric bipolar disorder, how they may present in the classroom setting, and what kinds of supports can be offered to help these children be successful at school.

Bipolar disorder is a chronic neurobiological illness that can be managed, but not cured. It affects learning in many ways that can range from difficulties with sleep, energy, and school attendance to troubles with concentration, executive functioning, and cognition.

The manic and depressive symptoms associated with bipolar disorder may present themselves in a variety of ways in a school setting. A child with pediatric bipolar disorder may seem euphoric and energized one minute, then depressed or hopeless the next. They may also experience mixed states in which they are experiencing both manic and depressive symptoms simultaneously. Because the presentation of the symptoms of pediatric bipolar disorder are so complex, teachers and other school professionals often overlook the signs and signals of a child with pediatric bipolar disorder who has not been
diagnosed or do not know how to manage the erratic behaviors of a student who has already been diagnosed.

A comprehensive understanding of what pediatric bipolar disorder is by teachers and other school professionals and its effects in the classroom are essential for ensuring that all is being done to create a positive and supportive academic and social environment for the student with pediatric bipolar disorder.

Background of the Problem

Bipolar disorder is a biological brain disorder causing severe fluctuations in mood, energy, thinking and behavior. Bipolar disorder was previously known as manic depression and was defined primarily as mood shifts between states of mania and states of depression. Further, it was identified mainly in adults, not children. Although the past 15 years has brought an increase in both diagnoses and attention from the scientific community regarding bipolar disorder in children, there have been few studies, which examine the specific effects it has on academic performance, school behavior, and peer functioning (Lofthouse & Fristad, 2006).

Statement of the Problem

Because the research on pediatric bipolar disorder is relatively new, often teachers and other school professionals find themselves unaware of what to do when they are faced with a child in their school or classroom who presents with the symptoms associated with pediatric bipolar disorder. It is not uncommon for teachers to assume that a student who seems energized and distracted may be suffering from Attention-
deficit/Hyperactivity Disorder (ADHD). Additionally, a child who is frequently irritable or angry may be considered oppositional or a “behavior problem” by teachers. Although comorbid conditions do commonly occur in children with pediatric bipolar disorder, the symptoms of many childhood disorders can mask the underlying presence of pediatric bipolar disorder.

Children with bipolar disorder are at risk for school failure, substance abuse, and suicide (CABF, 2007). While at school, they face tough challenges navigating through the many pressures of a typical school day. These students can be very affected by stress and may be easily overwhelmed (CABF, 2007). Teachers and school professionals need to be prepared with the knowledge and resources to make the appropriate accommodations to help these students stay in control while struggling with the many and varied symptoms associated with pediatric bipolar disorder.

**Purpose of the Project**

This study and the related workshop were designed to provide educational and staff development to school professionals about pediatric bipolar disorder, how it presents in a school setting, and what can be done to help accommodate this special population of students. Further, this study aims to teach educators ways to create a positive school environment through the teaching of psychosocial skills and the development of school-based teams that include teachers, administrators, parents, and families, to develop the best educational environment possible, both academically and emotionally, to support these students diagnosed with pediatric bipolar disorder.
Finally, the authors of this project believe that due to the significant increase of reported cases over the past decade, there is a current need for school professionals to be informed of how pediatric bipolar disorder affects children at school. It is likely that at some time during a teacher’s or school professional’s career, they will encounter at least one student with pediatric bipolar disorder. It is the hope of these authors that when this occurs, the educator will be able to draw from the information and resources provided in this project and be cognizant of a variety of approaches to increase the odds of dealing successfully with their student’s challenges.

Definition of Terms

*Attention-deficit/Hyperactivity Disorder (ADHD)*

One of the most common childhood disorders with symptoms that include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity) is ADHD. ADHD has three subtypes: Predominantly hyperactive-impulsive, predominantly inattentive, and combined hyperactive-impulsive and inattentive (National Institute of Mental Health [NIMH], 2008).

*Emotional Disturbance (ED)*

The current federal eligibility criteria includes a student exhibiting one of the following five characteristics: (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors, (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers, (c) inappropriate types of behavior or feelings under normal conditions, (d) a general, pervasive mood of unhappiness or
depression, and (e) a tendency to develop physical symptoms, pains, or fears associated with personal or school problems. These characteristics have to be displayed to a marked degree, observed over a long period of time, across settings, and have an adverse impact on the student’s education (National Dissemination Center for Children with Disabilities [NICHCY], 2010).

*Individualized Education Plan (IEP)*

An educational plan used to identify and organize individualized special education and related services for preschoolers and schoolchildren ages birth to 21. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students (when appropriate) to work together to improve educational results for children with disabilities. The IEP is the cornerstone of a quality education for each child with a disability (U.S. Department of Education, 2007).

*Individuals with Disabilities Education Act (IDEA)*

IDEA is a law ensuring services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities, and ensures the right to a free and appropriate education in the least restrictive environment (U.S. Department of Education, 2006).

*Oppositional Defiant Disorder (ODD)*

ODD is a disorder that involves an ongoing pattern of uncooperative, defiant, and hostile behaviors toward authority figures that seriously interferes with the child’s day-to-
day functioning. These behaviors are usually seen in multiple settings, but may be more noticeable at home or at school (American Academy of Child & Adolescent Psychiatry, 2009).

*Other Health Impaired (OHI)*

Other Health Impaired means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that (a) is due to chronic or acute health problems such as asthma, Attention-deficit Disorder or Attention-deficit/Hyperactivity Disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia; and (b) adversely affects a child’s educational performance (NICHCY, 2009).

Assumptions

Students with pediatric bipolar disorder can have positive experiences and successes at school with appropriate interventions based on the strong foundational knowledge of teachers and other school professionals understanding of pediatric bipolar disorder and how it presents in a school setting. Teachers can create educational environments that support and meet the individual needs of their students with pediatric bipolar disorder. Further, through collaboration among school professionals and families to develop the appropriate program supports, students with pediatric bipolar disorder can successfully complete school and become productive members of society (CABF, 2007).
Limitations

This workshop is designed for an audience of teachers and other school professionals, such as administrators, counselors, and school psychologists. The presenter’s manual allows the workshop to be delivered by any trained school psychologist, administrator, or teacher with some prior knowledge or training on the topic of pediatric bipolar disorder.

In an effort to research pediatric bipolar disorder and the effects it has on students in the classroom, the authors encountered difficulty in obtaining a vast quantity of information. Although there has been an increase in attention directed toward pediatric bipolar disorder by the scientific community, little is known about the management of the symptoms of the disorder by teachers and other school professionals in a school setting.

Statement of Collaboration

The authors of this study collaborated on all aspects of the project. In designing the workshop and related materials, each author contributed in researching past and present literature on adult and pediatric bipolar disorder, making decisions, and creating written guidelines for the project. In preparing this project, each author produced an initial draft of specific portions of each chapter. The authors then collaborated to review, edit, and revise the chapters repeatedly to create a cohesive final written product that was contributed to equally by both authors.
Chapter 2
LITERATURE REVIEW

In recent years, pediatric bipolar disorder has become a widely recognized, researched, and diagnosed mood disorder. This increase in occurrence may be a result of underdiagnosing in the past or overdiagnosing, or misdiagnosing now, as there is not currently a specific set of diagnostic criteria established for children with bipolar disorder (NIMH, 2007). According to an article on the NIMH’s website, the number of visits to a doctor’s office that resulted in a diagnosis of bipolar disorder in children and adolescents has increased 40 times over the last decade. Despite this increase in attention from the medical and scientific community and the general public, school professionals often lack an understanding of pediatric bipolar disorder and how it can affect children in a school setting. Often, teachers in particular, have questions regarding how to understand and deal with the symptoms of pediatric bipolar disorder when displayed in the classroom. According to Anglada (2009), concerns such as how to handle rages, help the child feel that he or she fits in, and what to do if a teacher feels a child may have undiagnosed pediatric bipolar disorder, have been reported.

This document reviews current literature in the psychological, medical, and educational fields that defines pediatric bipolar disorder and discusses how it affects children’s ability to succeed in a school environment. Various terms are used to describe bipolar disorder in children. For the purpose of this literature review, the term pediatric bipolar disorder (PBD) will be used to describe this disorder.
Defining and Diagnosing Pediatric Bipolar Disorder

The NIMH (2008) defines bipolar disorder as “a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks” (p. 1). Diagnosing bipolar disorder in children can be difficult as research suggests that it presents differently in children than in adults. According to a 2008 review of recent developments in the study of pediatric bipolar disorder, there are two primary developmental differences suggested between how pediatric bipolar disorder presents in children and how it presents in adults. They are: (a) chronic symptoms and/or rapid mood cycles in youths, rather than periods of euthymia or subsyndromal symptoms seen in adults, and (b) mania exhibited as severe irritability rather than euphoria, which is seen more frequently in adults (Leibenluft & Rich, 2008).

The American Psychiatric Association’s (2000) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM IV-TR, p. 382-401), identifies four primary subtypes of bipolar disorder: Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, and Bipolar Disorder NOS (Not Otherwise Specified). Some children with bipolar disorder meet all of these criteria, but there are others who may meet some but not all the criteria (NIMH, 2007).

To identify early-onset bipolar spectrum disorder (EOBPSD) using the DSM-IV-TR criteria, we look at each subtype more specifically. Bipolar I involves at least one manic episode, with or without a major depressive episode. Bipolar II involves the occurrence of one or more major depressive episodes and one or more hypomanic
episode, with no previous history of manic or mixed episodes in the past. Cyclothymic disorder involves chronic fluctuating between hypomanic and depressive symptoms and is not as severe as Bipolar I or Bipolar II, but is more chronic, lasting for one year or more in children. Bipolar Disorder NOS involves the occurrence of some bipolar features but does not meet the criteria for the three previously listed classifications (APA, 2000; Lofthouse & Fristad, 2006). It is within the category of Bipolar Disorder NOS that most children with pediatric bipolar disorder fit. However, some researchers believe that even this category is not an accurate description of how bipolar disorder presents in children, and that the need for separate criteria for pediatric bipolar disorder is still necessary (Papolos & Papolos, 2006).

Special Education Eligibility Criteria

Among the Individuals with Disabilities Education Act (IDEA) there are 13 classifications; the two most frequently used in identifying bipolar children for special education are “other health impaired” (OHI) or “emotional disturbance” (ED; Brock, 2007; Papolos & Papolos, 2006). Children with bipolar disorder can meet the criteria for both; however, it is important for families and educators to understand each classification in regards to how they drive special education services.

The criteria for OHI includes having limited strength, vitality, or alertness, including heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that; is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity
disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia, and adversely affects a child’s educational performance (NICHCY, 2009).

The criteria for ED includes an inability to learn that cannot be explained by other factors, an inability to build or maintain satisfactory interpersonal relationships with peers and teachers, inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, and/or a tendency to develop physical symptoms or fears associated with personal or school problems (NICHCY, 2010). Oftentimes the classification of OHI versus ED determines how school personnel will view and work with a child with pediatric bipolar disorder. An ED classification may place a child with pediatric bipolar disorder in a classroom with students who have behaviors that are more delinquent. This may influence how the child is viewed by teachers or administrators and can have negative connotations, affecting a bipolar child’s already low self-esteem, and de-emphasizing the presence of a medical condition that is out of the child’s control (Papolos & Papolos, 2006). As suggested, a lack of understanding of pediatric bipolar disorder by school professionals can have a striking effect on how a bipolar child’s needs are met in a school setting.

How Pediatric Bipolar Disorder Affects Cognitive Learning and School Functioning

Because pediatric bipolar disorder is a neurobiological illness, it is important to consider how the parts of the brain are affected by this disorder, thus affecting how a child with bipolar disorder learns and functions in school and among peers. According to
an article titled *An Educator’s Guide to Pediatric Bipolar Disorder*, the use of neuroimaging technology by scientists has identified physical differences in the brain associated with pediatric bipolar disorder (CABF, 2010). The dorsolateral prefrontal cortex is located in the frontal lobe of the brain and regulates executive functions such as planning, problem solving, and the expression and control of emotions. If compromised because of a neurobiological illness such as, pediatric bipolar disorder, these vital skills for school success may be difficult for a child to access or master. The orbital frontal cortex is located in the prefrontal cortex and is responsible for the regulation of social behaviors and the ability to read social cues. If affected, as is the case in children with pediatric bipolar disorder, a child may have a hard time following social norms at school and may struggle with reading the facial expressions of teachers and peers (CABF, 2010).

According to the CABF (2010), scientists have identified four primary brain chemicals that may be related to pediatric bipolar disorder. Monoamine oxidase is an enzyme that breaks down brain chemicals. A shortage of monoamines can result in depression. When it presents in excess, it can result in mania. Serotonin is a neurotransmitter that allows neurons to communicate and coordinate body functions. An imbalance in serotonin can result in intense worry and tension. Dopamine is the neurotransmitter responsible for movement, emotional response, pleasure, and pain. If imbalanced, the result can be thought and mood disturbances, delusions or disorganized thinking. Noradrenaline is a neurotransmitter that controls the sleep cycle, regulates
drive and motivation and when unbalanced can result in depressive symptoms. These chemicals, when affected, can interfere with normal activity, feelings, and thoughts.

Comorbid and Look-Alike Disorders

Another factor that contributes to the difficulty of identifying and understanding bipolar disorder in children is the occurrence of other disorders that may look like pediatric bipolar disorder or that are occurring at the same time. Many of the manic and/or depressive symptoms that are present in children with pediatric bipolar disorder can also be present in children who have Attention-deficit/Hyperactivity Disorder (ADHD), Anxiety Disorders, Conduct Disorder, Oppositional Defiant Disorder (ODD), Psychosis, and/or Unipolar Depression (Brock, 2007; Papolos & Papolos, 2006). In addition, comorbid disorders are common among children diagnosed with pediatric bipolar disorder (Leibenluft & Rich, 2008). A study looking at phenomenology of children and adolescents with bipolar spectrum disorders found that ADHD might co-occur in approximately 70% of children and youths with pediatric bipolar disorder. Further, the occurrence of ODD ranged from 46% to over 80%; conduct disorder rates ranged from 12% to 41%, and anxiety rates ranged from 45% to 78% (Axelson et al., 2006). According to the CABF (2010), some problems common to both pediatric bipolar disorder and ADHD, and which makes it hard to tease out one disorder from the other, are learning disabilities, communication disorders, pervasive developmental disorder, and seasonal affective disorder. The presence of comorbid conditions may act as stressors for
children with pediatric bipolar disorder and may trigger episodes of mania or depression (Lofthouse & Fristad, 2006).

The manic and depressive symptoms of pediatric bipolar disorder interfere significantly with a child’s typical functioning and may express themselves in many different ways in a school environment. Tables 1 and 2 lists the manic and depressive symptoms of pediatric bipolar disorder and give examples of how they may present themselves in a school setting (Lofthouse & Fristad, 2006).

Table 1: Manic Symptoms and Their Expression in the School Environment

<table>
<thead>
<tr>
<th>Symptom and Definition</th>
<th>Example</th>
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<tr>
<td><strong>Euphoria:</strong> Elevated (too happy, silly, giddy) and expansive (about everything) mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time.</td>
<td>A child laughs hysterically for 30 minutes after a mildly funny comment by a peer and despite other students staring at him.</td>
</tr>
<tr>
<td><strong>Irritability:</strong> Energized, angry, raging, or intensely irritable mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time.</td>
<td>In reaction to meeting a substitute teacher, a child flies into a violent 20-minute rage.</td>
</tr>
<tr>
<td><strong>Inflated Self-Esteem or Grandiosity:</strong> Believing, talking, or acting as if he is considerably better at something or has special powers or abilities despite clear evidence to the contrary.</td>
<td>A child believes and tells others she is able to fly from the top of the school building.</td>
</tr>
<tr>
<td><strong>Decreased Need for Sleep:</strong> Unable to fall or stay asleep or waking up too early because of increased energy, leading to a significant reduction in sleep yet feeling well rested.</td>
<td>Despite only sleeping 3 hours the night before, a child is still energized throughout the day.</td>
</tr>
<tr>
<td><strong>Increased Speech:</strong> Dramatically amplified volume, uninterruptible rate, or pressure to keep talking.</td>
<td>A child suddenly begins to talk extremely loud, more rapidly, and cannot be interrupted by the teacher.</td>
</tr>
</tbody>
</table>
**Flight of Ideas or Racing Thoughts:** Report or observation (via speech/writing) of speeded-up, tangential, or circumstantial thoughts.
- A teacher cannot follow a child’s rambling speech that is out of character for the child (i.e., not related to any cognitive or language impairment the child might have).

**Distractibility:** Increased inattentiveness beyond a child’s baseline attention capacity.
- A child is distracted by sounds in the hallway, which would typically not bother her.

**Increase in Goal-Directed Activity or Psychomotor Agitation:** Hyper-focused on making friends, engaging in multiple school projects or hobbies or in sexual encounters, or a striking increase in and duration of energy.
- A child starts to rearrange the school library or clean everyone’s desks, or plans to build an elaborate fort in the playground but never finishes any of these projects.

**Excessive Involvement in Pleasurable or Dangerous Activities:** Sudden unrestrained participation in an action that is likely to lead to painful or very negative consequences.
- A previously mild-mannered child may write dirty notes to other children in class or attempt to jump out of a moving school bus.

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**Table 2 Depressive Symptoms and Their Expression in the School Environment**

<table>
<thead>
<tr>
<th>Symptoms and Definition</th>
<th>Example</th>
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<tr>
<td><strong>Depressed Mood:</strong> Feels or looks sad or irritable (low energy) for an extended period of time.</td>
<td>A child appears down or flat or is cranky or grouchy in class and on the playground.</td>
</tr>
<tr>
<td><strong>Markedly Diminished Interest or Pleasures in All Activities:</strong> Complains of feeling bored or finding nothing fun anymore.</td>
<td>A child reports feeling empty or bored and shows no interest in previously enjoyable school or peer activities.</td>
</tr>
<tr>
<td><strong>Significant Weight Loss/Gain or Appetite Increase/Decreases:</strong> Weight changes &gt;5% in 1 month or significant change in appetite.</td>
<td>A child looks much thinner and drawn or a great deal heavier, or has no appetite or an excessive appetite at lunchtime.</td>
</tr>
<tr>
<td><strong>Insomnia or Hypersomnia:</strong> Difficulty falling asleep, staying asleep, waking up too early or sleeping longer and still feeling tired.</td>
<td>A child looks worn out, is often groggy or tardy, or reports sleeping through alarm despite getting 12 hours of sleep.</td>
</tr>
<tr>
<td><strong>Psychomotor Agitation/Retardation:</strong> Looks restless or slowed down.</td>
<td>A child is extremely fidgety or can’t stay seated. His speech or movements are sluggish or he avoids physical activities.</td>
</tr>
<tr>
<td>Fatigue or Loss of Energy:</td>
<td>Complains of feeling tired all the time.</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Low Self-Esteem, Feeling of Worthlessness or Excessive Guilt:</td>
<td>Thinking and saying more negative than positive things about self or feeling extremely bad about things one has done or not done.</td>
</tr>
<tr>
<td>Diminished Ability to Think or Concentrate, or Indecisiveness:</td>
<td>Increased inattentiveness, beyond child’s baseline attentional capacity; difficulty stringing thoughts together or making choices.</td>
</tr>
<tr>
<td>Hopelessness:</td>
<td>Negative thoughts or statements about the future.</td>
</tr>
<tr>
<td>Recurrent Thoughts of Death or Suicidality:</td>
<td>Obsession with morbid thoughts or events, or suicidal ideation, planning, or attempts to kill self.</td>
</tr>
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Because children spend much of their day at school, where there are constant demands to concentrate and be alert, exhibit proper behavior, handle transitions and stimulation, as well as navigate through social interactions, it is important to consider how the symptoms of pediatric bipolar disorder can play out for a child who suffers from them. These children may struggle with any or all of these symptoms at various times. Further, when a child is being treated for the symptoms of pediatric bipolar disorder with medications, he or she may experience other symptoms such as, sleepiness or cognitive difficulties. At times, the symptoms of pediatric bipolar disorder may be exacerbated by
the typical challenges of school, which can lead to explosive frustration (Papolos & Papulos, 2006). It is vital for teachers and school staff to understand the symptoms of bipolar disorder in children, how it affects them in school, and what can be done to accommodate their needs.

**Treatment Approach**

Pediatric bipolar disorder cannot be cured or outgrown. For children diagnosed with pediatric bipolar disorder, their families, psychiatrists, and school professionals play an important role in increasing resiliency through medications, psychoeducation, psychosocial and school interventions (Lofthouse & Fristad, 2006). The combination of these interventions, along with the support of everyone involved in the child’s life, is critical to their success in living with bipolar disorder.

Usually children that have been diagnosed with pediatric bipolar disorder will be prescribed multiple medications to alleviate the symptoms of mania, depression, and co-occurring conditions. A mood stabilizer is usually the first pharmaceutical prescribed (Lofthouse & Fristad, 2006). Many times pediatric bipolar disorder may first be diagnosed as severe ADHD or as an anxiety disorder. However, if a child with pediatric bipolar disorder is treated with antidepressants and psychostimulants, there is a risk that these medications will activate the manic symptoms of pediatric bipolar disorder (Browning-Wright & Russell, 2008). Once mood is stabilized, an antipsychotic medication (i.e., Abilify, Clozaril, Resperdal, Zyprexa) may be prescribed to help reduce aggressive behaviors and psychotic symptoms. Additionally, antihypertensive
medications (i.e., Slonidine and Tenex) are sometimes prescribed to stabilize sleep patterns. In addition, a low-dose antidepressant (i.e., Prozac, Wellbutrin, Zoloft) may reduce symptoms of depression and anxiety. Lastly, norepinephrine reuptake inhibitors (i.e., Strattera) may be used to help reduce symptoms of ADHD. On other occasions, and only after the student’s mood is stabilized, a psychostimulant may be prescribed to reduce symptoms of ADHD. If the mood of a child diagnosed with pediatric bipolar disorder is not stabilized first, a psychostimulant may increase the symptoms of mania (Browning-Wright & Russell, 2008). Due to the side effects of pharmaceuticals, parents, psychiatrists and school professionals should communicate with each other daily to monitor the effects that these medications may have on the child.

In addition to pharmaceutical treatments, psychosocial treatment approaches are effective in helping students develop skills that will help them manage the symptoms of pediatric bipolar disorder (Papolos & Papolos, 2006). The school counselor or the school psychologist can facilitate small counseling groups, which focus on social skills and/or anger management support. By having these groups in the school setting, the student has the opportunity to develop a relationship with an adult who can help, as well as having a safe location to go to, to work through the intense mood changes and reestablish stability so they can rejoin the classroom when they are ready (Anglada, 2002).

Social skills curriculums such as “Second Step” or “Strong Kids” (Merrell, Carrizales, Feuerborn, Gueldner, & Tran, 2007), can be used in the classroom or in a small group setting to help teach students the skills needed at school. In addition to
social skills training, assisting the student with anger management techniques can also provide students with strategies in managing the intense mood changes. Both Second Step and Strong Kids address feelings of anger. Using the social skills curriculum in combination with activities from *Volcano in My Tummy* (Pudney & Whitehouse, 1996), or using a social skills curriculum that has an in-depth anger management section, might help teach students to develop skills that will help manage the symptoms of the pediatric bipolar disorder in school.

In addition to working with students, training school staff in effective de-escalation techniques is essential in keeping the school a safe environment. Using proper de-escalation techniques among student and teachers during intense mood changes can help the child regain stability at a faster rate and prevents the situation from escalating (LaRose, 2009). Trainings, such as Handle with Care (2010), provide teachers and school personnel with verbal and nonverbal skills to assist with de-escalation skills, providing a calm environment and becoming a stable person for the student.

*Positive School Environment*

A positive school environment set up in a way for students to succeed can facilitate the teachers to be in control of many situations. Many times parents understand better than anyone else does how pediatric bipolar disorder affects their child. Therefore, teachers and parents need to communicate frequently to share ideas and develop accommodations that specifically work for the individual student and allow the teacher to change the environment to set the student up for success. Lofthouse and Fristad (2006)
have developed seven fundamental recommendations from a number of sources to help facilitate a discussion between school professionals and parents. The fundamental recommendations are as follows:

**Build, maintain, and educate the school-based team.** It is important for the family, the student, and school personnel to collaborate with one another in developing a successful environment for the student. Having an understanding of what pediatric bipolar disorder is and what educational challenges may arise for the student are pivotal in providing a successful school environment. This team should meet regularly to monitor the student’s progress and make changes that are appropriate for the classroom to ensure these students are progressing towards their goals (Anglada, 2009).

**Prioritize Individualized Education Plan (IEP) goals.** IEP goals can include, but should not be limited to, attendance, emotional stability, physical safety, knowledge acquisition, relationship building, and work production (Papolos & Papolos, 2006). Developing measurable goals to assist with the management of the disorder and ensure that the student learns ways to manage and control the disorder is beneficial to him or her (Papolos, Hatton, Norelli, Garcia, and Smith, 2002). Lastly, it is important to develop goals in order from most important to least important to help the student be successful in school.

**Provide a predictable, positive, and flexible classroom environment.** Transition times throughout the day tend to be the most difficult for students, but even more so for a student with pediatric bipolar disorder (CABF, 2007). Providing a predictable schedule
and alluding to a transition assists in reducing the student’s anxiety as well as providing
the student with a smooth transition to the next subject or activity. Building the
foundation for the classroom by using a positive discipline strategy approach in
conjunction with having a predictable classroom setting, helps the student be set up for
success rather than failure. Negative consequences, such as ignoring attention-seeking
behaviors, time-outs, or using suspensions and expulsions for behaviors that break school
rules, may increase the undesirable behaviors (Packer & Pruitt, 2010).

*Be aware of and manage medication side effects.* Having an understanding of
how the medication can affect the student while he or she is in the classroom
environment will help to reinforce the third recommendation of having a positive and
flexible classroom environment. Parents and school personnel should be in
communication regarding changes to medication or dosage as they occur. If the student
does not receive medications consistently, or is experiencing side effects from the
medications, he or she may require modified classroom expectations to ensure that these
variables do not interfere with the student being successful in the classroom.

*Develop Social Skills.* School professionals should work collaboratively to
develop and assist with building social skills for students with pediatric bipolar disorder.
Working along with parents regarding the skills being taught at school allows parents to
reinforce these skills at home. This may allow the student to practice developing the
desired skills in multiple settings (Merrell et al., 2007). Providing students with social
skills and additional supervision during unstructured time, such as recess or lunchtime, can set the students up for success and help them function better at school.

*Be prepared for episodes of intense emotion.* It is imperative that school personnel are prepared for episodes of intense emotional changes. Having a plan developed in advance to assist the teacher or school personnel will help all school staff be prepared to manage these intense moods and be confident in their ability to remain calm. Research shows when people are prepared with the tools in safety planning, school personnel remain calm, which allows the child to stabilize their mood enough to return to class (Packer, 2002).

*Consider alternatives to regular classrooms.* The consideration of an alternative placement may need to be discussed if the symptoms of the disorder escalate. In discussing an alternative placement for a student with special needs, the least restrictive environment is required. Lofthouse and Fristad (2006) developed a list that ranges in order from the least restrictive to the most restrictive alternative placements. These alternative placements starting from the least restrictive include, (a) if additional support is warranted provide the student in the regular classroom with a one-to-one aide; (b) if more support is needed, working with the special education teacher or resource support should follow; (c) if the student’s behavior continues to warrant additional support, the next option would be the consideration of a self-contained classroom such as a Special Day Class; (d) if the symptoms continue, a more restrictive placement such as home schooling, the use of a therapeutic day school, hospital day treatment program, or a
residential treatment center may need to be considered; and (e) lastly, the most restrictive program that may need to be considered as an alternative placement would be a therapeutic boarding school.

*Helping Parents*

Often, a parent of a child with pediatric bipolar disorder knows that something is wrong but does not have the tools to recognize the disorder. These parents may also feel that they are unable to provide the help their child needs to succeed in school. When school professionals (usually the school psychologist and/or teacher) recognize the symptoms of pediatric bipolar disorder and encourage them to speak to their family doctor, it can provide parents with answers and a sense of relief that their child’s illness is not due to a lack of parenting skills.

Children attend school more than half of their waking hours. Because of this, teachers and school professionals often know their students well and have some understanding of what does and does not work for them. Often, parents of children with pediatric bipolar disorder contact school personnel to seek help in understanding what works for their children since many times the intense mood changes occur across multiple settings. Having input from others helps parents define what works best for their child. When school personnel work closely as a team with parents and physicians, they can provide the best support for the student with pediatric bipolar disorder.

Having a school-based team that is diverse with many different professional backgrounds working together to provide professional knowledge helps build a firm
foundation in understanding pediatric bipolar disorder and how it is defined in relation to the individual student (Anglada, 2009). Children diagnosed with pediatric bipolar disorder may function within the classroom with little help or with the help of Section 504 accommodations. A large majority, 80% of children diagnosed with pediatric bipolar disorder, have an Individualized Education Program (IEP; Anglada, 2009). When parents and school personnel work collaboratively at an IEP meeting, they can learn how the school is managing the intense mood changes and symptoms of pediatric bipolar disorder in their child (Papolos & Papolos 2006). In addition to working collaboratively during the IEP meeting, parents should be educated about how the IEP process benefits their child. Prior to the meeting, a copy of the current *Parent’s Rights and Procedural Safeguards* must be provided to the parents to read so that they can understand the process. With a better understanding of the IEP process, parents will be better equipped to take an active role in ensuring that all members of the IEP team understand their individual roles, and make sure that all areas of the IEP are implemented with fidelity while at school. The student should have goals that are developed specifically for him or her to help manage the specific symptoms they are experiencing.

As the understanding of pediatric bipolar disorder develops professionally, more and more resources will be created for parents to assist them in becoming advocates for their children. This trend has already begun. Some parents who have children diagnosed with pediatric bipolar disorder have created web-based nonprofit organizations, such as *The Child and Adolescent Bipolar Foundation* (www.bpkids.org), to support other
parents with similar challenges. Such websites help parents understand and provide support in how to manage their own feelings and the daily challenges faced by their children. In addition to the Internet, recent books have been published to help parents work with their bipolar children, rather than against them (McDonnell, Wozniak, & Fort Brenneman, 2009; Pavuluri, 2008).

Summary

Children diagnosed with pediatric bipolar disorder are some of the most extraordinary children that school professionals and parents will work with on a daily basis. It is to the advantage of the students with bipolar disorder, their parents, and the school professionals who interact with these students, for teachers and school staff to have a thorough understanding of how pediatric bipolar disorder presents in a school setting. It is only when this disorder is understood and treated, and appropriate accommodations are made at school, that the students have the best opportunity to be successful at school. When families and school staff work as a team to develop a supportive and positive environment for the student diagnosed with pediatric bipolar disorder, they will be better able to function within a classroom setting.

It is the goal of this workshop to provide education and staff development to school professionals about pediatric bipolar disorder, how it presents in a school setting, and what can be done to help accommodate this special population of students. It is our hope that this information will be useful in supporting teachers who have these students in their classes and help them recognize the symptoms and behaviors associated with
pediatric bipolar disorder and how to manage them throughout the day. This workshop is also designed to help teachers and school professionals to understand the need for a team approach in order to develop the best appropriate educational environment for these students to be successful both academically and emotionally.
Chapter 3

METHODOLOGY

The motivating force for creating this workshop was observations from working with school psychologists, behavior specialists, and teachers working in public schools who struggle with understanding students that have symptoms consistent with, or have been diagnosed with, pediatric bipolar disorder. As school psychologist trainees, it became apparent that teachers and school psychologists lack resources when faced with the challenges of helping manage the symptoms of the disorder. Participation in graduate courses through the Department of Education, Rehabilitation, School Psychology, and Deaf Studies at California State University, Sacramento, between Fall 2008 and Spring 2011, as well as the authors’ personal experiences within the field of school psychology, helped confirm the lack of understanding.

The project idea originated in the California State University, Sacramento, graduate course EDS 239 Education Specialist Seminar conducted in the Fall of 2010. Guidelines for an Education Specialist degree-culminating project in the form of a training workshop were presented by the instructor, Dr. Melissa Holland. The authors decided to produce a resource that can be used by school psychologists and teachers to guide them in developing plans to assist students and teachers in creating a positive environment for students diagnosed with pediatric bipolar disorder.

The research for this project utilized several techniques. The Academic Search Premier, ERIC, and PsychArticles databases were searched for journal articles using a
variety of search terms. The key words pediatric bipolar disorder were used in combination with other terms such as children, school, elementary school, side effects, and behavior. Early onset bipolar disorder was also utilized in the search. In addition, specific interventions were searched for in the databases such as social skills, psychoeducational services, Second Step, mood charts, functional behavior assessment, and social emotional learning. The National Association of School Psychologist’s website, (nasponline.org) was searched for topics such as bipolar disorder.

Books used in graduate courses and in professional practice were also utilized as resources, such as The American Psychiatric Association’s (2000) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR).* Prominent authors in the field were used as determinants during a web-based periodical search. References cited within articles and books were also utilized for additional information. Both qualitative and quantitative studies were considered. The articles found were categorized by themes according to an initial outline. The outline was then adapted based on the information gathered. Each author then focused on specific topics to write sections of the literature review.

A 30-minute outline of the projected workshop was presented to classmates in December of 2010. The main points from the literature review were summarized in the presentation in order to create a sense of urgency with the audience and motivate them to become proponents for developing teacher’s understanding of how children diagnosed
with pediatric bipolar disorder affect the classroom. Further, feedback from Dr. Holland and classmates was utilized to enhance the presentation’s effectiveness.

The final literature review was created in the spring of 2010, based on feedback from EDS 239 class members, Dr. Holland, and Dr. Brock as part of the California State University, Sacramento, graduate course EDS 542 Education Specialist Thesis/Project. The information in the literature review was utilized to create the project addendum workshop, manual and reference handout. Introductory, methods, and summary chapters were added. Dr. Brock provided feedback and suggestions on materials prepared during EDS 542.

The project’s development was based upon current federal law and regulations according to IDEA, the National Association of School Psychology and American Psychology Association ethical guidelines, and published accounts of professional personal experience and recommendations found in research. The information gathered was integrated into a comprehensive guide and workshop delineating the different components necessary in working with these students. A resources list was collected as a further source of information to aid teachers and school psychologists in furthering their research and knowledge. It is important to note that this project was constructed and heavily influenced through the most recent definitions and laws under IDEA. Best practice and ethical standards were supported through additional school psychology associations and educational personnel, and as such, the workshop’s basis was developed accordingly.
Chapter 4

RESULTS

The workshop for *Understanding the Effects of Pediatric Bipolar Disorder in the Classroom* was developed to create a convenient and user-friendly training workshop for new and experienced administrators, school psychologists, and teachers. The workshop is designed to last approximately six hours. The manual, slides with presentation notes, and activities are included in the project addendum and are designed for any trained school psychologist to be able to present. This workshop will assist in creating a plan to meet the complex needs of students diagnosed with pediatric bipolar disorder. Finally, the authors provide teachers with a reference guide to help develop a positive environment for students diagnosed with pediatric bipolar disorder.

Summary

School psychologists are relied upon to assist teachers with behavioral supports for students in their classroom. Research in the field of pediatric bipolar disorder has been limited but has been slowly increased over the past 10 years. Children diagnosed with pediatric bipolar disorder are unlike any other students that school professionals and parents work with. It is to the advantage of all that work with these students, to have a thorough understanding of how pediatric bipolar presents itself in the school setting, specifically in the classroom.

Furthermore, students diagnosed with pediatric bipolar disorder pose exceptional challenges to teachers who try to instruct them. Administrators have difficulty creating a
program for students diagnosed with pediatric bipolar disorder, as it can be difficult to understand how to meet their needs. Schools may not have adequate resources or funds to serve these students most efficiently. Only when this disorder is understood, treated, and appropriate accommodations and interventions are made, will these students, have the best opportunity to succeed in school. When everyone in the student’s life works as a team to develop a supportive and positive environment at school for students diagnosed with pediatric bipolar disorder, that student will be better able to function within a classroom setting.

Workshop Objectives

The workshop is designed as a summary of what is known regarding research and issues related to pediatric bipolar disorder and the effects that it has on students in the classroom environment. It is hoped that workshop participants will obtain a foundation of what pediatric bipolar disorder is and how to help students succeed in the classroom. Attendees will better understand the symptoms of the disorder, how to help students be successful through Section 504 or special education, treatment approaches, and building a positive environment for these students through proper interventions and accommodations.

Recommendations

It is recommended that school personnel view the contents of this project with the understanding that the workshop is intended for expanding the comprehension of pediatric bipolar disorder with the current research. This project is designed as a
template for both the universal educational requirements as well as the possible ethical and best practices for IEP protocol. It is the goal of this project, that the workshop produced, serves as a guideline for teachers, administrators, and school psychologists.

The authors of this project are cognizant that every student is unique and may require specific interventions in order to be successful in school. It is hoped that teachers, administrators, and school psychologists will find this workshop useful in further developing an understanding of pediatric bipolar disorder in the classroom and deciding how to set the student up for success by understanding and utilizing interventions and accommodations that best meet the student’s needs. However, this workshop is one of many resources available to help students with pediatric bipolar disorder and does not have the solution to every student’s needs, yet it offers additional resources that school professionals can use to seek further help with these students. Last, it is recommended that teachers, administrators, and school psychologists have a committed practice of furthering their knowledge with current research to serve the students in this population.
APPENDICES
APPENDIX A

Presenter’s Manual

Understanding the Effects of Pediatric Bipolar Disorder in the Classroom

Introduction

It can be difficult to determine what a student needs to be successful in the classroom environment with the diagnosis of pediatric bipolar disorder. Understanding what effects on learning the disorder has on the student can be challenging. As more and more children are identified with having this diagnosis, the greater the understanding is required by all school personal.

This manual and accompanying PowerPoint presentation are designed to educate teachers, administrators, and school psychologists in understanding the effects of pediatric bipolar disorder in the classroom. The information is based on a literature review performed between September 2010 and February 2011.

Nature of the Presentation

The presentation is designed for an audience of teachers, administrators, and school psychologists. Other school personnel that work with these students may also find some of the information useful.

The presentation is designed to be 5½ hours. Two 10-minute breaks and a 45-minute lunch break are incorporated. Audience participation is an integral aspect of this presentation. Presenters must use quality presentation techniques such as pausing for questions, demonstrating active listening, and validating audience input. To foster participation during the workshop, it is recommended that presenters and participants wear name badges that can be read from a distance. Before beginning the workshop, the presenter will need to make copies of the handout for each participant. The handout is available at the end of this manual.

In preparation for giving this workshop, presenter(s) should read over the slides and accompanying notes thoroughly. Presenter(s) may add their own names and contact information to the initial slide. In addition, it is recommended that presenters become familiar with the information cited and referenced at the end of the presentation. It is possible that audience members will have questions that are not directly answered within the scope of the presentation. The final informational slide also includes the author’s contact information as an additional resource.

Guidance for Presenters

The workshop is presented as a series of Microsoft PowerPoint slides. The slides are prepared with all the necessary information for presenting the workshop. On the note
section of each slide there is general information about the slide and its purpose. The presenter or presenters may use their own language when presenting, however, sample language has also been provided in italic. Many slides include discussion points after certain bullets. The notes will direct the presenter or presenters to first **READ** the slide or a portion of the slide, then **SAY** wording provided in italic.

The workshop is designed to include audience participation. Questions and activities are embedded throughout the slide notes. To highlight these important notes, questions the presenter should ask of the audience are prefaced with the word “ask” in bold (**ASK**) in the notes section of the slides. Directions for each activity are provided.

Some slides use the animation feature of Microsoft PowerPoint. When the slide uses the animation feature, the slide may emerge only after a secondary click of the computer mouse or slide progress button. This feature allows the presenter to discuss part of a slide before exposing more information. It is also a useful tool when posting and asking a question before showing the answer. When this feature is used, the word “click” in bold (**CLICK**) indicates when the next portion of the slide should be exposed. The slide should progress with the animation before continuing with the sample language.

This presentation can be performed with one or multiple presenters. If there are two presenters, a natural place to change is after the first break when the topic changes from how pediatric bipolar disorder differs from adult onset bipolar disorder to how pediatric bipolar disorder is expressed in school. Additional presenters may be in charge of activities. There are no firm rules regarding presenter changes or segments. However, it is recommended that each presenter introduce his or herself at the beginning of the presentation and again prior to beginning the next segment (other than the first presenter).

A recommended timeline for the workshop follows:

<table>
<thead>
<tr>
<th>Slides</th>
<th>Topic</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1-3</td>
<td>Introduction and Outline</td>
<td>10 minutes</td>
</tr>
<tr>
<td>#4-9</td>
<td>Pediatric Bipolar Disorder</td>
<td>15 minutes</td>
</tr>
<tr>
<td>#10-11</td>
<td>Symptoms Activity</td>
<td>30 minutes</td>
</tr>
<tr>
<td>#12-22</td>
<td>The Brain and Pediatric Vs. Adult Onset</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Break</td>
<td></td>
<td>10 minutes</td>
</tr>
<tr>
<td>#25-45</td>
<td>School and Prevalence Rates</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>
Lunch 45 minutes

#46-64 Supporting the Student 60 minutes

Break 10 minutes

#65-69 IEP Goal Activity 30 minutes

#70-76 Accommodations 20 minutes

**About the Authors**

Cate Thompson and Joanna Pastor are Nationally Certified School Psychologists. They have both completed their Masters and Education Specialist degrees at California State University, Sacramento. This workshop was completed to satisfy part of the requirements of their Education Specialist degrees.
Sample Presentation Language: *Welcome to this workshop on Understanding the Effects of Pediatric Bipolar in the Classroom. I am...* [Introduce yourself. Share with the audience your experiences with pediatric bipolar disorder while in the classroom and what your personal interest in the topic is. Have additional presenters introduce themselves as well. Allow approximately 3 minutes per presenter.]

- If the workshop group is small (i.e., 20 or fewer) give each participant a chance to identify him or herself. **ASK** each participant to share how pediatric bipolar disorder affects them.

- If the group is large (i.e., 25 or more) **ASK** questions such as the following: *How many of you work with a student that has been diagnosed with pediatric bipolar disorder? How many of you believe you have a student in your classroom that may have pediatric bipolar that is undiagnosed?*

Then **SAY**: *This presentation will help you understand the effects of pediatric bipolar disorder in the classroom and help you create a successful environment for these students. In turn, we will discuss what pediatric bipolar disorder is, the symptoms of the disorder and how they may present in the school environment, and how we can support these students. This workshop includes activities and discussions that call for the active involvement of all participants. There will be opportunities for you to work in pairs, and activities where you will consider making a successful environment for these students based on the information we present. Before we begin, let us review logistics. This workshop will last 6 hours. We will have two 10-minute breaks along with a 45-minute lunch break.*
What is Pediatric Bipolar Disorder?

Pediatric Bipolar vs. Adult Bipolar

How Symptoms Present in the School Setting

Comorbidity

Treatment Approach

Academic/Behavioral Supports

Sample Presentation Language: Again, the objective of this workshop is to discuss what pediatric bipolar disorder is; pediatric bipolar disorder vs. adult bipolar disorder; how the symptoms of pediatric bipolar disorder present in the school setting; comorbid conditions related to pediatric bipolar disorder; appropriate treatment approaches; and finally, we will spend time discussing academic and behavioral supports for teachers who work with bipolar students.
Participants will:
- Have an understanding of what pediatric bipolar disorder is.
- Be able to identify symptoms of pediatric bipolar disorder and how they present in school.
- Have an understanding of how to set the student up for success in the classroom.

Sample Presentation Language:  *By the end of this workshop, participants will have a better understanding of what pediatric bipolar disorder is and how it presents itself in the school setting. Lastly, you will have a better understanding of how to set these students up for success in the classroom.*
Sample Presentation Language: *First, we are going to describe what pediatric bipolar disorder is. Then we are going to discuss how pediatric bipolar disorder is defined by the mental health community and the many symptoms that are prevalent among adults or children affected by bipolar disorder.*

**ASK:** *Can anyone in this room offer a definition of pediatric bipolar disorder?*

[Pause. Allow audience to provide answers. Accept answers for up to 2 minutes]

For the answer, see the next slide.
“a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks” (National Institute for Mental Health, 2008)

**SAY:** The National Institute for Mental Health defines pediatric bipolar disorder as... [READ Slide]

Sample Presentation Language: *This is a complex disorder, which is relatively new to school professionals who often lack an understanding of bipolar disorder and how it affects children in the school setting.*
Sample Presentation Language: *The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders* identifies four primary subtypes of bipolar disorder.

[READ Slide]

**SAY:** Some children with bipolar disorder meet all of these criteria but there are others who may meet some, but not all, of the criteria.
**DSM-IV CRITERIA FOR BIPOLAR**

- **Bipolar I**
  - involves at least one manic episode, with or without a major depressive episode.

- **Bipolar II**
  - involves the occurrence of one or more major depressive episodes and one or more hypomanic episode, with no previous history of manic or mixed episodes in the past.

[READ Slide] Then CLICK to next slide
Cyclothymic disorder involves chronic fluctuating between hypomanic and depressive symptoms.

Bipolar Disorder NOS involves the occurrence of some bipolar features, but does not meet the criteria for the three previously listed classifications.

READ first bullet: Then SAY: Cyclothymic disorder is not as severe as Bipolar I or Bipolar II, but is more chronic, lasting for one year or more in children.

READ second bullet: Then SAY: It is within the category of Bipolar Disorder NOS that most children with pediatric bipolar disorder fit. However, some researchers believe that even this category is not an accurate description of how bipolar disorder presents in children and that the need for separate criteria for pediatric bipolar disorder is still necessary.
Sample Presentation Language: Symptoms may be present since early childhood or may suddenly emerge in adolescence or adulthood. These go beyond the normal mood fluctuations, temper outbursts, fantasies that are associated with normal child development. To qualify for a diagnosis of bipolar disorder a child would experience the extreme in moods known as mania and depression. These are the two “poles” of bipolar disorder.

SAY: Next, we are going to do an activity that will help us understand how these symptoms may translate in the classroom and how teachers perceive the children who experience the symptoms associated with pediatric bipolar disorder.
First, write as many characteristics as you can think of that may be attributed to a child with pediatric bipolar disorder. For example, “easily distracted” or “gets upset easily.”

Sample Presentation Language: [Have the Activity #1 handout ready to distribute to each participant]  

Inside the first silhouette, we want you to write as many characteristics as you can think of that may be attributed to a child with pediatric bipolar disorder. For example, “easily distracted” or “gets upset easily.”

[Allow participant approximately 5 minutes to work on activity.]

**SAY:** Now please take a moment to look over your lists.

**ASK:** How many of you wrote mostly undesirable characteristics or negative attributes? Would anyone be willing to share what they’ve written?

[Allow audience to share for 5 minutes.]

Then **CLICK** for next slide
SAY: Look at your list one more time. Now look at the other empty silhouette on your paper. We’d like you to come up with some positive characteristics that you may find in a child with pediatric bipolar disorder and write them in the second silhouette. More specifically, take some of the traits from your first silhouette and try to flip them to find the positive side of them; for example, “easily distracted” can be flipped into “notices many things.”

[Allow participants approximately 5 minutes to work on activity.]

ASK: Who would like to share what they’ve come up with?

[Allow audience to share for 5 minutes.]

Sample Presentation Language: We had you do this exercise because we believe it’s important to understand that students with bipolar disorder face tough challenges in navigating through the demands of a typical school day.

[CLICK to show slide of completed silhouettes side by side]

SAY: If, as educators we can acknowledge these challenges and find out how they may be able to work to the advantage of the child rather than against them, then we may be able to make things easier for both our students and ourselves. Bipolar disorder affects the emotions, behaviors, cognitive skills, and social interactions of the children affected by it. The most important factor in these children’s success is the way adults respond to and work with them. The teacher who works best with them is resourceful, caring, and knows how to find and work with their strengths.
Sample Presentation language: Next, let’s look more closely at all of the symptoms that are associated with the depression and mania of bipolar disorder. Think about if you’ve ever had or currently have a student who’s exhibited any of these symptoms. Lofthouse and Fristad (2006) provide the following symptoms of depression:

[READ Slide]
**SYMPTOMS OF MANIA**

- Euphoria
- Irritability
- Inflated Self-Esteem or Grandiosity
- Decreased Need for Sleep
- Increased Speech
- Flight of Ideas or Racing Thoughts
- Distractibility
- Increase in Goal-Directed Activity or Psychomotor Agitation
- Excessive Involvement in Pleasurable or Dangerous Activities

Sample Presentation Language: *Lofthouse and Fristad (2006) also offer the following symptoms of manic symptoms and how they might be expressed in a school environment:*

**[READ Slide]**

**SAY:** As you can see, the symptoms of depression and mania may express themselves in a variety of ways. As with adults, if a child experiences any or all of these symptoms, they may escalate and become potentially harmful to the child or others. What we’d like you to start gathering from this so far, is that bipolar disorder is complex and difficult for the child who is living with it as well as for the people in their lives. It’s also important to consider that bipolar disorder has biological origins that affect brain functioning, and the behaviors exhibited as a result are NOT intentional.
Sample Presentation Language: Now let’s talk about those biological origins and how certain parts of the brain are affected by the disorder, thus affecting how a child with bipolar disorder learns and functions in school.
Sample Presentation Language: According to the Child and Adolescent Bipolar Foundation, scientists have identified four primary brain chemicals that are affected by pediatric bipolar disorder, which when effected, can interfere with normal activity, feelings, and thoughts.

[CLICK for first bullet] [READ first bullet and sub-bullet]

[READ second bullet]
Dopamine
- A neurotransmitter responsible for movement, emotional response, pleasure and pain.
  - If imbalanced the result can be thought and mood disturbances, delusions or disorganized thinking.

Noradrenaline
- A neurotransmitter that controls the sleep cycle and regulates drive and motivation.
  - When imbalanced can result in depressive symptoms.
Sample Presentation Language: *With the use of neuroimaging technology, scientists have also been able to identify physical differences in the brain associated with pediatric bipolar disorder.*

[CLICK first bullet] [READ first bullet and sub-bullets]

Then **SAY:** *If the dorsolateral prefrontal cortex is compromised because of a neurobiological illness, such as pediatric bipolar disorder, those vital skills needed for school success may be difficult for a child to access or master.*
The orbital frontal cortex located in the prefrontal cortex is responsible for the regulation of social behaviors and the ability to read social cues.

Sample Presentation Language: The next area of the brain we are going to look at in regards to pediatric bipolar disorder is the orbital frontal cortex.

[CLICK first bullet] [READ first bullet and sub-bullets]

Then SAY: If affected, as is the case in children with pediatric bipolar disorder, a child may have a hard time following social norms at school and may also struggle with reading the facial expressions of teachers and peers.
Diagnosing bipolar disorder in children can be difficult, as research suggests that it presents differently in children than in adults. Whereas adults with bipolar disorder generally have discrete periods of depression and discrete periods of mania, children with bipolar disorder are more likely to have moods that are not distinct. The first episode of bipolar disorder a child experiences may be in the form of depression, mania, or a combination of both. It may be difficult to identify a child's "first episode" of bipolar disorder if mania and depression occur at the same time or if these moods occur chronically rather than during discrete periods of time.
Children have much faster and more frequent cycles than adults. Children rarely have pure euphoric mania as defined by the DSM-IV. Children are more likely to have dysphoric mania or mixed states. Depression in children often manifests as anger and aggression instead of sensitivity and withdrawal.

Sample Presentation Language: Now we are going to look more specifically at how pediatric bipolar disorder differs from adult bipolar disorder.

SAY: We can refer to the mood shifts of these children as rapid cycling. Rapid cycling itself involves four or more mood episodes per year. Ultra-rapid cycling involves between 5 and 364 mood episodes per year. Ultradian cycling involves multiple episodes per day.

SAY: Unlike adults who present with more discrete cycles of mania and depression, children with bipolar disorder may exhibit both manic and depressive symptoms (mixed states) at the same time or within the same day. Euphoric mania refers to silliness or elation that is inappropriate and impairing. A child presenting with a mixed state may have a depressed mood with high energy. This translates into irritability, which doesn’t look like a clear-cut adult manic episode. This may present more as energized or raging or as an inappropriate reaction to external events for an extended period of time.

SAY: Whereas an adult with depression may seem withdrawn, children exhibiting depression associated with pediatric bipolar may present as intense irritability and may be aggressive towards peers, teachers, or parents.
Children often have comorbid conditions accompanying the bipolar disorder that are commonly found in childhood. The comorbidity of other disorders can make medical treatment very difficult in children. Bipolar in children is very often misidentified as unipolar depression with hyperactivity.

**SAY:** Another difference between adult bipolar disorder and pediatric bipolar disorder is that...

[CLICK for first bullet] [READ first bullet.]

Sample Presentation Language: *We’ll discuss these comorbid conditions later on in this workshop.*

[CLICK for second bullet] [READ second bullet]

Sample Presentation Language: *Many of the medications used to treat other common childhood disorders can make the symptoms worse for a child who is bipolar. Antidepressant treatment or psychostimulants, for example, can induce hypomania, rapid cycling, and mixed states – often accompanied by severe aggressive or violent behaviors in those who have as yet unexpressed predisposition to bipolar disorder.*

[CLICK for third bullet] [READ third bullet]

Sample Presentation Language: *Many times pediatric bipolar disorder may first be diagnosed as severe ADHD or as an anxiety or mood disorder.*
### How is Pediatric Bipolar Disorder Similar to Adult Bipolar Disorder?

- Children can be suicidal, even as young as 2 years of age.
- Children with mania have the same urges as adults.
- Children with depression also have the same tendencies as adults.
- Children, like adults, require medication to stabilize symptoms.

**SAY:** Now let’s take a closer look at how pediatric bipolar disorder is similar to adult bipolar disorder.

[CLICK for first bullet] [READ first bullet]

Sample Presentation Language: *These ideations can quickly develop into plans and actions because of the impulsive nature of bipolar disorder and the inability of children to consider the consequences of their actions.*

[CLICK for second bullet] [READ second bullet]

Sample Presentation Language: *This is accurate in the sense that they also may become hypersexual, grandiose, or obsessive and may want to engage in excessive involvement in pleasurable or dangerous activities.*

[CLICK for third bullet] [READ third bullet]

Sample Presentation Language: *They may avoid talking about their situation, withdraw from activities and people they once enjoyed, may require extraordinary amounts of sleep or very little sleep in order to function, and have a decreased stress threshold making daily functioning nearly impossible.*

[CLICK for fourth bullet] [READ fourth bullet]

Sample Presentation Language: *As is the case with adults with bipolar, children who have been diagnosed with pediatric bipolar disorder will be prescribed multiple medications to alleviate the symptoms of mania, depression, and co-occurring conditions.*
Sample Presentation Language: *Are there any questions about what we have covered so far?*

[Allow audience to ask questions. Answer appropriately.]

Then **SAY:** *We will now take a 10-minute break. Please return at (give time).*

[**CLICK** to show next slide]

[Break for 10 minutes]
Sample Presentation Language: *Now we’re going to take a quick 10-minute break.*
Sample Presentation Language:  *We would now like to take a closer look at how the symptoms of pediatric bipolar disorder may express themselves in the school environment. These symptoms may be expressed by an already diagnosed child with bipolar disorder or by an undiagnosed child. In this case, they may be specific clues suggesting the possibility of pediatric bipolar disorder. Children with bipolar disorder are at greater risk for school failure, substance abuse, and suicide. If the symptoms can be recognized in the classroom by teachers, the chances of the child receiving appropriate diagnoses and treatment can increase. Further, despite the challenges a child with bipolar disorder faces, often they can succeed in the classroom with the right supports and accommodations.*
First, let’s look at the depressive symptoms of pediatric bipolar disorder and their expression at school.

[READ Slide]
Insomnia or Hypersomnia:
- A child looks worn out, is often groggy or tardy, or reports sleeping through alarm despite getting 12 hours of sleep.

Psychomotor Agitation/Retardation:
- A child is extremely fidgety or can’t stay seated. High speech or movements are sluggish or he/she avoids physical activities.

Fatigue or Loss of Energy:
- Child looks or complains of feeling tired even with adequate sleep.
Low Self-Esteem, Feeling of Worthlessness or Excessive Guilt:
- A child frequently tells itself or others “I’m no good,” “I hate myself,” “no one likes me,” “I can’t do anything.” He/she feels bad about and dwells on accidently bumping into someone in the corridor or having not said hello to a friend.

Diminished Ability to Think or Concentrate, or Indecisiveness:
- A child can’t seem to focus in class, complete work, or choose unstructured class activities.

[READ Slide]
Hopelessness:
- A child frequently thinks or says “nothing will change or will ever be good for me.”

Recurrent Thoughts of Death or Suicidality:
- A child talks or draws pictures about death, war casualties, natural disasters, or famine. He reports wanting to be dead, not wanting to live anymore, wishing he’d never been born; he draws pictures of someone shooting or stabbing him, writes a suicide note, gives possessions away or tries to kill self.
Euphoria: A child laughs hysterically for 30 minutes after a mildly funny comment by a peer and despite other students staring at him.

Irritability: In reaction to meeting a substitute teacher, a child flies into a violent 20-minute rage.

Inflated Self-Esteem or Grandiosity: A child believes and tells others she is able to fly from the top of the school building.

Sample Presentation Language: *Now let’s look at how the manic symptoms of pediatric bipolar disorder may be expressed in the school environment.*

[READ Slide]
Decreased Need for Sleep:
- Despite only sleeping 3 hours the night before, a child is still energized throughout the day.

Increased Speech:
- A child suddenly begins to talk extremely loud, more rapidly, and cannot be interrupted by the teacher.

Flight of Ideas or Racing Thoughts:
- A teacher cannot follow a child’s rambling speech that is out of character for the child (i.e., not related to any cognitive or language impairment the child might have).
Distractibility:
- A child is distracted by sounds in the hallway, which would typically not bother her.

Increase in Goal-Directed Activity or Psychomotor Agitation:
- A child starts to rearrange the school library, hyper-focused on making friends, engaging or cleaning everyone’s desks, or plans to build an elaborate fort in the playground, but never finishes any of these projects.

Excessive Involvement in Pleasurable or Dangerous Activities:
- A previously mild-mannered child may write dirty notes to other children in class or attempt to jump out of a moving school bus.
Sample Presentation Language: Now we are going to switch gears a little bit and talk about the prevalence and comorbidity of pediatric bipolar disorder. In recent years, pediatric bipolar disorder has become a more widely recognized, researched, and diagnosed mood disorder. According to the National Institute of Mental Health, the number of visits to a doctor’s office that resulted in a diagnosis of bipolar disorder in children and adolescents has increased 40 times over the last decade.
Researchers looked at the number of times children younger than 19 went to the doctor and were diagnosed with or treated for bipolar disorder. They found the number of such visits soared from an estimated 20,000 in 1994 to 800,000 in 2003. (Moreno, et. al., 2007)
SAY: As we mentioned earlier, there are often comorbid conditions associated with pediatric bipolar disorder. Learning disorders, ODD, and anxiety disorders are among the most common conditions to occur with bipolar disorder. While the rates of occurrence are still being researched, the charts on the next two slides outline some of the most common co-occurring conditions.

[READ Slide]
# Rates of Comorbidity

<table>
<thead>
<tr>
<th>Co-occurring Condition</th>
<th>How often does it occur with pediatric bipolar disorder?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Disorder</td>
<td>Up to 37%</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>Up to 75%</td>
</tr>
<tr>
<td>Tourette’s Syndrome</td>
<td>Tourette’s patients are 4 times more likely to also have bipolar disorder.</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>Reports indicate that up to 50% have disorders of written expression. Other learning disabilities may also be found.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Up to 40%</td>
</tr>
</tbody>
</table>
Now that we have a better understanding of what pediatric bipolar disorder is and how it presents itself in children at school, we are going to talk about the treatment approaches for students that already have the diagnosis of pediatric bipolar disorder. Pediatric bipolar disorder cannot be cured or outgrown. Children diagnosed with pediatric bipolar disorder, their families, psychiatrists, and school professionals play an important role in increasing resiliency in these children through medications, psychoeducation, psychosocial and school interventions. Next, we are going to discuss further these treatment approaches in further detail.
It is important to stabilize mood first. Psychostimulants and antidepressants can pose a risk of activating the manic symptoms of pediatric bipolar disorder. Medications that may be prescribed:

- **Antipsychotic medication**
  - Abilify, Clozaril, Resperdal, Zyprexa

- **Antihypertensive medications**
  - Slonidine and Tenex

- **A low-dose antidepressant**
  - Prozac, Wellbutrin, Zoloft

- **Norepinephrine reuptake inhibitors**
  - Strattera

On other occasions, and only after the student’s mood is stabilized, a psychostimulant may be prescribed to reduce symptoms of ADHD.

Sample Presentation Language: *Many times children that have been diagnosed with pediatric bipolar disorder will be prescribed multiple medications to alleviate the symptoms of mania, depression, and co-occurring conditions. As we have learned earlier, pediatric bipolar disorder may first be diagnosed as severe ADHD or as an anxiety disorder. However, if a child with pediatric bipolar disorder is treated with antidepressants and psychostimulants, there is a risk that these medications will activate the manic symptoms of the disorder. Once mood is stabilized, any antipsychotic medication such as Abilify, Clozaril, Resperdal, or Zyprexa may be prescribed to help reduce aggressive behaviors and psychotic symptoms. An antihypertensive medication, such as Slonidine and Tenex, may sometimes be prescribed to stabilize sleep patterns since these children will suffer from irregular sleep. Sometimes, a low-dose antidepressant such as Prozac, Wellbutrin, or Zoloft may reduce symptoms of depression and anxiety. Lastly, norepinephrine reuptake inhibitors, such as Strattera, may be used to help reduce symptoms of ADHD rather than an antistimulant. However, on other occasions and only after the student’s mood is stabilized, a psychostimulant may be prescribed to reduce symptoms of ADHD.*
Psychoeducation
- If mood is stabilized a student may benefit from 504 accommodations.
- Eligibility for Special Education through OHI or ED
  - 80% of students diagnosed with Pediatric Bipolar Disorder receive special education services. (Anglada, 2009)

Sample Presentation Language: *Providing academic and behavioral supports can provide the supports that a student with pediatric bipolar disorder needs to be successful at school. Depending on how many symptoms of the disorder the student displays, if it is found that the medications work well for the student, will determine the level of supports needed. Later we will discuss these areas in more depth.*
Sample Presentation Language: *Psychosocial treatment approaches are effective in helping students develop skills that will help them manage the symptoms of pediatric bipolar disorder. The school counselor or the school psychologist at your schools can facilitate small counseling groups that benefit many students with or without the diagnosis of pediatric bipolar disorder. These groups should focus on social skills and/or anger management support. By having these groups in the school setting, the student has the opportunity to develop a relationship with an adult who can help, as well as having a safe location to go to during times of intense mood changes which helps reestablish stability so the student can rejoin the classroom when they are ready.*

**ASK:** *How many of your schools have social skills and/or anger management groups available to help students? [Allow 30 seconds for participants to raise their hands] Of those of you that just raised your hands, do you know which curriculums are being used in your schools?*
The SECOND STEP program for Grades 1–5 can help your students develop strong bonds to school, solve problems without anger, and treat others with compassion.

The Strong Kids (Merrell, 2007) curriculum is a brief, practical program designed for promoting social and emotional learning of young children.

Sample Presentation Language: Social skills curriculums such as “Second Step” or “Strong Kids” can be used in the classroom or in a small group setting to help teach students the skills needed at school. Assisting the student with anger management techniques will also provide students with strategies in managing the intense mood changes. Both “Second Step” and “Strong Kids” address the feelings of anger. Using a social skills curriculum, like these that have an anger management section, will help students develop skills that will help manage the symptoms of the pediatric bipolar disorder in school.
Sample Presentation Language: Setting up a positive school environment in a way for students to succeed will help facilitate the teachers to be in control of many situations. Using proper de-escalation techniques between student and teachers during intense mood changes can help the child regain stability faster and helps prevent the situation from escalating.
Sample Presentation Language: *This will be discussed in more detail a little later, so I (We) will just go over this briefly. To set up a positive school environment it is important to build rapport with the student. If a student feels that they are always in trouble or that you do not understand them, they will have a more difficult time controlling themselves in the classroom. For the student to be successful, it is important for him or her to feel safe. Communicating frequently with the student can also help to understand their moods throughout the day. Using mood and/or behavior charts helps the student and the teacher communicate frequently. Here are a few different types of reports that can help facilitate communication between the student and teacher.*
**ASk:** How many of you have gone through a de-escalation training in your districts? [Allow 30 seconds to 1 minute for hands to be raised]

[Then CLICK for text]

Sample Presentation Language: Trainings, such as Handle with Care, provides teachers and school personnel with verbal and nonverbal de-escalation skills that help provide a calm environment as well as being a stable person for the student. Tension Reduction Cycle is taught during the Handle with Care Training, which is a theoretical model used to illustrate the dynamics of escalating and de-escalating tension on an individual or group basis. The Solid Object Relationship Model is based on the observation that a person in crisis will attach him or herself to a more solid object to regain stability. Teachers knowing how to be that solid object is key for students diagnosed with pediatric bipolar disorder.

[READ quote on slide]
Sample Presentation Language:  *Now we are going to take a 45-minute break for lunch. Please be back for the second half of our presentation. We will begin again at (name time).*

(During the break, get copies of handouts prepared before the workshop begins. There should be one handout for each participant. Place at the back table for participants to grab as they come back from lunch.)

[CLICK for next slide]
Sample Presentation Language:  I (We) would like to welcome everyone back from lunch.  I (We) hope that you are ready to begin the second half of the workshop.  I hope everyone saw, as you walked in, the handout packet on the back table.  If you did not, please raise your hand and we will pass them out quickly.  [Quickly pass out packets to anyone that is raising their hand.  Allow 2-3 minutes]  For the remainder of this workshop we are going to focus on how we as school professionals can best support our students with pediatric bipolar disorder.
Sample Presentation Language: *Teachers and parents need to communicate frequently to share ideas and develop accommodations that specifically work for the individual student and allow the teacher to change the environment to be successful once again. Lofthouse and Fristad (2006) have developed seven fundamental recommendations from a number of sources to help facilitate a discussion between school professionals and parents. Over the next seven slides, we will discuss these recommendations.*
Build, maintain, and educate the school-based team.

- Think broadly about who might be on this team.
- Should include, but not be limited to, teacher, school psychologist, school nurse and anyone that provides consistent and effective support for the student.
- Should meet regularly to monitor the student’s progress and make changes that are appropriate for the classroom.

**ASK:** Who do you think should be on the school-based team? [Allow 2-3 minutes for responses]

Sample Presentation Language: The first of the seven fundamental recommendations that Lofthouse and Fristad found to facilitate communication was to build, maintain, and educate school-based teams. This team would essentially be part of the IEP team. They should meet regularly to monitor the student’s progress and make changes to ensure the student is supported.
**SEVEN FUNDAMENTAL RECOMMENDATIONS TO HELP FACILITATE COMMUNICATION**

*Prioritize Individualized Education Plan (IEP) goals*

- Should include, but not be limited to, attendance, emotional stability, physical safety, knowledge acquisition, relationship building, and work production.
- Develop measurable goals to ensure that the student learns ways to manage and control the disorder is beneficial to him or her.

Sample Presentation Language: *Since most of us in this room are school professionals, we know that developing IEP goals are one of the most important areas of the IEP process, as it provides the team with the progress the student has made throughout the year. The goals for a student diagnosed with pediatric bipolar disorder should include areas that help them function within the classroom. These [READ slide, sub-bullet one]. When developing these goals, ensure that they are developed in ways to manage and control the disorder for themselves. As we know this is a lifelong condition, providing the students the tools early will help them through their journey of school.*
Sample Presentation Language: *The third fundamental recommendation Lofthouse and Fristad suggest is to [CLICK for bullet and READ].*

Sample Presentation Language: *Transition times tend to be difficult for most students, but especially for students with pediatric bipolar disorder. Providing students with a predictable schedule and alluding to transition times will help reduce the anxiety these students suffer from. Along with having a predictable classroom setting, using a positive discipline strategy approach helps the student in the class be set up for success rather than failure. Negative consequences, such as ignoring attention-seeking behaviors, time-outs, or using suspensions and expulsions for behaviors that break school rules may increase the unwanted behaviors.*
Be aware of and manage medication side effects

- Parents and school personnel should be in communication regarding changes to medication or dosage.
- If the student does not receive medications consistently or is experiencing side effects of the medications, he or she may require modified classroom expectations.

SAY: Next, Lofthouse and Fristad state that school professionals should... [READ bullet].

Sample Presentation Language: As the advancement of pharmaceuticals continues through the years, medications are changed and altered to meet the needs of many different people. A medication that works for one child may not necessarily work for another and a medication that has worked for years on a student may need to change as they age. Communicating frequently with parents ensures that we set the student up for success and that these variables do not interfere with the student being successful in the classroom.
Sample Presentation Language: *As we discussed earlier, developing social skills is especially important for students diagnosed with pediatric bipolar disorder. This is Lofthouse and Fristad’s 4th recommendation. [READ slide] Once again, developing social skills will help the student develop skills that will help manage the symptoms of the disorder.*
Be prepared for episodes of intense emotion. Due to the dramatic and unexpected shifts in mood, a functional behavior assessment can help identify triggers and develop a crisis intervention plan. Having a plan developed in advance to assist the teacher or school personnel will help all school staff be prepared to manage these intense moods and be confident in their ability to remain calm.

**SEVEN FUNDAMENTAL RECOMMENDATIONS TO HELP FACILITATE COMMUNICATION**

**LOVHOUSE & PORTER. (2004)**

- Be prepared for episodes of intense emotion.
  - Due to the dramatic and unexpected shifts in mood, a functional behavior assessment can help identify triggers and develop a crisis intervention plan.
  - Having a plan developed in advance to assist the teacher or school personnel will help all school staff be prepared to manage these intense moods and be confident in their ability to remain calm.

**SAY:** *One of the most important recommendations is to [READ bullet].*

**Sample Presentation Language:** *As we know, students diagnosed with pediatric bipolar disorder will experience episodes of intense emotion. Conducting a functional behavior assessment will help determine functions of their behaviors. Specifically, we will learn the antecedent or what happens right before the behavior occurs, that may trigger the mood change. From this, we can learn how to set up the positive environment for the student. In addition to that, we will develop a plan in advance to prepare the teacher and staff for these mood changes.*
Sample Presentation Language: *The last recommendation from Lofthouse and Fristad is to consider alternative placements to the regular classroom. We always want to make sure that we are placing the student in the least restrictive environment. The least restrictive environment decisions are made based on children’s learning needs and vary from child to child. Individuals with Disabilities Education Act (IDEA) also requires that schools provide a full continuum of services ranging from regular classrooms with support to special classes and special school placements as needed. Here is a list starting from the least restrictive environment to the most restrictive that may be used for students diagnosed with pediatric bipolar disorder.*
Sample Presentation Language: Now we’d like to discuss how we, as educators, can work with families and physicians to better support our bipolar students at school and in the classroom. A child diagnosed with pediatric bipolar disorder needs parents and health professionals who know how the illness affects learning, as well as supportive teachers and school staff. The child may need some special accommodations in the classroom or may need to spend some time in a therapeutic day school or residential treatment center to receive an education while treatment options are explored.
Sample Presentation Language: Academic and behavioral supports at school for children with pediatric bipolar disorder most often are provided under either a Section 504 plan or an IEP. Section 504 is part of a Civil Rights law (Rehabilitation Act) that applies to all students with qualifying disabilities. It follows an informal process and parent involvement is not mandated. Schools do not receive additional federal funding for services to qualifying students. As many as 80% of children diagnosed with bipolar disorder receive special education services through IDEA. An IEP applies to students who qualify for special education services in a core curriculum area and is governed by strict procedures and timelines. Parent involvement is mandated for an IEP, and schools receive additional federal funding for students receiving special education services. Both plans cover accommodations and modifications to the school environment and classroom materials, adaptive technology, and related services.
SAY: Now we are going to look more closely at special education eligibility criteria, as we think it’s beneficial for educators to understand the basics of the classifications that a child with bipolar disorder can qualify under and how those classifications are defined by the law.

[READ Slide]
Having limited strength, vitality, or alertness, including heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment that is due to chronic or acute health problems and adversely affects a child's educational performance.

Sample Presentation Language: *The criteria for Other Health Impaired or OHI includes...*
An inability to learn that cannot be explained by other factors, an inability to build or maintain satisfactory interpersonal relationships with peers and teachers, inappropriate types of behavior or feelings under normal circumstances, a general pervasive mood of unhappiness or depression, and/or a tendency to develop physical symptoms or fears associated with personal or school problems.

Sample Presentation Language: The criteria for Emotional Disturbance includes...

[READ Slide]

Sample Presentation Language: Oftentimes it is the classification of OHI versus ED that determines how school personnel will view and work with a child with pediatric bipolar disorder. Whereas an ED placement may be helpful for a student who presents with more delinquent behaviors, it can also have a negative connotation, affecting a bipolar child’s already low self-esteem and deemphasizing the presence of a medical condition that is out of the child’s control.
Sample Presentation Language: *The Individualized Education Plan (IEP) is developed by the school team. This is a written document that states goals, objectives, and services that will be in place to assist a child with special education needs. The federal law requires six parts for the IEP...*
Sample Presentation Language: *As we know, one of the first steps to getting an IEP in place through IDEA is a complete evaluation. The evaluation must be comprehensive and cover all aspects of the suspected disability. Listed here are the most important areas that should be included for an evaluation of a student with pediatric bipolar disorder.*

[READ Slide]
Sample Presentation Language: As mentioned earlier, the IEP team is very important for students diagnosed with pediatric bipolar disorder. From determining the least restrictive placement to developing the goals for these students, the team should consider [CLICK for first bullet] including accommodations to help the student when symptoms of depression and/or mania are affecting the student in the classroom or at school. Next [CLICK for bullet] Include accommodations to help the student experiencing side effects from the medication; excessive thirst, urination, sleepiness, or lack of endurance are common side effects for the common medications prescribed to students diagnosed with pediatric bipolar disorder. [CLICK for bullet] Include accommodations to help the student who has difficulty with executive functioning; organization, staying focused. [CLICK for bullet] If identified through the evaluation, provide student with accommodations that other children have benefited from when diagnosed with a specific learning disability. [CLICK for bullet] If a functional behavior assessment has not been conducted, determine if a formal assessment should be conducted to develop a positive behavior support plan or if a Positive Behavior Intervention Plan should be developed.
Sample Presentation Language: *Are there any questions about what we have covered so far?* [Allow audience to ask questions. Answer appropriately.]

Then **SAY:** *We will now take our last 10-minute break. Please return at (give time) to join us for the last part of the workshop.*

[**CLICK** to show next slide]

[Break for 10 minutes]
[CLICK for next slide and place handout on back table]
Sample Presentation Language: *I (We) would like to welcome everyone back from break. We are going to do an activity next. I (We) hope everyone saw, as you walked in, the handout on the back table. If you did not, please raise your hand and we will pass them out quickly.* [Quickly pass out packets to anyone that is raising their hand. Allow 2-3 minutes]
Sample Presentation Language: *It is our hope that this activity will be beneficial in helping you develop appropriate IEP goals for your students with pediatric bipolar disorder. We would like you to work in teams of 2 or 3. Your handout will look similar to the one here. [CLICK to bring up empty table.] Please read the concern and try to develop an IEP goal that will help address the concern. For example…*

[CLICK for next slide]
Bobby came to school looking worn-out. He is keeping his head down on his desk and complains of being tired. Bobby is asked why he is so tired. He states he didn’t sleep last night and laid awake in bed.

Bobby comes to school well-rested 3/5 days a week. Slowly increasing as Bobby becomes used to his medication.

[READ Slide]

Sample Presentation Language: In your teams, read each symptom expressed in the classroom and develop an IEP goal to go along with it. You will have 20 minutes to work together. When we rejoin as a group, we will discuss these together.

[Give 20 minutes to work on activity]

Sample Presentation Language: I (we) hope that was enough time for you to all come up with some ideas. Now we are going to take some time to discuss possible goals.

ASK: Are there any volunteers that can share what they came up with for the first symptom?

[Select volunteers and respond appropriately]

[Continue asking for volunteers for each symptom.]

After each symptom is discussed, ASK: Are there any questions regarding this activity?

[Respond to questions appropriately.]

Then SAY: Next, we will discuss two sample goals and how they might look in the Special Education Information System (SEIS). A goal may be included on the behavior support plan or included with other academic goals.
Sample Presentation Language: *Here is a goal written for a student who needs to work on a positive attitude. Bobby is able to have a positive attitude when he is participating in a choice activity; however has a difficult time transitioning to a new task. Bobby’s goal may be...*

[READ measurable goal]
Bobby will quietly go to a designated area for the purpose of relieving frustration. Instead of disrupting the class or becoming verbally or physically aggressive when upset or frustrated and/or an adult prompts him to "take a break". In 8/10 opportunities, the teacher will have him model correct ways to access the area, what calming activity he is to do in the area, and how to appropriately return to instruction. By 2/2013, as measured by teacher’s daily chart and observation.
Sample Presentation Language: *On the next two slides, you will find common challenges that you may see in the classroom while working with a student that has been diagnosed with pediatric bipolar disorder along with possible accommodations. If a student has …*

[READ Slide; Common difficulty then possible accommodation.]

[CLICK for next slide]
### Common Difficulty Possible Accommodation

<table>
<thead>
<tr>
<th>Common Difficulty</th>
<th>Possible Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerous physical complaints such as headaches, stomachaches and back aches.</td>
<td>- The student is allowed to go to the nurse when he/she feels ill.</td>
</tr>
<tr>
<td>Medication side effects.</td>
<td>- Allow the child to have access to water (water bottle, unlimited access to restroom).</td>
</tr>
<tr>
<td>Obsesses over the safety of family members.</td>
<td>- Allowed to check in with family as needed</td>
</tr>
<tr>
<td>Difficulty with social interactions.</td>
<td>- Social skills groups with professional to help develop skills.</td>
</tr>
</tbody>
</table>

Adapted from (Anglada and Hakala, 2008)
Sample Presentation Language: Alright, now I (we) am going to quickly summarize what we covered in this workshop.

The topics discussed throughout this workshop attempted to close the gap that exists from the lack of understanding of pediatric bipolar disorder by school professionals. We hope that by providing you with background information on what the symptoms may look like in the school environment, different treatment approaches, and key components of developing academic and behavioral supports at school, you will have a better understanding of what pediatric bipolar disorder is and how you can take on the challenges of the disorder in your schools. We also cited the latest research in the field, which emphasizes the importance of helping educators in the classroom. It is our hope that this workshop gives you the foundation for how to set up your schools to best support students with pediatric bipolar disorder.
Teaching a student with bipolar disorder will bring more than its share of joys and frustrations. Through knowledge, understanding, communication and cooperation, the parent/teacher team will ensure the best year possible. Perhaps you will touch and inspire this student in ways that will be fondly remembered throughout a lifetime. And perhaps you will find that your own life has been enriched along the way.


Sample Presentation Language: Before we let you go, I (We) thought this quote says it all.

[READ Slide]
Thank you for your attendance, time, and participation in today’s workshop!

For further questions and/or comments, please contact the presentation authors via email:
Cate Thompson catethompson@mac.com
Joanna Pastor joannapastor@comcast.net

Sample Presentation Language: Thank you for your time today. I (We) truly appreciate everyone coming and participating. I (We) hope that you all have a better understanding of what pediatric bipolar disorder is, how it looks in the classroom, and how to support these students. I (We) hope that you can take this information back to your districts and classrooms to help set these students up for success.

Thank you again. If you have any further questions or comments, please refer to the presentation authors. Their contact information if provided here.
REFERENCES

REFERENCES


REFERENCES

REFERENCES

APPENDIX C

Workshop Handouts

Activity 1
### Activity 2

<table>
<thead>
<tr>
<th>SYMPTOMS EXPRESSED IN CLASSROOM</th>
<th>IEP GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susie often seems sad at school. At certain times each day she sits in your class with a hollow, empty look. One day during a history lesson, you notice Susie looking sad and distracted by her thoughts. After the lesson, you ask if there is anything bothering her. Susie says, “Don’t you think it’s sad that all the people we are studying are dead?” As you try to explain how their accomplishments continue to live on and influence the present world, Susie seems to have slipped back into her own private thoughts. This is only one example of how Susie’s sadness presents in the classroom, as scenarios such as this one occur often.</td>
<td></td>
</tr>
<tr>
<td>Jennifer is stuck on a math problem. When you try to help her work through it she says she cannot do anything right. When you point out her good grade in another subject, she rolls her eyes and grunts. She does not seem to be listening or willing to try to work through the problem. This is not uncommon behavior for Jennifer. When she is challenged by a subject or activity that she does not feel she can immediately be successful at, she will become upset and hard on herself and is often unable to get over it and move on.</td>
<td></td>
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<tr>
<td>When you ask a question in class, Jacob is often quick to raise his hand. As he answers, you cannot follow along with what he is saying. Although he began by discussing the topic at hand, he is now rambling on about several different topics at once. It is very difficult for you to interrupt Jacob to get him back on topic, and even after you tell him you are going to give someone else a chance to answer, he seems to not hear you and continues to speak quickly and go off on tangents even less related to the initial question.</td>
<td></td>
</tr>
<tr>
<td>Billy has no real friends at school. His mother brings him to school each day instead of his riding the bus because some of the kids tease him and he ends up fighting with them. He is viewed by some of his peers as bossy and authoritative. He does not seem to know how to access a social group and has trouble with the give-and-take of relationships. Billy has told you that he would very much like to be a friend and that he would like to have friends like the other children in class.</td>
<td></td>
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</tbody>
</table>
## APPENDIX D

Reference Handout

### Pediatric Bipolar Disorder in the Classroom

This guide is designed to increase your understanding of Pediatric Bipolar Disorder (PBD) and your effectiveness in working with these students.

### What is Pediatric Bipolar Disorder?

The National Institute of Mental Health (NIMH, 2008) defines bipolar disorder as "a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks" (p.1). Diagnosing bipolar disorder in children can be difficult, as research suggests that it presents differently in children than it does in adults. According to a 2008 review of recent developments in the study of pediatric bipolar disorder, there are two primary differences between how pediatric bipolar disorder presents in children versus how it presents in adults. They are: (a) chronic symptoms and/or rapid mood cycles in youths, rather than periods of normal, non-depressed mood as seen in adults; and (b) mania exhibited as severe irritability rather than the euphoria seen more frequently in adults (Leibenluft & Rich, 2008).

### Symptoms

<table>
<thead>
<tr>
<th>Depression</th>
<th>Mania</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Depressed Mood</td>
<td>- Euphoria</td>
</tr>
<tr>
<td>- Markedly Diminished Interest or Pleasures in All Activities</td>
<td>- Irritability</td>
</tr>
<tr>
<td>- Significant Weight Loss/Gain or Appetite Increase/Decrease</td>
<td>- Inflated Self-Esteem or Grandiosity</td>
</tr>
<tr>
<td>- Insomnia or Hypersomnia</td>
<td>- Decreased Need for Sleep</td>
</tr>
<tr>
<td>- Fatigue or Loss of Energy</td>
<td>- Increased Speech</td>
</tr>
<tr>
<td>- Low Self-Esteem, Feeling of Worthlessness or Excessive Guilt</td>
<td>- Flight of Ideas or Racing Thoughts</td>
</tr>
<tr>
<td>- Diminished Ability to Think or Concentrate; Indecisiveness</td>
<td>- Distractibility</td>
</tr>
<tr>
<td>- Hopelessness</td>
<td>- Increase in Goal-Directed Activity or Psychomotor Agitation</td>
</tr>
<tr>
<td>- Recurrent Thoughts of Death or Suicidality</td>
<td>- Excessive Involvement in Pleasurable or Dangerous Activities (Lofthouse &amp; Fristad, 2006)</td>
</tr>
</tbody>
</table>

### Treatment

Medication is the primary treatment of PBD, but other helpful, research-validated treatments for students diagnosed with PBD include:

- behavior management
- psychosocial interventions
- psychoeducational interventions

Whether or not to medicate a student is a decision between parents and their doctor. Teachers should not advocate one way or the other. The teacher’s role in helping the student is to provide the appropriate structure, instructional strategies, and necessary supports and accommodations (behavioral, environmental, and academic interventions; Lofthouse & Fristad, 2006).
Within the Individuals with Disabilities Education Act (IDEA) there are 13 classifications; the two most appropriately used in reference to the student with PBD are “other health impaired” (OHI) or Emotional Disturbance” (ED; Papolos & Papolos, 2006). PBD can be considered either a chronic health problem (as it is a brain disorder) or an emotional disturbance (as it is a mental health challenge). Criteria for OHI involves having a chronic or acute health problem (such as PBD) that results in limited strength, vitality, or alertness, including heightened alertness to environmental stimuli that results in limited alertness and adversely affects a child’s educational performance (National Dissemination Center for Children with Disabilities, 2010). Criteria for ED involves having an emotional disturbance (such as PBD) that results in one of five characteristics. Of these five, three appear to be appropriate for a child with PBD: (1) a general pervasive mood of unhappiness or depression; (2) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; and (3) inappropriate types of behaviors or feelings under normal circumstances. ED criteria further requires that the characteristic have occurred over a long period of time, to a marked degree, and adversely affect educational performance.

Oftentimes, the classification of OHI versus ED determines how school personnel will view and work with a child with PBD. An ED classification may place a child with PBD in a classroom with students who have behaviors that are more delinquent. This may sway how the child is viewed by teachers or administrators and can have a negative connotation, affecting a bipolar child’s already low self-esteem and de-emphasizing the presence of a medical condition that is out of the child’s control (Papolos & Papolos, 2006). When a student with PBD meets the eligibility criteria under OHI, this is often a less stigmatizing label, as it implies a medical condition that is outside the student’s control. As suggested, a lack of understanding of PBD by school professionals can have a striking effect on how a bipolar child’s needs are met in a school setting.

Eligibility for an IEP or 504 Plan:

The best classroom management involves anticipating potential problems and avoiding them through careful planning and proactive classroom management techniques. Students diagnosed with PBD are at-risk for school failure, substance abuse, and suicide. When student’s moods are stable and have the right supports in place, they are more likely to succeed in school and develop satisfying peer relationships. Commonly seen behaviors in students with PBD include, but are not limited to, crying excessively, feelings of sadness, extreme irritability, impaired judgment, impulsivity, or racing thoughts, delusions, hallucinations, and explosive rages (Child & Adolescent Bipolar Foundation, 2007).

Setting the Student up for Success:

- Adjust environmental factors that can trigger problems (noise level, space, seating arrangement, structure).
- Establish a visual and auditory signal for getting students to communicate with you and staff.
- Monitor behavior by scanning the room frequently.
- Use sincere praise when the student exhibits positive behaviors.
- Because transitions can be difficult for the student with PBD, display a visual schedule that is reviewed and referred to frequently. When changes occur to the schedule, prepare the students in advance.
- Develop a safe place at school where the student can take a break to calm down and regain control of his or herself.
- Teach and model positive strategies for: anger management, conflict resolution, dealing with frustration, and stopping/thinking/planning before acting.
- Have a person at school be available to help the student calm down during times of intense mood changes.

Responding to PBD Behaviors:

- Watch for warning signs causing the student to become over stimulated, upset, frustrated, agitated, and/or restless and intervene immediately by diverting their attention and redirecting him or her.
- Discuss inappropriate behavior with the student in private when possible. Use a visual ABC chart to help facilitate discussion.
- Ignore minor inappropriate behaviors.
- Be very careful in responses to the student. Remain professional; keep your cool; watch voice level, words, and body language. Lower your voice and speak in a calm, non-emotional, matter of fact manner.
- Use a daily behavior monitoring chart to provide frequent feedback and stronger incentives.
Communication between the home and the school is especially important when serving the student with PBD. Often a parent of a child with PBD knows something is wrong and does not recognize the disorder. These parents may often feel that they are not able to provide the help their child needs to succeed in school (Papolos & Papolos, 2006).

- **Build, maintain, and educate the school-based team.** It is important for the family, the student, and school personnel to collaborate with one another in developing a supportive environment for the student with PBD such as, developing appropriate academic and behavioral accommodations. This team should meet regularly to monitor the student’s progress and make indicated changes, to ensure these students are progressing towards their goals (Anglada, 2002).

- **Prioritize Individualized Education Plan (IEP) goals.** IEP goals for the PBD student can include, but should not be limited to, attendance, emotional stability, physical safety, knowledge acquisition, relationship building, and work production (Papolos & Papolos, 2006). It is important to develop goals in order from most important to least important to help the student be successful in school.

- **Provide a predictable, positive, and flexible classroom environment.** Provide the student with PBD a predictable schedule to reduce anxiety as well as to help provide a smooth transition to the next subject or activity. Often students with PBD have difficulty with transition and/or unstructured time. Using positive discipline strategies such as reducing exposure to stressors, offering praise and encouragement or using a key word to elicit positive behaviors in conjunction with having a predictable classroom setting helps the student with PBD in the class be set up for success rather than failure (CAFB, 2007). Negative consequences, such as ignoring attention-seeking behaviors, time-outs, or using suspensions and expulsions for behaviors that break school rules, may increase the unwanted behaviors (Packer & Pruitt, 2010).

- **Be aware of and manage medication side effects.** Parents and school personnel should be in communication regarding changes to medication or dosage as they occur. If the student does not receive medications consistently, or is experiencing side effects of the medications, he/she may require modified classroom expectations to ensure that these variables do not interfere with his/her being successful in the classroom. Side effects from medication are usually more intense when starting a new medication, increasing dosage, or discontinuing medication. Side effects tend to subside after a few weeks while others may remain for the duration of the medications management. These side effects can include, but are not limited to, drowsiness, upset stomach, increased thirst, frequent urination, weight gain, dizziness, blurred vision, headaches, hand tremors, and/or cognitive dulling to name a few. Students experiencing these side effects may require special considerations such as, allowing the student to arrive to school late or shortening the student’s school day, unlimited bathroom use, providing access to water as needed, and reducing the amount of reading or workload (Anglada, 2006; Packer & Pruitt, 2010).

- **Develop Social Skills.** Providing students with PBD social skills through in-school counseling on a regular basis may help the student recognize how their condition is impacting their ability to deal with academic and peer relationships. Social skills training may also help the student develop self-advocacy skills and strategies to work around, or manage the impact of their symptoms in school. Counseling and/or social skills training IEP goals may include having the student seek adult assistance or support when he/she feels that he/she is having difficulty coping. Anger management skills may also be part of these goals (Packer, 2002).

- **Be prepared for episodes of intense emotion.** As the student with PBD is constantly experiencing a range of both positive and negative emotions (and as a result is often quite irritable) episodes of intense emotions (even rage reactions) should be anticipated and even planned for. Teachers and other school personnel need to discuss in advance how these intense moods will be addressed. Some accommodations that can be made when a child is experiencing intense emotions include, identifying a safe/private place for the student to go regain control or establish a private signal between the student and teacher to communicate the need to take a time out during class. In some cases, allowing the student to go for a walk when they are losing control may help them regain self-control. In other cases, allowing the student to use their muscles to do heavy lifting, digging, or making large arm movements may be helpful in dissipating some of the increased tension or irritability (Packer, 2002).

- **Consider alternatives to the general education classrooms.** If the symptoms of PBD adversely affect educational functioning, and even with the accommodations mentioned above and the IEP team feels the student’s needs cannot be met in the general education environment, then special education services may need to be considered. However, when doing so, it is essential to keep in mind that the student’s educational program should always be provided in the least restrictive environment.
RESOURCES

Websites:

- Child and Adolescent Bipolar Foundation
  http://www.bpkids.org
- The Bipolar Child
  http://www.bipolarchild.com
- Juvenile Bipolar Research Foundation
  http://www.jbref.org/
- National Institute of Mental Health
  http://www.nimh.nih.gov

Books:


If you have questions please contact authors: Catherine Cale-Thompson (catethompson@mac.com) or Joanna Pastor (joannapastor@comcast.net)
References


REFERENCES


