

Information about:

Bipolar Disorder

Revised 2013



Vermont
Family
Network

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Introduction

Information About Bipolar Disorder is part of a series of information packets developed by the Vermont Family Network (VFN). Designed to provide basic information, the packet includes fact sheets, articles, advocacy tips, and resources for families of children with special needs and for the professionals working with them.

After reading the packet, we hope that you'll have a greater understanding of bipolar disorder and the ways in which parents and professionals can support children at home, in school, and in the community. We've selected information from a variety of sources, and many articles are on the Internet.

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Child and Adolescent Bipolar Disorder

Can children and adolescents get bipolar disorder?

Bipolar disorder can occur in children and adolescents and has been investigated by federally funded teams in children as young as age six.

How common is it in children and adolescents?

Although once thought rare, caseloads of patients examined for federally funded studies have shown that approximately 7 percent of children seen at psychiatric facilities fit the research standards for bipolar disorder.

What are the symptoms of bipolar disorder in children and adolescents?

One of the biggest challenges has been to differentiate children with mania from those with attention deficit hyperactivity disorder. Since both groups of children present with irritability, hyperactivity and distractibility, these symptoms are not useful for the diagnosis of mania. By contrast, elated mood, grandiose behaviors, flight of ideas, decreased need for sleep and hypersexuality occur primarily in mania and are uncommon in ADHD. Below is a brief description of how to recognize these mania-specific symptoms in children.

- **Elation.** Elated children may laugh hysterically and act infectiously happy without any reason at home, school or in church. If someone who did not know them saw their behaviors, they would think the child was on his/her way to Disneyland. Parents and teachers often see this as "Jim Carey-like" behaviors.
- **Grandiose behaviors.** Grandiose behaviors are when children act as if the rules do not pertain to them. For example, they believe they are so smart that they can tell the teacher what to teach, tell other students what to learn and call the school principal to complain about teachers they do not like. Some children are convinced that they can do superhuman deeds (e.g., that they are Superman) without getting seriously hurt, e.g. "flying" out of windows.
- **Flight of ideas.** Children display flight of ideas when they jump from topic to topic in rapid succession during a normal conversation—not just when a special event has happened.
- **Decreased need for sleep.** Children who sleep only 4-6 hours and are not tired the next day display a decreased need for sleep. These children may stay up playing on the computer and ordering things or rearranging furniture.

Child and Adolescent Bipolar Disorder (continued)

- **Hypersexuality.** Hypersexual behavior can occur in children without any evidence of physical or sexual abuse in children who are manic. These children act flirtatious beyond their years, may try to touch the private areas of adults (including teachers) and use explicit sexual language.

In addition, it is most common for children with mania to have multiple cycles during the day from giddy, silly highs to morose, gloomy suicidal depressions. It is very important to recognize these depressed cycles because of the danger of suicide.

What treatments—medications and psychosocial—have been shown to be effective and what are their side effects?

First, it is important to recognize that bipolar disorder in children and adolescents is an emerging field and there is much more to learn. A comprehensive evaluation including family history is essential to understanding the diagnosis and the consideration of other possible diagnoses.

Bipolar disorder raises many risks in youth including substance use, suicide and poor school performance.

Be sure to ask your clinician about a comprehensive treatment approach. For an example of how expert clinicians conceptualize approaches to treatment for this condition, please review the [Treatment Guidelines by the American Academy of Child and Adolescent Psychiatry from March 2005](#).

There are medications that have been FDA approved for use in teens with bipolar disorder. All other medication use is “off label” which means that it has not been approved by the FDA for this purpose. Those drugs that are FDA approved were studied for effectiveness in short-term studies—which means we do not understand the positive impact and side effects of longer term use.

Antipsychotics

Several of the atypical antipsychotics—aripipazole (Abilify), quetiapine (Seroquel) and risperidone (Risperidol)—have FDA approval for bipolar disorder in youth ages 10 to 17. Olanzapine (Zyprexa) has FDA approval for youths ages 13 to 17 with bipolar 1 disorder.

Child and Adolescent Bipolar Disorder (continued)

What treatments—medications and psychosocial—have been shown to be effective and what are their side effects? (continued)

Lithium

Lithium, which is a mood stabilizer that is not an antipsychotic, also has FDA approval for youths aged 12 to 17. All of these compounds have important side effects that can include weight gain, increased cholesterol and diabetes risk for the antipsychotics. Lithium has risks in thyroid and kidney side effects. More needs to be learned about the safe and effective use of these medications over time in youth with bipolar disorder.

Anticonvulsants

The use of anticonvulsants such as valproic acid (Depakote) and topiramate (Topamax) are not FDA approved for use in youth with bipolar disorder.

Antidepressants

The FDA warning on antidepressants and the increased risk of suicidal ideation is also worth noting as some youth present first with depressive symptoms.

The medication management of youth bipolar disorder requires a clear understanding of the limited scientific data for longer term use. It is also important to know what side effects need to be monitored in youth.

There are no FDA approved medications for youth under age 10.

Are there any side effects associated with these treatments, including those that may only occur in young people?

Side effects that are particularly troublesome and that are worse in children include the following. Atypical neuroleptics (except aripiprazole) are associated with marked weight gain in many children. One day we hope to have specific genetic tests that will tell us beforehand which people will gain weight on these medications, but right now it is trial and error. The dangers of this weight gain include glucose problems that may include the onset of diabetes and increased blood lipids that may worsen heart and stroke problems later in life. In addition, these drugs can cause an illness called tardive dyskinesia—irreversible, unsightly, repeated movements of the tongue in and out of the mouth or cheek—and some other movement abnormalities. Depakote may also be associated with increased weight and possibly with a disease called polycystic ovarian syndrome (PCOS), which in some cases may be associated with infertility later in life.

Child and Adolescent Bipolar Disorder (continued)

Are there any side effects associated with these treatments, including those that may only occur in young people? (continued)

Lithium has been on the market the longest and is the only medication that has been shown to be effective against future episodes of mania and of depression and of completed suicides. Some people who take lithium over a long time will need a thyroid supplement and in rare cases may develop serious kidney disease.

It is very important that children on these medications be monitored for the development of serious side effects. These side effects need to be weighed against the dangers of bipolar disorder itself, which can rob children of their childhood.

How do children and adolescents with this disease fare over time and as adults?

At this time, regrettably, bipolar disorder in children and youth appears to be more severe and have a much longer road to recovery than is seen with adults. While some adults may have episodes of mania or depression with better functioning between episodes, children seem to have continuous illness over months and years.

Does bipolar disorder in children have an impact on educational achievement?

It is challenging to educate a child whose mood is much too "high" or too "low." Therefore educators need to be aware of the diagnosis and make special arrangements.

Is suicide a risk?

Talking about wanting to die, asking why they were born or wishing they were never born must be taken very seriously. Even quite young children can hang themselves in the shower, shoot themselves or complete suicide by other means.

Reviewed by Ken Duckworth, M.D.

National Alliance for the Mentally Ill. (July 2010). Child and Adolescent Bipolar Disorder. Retrieved from http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=13107

Bipolar Disorder in Children and Teens

Does your child go through intense mood changes?

Does your child have extreme behavior changes too? Does your child get too excited or silly sometimes? Do you notice he or she is very sad at other times? Do these changes affect how your child acts at school or at home?

Some children and teens with these symptoms may have **bipolar disorder**, a serious mental illness. Read this brochure to find out more.

What is bipolar disorder?

Bipolar disorder is a serious brain illness. It is also called manic-depressive illness. Children with bipolar disorder go through unusual mood changes. Sometimes they feel very happy or "up," and are much more active than usual. This is called **mania**. And sometimes children with bipolar disorder feel very sad and "down," and are much less active than usual. This is called **depression**.

Bipolar disorder is not the same as the normal ups and downs every kid goes through. Bipolar symptoms are more powerful than that. The illness can make it hard for a child to do well in school or get along with friends and family members. The illness can also be dangerous. Some young people with bipolar disorder try to hurt themselves or attempt suicide.

Children and teens with bipolar disorder should get treatment. With help, they can manage their symptoms and lead successful lives.

Who develops bipolar disorder?

Anyone can develop bipolar disorder, including children and teens. However, most people with bipolar disorder develop it in their late teen or early adult years. The illness usually lasts a lifetime.

How is bipolar disorder different in children and teens than it is in adults?

When children develop the illness, it is called **early-onset bipolar disorder**. This type can be more severe than bipolar disorder in older teens and adults. Also, young people with bipolar disorder may have symptoms more often and switch moods more frequently than adults with the illness.

Bipolar Disorder in Children and Teens (continued)

What causes bipolar disorder?

Several factors may contribute to bipolar disorder, including:

- **Genes**, because the illness runs in families. Children with a parent or sibling with bipolar disorder are more likely to get the illness than other children.
- **Abnormal brain structure and brain function.**
- **Anxiety disorders.** Children with anxiety disorders are more likely to develop bipolar disorder.

The causes of bipolar disorder aren't always clear. Scientists are studying it to find out more about possible causes and risk factors. This research may help doctors predict whether a person will get bipolar disorder. One day, it may also help doctors prevent the illness in some people.

What are the symptoms of bipolar disorder?

Bipolar mood changes are called "mood episodes." Your child may have manic episodes, depressive episodes, or "mixed" episodes. A mixed episode has both manic and depressive symptoms. Children and teens with bipolar disorder may have more mixed episodes than adults with the illness.

Mood episodes last a week or two—sometimes longer. During an episode, the symptoms last every day for most of the day.

Mood episodes are intense. The feelings are strong and happen along with extreme changes in behavior and energy levels.

Children and teens having a manic episode may:

- Feel very happy or act silly in a way that's unusual
- Have a very short temper
- Talk really fast about a lot of different things
- Have trouble sleeping but not feel tired
- Have trouble staying focused
- Talk and think about sex more often
- Do risky things.

Bipolar Disorder in Children and Teens (continued)

What are the symptoms of bipolar disorder? (continued)

Children and teens having a depressive episode may:

- Feel very sad
- Complain about pain a lot, like stomachaches and headaches
- Sleep too little or too much
- Feel guilty and worthless
- Eat too little or too much
- Have little energy and no interest in fun activities
- Think about death or suicide.

Do children and teens with bipolar disorder have other problems?

Bipolar disorder in young people can co-exist with several problems.

- **Substance abuse.** Both adults and kids with bipolar disorder are at risk of drinking or taking drugs.
- **Attention deficit/hyperactivity disorder or ADHD.** Children with bipolar disorder and ADHD may have trouble staying focused.
- **Anxiety disorders, like separation anxiety.** Children with both types of disorders may need to go to the hospital more often than other people with bipolar disorder.
- **Other mental illnesses, like depression.** Some mental illnesses cause symptoms that look like bipolar disorder. Tell a doctor about any manic or depressive symptoms your child has had.

Sometimes behavior problems go along with mood episodes. Young people may take a lot of risks, like drive too fast or spend too much money. Some young people with bipolar disorder think about suicide. **Watch out for any sign of suicidal thinking. Take these signs seriously and call your child's doctor.**

How is bipolar disorder diagnosed?

An experienced doctor will carefully examine your child. There are no blood tests or brain scans that can diagnose bipolar disorder. Instead, the doctor will ask questions about your child's mood and sleeping patterns. The doctor will also ask about your child's energy and behavior. Sometimes doctors need to know about medical problems in your family, such as depression or alcoholism. The doctor may use tests to see if an illness other than bipolar disorder is causing your child's symptoms.

Bipolar Disorder in Children and Teens (continued)

How is bipolar disorder treated?

Right now, there is no cure for bipolar disorder. Doctors often treat children who have the illness in a similar way they treat adults. Treatment can help control symptoms. Treatment works best when it is ongoing, instead of on and off.

1. Medication. Different types of medication can help. Children respond to medications in different ways, so the type of medication depends on the child. Some children may need more than one type of medication because their symptoms are so complex. Sometimes they need to try different types of medicine to see which are best for them.

Children should take the fewest number and smallest amounts of medications as possible to help their symptoms. A good way to remember this is "start low, go slow". **Always tell your child's doctor about any problems with side effects.** Do not stop giving your child medication without a doctor's help. Stopping medication suddenly can be dangerous, and it can make bipolar symptoms worse.

2. Therapy. Different kinds of psychotherapy, or "talk" therapy, can help children with bipolar disorder. Therapy can help children change their behavior and manage their routines. It can also help young people get along better with family and friends. Sometimes therapy includes family members.

What can children and teens expect from treatment?

With treatment, children and teens with bipolar disorder can get better over time. It helps when doctors, parents, and young people work together.

Sometimes a child's bipolar disorder changes. When this happens, treatment needs to change too. For example, your child may need to try a different medication. The doctor may also recommend other treatment changes. Symptoms may come back after a while, and more adjustments may be needed. Treatment can take time, but sticking with it helps many children and teens have fewer bipolar symptoms.

You can help treatment be more effective. Try keeping a chart of your child's moods, behaviors, and sleep patterns. This is called a "daily life chart" or "mood chart." It can help you and your child understand and track the illness. A chart can also help the doctor see whether treatment is working.

Bipolar Disorder in Children and Teens (continued)

How can I help my child or teen?

Help your child or teen get the right diagnosis and treatment. If you think he or she may have bipolar disorder, make an appointment with your family doctor to talk about the symptoms you notice.

If your child has bipolar disorder, here are some basic things you can do:

- Be patient
- Encourage your child to talk, and listen to him or her carefully
- Be understanding about mood episodes
- Help your child have fun
- Help your child understand that treatment can help him or her get better.

How does bipolar disorder affect parents and family?

Taking care of a child or teenager with bipolar disorder can be stressful for you too. You have to cope with the mood swings and other problems, such as short tempers and risky activities. This can challenge any parent. Sometimes the stress can strain your relationships with other people, and you may miss work or lose free time.

If you are taking care of a child with bipolar disorder, take care of yourself too. If you keep your stress level down you will do a better job. It might help your child get better too.

Where do I go for help?

If you're not sure where to get help, call your family doctor. You can also check the phone book for mental health professionals. Hospital doctors can help in an emergency.

I know a child or teen who is in crisis. What do I do?

If you're thinking about hurting yourself, or if you know someone who might, get help quickly.

- Do not leave the person alone
- Call your doctor
- Call 911 or go to the emergency room
- Call a toll-free suicide hotline: 1-800-273-TALK (8255) for the National Suicide Prevention Lifeline. The TTY number is 1-800-799-4TTY (4889).

Bipolar Disorder in Children and Teens (continued)

Contact us to find out more about bipolar disorder.

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Fax: 301-443-4279
E-mail: nimhinfo@nih.gov
Web site: www.nimh.nih.gov

U.S. Department of Health and Human Services
National Institutes of Health
NIH Publication No. TR-08-6380

National Institute of Mental Health. (n.d.) Bipolar Disorder in Children and Teens. Retrieved from <http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens-easy-to-read/index.shtml>

Parenting an Unstable Child with Bipolar Disorder

By Debby Rohr

***First and foremost, understand that this is a chemical imbalance of the brain, a genetic, neurobiological brain disorder that often mimics a behavior issue or parenting issue.** Some of the newest research is focusing more on the intracellular level (neuron) more so than what is taking place outside of the neuron between the neurotransmitters (chemicals) as they make their way to the neuron. **Because the “target” of your child’s symptoms (disruptive behaviors) is typically you, the parent (a safe-haven who offers unconditional love and support), it can appear to “outsiders” that you are to be blamed or partially to be blamed for your child’s behavior.** (For those who feel a lack of “normal”, effective parenting skills, check with your area’s community resources. It’s better to ask for help (prevention/intervention), than to find yourself in a negligent or abusive situation, worsened by the stressors of raising an ill child.) Some communities may offer resources to parents dealing with children with bipolar and other neurobiological brain disorders. For example, in Ohio, NAMI (National Alliance for the Mentally Ill) has developed Hand-to-Hand training to help parents learn about these types of brain disorders and the “systems” in the parents’ communities.

***Start where your child is.** Is the child **refusing OR unable** to cooperate? Look at underlying causes. A child may refuse to do something to “save face” (such as refusing to read because he/she perceives himself/herself as a “poor” reader) because it is beyond his/her ability. As the child develops and begins to recover with the proper treatment for their individual needs, he/she will need to begin to accept that everything does not “revolve” around him/her and that often an activity will need to end without any “heads-up” from you. However, this is very individualized, as some children will have difficulty in transitions no matter what, as well as potentially having adverse reactions to many of the psychotropic medications. **Stay flexible, while setting boundaries that are practical for your situation. Consequences should fit the individual child’s ability to understand their actions.**

***Understand that children with bipolar often have distorted perceptions of reality.** They may actually believe something to be true when it is known by others to be untrue. They may make up stories which are believable to others, or they may know the truth but attempt to make others believe them. When asked, some children will state that they tell “mistruths” out of boredom or because it makes them feel powerful. Other children may be having delusions and/or hallucinations. Speak to your child’s therapist and/or treating doctor about these issues.

Parenting an Unstable Child with Bipolar Disorder (continued)

***Learn to “pick your battles”.** If you haven’t learned already, you’ll be saving yourself from major health problems by evaluating what is and what is not important in raising your ill child. When the child is at his/her most unstable, it is often best to “let go” of what you would consider “normal” parenting, while keeping the child as safe as possible. When deciding on whether to pursue a behavior issue, whether it stems from the child’s illness or not, the parent will need to prioritize the importance of different issues.

***Document (chart/journal) your child’s behaviors, mood swings, sleeping cycles, menstrual cycles if applicable, statements made and anything that may have precipitated a mood shift, such as setting limits (The parent stating “No” can “set-off” a child with bipolar).** You can do this on a big, blank calendar or use a mood chart. Because many children with bipolar cycle throughout the day, exhausted parents can simply jot down the most pertinent information, giving examples: [Johnny stated, “I want to die and go to heaven”; Johnny stated, “I can’t control my thoughts....that’s why I broke my favorite toy.”] Remember to jot down these statements and the date and time as soon as you can, since it can be difficult to remember exactly how they were stated. This information can be helpful for the doctor, showing a pattern of the cycling. Praise your child for his/her insightfulness into his/her disorder and continue to encourage him/her to report these feelings to you.

***The adults should be consistent with one another when dealing with children with bipolar. It’s very common for a child or adolescent with bipolar to attempt to “stack” one adult against another adult.** Recognize that children with bipolar will often use **defense (coping) mechanisms** by putting up “barriers” to avoid dealing with a scary/uncomfortable situation. It is common for a child to call a parent or professional inappropriate names or to say one thing to one adult and say the opposite to the other (i.e. To the therapist, a teen may state, “My mom said that you were a stupid jerk and doesn’t know why I have to come here weekly.” And the child may state to the mom on the same day, “The therapist told me that you don’t know how to parent me and need to take parenting classes.” Though it certainly is common for these statements to be made, many times it is the child who is attempting to sabotage the situation). When the adults recognize these coping mechanisms and keep in contact with one another, it can immensely decrease tensions between those adults who are attempting to help the child. This includes significant others, doctors, therapists, teachers, social workers, etc. **The bottom-line is that, although the child may want to feel better, he/she may never express this, and may try everything they can to sabotage a situation to avoid having to deal with an issue.**

Parenting an Unstable Child with Bipolar Disorder (continued)

***Document the child's biological family history on all four sides, if possible.** Who has bipolar, schizophrenia, depression, obsessive-compulsive tendencies, odd behavior, alcohol/drug issues, attempted or completed suicide, etc.?
Foster and adoptive parents should make every attempt at getting the biological family history through the agency. Even knowing "bits and pieces", such as a biological family history of drug/alcohol abuse or receiving information that a family member was in a state hospital, can be very helpful for the doctor. For foster and adoptive parents, check with your area's laws for privacy issues regarding this.

***Don't compare your child to another child with bipolar.** Each will have individual symptoms and needs. For example, many children with bipolar do not have rages, hypersexuality and/or hallucinations.

***Take care of your own basic needs, so that you will be able to take care of your child's needs.** If you find it hard to take care of your own needs, think of it as ultimately helping your child.

***Remember to breathe naturally.** Parents often are so consumed in finding help for their children, that they do not recognize their own body's 'SOS' symptoms. To relax, find a quiet spot (usually when your child is sleeping), sit up tall (can sit Indian-style), close your eyes, close your mouth, and slowly breathe in through your nostrils slowly (as if you are appreciating a beautiful rose). Hold it for 2 seconds, and then slowly release, parting your lips slightly. Do this 3X.

***Strive to find the right medication or combo of medications for your child's individual needs.** Each child differs, and what works for one, won't necessarily work for the next.

***Stimulants and/or anti-depressants can, and often DO worsen a bipolar condition, at least when the child is not stabilized with his/her moods first.** Worsening behaviors may be increased mania, depression, suicide attempts or suicides. Many children can successfully try stimulants AFTER their moods are more congruent. However, many children will also be unable to tolerate stimulants. There are non-stimulants that might be beneficial in those cases. Discuss your concerns with doctors who want to prescribe a classification of medication that is not geared towards mood stabilization. It may be necessary to find a new doctor who better understands, recognizes and has a successful track record (for the most part) of treating children with bipolar.

Parenting an Unstable Child with Bipolar Disorder (continued)

***For those professionals, particularly doctors who refuse to acknowledge and/or treat bipolar in children, offer them literature in the Learning Center at www.thebalancedmind.org. For those who feel that children cannot be diagnosed with pediatric bipolar (currently the criteria is **not** in the Diagnostic Statistical Manual for younger children (The DSM is the book that doctors use to diagnose “mental” illness), refer them to the National Institute of Mental Health Research Roundtable on Prepubertal Bipolar article. **This article states that childhood bipolar can now be (since 2000) diagnosed using ‘Bipolar Disorder NOS’ (Not Otherwise Specified)**. Some diagnosticians will flatly refuse to diagnose bipolar in children, stating that they do not want to “label” the child. The professional needs to understand that, you, neither, want to “label” the child, but rather want the child to be properly **diagnosed** so that the appropriate treatment that matches the child’s symptoms can begin. It is unethical for a treating doctor, who suspects bipolar in a child, to prescribe medication that is known to potentially induce or worsen bipolar symptoms (such as stimulants or antidepressants) **in order to make** a diagnosis of bipolar disorder. This is a somewhat common occurrence and can lead to not only worsened symptoms from these other classifications of medications, but also can lead to suicide. Many doctors simply do not understand the potential ramifications of such actions and need to be educated on this issue.**

***In general, it is best to seek out a pediatric psychiatrist since they take additional years of schooling to work with children.** Due to a lack of pediatric psychiatrists (there are only approx. 6,300 in the U.S., with a need for approx. 30,000), however, this is not always possible. Some parents will seek out an expert in pediatric bipolar, often hours away, to get a thorough evaluation and then have the expert confer with an area doctor for follow-up treatment. Some parents will seek out a research hospital and/or look into research trials. These are often at no or little cost to the family if the criteria is met. (Research trials can be found on <http://www.thebalancedmind.org/>) Some doctors prefer to take a “backdoor approach” and first treat the bipolar symptoms to see if there is a decrease in symptoms. If so, they then would make the bipolar diagnosis. The typical first-line treatment would be a mood stabilizing agent. Some of the atypical anti-psychotics are also starting to be used as mood stabilizing agents alone or as an adjunct. In general, any residuals (leftovers) of other symptoms such as ADHD or depression often can be **cautiously** treated with other classifications of medications after mood stabilization has occurred or mostly occurred. Speak to the doctor about options when there are residual symptoms.

Parenting an Unstable Child with Bipolar Disorder (continued)

***As a last resort in getting a proper diagnosis and treatment** (due to the doctor not recognizing/observing the symptoms) a parent may want to **cautiously try video-taping the child's rages and/or other bipolar symptoms.** The parent needs to be **very careful** with this strategy since the child may find the camera and become upset. Ideally, at least two adults should be on hand. The camera ideally should be small enough to fit in a palm of a hand and put somewhere in which the child cannot see it. Any red lights should be covered and batteries should be checked. The camera should be positioned in an area of the home in which the child is known to exhibit behaviors from their illness. The parent should not "egg on" (provoke) a situation, but rather should simply parent the child in what would be considered an accepted manner. Note that extra precautionary measures need to be taken with older children. Use common sense and your parental intuition when weighing the risk factors in video-taping. It's best to discuss with the doctor before using this as a resort. Foster parents should ask their county workers about the possibility of video-taping prior to doing so.

***Remove all objects that could be considered dangerous to your child and lock these items up or remove them from the home.** This includes guns and any sharp objects, sheets and cords that could be used to tie around a neck, etc. Lock up the medications. Ideally, any potential weapons should be removed from the home when your child's moods are unstable. **Those who refuse to remove guns from the home should understand the potential occurrence of suicidal and/or other dangerous situations.** Guns should never be loaded and bullets should never be in the same area of the home as the gun. The risk of suicide attempts and suicides are too high in children with bipolar to not take these precautions seriously.

***When your unstable child is cursing or being abusive in other ways, take a deep breath and count to 10. Walk away to compose yourself if necessary (Disengage).**

***Know how to potentially redirect a meltdown.** (Meltdowns can be considered as something that has the potential to become a rage, but is less intense.) During a meltdown the child is possibly starting to become upset, possibly throwing an object, while with rages the child is possibly throwing multiple objects, being uncontrollable, possibly ripping off posters off the wall, bouncing non-stop on the bed, using physical contact to hurt self, others or objects (i.e., banging head on wall continuously). Some ways to redirect a meltdown:

Parenting an Unstable Child with Bipolar Disorder (continued)

More than anything simply know your child's "trigger points": What sets him/her off? Don't "challenge" your child (very difficult, especially for parents with bipolar themselves). Don't necessarily avoid the trigger points (if they are difficult to avoid in every-day-life), but instead, find ways to decrease a hostile response. Disengage from your child in a non-threatening manner when he/she is irrational.

***Check to see when your child ate last. Protein is very important for children with bipolar. When their sugar starts fluctuating, a meltdown may start to occur.** Ask your child when the last time he/she ate and what it was. If your child is starting to melt down due to limit-setting (such as telling the child, "no"), try offering two choices instead. "John, would you like to go to the video store with me to pick out a video or would you like to stay home instead?" Don't make a "big production" out of it...just simply ask the question in a neutral, inviting manner. It's also important that the parent does not allow the child to "reel" the parent in. If a parent calls the child down from the bedroom for supper, the parent should not stick around to listen to the child attempting to "sabotage" the situation. (I HATE chicken! You're stupid!!!)--- when the parent knows this is the child's favorite food) A meltdown can often be quickly redirected by the parent making a simple, matter-of-fact, non-threatening statement during the meltdown such as, "Katie, let me know if you want a chicken sandwich. Dad's going to drive to our favorite chicken place. I'll be downstairs doing the laundry if you want anything from there." And then the parent simply leaves the area. The child will often "come around" within 0-10 minutes. **This does two things: allows your child to make his/her own choice without having an "audience" to "attack", as well as getting your child the necessary protein in his/her system, potentially decreasing or eliminating the meltdown.** The bottom-line is that a meltdown can be potentially decreased or eliminated by the parent making simple, non-threatening communications and not allowing (not engaging) the child with the opportunity (by limiting time) to "attack" verbally, emotionally or physically. By engaging your child with something that he/she is highly interested in, a rage can be avoided.

***Understand that, while meltdowns can often be redirected, rages typically need to take their "course", just like a tornado or hurricane...it just has to go through a (sometimes destructive) path before things are calm again.** (Rages can last typically from 20 minutes to 2-4 hours and often occur in the home with only one adult available.) It's important to keep an eye on your child during raging to ensure that he/she is as safe as possible; however, interfering during a rage can get the parent, other bystanders or child hurt. Once your child starts to calm down, he/she may respond to a parent who talks calmly, quietly, in a neutral tone and does not say anything that could be perceived (to the ill child) as disrespectful or condescending.

Parenting an Unstable Child with Bipolar Disorder (continued)

If the parent feels safe, it is typically best to be physically at the same level as, or lower level than the child. (i.e., sit on the bed if the child is sitting or sit while the child stands) This decreases the chances of the child perceiving the adult as someone who is attempting to control/overpower them. Typically, for the younger child, a parent can ask if he/she wants to be held. Often the child does, but cannot verbalize it, while others are "touchy" (possible sensory issues) and may start becoming more agitated. Some younger children (and sometimes, older children) like to be hugged or held. Back rubs or back scratches may also be helpful. Lavender oil is known to have a calming effect and can be used for back rubs or in the bath tub. **The bottom-line is to become aware of how your individual child responds to you and what techniques work and which ones do not.** This often allows your child to calm down and allows him/her to know that you love and accept him/her unconditionally. Once your child's moods are stabilized, your child has the potential to "unlearn" negative behaviors that he/she may have developed (coping mechanism) while unstable. Sometimes this will take therapy, but many parents can help the child deal with behaviors once the moods are stabilized.

***Always strive to remain calm, cool and collected when your child is out-of-control.** Do NOT raise your level of tone to his/her level. (It may feel good for the moment but it will only exacerbate the situation.) Instead, keep a neutral stance and speak with a soft, lowered voice. (ie. don't "feed" off of one another). (Many parents use specific techniques such as 'Low Expressed Emotion' [LEE].) If your child is doing something that you consider unacceptable, simply state that it is inappropriate and ask him/her, in a civil manner, not to do it...then walk away and do your other activities, such as washing clothes, making dinner, etc. If your child follows you around the house, but is not being disruptive, allow him/her to do so, while you continue to work around the house. If your child starts to attempt to "egg on" a situation, you should not allow yourself to be negatively influenced by it. Simply repeat in a matter-of-fact tone that, what your child did was inappropriate. Do not focus on your child's behavior at this point. If the situation worsens, you may be successful in having a **younger child** lie down on the couch, etc. until he/she can calm down. **Preadolescent children** may need to go into another area of the home to "settle down". Often they will state to the parent later, "If you just give me some time, I'll be fine...don't keep yelling at me!" This personal insight is invaluable and can allow the parent and child to find some common ground about how to deal with meltdowns. Allowing the child to come up with a plan can help build his/her self-esteem and be part of his/her maintenance plan, such as the child stating, "Give me 10-15 minutes of alone time without you yelling and I should be okay by then. When I come out of my room, you'll know I've cooled down."

Parenting an Unstable Child with Bipolar Disorder (continued)

For **older teens** it can get quite tricky since they are transitioning into adulthood and may try to undermine the parent's authority even more than the younger children. ("You can't do anything, I have rights, you know! I'll just stay with my friend tonight! If you try to stop me, I'll call Child Protective Services on you!!!") **Using a balance of boundaries, compromise and respect is critical.** Setting basic house rules without sounding like a "drill sergeant" is ideal. For all age groups, learning to work with the child on his/her behaviors may take some adjustment time, while your child is trialing different medications, but it may help him/her understand that some behaviors will be unacceptable, whether he/she is cycling or not.

***If your child is out-of-control in a way that he/she is being harmful or potentially harmful to him/her or other family members, privately talk to the hospital and/or an ambulance service and explain the situation.** Don't allow your child to hear the conversation since it may get out-of-control before an ambulance arrives. If your child is young and not overly strong, an ambulance may suffice. If your child is older and is difficult to physically handle, police back-up may be necessary. Ideally, before a situation such as this potentially occurs, try scheduling a trip to the police station with your child, so that, if the police become involved (through you or a neighbor, etc.), they will have a better understanding on how to effectively handle the situation. By offering police officers some effective tips, such as asking them to talk in an even-keel, non-threatening tone, you are helping your child establish a rapport with the police officers, as well as educating the police officers on these types of serious matters.

***Do NOT attempt to drive your vehicle when alone with a raging child.** Many children with bipolar who are unstable have a tendency to attempt to jump out of moving vehicles or to "attack" the driver. If you happen to find yourself in this situation, make an effort to pull over to a safe area off the road before stopping (preferably in a low-traffic area). If it is necessary to drive, try to bring at least another adult (who is physically and successfully able to control the child) in case this occurs.

***Understand that most communities will use the least restrictive services first, exhausting all of the community services before attempting more intense services.** For example, your community resources may start off with utilizing a social worker or therapist first. If those professionals feel that a psychiatrist is necessary, they may make those recommendations.

Parenting an Unstable Child with Bipolar Disorder (continued)

If, after working with a psychiatrist, making little progress, the group of professionals may discuss ‘wrap-around’ services, pulling in more services from the community and working on a solution as a team for those children at risk in the community. Prior to discussing RTCs (residential treatment centers) as an option, try to work with a child psychiatrist to figure out the best treatment regimen for your child's needs. Parents need to be able to relate when their ill children are expressing (verbally or otherwise) signs of the child wanting to hurt themselves and/or others. Hospitalization may be the best option at that point.

***Check local areas for respite care.** Easter Seals is one place that offers respite services in many areas. It's important to find out the cost of the service. Some respite care providers will allow a sliding fee scale or will offer respite at no-cost to parents who meet the financial criteria. Local colleges also may be willing to offer respite through students majoring in programs which entail working with special needs children. For those lucky enough to find a good “match” with other area families, it can be a great opportunity to share respite with one another.

***Check for local support groups for caregivers of children with bipolar.** Your local United Way Info and Referral Agency or county's Mental Health Board may be able to refer you.

***Don't feel guilty about your feelings of sadness, anger, frustration, disappointment, etc.** These are all natural feelings and it's healthy to discuss them with others. For more serious thoughts or actions, parents should contact their medical professional. It's natural to go through the stages of the grieving process, just as if a parent has lost a child physically. The difference often is that parents dealing with children with bipolar may feel that they are going through the grieving process 1000X over, as the child's moods rapidly change. (roller-coaster riding).

***Learn to laugh and have a sense of humor (appropriate, of course!).** If you don't have a sense of humor, learn to acquire one. If you don't laugh, learn. Take brisk walks. By doing these things you will release endorphins, the chemicals that decrease depression and lift the spirits.

***Some things that have been helpful to families with children with bipolar:** soft music, a favorite tape/CD, massages, pure lavender oil in a warm bath or used as a massage.

Parenting an Unstable Child with Bipolar Disorder (continued)

There are also children's books in the <http://www.thebalancedmind.org/> bookstore that may help the child relate to and accept his/her illness. It's also helpful to accommodate the child's 'inflexible mind' by giving him/her enough time to end an activity, such as playing video games or watching television by giving them a 10-15 minutes "heads-up". Setting an egg timer can do wonders.

***Don't give up hope.** There are many medications and combos of medications that can be tried, as well as many new medications coming out in the future.

***Understand that all children (and all people) manipulate in order to get something.** It's human nature but has taken on a negative connotation. It's doubtful that the human race would be able to survive without people manipulating their environment. The difference with many ill children with bipolar, is that they often do not feel in control of **anything**, especially their brain functioning. If a parent thinks about the lack of control that children with bipolar may feel in all areas of their lives: being told when to go to bed, when to get up, when to go to school, being told to do schoolwork and housework, having peer-activity restrictions placed on them, feeling no control over their behaviors...it's no wonder that that they will manipulate to protect themselves from their environment. **Refusing to do something or acting or lashing out, is often a way for children with bipolar to feel in control.** Often they feel badly afterwards and may express remorse. It can be very beneficial to relate this to professionals and other adults who will tell the parent that the parent is being manipulated by their child. You don't need to say, "No he is not!" (That will simply make a parent appear defensive and in denial). Instead, simply state calmly and matter-of-factly something such as, "Yes, you are right, my child manipulates...we all do...but, for the most part, he is likely doing it to protect himself from his environment and to gain some control over his life. Can you imagine feeling out-of-control of every instance of your life, including your emotions stemming from a brain disorder? Hopefully as his moods are not cycling as much, my child can learn how to cope with his illness in a more effective manner."

***Go "straight to the source."** Many adults will be amazed at what they can find out when they discuss the child's illness and behaviors with him/her. An adult (parent, teacher, police officer, social worker, doctor, therapist, etc.) often can get the best feedback from the child when the child is treated as a partner of the recovery process. Establishing a rapport and respecting the child's feelings and feedback is critical. Find a quiet area, away from others to discuss issues with the child. Talk in a neutral, respectful, matter-of-fact manner. For school-age children, an adult might say something such as, "Katie, I can't imagine what you are going through. I wish I knew, but since I don't know your thoughts (and/or 'I don't have bipolar'), it's hard for me to understand."

Parenting an Unstable Child with Bipolar Disorder (continued)

All I know is that we all have different challenges we have to face, and that, at least in some ways I can relate to you because of my own challenges I have had to overcome. When I was younger, I remember how I felt when I found out my dad left our family. People kept trying to help me and I kept screaming at them to get away from me. I think I was about your age when that happened. I knew they could never fully understand my emotions I was feeling at that time. Even though I know I can never fully understand, I want to learn and appreciate more about what is going on with you. Can you help me understand?" Offer some coping tips in times when the child is unstable or semi-unstable with his/her moods. The best time to discuss ways in which to cope is when the child is in a "normal" period of their illness (Euthymia), which may occur rarely if the child cycles rapidly and continuously, or if the child is on medication that is inappropriate for the primary symptoms. In general, do not "sugar-coat" the illness. Your child has to live with the illness and it helps him/her to understand that, although it will be a struggle, his/her situation can improve with the proper treatment. At the same time, it's imperative not to inundate the child with too much information that may overwhelm him/her. Use age-appropriate discussions. **Form an alliance with your child and discuss coping strategies which may work for his/her individual needs. This may be the foundation that your child needs in order to start feeling in control again.**

***Help your child establish a way to document their moods and feelings.** (Mood Charts for children can be found on <http://www.thebalancedmind.org>. Many psychiatrists and agencies will also have charts). Put each chart in a safe place, possibly using clear plastic shields, in case your child later tries to rip it up.

***Learn to recognize that this illness can be difficult for many people to understand and accept.** Because the illness often manifests itself as a behavior or parenting issue, it can be difficult for people to differentiate between the illness and a true behavior issue. While you are learning how to cope with your child's illness and your own needs, try to also educate family members and others who work closely with your child, and who appear to not understand the illness. For those with significant others who refuse to see their child's behaviors as a bipolar illness, it often is helpful to put some short, easy reading material in the bathroom or other place where there would be undivided attention. Book-marking and highlighting a page from The Bipolar Child book or other reading material and sitting it on a stool beside the toilet can do wonders. This offers your significant other the chance to read material that he/she may otherwise be hesitant to read in front of you. (It's best, of course, to remove or put out of reach other "more favored" reading material.) They do not need to know that the purpose was for them to read it.

Parenting an Unstable Child with Bipolar Disorder (continued)

It could be just you catching up on some reading. It is their choice as to accept your information or not, and it is up to them to deal with it in their own way. The best that parents can do is to attempt to educate themselves and others while continuing to strive for mood stability in their ill children. **Put your "horse-blinders" on and keep your focus on the prize...which is to find the most appropriate treatment for your child. There is little time or value in allowing yourself to be dictated by guilt, whether deriving from yourself or others. Strive to overcome it. Your ill child's life and childhood are much too precious to allow guilt to be a hindrance to his/her recovery.**

*Lastly, remember that you are human, often doing a **super-human** job. There are **few** others who have an impressive parenting "resume" such as yours. Appreciate all of your parenting accomplishments with others who have an impressive parenting "resume" such as yours. Appreciate all of your parenting accomplishments which you have achieved in raising a child with bipolar.

Debby Rohr (Author)-Licensed Social Worker and parent of a child with Bipolar Disorder
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As long as my name and this info is listed, those who wish, may make copies of the above tips and pass them out to parents/caregivers, family members, friends, professionals and others who may benefit---for personal or educational purposes. Professionals such as doctors, therapists, social workers or police officers can easily adapt many of these tips/techniques when dealing with unstable children with Bipolar Disorder and other children with disorders, such as Conduct Disorder and Oppositional Defiant Disorder. Those wanting these tips in a Word document can e-mail me at the above e-mail address.

Updated June 2004

Rohr, D. (June 2004). Parenting an Unstable Child with Bipolar Disorder. Retrieved from <http://www.thebalancedmind.org/learn/library/parenting-an-unstable-child-with-bipolar-disorder>

Educating the Child with Bipolar Disorder

What is Pediatric Bipolar Disorder?

Bipolar disorder is a biological brain disorder causing severe fluctuations in mood, energy, thinking and behavior. It was previously known as manic depression, as it causes moods to shift between mania and depression. Children—whose symptoms present differently than those of adults—can experience severe and sudden mood changes many times a day. Symptoms of mania and depression can also occur simultaneously. Young people with this disorder are frequently anxious and have very low frustration tolerance.

At least one million American children and teenagers struggle with bipolar disorder, most of them undiagnosed and untreated. Children with bipolar disorder are at risk for school failure, substance abuse, and suicide. The lifetime mortality rate for bipolar disorder (from suicide) is higher than some childhood cancers. Yet children who are stable and have the right support can thrive in school and develop satisfying peer relationships.

Depressed children may not appear to be sad. Instead they may withdraw, not want to play, need more sleep than usual, display chronic irritability, or cry for no obvious reason. Children may also talk of wishing to die and may need to be hospitalized for harm to themselves or others.

Symptoms of mania may include elation, grandiose thinking, racing thoughts, pressured speech, hypersexuality, and decreased need for sleep. Since hyperactivity can be seen in both bipolar disorder and ADHD, a growing number of researchers believe that many children who are diagnosed with “severe ADHD” may actually have undiagnosed bipolar disorder.

Educating the Child with Bipolar Disorder (continued)

Commonly Seen Behaviors

- crying for no apparent reason
- an expansive or irritable mood
- depression
- rapidly changing moods lasting a few minutes to a few days
- explosive, lengthy, and often destructive rages
- separation anxiety
- defiance of authority
- hyperactivity, agitation, and distractibility
- sleeping too little or too much
- night terrors
- strong and frequent
- cravings, often for carbohydrates and sweets
- excessive involvement in multiple projects and activities
- impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
- dare devil behaviors
- inappropriate or precocious sexual behavior
- delusions and hallucinations
- grandiose belief in personal abilities that defy the laws of logic (ability to fly, knows more than the teacher or principal)
- extreme irritability

How Bipolar Disorder Affects Cognition and Learning

Recent brain imaging studies show biological differences in patients with bipolar disorder. The disorder affects learning in a number of ways, ranging from difficulties with sleep, energy, school attendance, concentration, executive function, and cognition. Side effects from medications can affect the child's learning and energy. Moreover, while many of these children are uncommonly bright or creative, they often have co-occurring learning disabilities.

Even when moods are stable, the condition often causes cognitive deficits, including the ability to:

- Pay attention
- Remember and recall information
- Think critically, categorize, and organize information
- Employ problem-solving skills
- Quickly coordinate eye-hand movements

Educating the Child with Bipolar Disorder (continued)

How Bipolar Disorder Affects Cognition and Learning (continued)

In addition, bipolar disorder can cause a child to be at times impulsive, talkative, distractible, withdrawn, unmotivated, or difficult to engage. Medications to manage the illness can cause cognitive dulling, sleepiness, slurring of speech, memory recall difficulties, and physical discomfort such as nausea and excessive thirst.

Despite all these challenges, a student with bipolar disorder can succeed in the classroom with the right supports and accommodations.

Strategies for Teaching a Child with Bipolar Disorder

The teaching skills that make a classroom teacher successful with typical students are essential when working with children who have bipolar disorder.

Flexibility to adapt assignments, curriculum, and presentation style as needed.

Patience to ignore minor negative behaviors, encourage positive behaviors, and provide positive behavioral choices. Most important is the ability to stay calm and be a model of desired behavior.

Good conflict management skills to resolve conflicts in a non-confrontational, non-combative, safe, and positive manner.

Receptivity to change and to working collaboratively with the child's parents, doctors, and other professionals to best meet the needs of the child.

Teaming Up to Help the Child

Since bipolar disorder affects all aspects of a child's life, it takes a well-coordinated team of concerned adults to give the child the best chance for a full and productive life. The team might include parents, teachers, special education specialists, a guidance counselor, an adjustment counselor or social worker, a school psychologist, an occupational therapist, a speech therapist, and the school nurse. The school team should feel comfortable consulting with the child's psychiatrist and/or outside therapist. It is critical to work closely with the child's family to understand the symptoms and course of the illness.

Educating the Child with Bipolar Disorder (continued)

Teaming Up to Help the Child (continued)

Parents should identify patterns in behavior that could signal a change in the illness, and help teachers brainstorm better ways of handling specific situations. Teachers and school personnel also need to know about changes in the child's home life or medication in order to work around them constructively at school. At times of transition, the current or previous year's teacher needs to work closely with the new teacher or team to smooth the way—change is difficult for any child, but even more difficult for the child with a neurological disorder.

Suggested Accommodations

- Students with bipolar disorder benefit enormously from stress reducing accommodations such as:
- Consistent scheduling that includes planned and unplanned breaks
- Seating with few distractions, providing buffer space and model children
- Shortened assignments and homework focusing on quality, not quantity
- Prior notice of transitions or changes in routine—minimizing surprises
- A plan for unstructured time or lulls in the day
- Scheduling the student's most challenging tasks at a time of day when the child is best able to perform (allowing for medication-related tiredness, hunger, etc.)

Successful Teaching Strategies

Students with bipolar disorder face tough challenges navigating through the many pressures of a typical school day. Their neurologically-based mood disorder affects emotion, behavior, cognitive skills, and social interactions.

These students are very vulnerable to stress that can easily overwhelm their coping skills. Therefore, it is paramount to their success in the classroom to reduce exposure to stressors and help them build coping skills that they will need throughout their lives. More than anything else, these children need structure and predictability to frame the day, provided by supportive and flexible teachers who calmly help them stay in control when any difficulties develop.

Educating the Child with Bipolar Disorder (continued)

Successful Teaching Strategies (continued)

The most important factor in these children's success is the way adults respond to and work with them. The teachers who work best with these students are resourceful, caring, and calm, and know how to work positively with children's shifting moods and cognitive weaknesses. Praise, encouragement, and key words elicit positive behaviors, while negativity helps the child spin out of control. Experts recommend some praise for all children at least once every 5 minutes, or 12 positive comments for every negative statement.

Good communication between home and school is essential. Contact should be frequent, timely, and focused on facts and solving problems (rather than blame). The school needs to inform parents regularly about how the student is performing. This can be done via a notebook that goes back and forth to school with the child, or a daily chart or e-mail that records successes, progress, difficulties, and mood information. Parents can then reinforce and support the teacher and the child. Parents can also spot trends in the child's illness and respond before problems reach a crisis. They should inform teachers of any unusual stressors at home and changes in medication.

One of the challenges of working with these children is that even tried-and-true strategies may not work consistently due to the frequent mood shifts the students experience. Being prepared with a variety of approaches certainly increases a teacher's odds of dealing successfully with their students' challenges.

How to Handle Changing Moods

In a manic mood, children may exhibit distractibility, increased energy, grandiose thinking, rapid speech, and a strong goal orientation. Help them direct all that energy productively with hands-on projects and increased activity. The child will need help to set realistic goals. During lulls in the classroom, give the child an OT break, send the child on errands, or assign tasks involving motor activity, such as washing the board or moving items. Provide opportunities for the student to move around during class, work on computers, or use manipulatives and encourage him/her to get involved in other interactive activities. You might even set up games and intervention strategy that allow the children to become more conscious of and better able to control their need for movement.

Educating the Child with Bipolar Disorder (continued)

How to Handle Changing Moods (continued)

When children are sad or depressed, exhibiting low energy, shorten their assignments and check in frequently to help them stay on track. Sometimes, simply asking what is wrong and how you can help is enough to get the child back on track. Children in a depressed state can find it extremely hard to wake up in time for school, particularly at certain times of the year. They should not be penalized for tardiness that is biologically based. Any talk of suicide must be taken seriously and reported to the child's parents.

You might not be able to discern clearly defined episodes of mania or depression because children with bipolar disorder often experience both states at once, producing chronic agitation and irritability. Defiance and aggression are probably the most challenging moods to manage. The best strategy for addressing these behaviors is to not take it personally, keep your composure, and do not get involved in power struggles. Remain a positive model. Prompt children who are rude to rephrase statements politely and try again. Be firm and consistent, and give the child acceptable, positive choices. An ultimatum or threat can easily force the child to make poor choices.

At times all students are more demanding or just need a lot of attention. Greet them when they enter the classroom, seat them near where you teach, give them opportunities to work with other students, use their names in spelling sentences, math problems, etc, and acknowledge them when they stay on task. Try to ignore inappropriate, attention-getting behaviors as much as possible. Use "bossiness" to everyone's advantage by making the child a leader or teacher.

Using Social Stories to Rehearse New Situations

Like children with other neurologically-based disorders, children with bipolar disorder often have difficulty in novel situations and don't know how to behave appropriately. When given some sort of structure or script, however, they are far more successful. Social stories, which have been used by children with autism spectrum disorders, prepare the child in advance for a given situation so he can respond appropriately when that situation occurs.

Educating the Child with Bipolar Disorder (continued)

Using Social Stories to Rehearse New Situations (continued)

Social stories can be simple, such as talking through and role-playing how to perceive that someone else doesn't want to be splashed. They can also be longer, such as a 20-page book on going to a new camp or school. It's important to not only give the child information on the situation, but also to reassure the child that he is capable of handling it. The story can also be a jumping off point for discussing "what if" scenarios, so the child has a chance to practice appropriate reactions for different outcomes. Involving the child in creating the story, either by coming up with what the child might say or by illustrating it, is a great way to capture the child's interest.

Carol Gray, noted expert on social stories, provides the following guidelines* for writing your own social stories:

- Picture the goal
- Gather information
- Tailor the text
- Teach with the title
- *Additional Resources:
<http://www.thegraycenter.org/social-stories/how-to-write-social-stories>
www.polyxo.com/socialstories/introduction.html#needforintervention

Managing Challenging Behaviors

Bipolar disorder affects the areas of the brain that regulate memory, speech, thought, emotions, personality, planning, anxiety, frustration, aggression, and impulse control. It's no surprise, then, that these children have difficulty behaving appropriately in all situations. Although medication helps the children control their behavior, they are highly influenced by their impulses and surroundings even when moods are stable.

Children with bipolar disorder need adults around them who are positive, calm, firm, patient, consistent, loving, and who encourage them to behave appropriately. Praise and key words elicit positive behaviors, while negativity helps the child spin out of control. In fact, experts recommend some praise at least once every 5 minutes, or 12 positive comments to every negative comment.

Educating the Child with Bipolar Disorder (continued)

Managing Challenging Behaviors (continued)

In addition, the child's team should have a behavior intervention plan. When a child is stable, the team needs to build the child's skills that lead to appropriate reactions and behavior, including emotion labeling, empathy, anger management, social rules, nonverbal communication, and making amends. Those who work with the child need training in nonviolent crisis prevention, focusing on verbal de-escalation techniques, to avoid crises.

Reward positive behavior with praise and privileges but don't set up a reward system in advance. Programs that reward the child for positive behavior, while punishing negative behaviors set the child up for failure, raising stress. Punishing a child with bipolar disorder for a fit of anger is akin to punishing an asthmatic child for an asthma attack.

Modifying the Physical Environment

Children with bipolar disorder generally need an environment that reduces distractions and improves their ability to focus and behave appropriately. They benefit from accommodations like those made for students with ADHD, and in fact many of these children have ADHD in addition to bipolar disorder. Preferential seating near model students, with few nearby distractions, is critical. Some students do better near the teacher so that the teacher can unobtrusively check in and keep them on task, while others need extra space to pace or move around.

Noise is an issue for some children with bipolar disorder, as sensory integration problems are not uncommon. Ear plugs for loud events, headphones that screen out noise, or even calming music can help a child focus. If music is more distracting than helpful, try a tape with a background noise such as ocean sounds to filter out random classroom noises.

Discomfort from heat and light can be distracting. If you don't have control over the temperature in your classroom, suggest the child dress in layers to ensure comfort. Children who are tired or depressed may fall asleep if it's too dark in the room. Others, if they're sensitive to bright light, can be made more comfortable by sitting in carrels or away from bright sunlight.

Educating the Child with Bipolar Disorder (continued)

Other Accommodations for Comfort

Students with bipolar disorder need an established “safe” person—an adult to go to when feeling overwhelmed—and a safe place. This safe place should be a private location used for regaining composure or collecting one’s thoughts, away from peers or other staff. Sometimes the student simply needs to take a walk. Make arrangements in advance that do not call undue attention to the student, but also consider policies on safety.

Many children experience side effects from medication, including sleepiness, thirst, frequent urination, or constant hunger. Work out a plan to keep these issues from affecting the child’s success.

Some students, particularly younger ones, may need one-on-one adult supervision, not only in the classroom, but at times of transition or unstructured activities full of peer interaction, such as recess or lunch time.

Consider extending education about diversity to include learning differences and how individual minds can work differently. This information can increase peer acceptance and reduce stigma for these students.

Adjusting the Schedule

Many factors affect the way children with bipolar disorder experience time, including difficulties with sleep, concentration, memory, and moods, plus medication side effects and a tendency to hyper focus. Students with bipolar disorder may need several or all of the following schedule accommodations:

- permission to arrive later when necessary
- a shorter school day
- scheduling difficult tasks for a time of day when the student is best able to perform
- warnings before a change in activities
- more time for turning in homework or large projects
- extra time for tests
- breaking tests or assignments into shorter segments with breaks
- scheduling stimulating courses early in the day to get interest flowing
- periodic checks on progress during an assignment to ensure the student is on schedule

Educating the Child with Bipolar Disorder (continued)

Optimizing Testing Situations

Brain imaging shows that people with bipolar disorder have differences in their brains in the areas that control memory. With help, however, such as the following testing accommodations, students with bipolar disorder can succeed in demonstrating their knowledge more effectively:

- modified time constraints
- altered or simpler instructions
- oral testing or the use of a scribe
- an altered environment (such as a room with few or no other students)
- multiple-choice or matching rather than open-ended questions
- tools such as a calculator or word bank
- offering an alternative type of assignment to reduce the stress of testing

Special Education Classification

When developing an IEP for a child with bipolar disorder, educators are sometimes unsure of the most appropriate way to classify the student's special education needs. The Child and Adolescent Bipolar Foundation (CABF) advocates the classification Other Health Impaired (OHI). This classification acknowledges the biological nature of the illness. An OHI classification recognizes that:

- Bipolar disorder impairs a child's ability to function effectively in school due to impairment in cognitive, emotional, and physical functioning.
- The behavioral and emotional problems of the student are symptoms of a biological brain disorder requiring pharmacological and psychosocial intervention, not primarily behavior modification.
- Behavioral outbursts, negative peer relationships, and an inability to interpret social situations are symptoms of neurological instability. These symptoms are not always within the child's control, although proper medication can help.
- Repeated episodes of bipolar disorder cause deficits in social, vocational, and academic skills. Without proper accommodations within the academic program, these deficits lead to a high dropout and school failure rate.
- An OHI classification clearly defines the child's heightened levels of impulsivity, distractibility, sensory integration deficiencies, and poor decision making skills as being due to this neurological disorder.

Educating the Child with Bipolar Disorder (continued)

Special Education Classification (continued)

With appropriate program supports, pharmacological treatment, and environmental support, students with bipolar disorder are more likely to successfully complete school and become productive citizens.

The OHI classification is an essential building block of vital support that students with bipolar disorder need in order to succeed.

Advocating for Your Child: 25 Tips for Parents

By David Fassler, M.D.

According to the Surgeon General, 1 child in 5 will experience significant problems due to a psychiatric disorder. The good news is that we can help many, if not most, of these youngsters. The real tragedy is that so few, less than 1 in 3, are receiving the comprehensive treatment they really need.

Children and adolescents with emotional and behavioral problems deserve access to the best possible mental health care. Unfortunately, such services are often difficult to obtain. Parents can help by being informed, involved and persistent advocates on behalf of their children.

The following outline offers specific tips and suggestions which parents may find useful in such advocacy efforts.

Individual advocacy for your own child:

- 1. Get a comprehensive evaluation.** Child psychiatric disorders are complex and confusing. A full assessment will often involve several visits. Effective treatment depends on a careful and accurate diagnosis.
- 2. Insist on the best.** Talk to physicians, therapists, guidance counselors and other parents. Find out who in your community has the most experience and expertise in evaluating and treating your child's particular condition. Check the clinician's credentials carefully. Are they appropriately licensed or certified in your state? If he or she is a physician, are they "Board Certified"? Push schools, insurance companies and state agencies to provide the most appropriate and best possible services, not merely services which are deemed sufficient or adequate.
- 3. Ask lots of questions about any diagnosis or proposed treatment.** Encourage your child to ask any questions he or she may have, as well. Remember that no one has all the answers, and that there are few simple solutions for complex child psychiatric disorders. In addition, all treatments have both risks and benefits. Make sure you and your child understand the full range of treatment options available so you can make a truly informed decision.
- 4. Insist on care which is "family centered" and which builds on your child's strengths.** Ask about specific goals and objectives. How will you know if treatment is helping? If your child's problems persist or worsen, what options and alternatives are available?

Advocating for Your Child: 25 Tips for Parents (continued)

5. **Ask about comprehensive “wrap around” or individualized services, geared specifically to the needs of your child and family.** Are such services available in your state or community? If not, why not?
6. **Be prepared.** One of the most important things you can do to help your child is to keep all information, including past consultation and treatment reports, in an organized place. Insist on receiving your own copies of all evaluations. Records can easily be misplaced, delayed or even destroyed. Maintaining your own file with all relevant information can help avoid unnecessary duplication of previous treatment efforts.
7. **Feel free to seek a second opinion.** Any responsible mental health professional will be glad to help with referrals or by sharing information. If you have any questions at all about your child’s diagnosis or the proposed course of treatment, by all means, arrange an independent consultation with another clinician.
8. **Help your child learn about their condition.** Use books, pamphlets and the Internet. Make sure the information is age-appropriate. Answer questions with honest, accurate and consistent information, but don’t overload children with more detail than they need or want.
9. **Learn the details of your insurance policy, and learn about the laws governing insurance in your state.** For example, in some states, insurance companies must provide access to a specialist, such as a child and adolescent psychiatrist, within a certain distance from your home. If no such specialist is available as part of the company’s “network”, you may be able to receive treatment from a provider of your choice, with the insurance company responsible for full payment.
10. **Work with the schools.** Insist on access to appropriate mental health consultation services. Suggest in-service training programs to enhance awareness about child psychiatric disorders. Request copies of your child’s educational records, including the results of any formal testing or other evaluations. Ask to be included in any and all school meetings held to discuss your child.
11. **Learn about the reimbursement and funding systems in your state.** The more you know, the better you can advocate on behalf of your child. How does Medicaid work? Which services are covered and which are excluded? Is there a “waiver program” which allows increased flexibility based on the specific needs of children and families? Is your child eligible? If not, why not? What other sources of funding are potentially available?

Advocating for Your Child: 25 Tips for Parents (continued)

12. **Get to know the state insurance commissioner and healthcare “ombudsperson” or consumer representative.** Ask them to attend regular meetings with parent groups. Let them know about your experiences.
13. **Use a lawyer, if necessary.** Learn about the local legal resources. Find out which lawyers in your community are familiar with educational and mental health issues. Talk to your local Protection and Advocacy agency or American Civil Liberties Union for suggestions. Call the State Bar Association. Talk to other parents who are lawyers or who have used lawyers. Consider a legal consultation to make sure you are pursuing all appropriate avenues and options regarding services for your child.

Statewide advocacy for all children, including your own:

14. **Become politically active.** Meet with state senators and representatives. Question candidates about their positions on access to necessary and appropriate mental health services for children and families. Testify at hearings on state legislation and budgets. Legislators are more likely to be influenced and persuaded by personal stories than by data, statistics or the opinions of professionals.
15. **Build coalitions and work with local advocacy and parent organizations** such as NAMI, NMHA and the Federation of Families. Develop and publicize a common “Agenda for Children’s Mental Health”.
16. **Teach children about advocacy.** Invite them to become involved in advocacy activities, where appropriate, but don’t force them to participate.
17. **Develop a legislative strategy.** If your state does not yet have parity legislation, put this at the top of the agenda. Other “family protection” initiatives include:
 - access to an independent panel to review and potentially reverse insurance company denials
 - consumer representation on community mental health center boards
 - adequate network provisions, which mandate timely and appropriate access to specialists
 - adequate funding for school and community based mental health services.

Advocating for Your Child: 25 Tips for Parents (continued)

18. **Seek bipartisan support.** Mental illness affects families of all political persuasions. Building a broad base of support has been a key to successful legislative initiatives, both at the State and Federal levels.
19. **Fight stigma.** Develop an ongoing local education campaign that reiterates the key messages:
 - child psychiatric disorders are very real illnesses
 - they affect lots of kids and adolescents
 - fortunately, they are also quite treatable, especially if treatment begins early and is individualized to the needs of each child and family.
20. **Become involved with medical education.** Meet with local medical students and residents. Sensitize them to the issues and challenges families face when caring for a child with emotional and behavioral problems.
21. **Use the media.** Write letters to the editor and/or op-ed pieces on child mental health issues. Meet with local reporters covering health care topics. Suggest story ideas to local TV stations.
22. **Work with local professional organizations.** Psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors are natural allies with a common advocacy agenda. Coordinate efforts on issues such as parity, funding for mental health services, managed care oversight, etc. Professional organizations may also have access to resources, including funds for lobbying and/or public education initiatives, from their national associations.
23. **Talk to other parents.** Seek out and join local parent support groups. If none exist, consider starting one. Develop an email “listserv” to facilitate communication. Circulate articles, information and suggestions about local resources.
24. **Attend regional and national conferences** of parent and advocacy organizations. Such meetings provide information, ideas, camaraderie and support. Sharing experiences with other parents is both helpful and empowering.
25. **Don’t give up.** Aim for and celebrate incremental victories and accomplishments. Remember, advocacy is an ongoing process!

Advocating for Your Child: 25 Tips for Parents (continued)

There's no right or wrong way to be an advocate for your child. Advocacy efforts and initiatives should be individualized to your state, community and the particular issues, circumstances and needs within your family. Advocacy is also hard work. Even when people want to help, and are willing to listen, it takes lots of time and energy to change the system. But when it works, and it often does, the outcome is clearly worthwhile. You really can make a difference, both for your own child, and ultimately for all children who need and deserve access to appropriate and effective mental health treatment services.

Resources

The following organizations are excellent resources regarding advocacy on behalf of children's mental health:

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, NW
Washington, DC 20016
(202) 966-7300
www.aacap.org

American Psychiatric Association
Division of Public Affairs
1400 K Street, NW
Washington, DC 20005
(202) 682-6140
www.psych.org

Federation of Families for Children's Mental Health
1101 King Street, Suite 420
Alexandria, VA 22314
(703) 684-7710
www.ffcmh.org

National Alliance on Mental Illness
3803 N. Fairfax Dr. Suite 100
Arlington, VA 22203
(703) 524-7600
www.nami.org

Advocating for Your Child: 25 Tips for Parents (continued)

Resources (continued)

National Disability Rights Network (NDRN)
900 Second St. NE, Suite 211
Washington, DC 20002
(202) 408-9514
www.ndrn.org

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
1-800-969-6642
www.nmha.org

The Children's Defense Fund
25 E Street NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC 20005-5002
(202) 467-5730
www.bazelon.org

The Balanced Mind Foundation
1187 Wilmette Avenue
P.M.B. #331
Wilmette, IL 60091
(847) 256-8525

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201,
Landover, MD 20785 CHADD
1-800-233-4050
(301) 306-7070
www.chadd.org

Juvenile Bipolar Research Foundation
49 S. Quaker Road
Pawling, NY 12564
(203) 226-2216
www.bpchildresearch.org

Advocating for Your Child: 25 Tips for Parents (continued)

Resources (continued)

Depression and Bipolar Support Alliance (DBSA)
730 N. Franklin Street, Suite 501
Chicago, IL 60610
1-800-826-3632
(312) 642-0049
www.ndmda.org

Depression and Related Affective Disorders Association (DRADA)
Meyer 3-181, 600 North Wolfe Street
Baltimore, MD 21287-7381
(410) 955-4647
www.drada.org

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Fassler, D. (2003). Advocating for Your Child: 25 Tips for Parents. Retrieved from http://www.nami.org/Content/ContentGroups/CAAC/How_To_Advocate_For_Your_Child.htm