

# Bipolar Disorder

Childhood Onset Bipolar Disorder (COBPD) is just emerging as a form of Bipolar Disorder previously thought to exist mostly in adolescents or adults. Those with Bipolar Disorder experience mood swings that often alternate from periods of severe highs (mania) to severe lows, (depression). In adults, these abnormally intense can last for weeks or months. However, students with Bipolar Disorder can experience such rapid mood swings that they commonly cycle within a day. A frequent pattern of cycling among COBPD called Ultra Ultra Rapid is often associated with low arousal states in the mornings, followed by increase energy towards late afternoon or evening.

The exact incidents of Bipolar Disorder in children is still to be researched. It rarely occurs by itself. It is often accompanied by clusters of symptoms that suggest other coexisting disorders, such as ADHD, Excessive/Compulsive Disorder and Oppositional Defiant Disorder. It is estimated that from 50 to 80 % of those with COBPD have ADHD as a co-occurring diagnosis. This can make treatment problematic since stimulant medications often prescribed for Attention-Deficit have been known to escalate the mood and behavior fluctuations in those with Bipolar Disorder. Therefore, it is important to address the Bipolar Disorder before Attention-Deficit in many cases.

Several studies have reported that more than 80% of students who go on to develop Bipolar Disorder have five or more of the primary symptoms of ADHD. This includes distractibility, lack of attention to details, difficulty following through on tasks or instructions, motor restlessness, difficulty waiting one's turn and interrupting or intruding on others. In fact, difficulties with attention are so common in these students, that ADHD is often diagnosed instead of Bipolar Disorder. Actually, ADHD often appears before a clear development of the frequent alternating mood swings and temper tantrums are seen often associated with COBPD.

Symptoms of Bipolar Disorder are difficult to separate. There are differences emerging from research, however. For example, the destructiveness and misbehavior often seen in both disorders are usually more intentional in students with Bipolar. While those with Attention-Deficit, misbehavior is more often associated with carelessness or inattention.

Physical outbursts and temper tantrums are seen in both disorders, but are usually triggered by sensory over stimulation in Attention-Deficit students, but can be caused by limit setting with a bipolar student. For example, a simple "no" from a parent. Furthermore, those with Attention-Deficit seem to calm down after an outburst within fifteen to thirty minutes. Those with COBPD often continue to feel angry, sometimes for hours. It is also important to note that students with Bipolar are often remorseful following temper tantrums and express that they are unable to control their anger.

There are other symptoms, such as irritability and sleep disturbances often accompanied by night terrors with morbid life threatening content are more often seen in Bipolar students than in students with Attention-Deficit Disorder.

Other symptoms of Bipolar can include the following:

- Inexpansive or irritable mood
- Depression
- Rapidly changing moods lasting a few hours to a few days.
- Explosive, lengthy and often destructive rages.
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation, and distractibility
- Sleeping little or sleeping too much
- Bed wetting and night terrors
- Strong and frequent cravings for carbohydrates and sweets
- Excessive involvement in multiple projects and activities
- Impaired judgement, impulsivity, racing thoughts, and pressure to keep talking
- Daredevil behaviors
- Inappropriate or precocious sexual behavior
- Delusion and hallucinations
- Grandiose belief in ones own abilities that defy the laws of logic

Symptoms of Bipolar can emerge as early as infancy, although it is very difficult to know for certain. Mothers have reported that students later diagnosed with Bipolar Disorder are extremely difficult to settle and slept erratically. These babies seemed extraordinarily clingy and from a very young age often had uncontrollable seizure like tantrums or severe rages that were out of proportion to any event. The “no” often triggered these rages.

Ranging from very common to common, the symptoms and behavioral traits have been consistently observed in students with early onset Bipolar Disorder, include:

### **Very Common**

1. Separation anxiety
2. Rages and explosive temper tantrums lasting up to several hours.
3. Irritability
4. Oppositional behavior
5. Rapid cycling (frequent mood swings occurring within an hour a day or several days)
6. Distractibility
7. Hyperactivity
8. Impulsivity
9. Restlessness, fugitiveness
10. Silliness, giddiness, goofiness
11. Racing thoughts
12. Aggressive behavior
13. Grandiosity
14. Carbohydrate cravings
15. Risk taking behaviors
16. Depressed mood

17. Lethargy
18. Low self-esteem
19. Difficulty getting up in the morning
20. Social anxiety
21. Oversensitivity to emotional or environmental triggers

### **Common**

- Bedwetting, especially in boys
- Night terrors
- Rapid or pressured speech
- Obsessional behavior
- Compulsive behavior
- Excessive daydreaming
- Motor and vocal tics
- Learning disabilities
- Poor short-term memory
- Lack of organization
- Fascination with gore and morbid topics
- Hypersexuality
- Manipulative behavior
- Extremely bossy behavior with friends/bullying
- Lying
- Suicidal thoughts
- Destruction of property
- Paranoia
- Hallucinations and delusions

It is important to remember that the diagnosis of Bipolar Disorder is not a scientific fact. It is a considered opinion, based on the behavior of Andrew over time, what is known of the student's family history, the student's response to medications, his or her developmental stage, the current state of scientific knowledge and the training and experience of the doctor making the diagnosis. These factors, as well as the diagnosis, can change, as more information becomes available. Competent professionals can disagree on which diagnosis fits an individual best.

A diagnosis is important, however, because it guides treatment decisions and allows the family to put a name to the condition that affects their student. A diagnosis can provide answers to some questions, but raises others that are just not answerable at this time, given the current state of our scientific knowledge.

### **Treatment**

Although there is no cure for Bipolar Disorder, in most cases treatment can stabilize the mood and allow for management and control of the symptoms. A good treatment plan is going to include medication, close monitoring of symptoms, education about the illness, counseling for the individual and the family, stress reduction, good nutrition, regular sleep and exercise and participation in a network of support.

The first line of treatment is to stabilize the student's mood and to treat any sleep disturbances and psychotic symptoms that are present. Once the student is stable, therapy that helps the student understand the nature of the illness and how it affects the student's emotions and behaviors is a critical component of a comprehensive treatment plan.

Some medications have proved useful. Although few treatment studies have been conducted in students, most clinicians can use drugs that have been tested and proved successful in adult forms of Bipolar Disorder. For mood stabilization, these include forms of lithium carbonate as found in Lithobid, Lithene, and Eskalith, as well as other medications such as Depakote and Tegretol. Other agents being used are Neurontin, Lamictal, Gabitril and Topomax. Anti-anxiety medications such as Klonopin, Xanax, Buspar and Ativan can help decrease anxiety, agitation and over-activity, and help promote standard sleep. These medications may be used in addition to mood stabilizers.

No medication works on all students. The family should expect a trial and error process, lasting weeks, months or longer, as doctors try several medications alone and in combination. They find the best treatment for your particular student.

Parents often find it difficult to accept that their student has a chronic condition that may require treatment, with several medications. It is important to remember that untreated Bipolar Disorder has a fatality rate of 18% or more from suicide. This is equal or greater than that from any serious physical illnesses. The untreated disorder carries a risk of drug and alcohol addiction, damaged relationships, school failure, and difficulty finding and holding jobs. The risks of not treating are substantial and must be measured against the unknown risks of using medication to safety inefficacy has been established in adults but not yet in students.

This diagnosis can certainly impact the educational needs of a student. A diagnosis of Bipolar Disorder means a student has a significant health impairment that requires ongoing medical management. As a result, the student is entitled to accommodations in school to benefit from the student's education.

Bipolar Disorder and the medications used to treat it can affect a student's school attendance, alertness and concentration, since study light, noise, and stress motivation and energy available for learning. The student's functioning can vary greatly at different times through the day, season and school year.

### **Educational Accommodations for Bipolar**

The educational needs of a particular student with bipolar disorder vary depending on the frequency, severity and duration of episodes of illness. These factors are difficult to predict in an individual case. Transitions to new teachers and new schools, return to school from vacations and absences, and changing to new medications are common times of increased symptoms for students with bipolar disorder. Medication side effects that can be troublesome at school include increased thirst and urination, excessive sleepiness or agitation, and interference with concentration. Weight gain, fatigue, and a tendency to become easily overheated and dehydrated impact a student's participation in gym and regular classes.

These factors and any others that affect the student's education must be identified. A plan (called an IEP) will be written to accommodate the student's needs. The IEP should include accommodations for periods when the student is relatively well (when a less intense level of services may suffice), and accommodations available to the student in the event of relapse. Specific accommodations should be backed up by a letter or phone call from the student's doctor to the director of special education in the school district.

Examples of accommodations helpful to students and adolescents with Bipolar Disorder include:

- preschool special education testing and services
- small class size (with students of similar intelligence) or self-contained classroom with other emotionally fragile (not "behavior disorder") students for part or all of the day
- one-on-one or shared special education aide to assist student in class
- back-and-forth notebook between home and school to assist communication
- homework reduced or excused and deadlines extended when energy is low
- late start to school day if fatigued in morning
- recorded books as alternative to self-reading when concentration is low
- designation of a "safe place" at school where student can retreat when overwhelmed
- designation of a staff member to whom the student can go as needed
- unlimited access to bathroom
- unlimited access to drinking water
- art therapy and music therapy
- extended time on tests
- use of calculator for math
- extra set of books at home
- use of keyboard or dictation for writing assignments
- regular sessions with a social worker or school psychologist
- social skills groups and peer support groups
- annual in-service training for teachers by student's treatment professionals (sponsored by school)
- enriched art, music, or other areas of particular strength
- curriculum that engages creativity and reduces boredom (for highly creative students)
- tutoring during extended absences
- goals set each week with rewards for achievement
- summer services such as day camps and special education summer school
- placement in a day hospital treatment program for periods of acute illness that can be managed without inpatient hospitalization
- placement in a therapeutic day school during extended relapses or to provide a period of extra support after hospitalization and before returning to regular school
- placement in a residential treatment center during extended periods of illness if a therapeutic day school near the family's home is not available or is unable to meet the student's needs