What School Teachers Should Know About Bipolar Disorder

by

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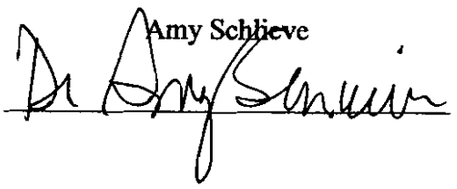

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ABSTRACT

This study critically reviews the literature on mood disorders, specifically bipolar disorder in children, and how school professionals, specifically teachers can effectively meet such challenges in the classroom setting. This researcher met many challenges while conducting this research, including overcoming the struggles of limited information in regards to childhood bipolar disorder, however, the researcher has strived to provide a comprehensive understanding of what bipolar disorder is, how it affects students in the school setting, as well as how teachers can effectively help students with bipolar disorder.

Research indicates that even today mental health professionals have only limited knowledge about bipolar disorder in general, and even less information about childhood bipolar disorder. Due to this limited knowledge even by the mental health professionals, it is reasonable

then that the general public, including school professionals do not fully understand what it means to struggle with bipolar disorder in the school setting.

Despite this limited information, it is possible to develop an understanding of what childhood bipolar disorder entails, how the child is affected, as well as ways that school professionals can help these students to reach their full potential. Research indicates mental health professionals and other researchers have begun to study parts of the human brain in hopes of better understanding how mood disorders affect a person's thought process. As a result of this research it is now known bipolar disorder, and other mood disorders are partially a result of a person's genetic makeup. In the future, people will learn more about bipolar disorder and how it affects a persons functioning.

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Chapter One: Introduction

What do Sir Isaac Newton, Ludwig von Beethoven, Charles Dickens, Abraham Lincoln, Ernest Hemmingway, and Winston Churchill all have in common? Many believe these famous people all suffered from mood disorders, most likely bipolar disorder (Child and Adolescent Bipolar Foundation, 2008). Since members of my own family have also been diagnosed with bipolar disorder, would one suggest that any of us will be considered geniuses someday? Only time will tell!

Bipolar disorder is a complex mental health disorder that is difficult to diagnose. Though bipolar is similar to other mental health disorders, there are important differences and a variety of treatments for other mental health disorders, which can actually be harmful to individuals with bipolar disorder (Kutscher, 2005). Bipolar disorder, historically, was thought only to exist in adults. Within the past few decades, however, children have begun to be diagnosed with this condition.

Bipolar and other mental health disorders can be devastating in children, leading to serious adverse effects on classroom performance. Affected children have difficulty concentrating or staying focused and have a dramatically increased likelihood of demonstrating disruptive classroom behaviors. Teachers and other educational professionals are often called upon by mental health professionals to recall certain behaviors children have exhibited as a means of assisting in accurately diagnosing mental health disorders in children. As teachers spend a significant amount of time with today's youth, the teacher can often recognize behaviors which go unnoticed by others. Since many of the behavioral signs and symptoms of different mental health disorders are similar, the more knowledge a teacher has about such disorders the better the teacher will be at detecting the differences, the more helpful of an assessment the teacher will provide.

Getting the correct diagnosis is essential in determining the most appropriate treatments. Appropriate treatment means reduction in undesirable classroom behaviors. Even without diagnosis, if a teacher is suspicious of such a disorder, there are a wide variety of adaptations that can be employed to reduce those undesirable behaviors. Therefore, teachers benefit to be well-informed about these disorders. This information will allow the classroom teacher to be able to recognize typical behaviors associated with each, and to be aware of solutions. The classroom teacher will also be able to reduce undesirable behaviors, to maintain a more functional classroom setting, resulting in the improvement of education for all students in the class.

The following is one example of what can happen when a child, unbeknownst to prominent figures in the child's life, is struggling with bipolar disorder.

As soon as my son Austin began kindergarten, the level of difficulty Austin would have in school became apparent. The teacher frequently discussed Austin's inability to sit still, to focus, and to stop talking. On more than one occasion, the concern about Austin possibly struggling with attention deficit disorder with hyperactivity/impulsivity (ADHD) was discussed. The teacher was more concerned with Austin's stuttering and, at first the focus was on helping to correct Austin's speech. The school speech therapist completed an evaluation and Austin began a speech therapy program before the end of the school year.

By the time Austin entered second grade, multiple educators had mentioned ADHD, and my husband and myself decided the time to get Austin tested by a clinical psychiatrist had come. In our decision to seek help, we had to battle two of the biggest myths that currently exist regarding mental health disorders. The two myths are heavily related and state children's behaviors are the result of bad parenting skills and a person who seeks treatment for mental health concerns is

somehow weak or has failed (Fristad & Goldberg Arnold, 2004). Though nobody had specifically made any related comments to me at this point in my life, I still felt incredibly guilty.

Here's the truth about these myths. Oftentimes, parents choose not to seek treatment for the child for fear of being seen as having failed as a parent (Fristad & Goldberg Arnold, 2004). Fristad and Goldberg Arnold (p. 50, 2004) advise parents that "if friends, family, and even professionals have suggested that your parenting strategies are at fault, you're not alone." According to Fristad and Goldberg Arnold(2004), a wealth of research evidence exists in regards to children's health issues, including those with mood disorders; proving bad parenting is not the cause for the child's problems. "The truth is that the cause of mood disorders is probably in some fundamental way biological" (p. 50, Fristad & Goldberg Arnold, 2004). Fristad and Goldberg Arnold (2004), also believe the course of a psychiatric illness is greatly influenced by psychosocial events.

We knew we needed help so we scheduled the appointment. The psychiatrist told us the tests did not show Austin was dealing with ADHD but, there was more concern about other things Austin said to the psychiatrist. The psychiatrist informed us there should be concern Austin was suicidal at the age of seven. The psychiatrist asked us if we could put all sharp objects out of Austin's reach and if we could ensure Austin was supervised at all hours of the day and night. The conversation led us to face yet another myth about mental health disorders, the one which tells us depression does not occur in children. This misconception is based on the belief mental health illnesses are caused from environmental and psychological factors and mental health issues are not biologically based (Fristad & Goldberg Arnold, 2004). As a result of this misconception, mood disorders in children were not recognized in the United States until recently, with childhood depression first documented in the 1970s and 1980s, and childhood bipolar

disorder first documented in the mid-1980s. Today, society has begun to better understand the role biology, particularly genetics, plays in these types of disorders. This understanding has allowed for the recognition of childhood mood disorders, as well as research and treatment of these disorders (Fristad & Goldberg Arnold, 2004). At this point, seeking counseling and putting my son on medication seemed necessary. The counseling helped us all to get a better understanding of what Austin was experiencing, but the medication Austin was given did not seem to help and things seemed to worsen.

By the time Austin started third grade, the medication had been discontinued due to lack of effectiveness. The hope was, even without medication, Austin would have a satisfactory school year. But the third grade year did not start well, and by the middle of the year we were again having ADHD discussions with Austin's teacher. The teacher reiterated the concerns we had heard repeatedly in past years: Austin was unable to sit still, to focus on the task at hand, and to stop talking during class. Interestingly, and in hind sight, there was never any discussion about having the school test Austin for ADHD or to conduct any type of assessment of Austin's abilities. All speech services were being discontinued, as these services did not seem to be necessary anymore.

Then, however, notes began coming home from the school about how Austin was getting into fights with his peers, throwing snowballs at teachers' doors, and saying the teacher was stupid and Austin was going to kill the classroom teacher. At home things were not any better, as Austin would have terrible tantrums, lasting for hours and sometimes days, during which Austin would scream, cry, and vomit, throughout our home. The struggle to get chores and homework done in the evenings took all the available energy we, as parents, had. Austin's difficulty concentrating in school became even more apparent, as Austin often did not know what the assignments

were in their entirety or how to do the work, leaving Austin to try to piece things together at home in the evening. As Austin struggled to do the homework, frustrations mounted, leading into raging tantrums and excessive frustration. Though the tantrums, anger, and frustration were often only demonstrated at home, people outside our home were also noticing changes. Others commented to us about how sad and lonely Austin seemed and I realized the genuine smiles I used to see regularly were now few and far apart. According to Stillman (2005), the symptoms of depression in youth aged five and older can include such things as anger or aggression; a low level of tolerance for frustration; irritability with a dark attitude; expression of feelings of hopelessness or loneliness; or a tendency to have a gloomy mood.

During Austin's first semester of fourth grade, things deteriorated even more. The problems at school were escalating, and the teacher Austin had was less than understanding. Austin's teacher refused to meet with me outside of conferences and when I would bring up concerns about Austin's behavior in the classroom the teacher would often change the topic as quickly as possible. But, when we met with Austin's teacher at semester break, we found ourselves in yet another discussion about ADHD…Austin's inability to sit still in class and pay attention to the lesson, Austin's incessant talking, and the need to share his stories immediately with the teacher.

Home life was considerably worse than at school, as Austin's mood had became rather dark and, for the second time in his young life Austin began to threaten to kill himself, his stepdad, and/or me, depending on the day. Austin struggled to express his feelings of hopelessness both at home and at school. Stillman reports this as a sign that a child may be struggling with bipolar disorder (2005).

Due to the lack of communication with the school, the school staff did not know at the time we had again contacted Austin's psychiatrist for some help. There seemed to be no real an-

swer for us as to what was causing Austin's problems, but this was the first time the possibility of bipolar disorder was mentioned to my husband and myself. As a family, we had no idea what that meant, but we would soon discover.

After school one night, Austin was extremely excited about the weekend plans because Austin was going to spend the night at a cousin's house. At the time, nobody thought too much about the excitement, but looking back his excitement was excessive. When Austin was told his step-dad would pick Austin up from the Boys & Girls Club so Austin could eat supper and wash the dishes, Austin stated clearly going home with my husband was not something Austin wished to do. Austin was sent anyway. While at home, Austin hit a manic high, entered a state of psychosis, and became physically aggressive with my husband, again a common symptom of bipolar disorder in children Austin's age according to Stillman (2005). The conflict left both my son and my husband with bruises. Austin's bruises were on his face and clearly visible.

As a result of this incident, our family began a long healing process. With the help of a new psychiatrist, a more thorough evaluation was conducted. The conclusion was Austin did struggle with bipolar disorder and we called a meeting at school; the meeting involved Austin's teacher, the school social worker, the school counselor, the principle, and a county social worker. Surprisingly, prior to the time the meeting was called, the teacher was the only school professional even aware a problem existed. Austin never personally spoke to the school counselor or other professionals in the school, however, teachers often do seek assistance for students who are struggling with behaviors similar to Austin's from other school professionals (Cooley, 2007). Why Austin's behaviors did not raise more flags for the school staff is unknown. I will never forget the teacher's words when the teacher said at the meeting, Austin may have ADHD, but Austin was definitely too smart to have any major mental health disorder, such as bipolar disord-

er and, therefore, we must just be terrible parents. The teacher suggested we take some parenting classes. The comment really hit home, as this was a myth I had a hard time overcoming the first time we elected to seek professional help. However, I was now well aware Austin's disorder was not my fault; but, the guilt was still very much present.

Our discussions with Austin's teachers each year have led my husband and me to believe teachers are armed with little knowledge about bipolar disorder. As more is learned about this disorder and the diagnosis of bipolar disorder is being made with increased frequency, the teacher having some basic knowledge is becoming ever more important. In hindsight, had we or any of Austin's teachers been informed about this disorder and the symptoms, Austin may have been diagnosed sooner and, perhaps, we may have avoided some of the struggles we had. Having teachers who understand this disorder may prevent others from repeating our experiences. We feel lucky. Austin's condition has been diagnosed, is being treated and managed, and Austin's future looks much brighter as we move forward. Many youth today are having this same struggle and are not getting diagnosed or getting assistance coping with this disorder at home or at school.

I've already mentioned some of the myths my family had to confront about childhood mood disorders as are stated by Fristad and Goldberg Arnold (2004): if a person were to seek treatment for mental health concerns then the person is somehow weak or has failed; parents are to be blamed for a child's bad behavior and should seek help with their parenting skills; depression does not occur in children. Other myths exist and also need to be considered. According to Fristad and Goldberg Arnold (2004), these include the following and will be discussed in greater depth in chapter two: people should be able to just stop being depressed; a person who is suffering from depression will not be depressed long because the depression will go away quickly,

without treatment; everyone gets depressed at some point in their lives; and all teenagers are moody therefore attention should not be paid to these behaviors.

The myth which states, if a person were to seek treatment for mental health concerns than the person is somehow weak or has failed stems from clear societal stigma regarding mental health disorders. Research proves this stigma exits. According to a survey conducted by the American Psychological Association (2007), 21 percent of Americans stated personally seeking out a mental health professional would cause concerns as someone else might find out, and 25 percent would be concerned if the human resource department at the place of a persons' employment had access to personal mental health records. Additionally, 68 percent stated privacy was important in regards to an individual's mental health status. The American Psychological Association (2007), continued by stating as many as 20 percent of Americans, in any given year, may decide against seeking help from a mental health professional, because of the stigma around such issues. With these statistics from American adults, one could reasonably assume these individuals may also be reluctant to bring a child to a mental health professional, not only for treatment, but for initial diagnosis.

Equipped with this information, the possibility the prevalence of bipolar disorder might be seriously underestimated exists; however previous research still shows this disorder affects a large number of today's youth. Bipolar disorder, formerly known as manic-depressive disorder, is believed to occur in as many as 300,000 teenagers in the United States, which works out to be one to two percent of students in the age group, as indicated by the 1990 census, and an unknown number of children, according to Fristad and Goldberg Arnold (2004). Papolos and Papolos (p. 4, 2006), state "bipolar disorder is a neglected public health problem" and one-third of the children in this country diagnosed with ADHD may actually have the early symptoms of bipolar disorder.

"Since close to 4 million children were prescribed stimulants such as Ritalin in 1998, that is over 1 million children who eventually will be diagnosed as bipolar" in the United States alone (p. 4, Papolos & Papolos, 2006). Papolos and Papolos (2006), continued by stating, one-third of children who seem to be suffering from depression later develop bipolar disorder. There are 3.4 million cases of depression in children and adolescents, equating to another approximately 1.1 million cases of bipolar disorder. Added together, the estimated population of children and adolescents suffering from bipolar disorder is close to three million. A study conducted by "Dr. Peter M. Lewinsohn and his colleagues examined more than 1,700 high school students in western Oregon, and found that 5.7 percent of this group of adolescents—or ninety-seven students—suffered some form of bipolar spectrum disorder" (p. 4, Papolos & Papolos, 2006).

Statement of the Problem

Bipolar disorder affects a significant proportion of today's students. However, the disorder is difficult to diagnose. Some of the signs may be mild, preventing any action on the parents' part to seek assistance from professionals. The presenting signs are often non-specific and potentially associated with a variety of different disorders, not limited to mood disorders. Diagnosis is not limited to a particular age group of students, and the symptoms may change depending on the age of onset. Finally, societal stigma, finances, or other concerns preclude diagnosis in many cases. Many teachers do not have adequate knowledge about mental health disorders and often do not recognize key signs which might aid in an accurate diagnosis. Teachers spend a significant amount of time with today's youth and their input is often requested by the psychiatrist conducting the initial evaluation in regards to school-related issues (Stillman, 2005). If teachers can gain a better understanding of the signs which might distinguish bipolar disorder from other disorders, then the possibility more children might be properly diagnosed with this and other mood

disorders exists. Proper diagnosis is imperative. When the teacher has appropriate knowledge about bipolar disorder, the teacher will be better able to understand the child's behaviors, to aid in diagnosis, to assist in assessing therapies, and to maintain structure and effective teaching methods in any classroom, but especially when there is a student with bipolar disorder in the class.

Purpose of the Study

The purpose of this study is to review literature for school professionals, specifically classroom teachers, but also school counselors, special education teachers, social workers, school psychologists, and principals in the following manner. First, to help school professionals understand how bipolar disorder is similar to and different from other mood disorders, and become acquainted with the signs that will help the mental health professional make the appropriate diagnosis. Secondly, to help school professionals understand how mood disorders, especially bipolar disorder, in school-age children can affect classroom behavior, level of motivation, social patterns and self-esteem. Third, provide school professionals with a better understanding of the treatment of bipolar disorder including the benefits and side effects of the treatment. Fourth, to provide school professionals, specifically classroom teachers, with research based classroom interventions which can help the classroom teacher to maintain an educational environment conducive to effective teaching of all students.

Assumptions of the Study

The assumptions of the study include:

1) Bipolar disorder and other mental health disorders have only recently been discovered in children, therefore one can reasonably assume most school professionals, including school counselors, will have very limited knowledge about bipolar disorder.

2) Due to the stigma associated with most mental health illnesses many children are not diagnosed. In many cases where the diagnosis has been made, parents and children choose to not tell school personnel for fear of rejection, humiliation, or shame.

3) Bipolar disorder tends to be difficult to diagnose in children because the symptoms of bipolar disorder present similar in children to the symptoms of other mood disorders or ADHD.

Definitions

Several terms should be noted for a better understanding of the research. The following terms will be used throughout this paper:

Mood disorder. "Any of a group of psychiatric disorders, including depression and bipolar disorder, characterized by a pervasive disturbance of mood that is not caused by an organic abnormality, also called affective disorder" (Dictionary.com).

Depression. "An episode of mood in which sadness and other typical symptoms such as loss of interest or pleasure last for at least two weeks and are intense enough to cause significant distress or impairment" (p. 134,Mountain, 2003).

Dysthymic disorder. "is defined as depression for more days than not over a two-year period (although children/adolescents are only required to be irritable for at least one year)" (p. 156, Kutscher, 2005).

Major Depressive Disorder. "A major depressive episode is marked by the experience nearly every day for at least two weeks of feelings of sadness, emptiness, or loss of "zest." (p. 155, Kutscher, 2005).

Bipolar Disorder. "A mood disorder in which the brain does not consistently regulate mood within a normal range. Bipolar disorder includes a spectrum of disorders. (See Bipolar I

disorder, bipolar II disorder, and Cyclothymic disorder.) From words meaning *two poles"* (p. 133, Mountain, 2003).

Bipolar I disorder. "A bipolar disorder whose chief characteristic is mania punctuated by depression" (p. 133, Mountain, 2003).

Bipolar II disorder. "A bipolar disorder whose chief characteristic is depression punctuated by hypomania" (p. 133, Mountain, 2003).

Cyclothymic disorder. "A type of bipolar disorder that is characterized by mood changes with symptoms of mania and depression. Symptoms do not meet the full criteria for Major Depression or Hypomania, either because they are fewer than the required number or their duration is shorter than required" (p. 134, Mountain, 2003).

Mania. "An episode of mood that is characterized by instability and that is above the range of normal mood" (p. 136, Mountain, 2003).

Hypomania. "An episode of mood that is in a range above that of normal mood but that is not as extreme as mania. From words meaning under and mania" (p. 136, Mountain, 2003).

Psychosis. "A condition in which there is a break from reality or one's personality" (p. 138, Mountain, 2003).

Psychomotor agitation. "A condition often associated with mania, in which increased physical motion is associated with increased mental activity" (p. 138, Mountain, 2003).

Psychomotor retardation. "A condition often associated with depression, in which decreased physical activity is associated with a slowing of mental activity" (p. 138, Mountain, 2003).

Racing thoughts. "Rapid thinking associated with mania or hypomania. Often the person experiencing racing thoughts will not perceive them as such, but will have the sensation that the

world is slowed down or that thoughts are intrusive, interfering with concentration and focus" (p. 138, Mountain, 2003).

Rapid cycling. "Technically, rapid cycling is diagnosed when there are four or more distinct episodes of depression, mania or hypomania within one year. However, the episodes are likely to be more frequent than four times yearly" (p. 138, Mountain, 2003).

Chapter Two: Literature Review

This chapter will consist of a literature review. First will be a brief discussion of the history related to bipolar disorder, followed by a review of societal myths and stigmas about mental health disorders. Next, the chapter will include a comprehensive definition of a mood disorder as defined by past literature. This chapter will give a general understanding of how depression is defined and diagnosed, as well as the different kinds of depression. The paper will then discuss bipolar spectrum disorders. The document will discuss how bipolar disorder appears similar to and different from depressive disorders, specifically in children, as well as how bipolar disorder affects students in the classroom. This chapter will then discuss some basic treatment options for bipolar disorder, along with some potential side effects. The chapter will use past literature to explain the techniques that can be used in the classroom to help children who present with bipolar disorder type symptoms. Finally, this chapter will discuss what research finds should be done by the school professional when there is reason to believe a student is suicidal.

History of Mood Disorders

German psychiatrist Emil Kraepelin coined the phrase "manic-depressive disorder" in the late 19th century (Kraepelin, 2003). Kraepelin theorized at the time many disorders had common symptoms and with recognition of the patterns of these symptoms eventually lead to differentiation among mental health disorders (Kraepelin, 2003). Kraepelin referred to the method of personal choice in diagnosing as clinical. Previously, individuals had been diagnosed using the symptomatic method, in which the symptoms themselves, rather than the pattern of those symptoms, defined the disorder (Kraepelin, 2003). Using the clinical method, Kraepelin was able to distinguish between manic depressive disorder and schizophrenia (Kraepelin, 2003). Kraepelin even theorized these disorders had a genetic basis, as individuals experiencing schizophrenia

tended to have relatives with the same symptomatic tendencies, while those who suffered from manic depressive disorder also had family members suffering from the same symptomatic tendencies (Kraepelin, 2003). In fact, Positron Emission Tomography scans (PET scans), used today prove Kraepelin's theory, as these scans show certain parts of the brain in an individual who has bipolar disorder are more active than the corresponding parts of the brain of a person without bipolar disorder. PET scans also show certain parts of the brain develop differently in people with bipolar disorder than those without bipolar disorder (Geller and DelBello, 2003). Kraepelin also tried to determine if the symptoms had an internal cause, such as brain damage, hereditary factors, or metabolic dysfunctions, as Kraepelin believed these issues would make the associated mental health disorder incurable (Kraepelin, 2003). Kraepelin's early work serves as the basis for all major diagnostic systems in use today, including the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health Disorders (DSM) classification system (Kraepelin, 2003).

In 1957, Karl Leonhard, another German psychiatrist, further categorized mood disorders, and separated unipolar disorders, such as major depressive disorder, from bipolar disorders (Carroll, 1998). Even in the mid 1900s, however, these disorders were thought to exist only in adults and not in children. In the 1970s and 1980s mental health professionals began looking at the possibility of children suffering from depression (Fristad & Goldberg Arnold, 2004). The concern of bipolar disorder occurring in children followed in the mid-1980s (Fristad & Goldberg Arnold, 2004).

Historically, people who were diagnosed with mental health disorders were institutionalized (Kraepelin, 2003). This treatment led to a very strong societal stigma as well as the development of a number of myths about mental health disorders (Kraepelin, 2003). Unfortunately,

these myths and stigma still exist, though the stigma of mental health disorders has certainly diminished in recent years (Sirey et. al., 2001).

Myths and Societal Stigma

There were several important ideas presented in chapter one which need to be reviewed before proceeding. According to a survey conducted by the American Psychological Association (2007), 21 percent of Americans stated personally seeking out a mental health professional would cause concerns as someone else might find out, and 25 percent would be concerned if the human resource department where employed had access to an individuals mental health records. Additionally, 68 percent stated privacy was important in regards to an individual's mental health status. The American Psychological Association (2007), continued by stating that as many as 20 percent of Americans, in any given year, may decide against seeking help from a mental health professional, because of the stigma around such issues. With these statistics from American adults, one could reasonably assume these individuals may also be reluctant to bring a child to a mental health professional, not only for treatment, but for initial diagnosis.

In chapter one, several myths were discussed. Reviewing these myths will help to refocus on the facts about bipolar disorder. One myth is if a person were to seek treatment for mental health concerns than the person is somehow weak or has failed (Fristad & Goldberg Arnold, 2004).This is possibly one of the most dangerous and harmful myths in regards to bipolar and other mood disorders, as proper diagnosis and treatment are inhibited. The fact is, oftentimes, parents choose not to seek treatment for the child for fear of being seen as having failed as a parent (Fristad & Goldberg Arnold, 2004).

The second myth according to Fristad and Goldberg Arnold (2004), is parents are to be blamed for a child's bad behavior and should seek help with personal parenting skills. Fristad

and Goldberg Arnold (p. 50, 2004), provide the following advice to parents by stating "if friends, family, and even professionals have suggested your parenting strategies are at fault, you're not alone". According to Fristad and Goldberg Arnold (2004), a wealth of research evidence exists in regards to children's health issues, including those with mood disorders, proving bad parenting is not the cause for the child's problems; however, these myths continue to persist in American society. Research has proven mood disorders have a genetic basis and thus are not the fault of the parent (Fristad & Goldberg Arnold, 2004). Fristad and Goldberg Arnold (2004), also believe the course of a psychiatric illness is greatly influenced by psychosocial events.

A third myth states depression does not occur in children. This misconception is based on the belief that mental health illnesses are caused from environmental and psychological factors and mental health issues are not biologically based (Fristad & Goldberg Arnold, 2004). As a result of this misconception, mood disorders in children were not recognized in the United States until recently, with childhood depression first documented in the 1970s and 1980s, and initial documentation of childhood bipolar disorder in the mid-1980s. Today, as a society, we have begun to better understand the role biology, particularly genetics, plays in these types of disorders. This has allowed for the recognition of childhood mood disorders, as well as research and treatment of those disorders (Fristad & Goldberg Arnold, 2004).

A fourth myth says people should be able to just stop being depressed (Fristad & Goldberg Arnold, 2004). The lows most people feel are not true depression, but are lows from which people can recover. However, if a person is truly clinically depressed, the fact is the person is suffering from an illness and will require specialized treatment to meet personal needs in order to recover (Mountain, 2003).

The fifth myth is similar and says a person who is suffering from depression will not be depressed long because the depression will go away quickly, without treatment (Fristad & Goldberg Arnold, 2004). According to Fristad and Goldberg Arnold (2004), the facts are an episode of depression can last anywhere from seven to nine months or the equivalent of the entire school year for a child. Moreover, "40 percent of children who have had a single depressive episode will have another one within two years, 70 percent will have a relapse within five years" (p. 9, Fristad & Goldberg Arnold, 2004). When treatment is received, treatment may help to reduce the frequency as well as the severity of episodes. However, watching for signs of recurrence is still extremely important (Fristad and Goldberg Arnold, 2004).

There is no doubt most people will experience many lows at different points in life. The sixth myth is the belief that everyone gets depressed at some point (Fristad & Goldberg Arnold, 2004). However, most people do not feel the extreme lows suffered by someone with clinical depression. Most people do not reach the point in which a clinical diagnosis could be made in regards to a mood disorder (Mountain, 2003).

A seventh myth is the belief all teenagers are moody and attention should not be paid to these mood swings (Fristad & Goldberg Arnold, 2004). The fact is everyone has some fluctuation in mood, but in the majority of individuals including teenagers, mood swings tend to occur less frequently, with less severity, and do not tend to last as long as signs of clinical depression or bipolar disorder will last. Due to these and many other myths, there is a general attitude in American society which leaves many who suffer with mental health illnesses to fight against social stigma as well as cope with an illness.

Though research proves this stigma still exits and people currently believe a lot of myths regarding mental health disorders, research also shows societal stigma is decreasing. According

to the American Psychological Association (2007), 25 percent of respondents to a survey stated the concern one would have in regards to others knowing about personally being treated by a mental health professional has decreased compared to five years ago. The American Psychological Association (2007), also found as many as 50 percent of Americans believe the stigma around mental health illnesses has decreased, and as many as 91 percent of Americans stated either the chances were higher one would personally consult a mental health professional or suggest a consultation with a mental health professional to a family member than in the past. According to the survey, Americans are changing how mental health issues are viewed and are more likely to seek out mental health professionals today than in the past. However, there are still issues with social stigma in regards to mental health concerns which need to be addressed.

Defining Mood Disorders

As noted previously, bipolar disorder falls under the classification of a mood disorder, of which, there are two broad categories. The first category consists of depressive disorders (Stillman, 2005). Depressive disorders include dysthymic disorder, major depressive disorder, and depression not otherwise specified; which will not be specifically discussed. The second category of mood disorders includes those in which a person experiences either mania or hypomania along with the depressive symptoms; these disorders are known as bipolar spectrum disorders (Hirschfeld et. al., 2000). There are four main types of bipolar spectrum disorders which include cyclothymic disorder, bipolar I disorder, bipolar II disorder (Hirschfeld, et. al., 2000), and bipolar disorder not otherwise specified; which will not be specifically discussed.

Depressive Disorders

Depression can be defined as "an episode of mood in which sadness and other typical symptoms such as loss of interest or pleasure last for at least two weeks and are intense enough

to cause significant distress or impairment" (p. 134, Mountain, 2003). The National Mental Health Association (2008), states "about 20 percent of the U.S. population reports at least one depressive symptom in any given month as well as 12 percent who report two or more in a year" (p. 1). The American Psychological Association (2007), estimates that 121 million people worldwide may suffer from depression. The National Mental Health Association (2008), reports depression appears, in general, to be a common symptom or feature when a person experiences any form of mental illness. The American Psychological Association (2007), reported depression as one of the top worldwide reasons a person claims to be disabled. Research has shown a person who has suffered from any serious psychiatric disorder has an almost equal chance of suffering from major depression as someone who has had bouts with major depression in the past (National Mental Health Association, 2008).

Of the depressive disorders, dysthymic disorder, also known as dysthymia, is the least severe. Dysthymic disorder (DD) is defined as "depression for more days than not over a two-year period (although children/adolescents are only required to be irritable for at least one year)" (p. 156, Kutscher, 2005). Symptoms of this disorder in children may include the following: the child generally feels sad or unhappy, the child seems overly irritable, the child has difficulty getting enough sleep, the child's appetite diminishes or becomes overly excessive; the child has a poor self-image or lack of self-esteem; the child has difficulty thinking or concentrating; and/or the child expresses a sense of hopelessness (Fristad & Goldberg Arnold, 2004).

Major depressive disorder tends to be a more serious depressive disorder, as the feelings are often more intense and last for longer periods of time. A major depressive episode occurs when a person experiences feelings of sadness or emptiness, as well as lack of motivation nearly every day for at least two weeks (Kutscher, 2005). Clinical depression can be caused by many

different things including biological factors, cognitive factors, a persons' gender, and/or difficult situations (Geller & DelBello, 2003). Depression can be the side effect of some medications and co-occurs with some medical illnesses such as diabetes (Mental Health America, 2008).

Hypomania, and Mania

Before discussing the bipolar spectrum disorders one should know the basics about mania and how these symptoms present in children. According to Papolos & Papolos (2006), you may notice a child seems to be extremely goal-oriented, or may have periods of intense silliness, along with grandiosity. When a child is exhibiting grandiose behavior, the child may believe the rules do not apply and the child will not be afraid to express this feeling. Kutscher (2005), agrees with Papolos and Papolos, Kutscher even goes on to state the child may also have poor judgment, be extremely sensitive to stimuli, and experience extreme rages lasting for hours. Stillman (2005), states a child who is experiencing rapid thoughts may demonstrate this through rapid speech, which often presents as a compilation of random thoughts (The child often will jump from topic to topic and/or tell only part of an idea/story before moving on). Often, the child may actually spit while talking. Stillman (2005), also believed the child who is experiencing mania may begin to experience an increased appetite to the extent of taking food from others or hoarding food in a bedroom or other seemingly safe place.

Bipolar Spectrum Disorders

The mildest of the bipolar spectrum disorders is cyclothymic disorder, also known as cyclothymia. With this mood disorder, a person experiences emotional ups and downs (Mayo Clinic, 2008). Cyclothymia is distinguished from bipolar disorder by the lower intensity of the mood swings, meaning a person with cyclothymia will experience a milder depression and hypomania rather than mania (Pavuluri, 2008). A person who has cyclothymia will be at greater risk of sub-

stance and alcohol abuse, of having legal and financial problems, of committing suicide, and of developing bipolar disorder than those who do not suffer from cyclothymia or other mood disorders (Mayo Clinic, 2008). Often, children with cyclothymia have mood cycles which are mild enough to allow the child to be able to function (Pavuluri, 2008).

A second of the bipolar spectrum disorders is known as Bipolar II disorder. Someone who suffers from slightly more severe mood cycles than a person who experiences cyclothymia might be diagnosed with bipolar II disorder (Mountain, 2003). A person is diagnosed with bipolar II disorder when the person has experienced one or more major depressive episodes which have been accompanied by at least one hypomanic episode (Geller & DelBello, 2003). Bipolar II disorder is different from bipolar I disorder because those who are diagnosed with bipolar II disorder tend to experience a hypomanic state rather than a manic state (National Institute of Mental Health, 2008).

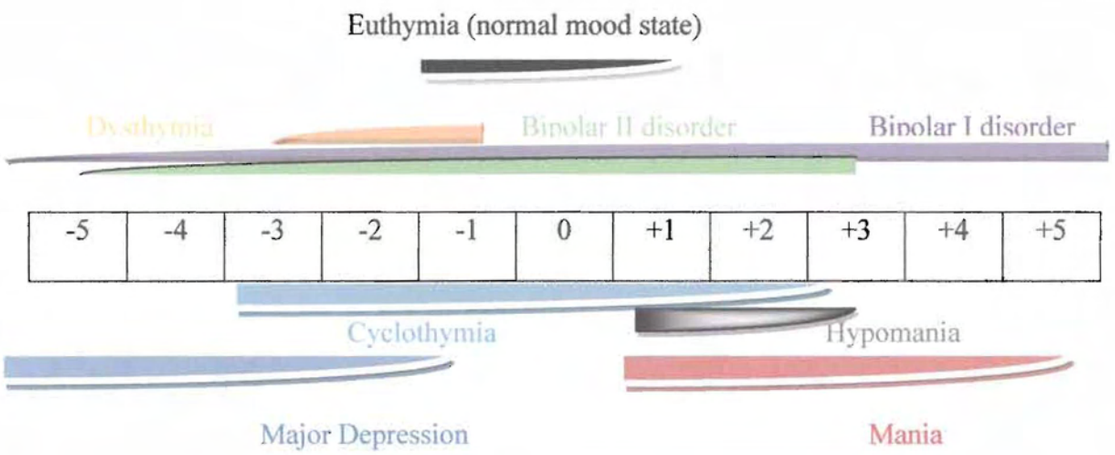
As with cyclothymia and bipolar II disorder, individuals with bipolar I disorder experience mood cycles but the mood cycles occur with a higher intensity (Pavuluri, 2008); the depressive episodes are consistent with major depressive disorder and the mania is true mania. A person who is diagnosed with Bipolar I disorder will have recurrent manic episodes alternating with major depressive episodes (National Institute of Mental Health, 2008). One must note in order to be diagnosed with bipolar I disorder a person must have experienced either a mixed state or a manic episode (Fristad & Goldberg Arnold, 2004). A mixed state occurs when a person is experiencing symptoms of both a manic episode and a depressive episode at the same time (Pavuluri, 2008). Children who experience bipolar I disorder are likely to experience a continuous cycling pattern which is known as ultradian (Fristad & Goldberg Arnold, 2004). For the latest

diagnostic criteria for any of the above mood disorders refer to the most current version of the DSM.

After reading the above criteria most people would be confused about what the differences are, as the criteria read similarly. For a better understanding of how all the mood disorders discussed above are similar and different you can reference Figure 1 on the next page. Figure 1 shows that mania and hypomania are both located on the plus side of the chart, while dysthymia and major depressive disorder are located on the minus side of the chart. The further away from 0, in either the positive or negative direction, the more intense the feelings are.

A person who experiences normal mood states will have moods varying from -1 to +1. Figure 1 shows that a person with dysthymia will express feelings of -1 to -3 intensity, while someone with major depressive disorder will experience feelings with a -1 to -5 intensity. Individuals with cyclothymia experience negative feelings of the same intensity as those with dysthymia and less intense than those with major depressive disorder. But, unlike those with depressive disorders, these individuals will also experience feelings in the +1 to +3 range. Cyclothymia is shown encompassing dysthymia and hypomania, but does not enter into either the major depression or mania levels of intensity. Individuals with both bipolar I and bipolar II disorders experience feelings in the -1 to -5 range, consistent with major depressive disorder, but additionally will experience feelings in the positive range. Those with bipolar II disorder will experience positive feelings with a +3 intensity and those with bipolar I disorder will experience positive feelings with a +5 intensity. A person who is experiencing bipolar I disorder will experience mood swings from +5 all the way to -5, ultimately encompassing the entire chart.

Figure I



(Figure 1 courtesy of p. 20, Faedda, & Austin, 2006)

Diagnosing Mood Disorders

Of importance for school professionals is to understand the process by which a student with a mood disorder is diagnosed, as the school professional is often involved in the process. The school professional may notice things others do not because of the difference in situations (Faedda, & Austin, 2006). The process for diagnosing a child with bipolar disorder is extremely complicated because there are no tests which can be utilized to determine if the child has bipolar disorder or not, even though many researchers currently believe bipolar disorder, like many other mental health disorders, is genetic. Most patients are diagnosed through a trial-by-error technique.

Once the help of a mental health professional is sought, thorough interviews of both the child and the child's parents are conducted. These interviews include a detailed physical and mental history of both the immediate and extended families (Fristad and Goldberg Arnold, 2004). Additionally, school professionals (teachers, counselors, psychologist, and/or social

workers) familiar with the student may be asked to fill out a form, an example of which is presented in appendix A of this document.

The information obtained through this process is used to create a working diagnosis according to Fristad and Goldberg Arnold (2004), which means that "although the child's exact diagnoses needs to be confirmed, this is the diagnosis (diagnoses) that most accurately describes the child" (p. 74). Fristad and Goldberg Arnold (2004), also stated that oftentimes doctors will use terms like "rule-out diagnosis," which means "there is significant reason to consider the diagnosis but the clinician wants to watch for additional signs and symptoms to develop over time before making a firm diagnosis"(p. 74). The working or rule-out diagnosis is then altered based on response to treatment and repeated evaluations and interviews.

Treatment

For children who are suffering with bipolar disorder, early treatment is extremely helpful in allowing the child to reach full potential as an adult. According to Mental Health America (2007), a comprehensive treatment plan most likely should include counseling along with medication.

There are many different classes of medications a mental health professional may use and the side effects of each can be dangerous (Kutscher, 2005). These include antidepressant medications, mood-stabilizing medications, atypical antipsychotic medications, and sleep aids (Stillman, 2005). Most children who must live with bipolar disorder will be given at least one type of medication, however, children are commonly placed on more than one medication (Stillman, 2005). Each medication has a list of possible side effects. Those side effects may be noted before the therapeutic effects are noted (Pavuluri, 2008).

Antidepressants include medications such as Prozac, Zoloft, Paxil, Celexa, Wellbutrin, Cymbalta, Togranil, Pamelor, Eldepryl, and Marplan, to name a few (Stillman, 2005). These types of medications are often used to relieve the effects of depression (Stillman, 2005). Students taking medications in this class may experience headaches, dry mouth, nausea and/or vomiting, confusion, trouble concentrating or thinking, blurred vision, profuse sweating, muscular twitches, increased or rapid heart rate, weight loss or gain, constipation or diarrhea, dizziness, skin rash, nervousness, agitation, or anxiety (Stillman, 2005).

Lithium, Depakote, and Tegretol are mood-stabilizing medications and are used to reduce the intensity and/or frequency of mood swings in a person with bipolar disorder (Stillman, 2005). Like the antidepressants, the list of side effects includes difficulty with concentration, weight gain, diarrhea, dizziness, sleepiness, nausea, and headache (Stillman, 2005). Other side effects a student might experience include fuzzy vision, thinning hair, tremors (slight, uncontrollable shaking of legs, feet, hands, or arms), frequent urination, and increased thirst (Stillman, 2005).

The third class of medications commonly used to treat bipolar disorder is atypical anti-psychotic medications (Stillman, 2005). According to Stillman (2005), these drugs may be used to give relief of the more severe symptoms of bipolar disorder, including rages, physical aggressiveness, or just strong emotional switches. These medications may be used on a long term basis and include drugs such as Risperdal, or Abilify (Stillman, 2005). The side effects for these medications include sedation (fogginess, or being groggy), constipation, dry mouth, dizziness, weight gain, upset stomach, headaches, and difficulty sleeping (Stillman,2005).

Finally, a mental health professional may prescribe a sleep aid. These include such medications as Ambien, Benzodiazepines (benzos), Melatonin, or Benadryl (Stillman, 2005). Ambien and Benzodiazepines are generally used as short-term sleeping aids, but may also be used to help

the child relax or to quiet anxiety so the child can sleep (Stillman, 2005). The side effects of Ambien and Benzodiazepines can include fearfulness, insomnia, impaired coordination, sensitivity to light, increased agitation rather than calming, visual or touch-sensitive hallucinations, muscle aches and pains, nightmares, excitability, constipation or diarrhea, dizziness, headaches, nausea or vomiting, or depressed moods (Stillman, 2005). Melatonin is a natural chemical our body produces to induce a regular sleep pattern and, when given as a supplement, creating and regulating the sleep pattern is helpful. The best part of this sleep aid is that there are no known side effects (Stillman, 2005). A mental health professional may prescribe Benadryl because of the known side effect of drowsiness. Additional side effects of Benadryl include dizziness, dry mouth, jitteriness and agitation, impaired thinking, sore throat, insomnia, nightmares, chest pain, and heart palpitations (Stillman, 2005).

As mentioned previously, the treatment plan should include counseling, along with the medications. Development of the treatment plan should include the family and the child whenever possible (Mental Health America, 2007). If the child is involved in the treatment plan, the child is more likely to participate in and comply with the plan (Kutscher, 2005). School professionals may be asked to monitor a child as the family begins treatment. For an example of such a form please reference appendix B of this document. The child's psychiatrist may also wish to speak directly with the teacher. Please refer to chapter 3 for a list of topics that should be covered when conferring with a child's physician.

The School's Role

In the previous section, mood disorders of particular importance to school professionals were discussed and the intensity of the emotions associated with each mood disorder were pre-

sented. However, this paper has yet to discuss particular recognizable symptoms of different mood states.

According to the National Health Association (2007), children who are experiencing a depressive state, may exhibit any combination of the following symptoms: frequent sadness or crying; withdrawal from friends and activities, decreased energy level; lack of enthusiasm or motivation; feelings of worthlessness or excessive guilt; extreme sensitivity to rejections or failure; major changes in habits such as over-sleeping or over-eating; frequent physical complaints such as headaches and stomachaches; recurring thoughts of death, suicide, or self-destructive behavior. The Child and Adolescent Bipolar Foundation (2008), identifies many of the same symptoms, but also adds the child may appear to be agitated or be irritable; and may suffer from a reduction in grades and may have a difficult time concentrating;

Remember students who have bipolar disorder may also appear to be suffering from depression. However, these students may be moody and the students' moods will alternate between depression and mania, sometimes very rapidly (Child and Adolescent Bipolar Foundation, 2008). This same source reports that a child who is experiencing mania could experience some of the following symptoms: the child may have an elevated, expansive or a irritable mood; may talk about having a decreased need for sleep; may have rapid speech or appear to be experiencing pressure to keep talking; may experience grandiose thoughts which could be expressed through refusing to follow classroom rules because, in the opinion of the child, the rules do not apply to the child or unrealistic highs in self-esteem, sometimes with feelings of indestructibility; the child may be excessively involved in activities found to be pleasurable but are considered to be risky such as abusing drugs and alcohol, attempting daredevil stunts, or being sexually active or having unprotected sex; may appear to have increased mental and physical activity levels; may

engage in making poor decisions; and sometimes may experience hallucinations (Child and Adolescent Bipolar Foundation, 2008; The National Health Institute 2007).

Children afflicted with bipolar disorder can suffer socially and teachers might notice these children appear somewhat isolated from others. This is especially true of those who experience racing thoughts. As a result of the rapid change in thoughts, the student may not be able to listen to a classmate's story or to hold even a short conversation (Olson & Pacheco, 2005). Other recognizable symptoms of racing thoughts include difficulty focusing or staying on task; not being able to hear, process, and follow simple instructions; and inability to complete work in a timely manner (Olson & Pacheco, 2005).

Many children with bipolar disorder tend to develop night terrors, which are characterized by bodily threat, dismemberment, and even death; these night terrors may be induced by a delusional or paranoid state (Olson & Pacheco, 2005). The lack of sleep a child experiences from the fear of night terrors and/or during the manic state can be unimaginable. A child with bipolar disorder could end up with a learning delay and other academic failures resulting from lack of sleep (Olson & Pacheco 2005). To see differences between depression, euthymia, and mania in an easy to reference guide please reference appendix C.

Recognizing the symptoms specifically of bipolar disorders is slightly more complicated than recognizing the symptoms of each of the general mood states. According to Nekola (2001), and Cooley (2007), children developing bipolar disorder present differently at different ages. According to Cooley (2007), the preschooler who has bipolar disorder may be more susceptible to accidents, could have multiple fears which may seem to be excessive for the child's age, and may exhibit self-deprecating behaviors. The child between the ages of six and eight who presents with bipolar disorder may have excessive vague physical complaints, may be aggressive at times

but also clingy to the parent(s), and may work hard to avoid new situations as well as new people (Cooley, 2007). Younger children with bipolar disorder are at increased risk of experiencing irritability and are more likely to get into fights (Kutscher, 2005). Children presenting with bipolar disorder between the ages of nine and the early teen years may experience morbid thoughts involving death, and may worry excessively about school work (Cooley, 2007). During adolescence, those presenting with bipolar disorder may demonstrate excessive anger, may seem withdrawn, may be extremely sensitive to criticism, and could be suicidal (Cooley, 2007). As the child approaches adulthood, the symptoms begin to present more like the symptoms would present in an adult, with feelings of sadness or emptiness, loss of energy and motivation, and loss of self-esteem (Kutscher, 2005). Adolescents with bipolar disorder often turn to drugs and alcohol; these individuals have the potential to become substance abusers, may practice self-mutilation, and may suffer from eating disorders, in addition to the bipolar disorder (Cooley, 2007). The child with bipolar disorder may appear to have frequent changes in moods often viewed as the child's personality by adults (Kutscher, 2005). For example, the classroom teacher may feel as though the child is caring, thoughtful, and respectful one moment and the next moment the child is rude, unruly, and disruptive in the classroom.

One could use appendix D as an easy reference if a child is thought to be dealing with a bipolar spectrum disorder. Understanding these symptoms should help to bring some of these behaviors into perspective as the behaviors are related to the medical condition the child is experiencing (Faedda, & Austin, 2006).

Distinguishing between different mental health disorders can be extremely difficult as these disorders often have similar symptoms (Kutscher, 2005). Attention deficit disorder with hyperactivity/impulsivity (ADHD) is another mental health disorder, though not a mood disord-

er, that is frequently confused with bipolar disorder. ADHD presents similar in the classroom if little is known about the differences (Kutscher, 2005). The following is a comparison of the symptoms that might be noted with each disorder.

In ADHD, a child may have a difficult time concentrating and staying organized and may tend to be impulsive or overly active (Kutscher, 2005). Bipolar students also tend to have these same traits in the classroom. In fact, students who are diagnosed with bipolar disorder have often been diagnosed with ADHD first (Kutscher, 2005). One of the differences between bipolar disorder and ADHD is that students with bipolar disorder frequently have a family history of bipolar disorder or of substance abuse, while those with ADHD will not have as strong of a history of family struggles (Kutscher, 2005). A second difference is when a child with bipolar disorder has a tantrum; the tantrum tends to arise from limit setting, whereas a child with ADHD will more likely enter a tantrum due to over-stimulation (Kutscher, 2005). The length of the tantrums can vary in a child with bipolar disorder, but can last for hours. The child with ADHD will have a tantrum that lasts for just minutes (Kutscher, 2005). Students who have bipolar disorder generally tend to look miserable for no apparent reason; students with ADHD, however, will generally be chipper until frustrated by someone or something (Kutscher, 2005). The child with bipolar disorder will be irritable, but the child with ADHD will be irritated (Kutscher, 2005). A child with bipolar disorder tends to be oppositional and defiant, may appear to be intentionally aggressive or explosive, or may engage in risk-taking behaviors (Kutscher, 2005). A student with bipolar disorder could have irritability for hours in the morning, while the child with ADHD will have morning irritability for a few minutes (Kutscher, 2005). A student with bipolar disorder may also have separation anxiety, bad dreams, disturbed sleep, or fascination with gore; these things are not typical for a student with ADHD (Kutscher, 2005). Finally, a student with ADHD

will respond positively when given stimulants such as Ritalin, while a student with bipolar disorder will become worse when given the same medication (Kutscher, 2005).

The school is responsible, by law, to provide every child with a free and appropriate public education (Cooley, 2007). This law is known today as the Individuals with Disabilities Education Act (IDEA). Schools are also obligated to provide accommodations to students with any form of disability under Section 504 of the Rehabilitation Act of 1973 (Cooley, 2007). School professionals are taught about these laws during preparation and should understand the roles the educator must serve in order to comply. Unfortunately, for students with mood disorders, getting such services is not always easy (Cooley, 2007). One big problem is the student may be viewed more as having a discipline problem rather than having a disability. Children with discipline problems, however, can qualify for services under the serious emotional disturbance or other health impaired categories for an Individual Education Plan (IEP) (Cooley, 2007; Stillman, 2005; Kutscher, 2005). When the school can create a plan for the child, putting the child's behavior into context becomes easier (Stillman, 2005).

For students who qualify for accommodations, there are many things that need to be considered. Some students may benefit from interventions in the classroom which are designed to relieve frustration (Pavuluri, 2005). These things might include a squeeze ball or a bean bag chair or the ability to go to the back of the room and do jumping jacks for a few minutes. Some students may require unlimited access to water and/or unlimited bathroom breaks (Pavuluri, 2005). Others might benefit from attending daily therapy sessions in an otherwise regular school setting and some may require 24-hour care at an appropriate facility (Pavuluri, 2005). Some children will need assistance with developing appropriate social skills and self-esteem (Child and Adolescent Bipolar Foundation, 2008). Others may need speech therapy or other educational

supports (Child and Adolescent Bipolar Foundation, 2008). Scheduled meetings with appropriate specialists may be enough for some children (Child and Adolescent Bipolar Foundation, 2008). Others may need the freedom to make unscheduled visits to those specialists (Pavuluri, 2005). Many affected students may benefit from some sort of relaxation system (Child and Adolescent Bipolar Foundation, 2008). Other students may require relaxed policies on school arrival times (Pavuluri, 2005). The school plan will also need to take into consideration the child's medications and any side effects of the medications (Pavuluri, 2008).

For students who come to school with a formal diagnosis it is easier to know what accommodations the student will need because the case has been documented (Cooley, 2007). However, many students are not diagnosed with bipolar disorder but present at school with problems. For the classroom teacher remembering to talk only about observations made in regards to the child's behavior and not to give a diagnosis is going to be important (Cooley, 2007).

When a student, especially one with bipolar disorder, becomes agitated or manic, i.e., is experiencing intense emotions, the child may need some time to calm down before returning to participation in classroom activities (Fristad & Goldberg Arnold, 2004). One thing educators can do to assist children with bipolar disorder is to provide the child with a toolkit (Fristad & Goldberg Arnold, 2004). The toolkit should include things the child can do in each of four different categories: physical activity, creative thinking, social activity, and rest or relaxation (Fristad & Goldberg Arnold, 2004). The allowed activities in each category should be activities the child enjoys. Generally, the toolkit works best if more than one potential activity is available in each category (Fristad & Goldberg Arnold, 2004). A teacher and student might show this toolkit in written format on a student coping plan, an example of which is shown in appendix E. This plan enables a student to learn methods, appropriate for society, which the child can use to reduce the

intensity of the emotions (Cooley, 2007). The toolkit can be used to prevent undesirable behaviors by providing the student with appropriate outlets when the student is feeling vulnerable or overwhelmed.

Another method for helping students cope is to develop a behavior modification plan for the student (Cooley, 2007). Most often a child who needs a behavioral modification plan will already have an individual education plan (IEP), which was developed by a team of school professionals. This team often includes the classroom teacher, a special education teacher, a school psychologist, a school counselor, and anyone else deemed necessary by the school staff (Papolos & Papolos, 2006). This same team will develop the behavior modification plan and all staff members involved in educating the student will receive a copy of the plan and are responsible for following the plan (Papolos & Papolos, 2006). This plan allows the educator to hold the child responsible for the behaviors demonstrated (Cooley, 2007). The purpose of this plan is to help the student identify the inappropriate behavior, determine why the behavior was inappropriate, understand how the child's behaviors affected other students, and then to identify actions the child could take, when confronted with a similar situation, which would be considered more appropriate. An example of such a form can be found in appendix F.

A behavior contract, shown in appendix G is another tool that can assist the student in selecting appropriate behaviors, and even suggests rewarding desirable behaviors the student possesses, allowing the teacher to maintain focus on positive behaviors. This document serves as an agreement between the teacher and student. As with the behavior modification plan discussed above, this document can be used to help the student remember the classroom rules. Some similar plans might also suggest consequences if the student is unable to abide by the contract (Cooley, 2007).

The student should always be involved in developing any or all of the above plans if possible, as the student ultimately will be responsible for carrying out the plan (Cooley, 2007). Younger students will need assistance with this task. Appendixes H and I of this paper include examples of two different charts which will allow the student the opportunity to monitor the student's own behavior and to develop the skills and strategies needed later to function successfully in society.

The job of educators is to help students reach the student's full potential and to educate students (Cooley, 2007). One thing educators can do to help achieve this goal is to be educated about mental health disorders, the symptoms of each, and appropriate tools to manage a classroom in which one or more students in the class may be suffering with such a disorder (Naparstek, 2002). In order to help students most effectively, professionals within our schools must be able to distinguish between those students who are just having an off day or week and those who are suffering from a serious mental illness (Cooley, 2007). Making this distinction can be extremely difficult (Kutscher, 2005), and the task of recognizing children with bipolar disorder is further compromised by the large number of students who have been diagnosed with ADHD (Papolos & Papolos, 2006). A teacher's job is not to diagnose mental health disorders. However, a teacher can provide valuable assistance when bringing forth needed information for both assessment purposes and treatment (Naparstek, 2002).

Pavuluri (2008), lists ten tips for teachers who are working with the child who has bipolar disorder. For the complete list please reference chapter three. Pavuluri (2008), also recommends teachers of students with bipolar disorder establish and maintain good communication with the child's parents, as things that happen at school will affect what happens at home and things that happen at home will affect what happens at school.

Other authors provide a number of other suggestions which may be of benefit. According to Kutscher (2005), the key when teaching a student who has bipolar disorder is to underwhelm the student, which can be done by providing the student with a predictable, calm, and secure environment. A classroom can be made more predictable by placing the daily schedule on the board, by writing all assignments with due dates on the board, and/or by providing the students with notification a transition is coming (Kutscher, 2005). Even with notice, a student with bipolar disorder may need extra time to make the transition. Kutscher (2005), recommends allowing these students time to adjust.

Cooley (2007), and Kutscher (2005), both suggest the teacher develops a set of hand signals that a student may use to communicate confidentially with the teacher how the student is feeling. Being able to predict or understand the child's mood can prevent conflict and enable the teacher to better adapt to the student's needs (Kutscher, 2005). If the student can convey with accuracy the moods the student experiences or the teacher develops the ability to predict the mood swings, the teacher may be able to identify situations that seem to trigger undesirable behaviors and can work toward avoiding those triggers (Kutscher, 2005; Cooley, 2007). Additionally, if the student is in a manic state, the teacher may be able to shift to activities that help manage the student's energy. If the student is depressed, the teacher might elect to lighten the workload and shift the focus to quality of work rather than quantity (Kutscher, 2005). Regardless of the student's mood, teachers may choose to encourage all children to use opportunities to reflect prior to making decisions. This is especially important for children with bipolar disorder, as the child can be impulsive at times (Kutscher, 2005).

Not every child with bipolar disorder will require every suggested accommodation (Child and Adolescent Bipolar Disorder, 2008). Each case should be scrutinized and accommodations

provided as appropriate (Fristad & Goldberg Arnold, 2004). Some children may require certain accommodations while in the manic state and other accommodations while in the depressed state (Fristad & Goldberg Arnold, 2004). Some children may be rapid cyclers. These students may need several different types of accommodations within several minutes, as the mood of those students can change very rapidly (Fristad & Goldberg Arnold, 2004). For a student with bipolar disorder who is experiencing rapid cycling, the teacher must be remarkably flexible in the classroom routine (Child and Adolescent Bipolar Foundation, 2007).

According to the Child and Adolescent Bipolar Foundation (2007), the ideal teacher for the child with bipolar disorder would be flexible, have a great deal of patience, possess good conflict management skills, be receptive to student needs, and possess the ability to laugh at oneself. School professionals are not expected to perform perfectly for every student, but must make some attempts to meet the ever changing demands of individual student needs. With time, effort, patience, and perseverance, this task will likely become much easier. Even then, the task is still daunting (Cooley, 2007).

Recognizing and Helping Suicidal Students

Any child suffering from a mental health disorder is at increased risk of committing suicide (Kutscher, 2005). If a school professional hears a student talking about suicide or hears other students say someone is talking about suicide, there are steps which should be taken (Naparstek, 2002). According to Naparstek (2002), the following questions should be asked to the student who is talking about suicide (p. 121):

1. Has the student made suicidal comments? Keep in mind the threat to harm oneself could simply reflect a student's high level of frustration or anger about a situation the

student experienced. This is especially true for a young child who expressed the desire to die after getting caught doing something wrong.

2. Does the student have an active plan? If so, ask the student if the student has a time and place in mind where the attempt will be made.

3. Is there a family history for suicidal behavior and suspicion that the student is depressed?

4. Has the student exhibited any self-abusive behavior in the past?

5. Is the student showing a dramatic improvement without any apparent reason after being severely depressed? For example, is the student suddenly feeling better without going through treatment such as counseling or medication? Sometimes suicidal students get a burst of energy when the student is able to finalize the decision to kill themselves.

6. Has the student given away important possessions to friends?

7. Does the student have both depression and an alternative sexual orientation? Gay and lesbian adolescents make up almost 30 percent of adolescent suicides.

8. Does the student have a substance abuse problem while appearing to be depressed? Students who drink or take illegal drugs while feeling depressed may be more at risk for harming themselves.

If a teacher believes a student is suicidal and does not feel comfortable discussing the situation with the student directly, the teacher must seek out another staff member who can take control of this task. The principal, school counselor, or school psychologist should all know how to work with and assist a suicidal student and would be very appropriate choices (Cooley, 2007). According to the American School Counselor Association (2004), code of ethics, the school counselor is responsible to do the following (preamble A.7):

a. Informs parents/guardians or appropriate authorities when the student's condition indicates a clear and imminent danger to the student or others. This is to be done after careful deliberation and, where possible, after consultation with other counseling professionals.
b. Will attempt to minimize threat to a student and may choose to 1) inform the student of actions to be taken, 2) involve the student in a three-way communication with parents/guardians when breaching confidentiality or 3) allow the student to have input as to how and to whom the breach will be made.

This may require the school counselor or other school professional to call the police department if the safety of the child and others can not be ensured and the parents are not seeking medical assistance as viewed appropriate to the situation (Fristad & Goldberg Arnold, 2004).

Chapter 3: Discussion

Chapter three will restate the assumptions which are believed to have affected this work. Then will provide a summary of the literature review, recapping the history of mood disorders; as well as reviewing the myths and stigma associated with mood disorders. This chapter will also discuss the definition of mood disorders, including both depressive and bipolar disorders, reiterating the similarities and differences. Then look again at the treatments of bipolar disorder; and review the school's role and the role of the school professional when a student is suspected to be suicidal. Finally, there will be a critique of the research which was reviewed in this paper and make some recommendations for future work.

Assumptions

Assumptions affecting this paper include the following:

1) Bipolar disorder and other mental health disorders have only recently been discovered in children; therefore, one can reasonably assume that most school professionals, including school counselors, will have very limited knowledge about bipolar disorder.

2) Due to the stigma associated with most mental health illnesses many children are not diagnosed. In many cases where the diagnosis has been made, parents and children choose to not tell school personnel for fear of rejection, humiliation, or shame.

3) Bipolar disorder tends to be difficult to diagnose in children because the symptoms of bipolar disorder present similar in children to the symptoms of other mood disorders as well as ADHD.

History of Mood Disorders

The end of the 19th century was the first time the term "manic-depressive disorder" was used; the term was coined by Emil Kraepelin, a German psychiatrist (Kraepelin, 2003). Through

Kraepelin's own observations in treating patients, Kraepelin realized that many disorders had common symptoms, but the patterns of symptoms were different. With this knowledge, Kraepelin ultimately was able to distinguish between different types of mental health disorders (Kraepelin, 2003). Kraepelin also tried to determine the origins of the disorders. Kraepelin suspected many of these disorders were genetic in nature, which would make them incurable (Kraepelin, 2003). Currently, there are multiple categories of mood disorders and the division of them continues to evolve, but Kraepelin's early work still serves as the basis for all major diagnostic systems used today, including the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders commonly referred to as the DSM (Kraepelin, 2003).

Though there is still discrepancy in the profession, bipolar disorder is recognized by many mental health professionals as a disorder children may be diagnosed with (Fristad & Goldberg Arnold, 2004). According to Geller and DelBello (2003), Positron Emission Tomography scans (PET scans) are being used to identify areas of the brain which are affected in persons with mental health disorders; because of this research doctors and medical field personnel are able to clearly see what sections of the brain are more active in a person with bipolar disorder compared to a person without bipolar disorder (Geller & DelBello, 2003). Thus, the genetic basis of the disease has been well established.

Perhaps the determination of the genetic basis contributes to the lessening stigma about mental health disorders. However, there are still many myths held by society today, which those with such disorders must confront. Fristad and Goldberg Arnold (2004), state the following to be the most common of those myths: if a person were to seek treatment for mental health concerns then the person is somehow weak or has failed; parents are to be blamed for a child's bad behavior and should seek help with their parenting skills; and depression does not occur in children.

More myths believed to be held as stated by Fristad and Goldberg Arnold (2004), include the following: people should be able to just stop being depressed; a person who is suffering from depression will not be depressed long because the depression will go away quickly, without treatment; everyone gets depressed at some point in their lives; all teenagers are moody and attention should not be paid to these behaviors. It is important to remember these ideas are myths, and a child who has a mood disorder has an illness. Just like children who have diabetes, these children will not get better without treatment (Fristad & Goldberg Arnold, 2004; Olson Pacheco, 2005). However, there seems to be some lessening of such societal stigma in recent years (American Psychological Association, 2007).

Bipolar disorder is known to affect 300,000 teenagers in the United States alone (Fristad & Goldberg Arnold, 2004), the statistics for younger children are currently unknown. Papolos and Papolos (2006), also believe that as many as one million students diagnosed with ADHD may eventually be diagnosed with bipolar disorder. It is thought that one-third of the 3.4 million children and adolescents who suffer from depression may eventually be diagnosed with bipolar disorder (Papolos, & Papolos, 2006). When one does the math, a person could come up with a sum of approximately 1.1 million cases of bipolar disorder, making this a disorder of significance and one school professionals should be aware of.

Defining Mood Disorders

There are two broad categories of mood disorders which are well known today. These include depressive disorders and bipolar spectrum disorders. The first category, depressive disorders, includes such disorders as dysthymic disorder, major depressive disorders, and depression not otherwise specified (Stillman, 2005). The second category are the bipolar spectrum disorders,

including cyclothymic disorder, bipolar I disorder, bipolar II disorder, and bipolar disorder not otherwise specified (Hirschfeld, et. al., 2000).

Depressive disorders are disorders in which a person suffers from low moods. According to the Child and Adolescent Bipolar Foundation (2008), children could present with the following symptoms: pervasive sadness and crying spells, insomnia or hypersomnia, agitation or irritability, withdrawal from enjoyable activities, declining grades, difficulty concentrating, increased or decreased appetite, or thoughts of suicide. Dysthymic disorder (DD) is defined as "depression for more days than not over a two-year period (although children/adolescents are only required to be irritable for at least one year)" (p. 156, Kutscher, 2005). On the other hand, major depressive disorder occurs when a person experiences feelings of sadness or emptiness, along with lack of motivation nearly every day for a minimum of two weeks (Kutscher, 2005). To obtain specific clinical diagnostic criteria one should reference the most current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychological Association.

A person who is suffering from bipolar disorder will also experience the depressive symptoms listed above while the person is experiencing a depressive episode. However, the person who has bipolar disorder will experience either mania or hypomania in addition to the depression (Mountain, 2003). A student who is experiencing a manic episode may talk about having only a couple of hours of sleep and state how they do not feel tired, may be excessively talkative, may believe the rules do not apply to them, and/or may have a hard time focusing or concentrating due to either high energy levels or distractibility (Stillman, 2005).

Again, it is important to know the differences in the levels of mood. Not every person who has bipolar disorder will experience the high highs and the low lows; however, they will experience a range of highs and lows (Mountain, 2003). It is important to remember a person

with cyclothymia will experience dysthymia and hypomania (Pavuluri, 2008), a person with bipolar II disorder will experience major depressive episodes along with a hypomanic state, and a person who is suffering from bipolar I disorder will experience both major depressive episodes along with manic episodes, (Mountain, 2003). For a visual of these differences please reference figure 1 in chapter two of this document.

Diagnosing Mood Disorders

The diagnostic process can be a long and complicated ordeal for both the family and the school. This is because currently there is no test which can be given to determine if a person has or does not have bipolar disorder as one can do to determine if a person has diabetes (Faedda & Austin, 2006). When the parents take a child to a mental health professional for a formal diagnosis, the parents, and school professionals will have filled out a questionnaire (Fristad & Goldberg Arnold, 2004). While at this visit with the mental health professional, the family will answer questions in regards to the family history. The answers to questions regarding family history will be compiled with the questionnaire answers to make a formal or working diagnosis (Fristad & Goldberg Arnold, 2004).

Treatment

As the child begins treatment for the working diagnosis, the mental health professional will use the child's responses to the medication(s) to determine if the working diagnosis is correct or if they need to change the diagnosis before establishing a formal diagnosis (Fristad & Goldberg Arnold, 2004). For example, if a child is diagnosed with attention deficit disorder with hyperactivity/impulsivity (ADHD) and they begin to take Ritalin, but the child gets worse, then the child more likely has bipolar disorder, forcing the mental health professional to change the working diagnosis (Kutscher, 2005). Once the diagnosis has been determined, the mental health

professional will modify treatment as needed. It is important to remember even though the child is being treated; the child will experience side effects from the treatment which can affect school behavior and performance, often before the benefits of the medication(s) become apparent. Some of the more common side effects include headaches, dry mouth, blurred vision, trouble concentrating or thinking, nausea and/or vomiting, weight loss or weight gain, constipation or diarrhea, dizziness, skin rashes, nervousness, anxiety, and/or agitation (Stillman, 2005).

In many cases, the teacher may be asked to discuss the child's school behavior directly with the psychiatrist. The following is a list of the topics that Pavuluri (p. 253, 2008), recommends covering:

1. Assess individual education needs for the child.
2. Determine an appropriate educational plan.
3. Learn about bipolar disorder.
4. Address handling emotional issues at school.
5. Discuss learning problems and academic difficulties.
6. Discuss additional services such as occupational therapy, speech therapy, and social skills training.
7. Discuss communication between family and school.
8. Discuss medication issues.

The School's Role

The school is responsible, by law, to provide every child with a free and appropriate public education (Cooley, 2007). This law is known today as the Individuals with Disabilities Education Act (IDEA). Schools are also obligated to provide accommodations to students with any form of disability under Section 504 of the Rehabilitation Act of 1973 (Cooley, 2007). For stu-

dents with mood disorders, getting such services is not always easy (Cooley, 2007). One big problem is the student may be viewed more as having a discipline problem rather than having a disability. For students who come to school with a formal diagnosis, it is easier to know what accommodations the student will need because the case has been documented (Cooley, 2007). However, many students are not diagnosed with bipolar disorder but present at school with behavior problems consist with bipolar disorder.

When a child presents with problem behaviors in the classroom similar to those common in students with bipolar disorder the student may benefit from appropriate accommodations. When a student, especially one with bipolar disorder, becomes agitated or manic, i.e., is experiencing intense emotions, the child may need some time to calm down before returning to participation in classroom activities (Fristad & Goldberg Arnold, 2004). Although it is not the teachers job to diagnosis a student there are things that teachers can do to help (Cooley, 2007).

One thing educators can do to assist children with bipolar disorder is to provide the child with a toolkit (Fristad & Goldberg Arnold, 2004). The toolkit allows the student to engage in activities that will help them to calm down if such a situation arises. Another method for helping students cope is to develop a behavior modification plan for the student (Cooley, 2007). The behavior modification plan is a plan that helps the student learn when the behavior the student has engaged in is unacceptable and to develop better methods of coping with the student's own emotions. A behavior contract, is a third tool that can assist the student in selecting appropriate behaviors, and even suggests rewarding desirable behaviors the student possesses, allowing the teacher to maintain focus on positive behaviors. The student should be involved in developing any or all of the above plans, if possible, as the student ultimately will be responsible for carrying out the plan (Cooley, 2007). Younger students will need assistance with this task.

The job of educators is to help students reach the student's full potential and to educate students (Cooley, 2007). One thing educators can do to help achieve this goal is to be educated about mental health disorders, the symptoms of each, and appropriate ways to manage a classroom in which one or more of the students in the class may be dealing with such a disorder (Naparstek, 2002). A teacher can provide invaluable assistance when bringing forth needed information for both assessment purposes and treatment (Naparstek, 2002).

There are some benefits to the teacher when the possibility of a student suffering from a mental health disorder is recognized. Understanding there may be an underlying mental health disorder can help a teacher better understand why certain behaviors might occur, as well as what can be done to interrupt the undesirable behaviors, limiting classroom distractions (Cooley, 2007). Recognizing the possibility that a student may have a mental health disorder can also help the teacher remain calm and clear headed in difficult situations (Fristad & Goldberg Arnold, 2004). A teacher who understands and accepts a student's experiences has the power to accomplish great things (Naparstek, 2002).

Pavuluri lists ten tips for teachers who are working with the child who has bipolar disorder. These include:

1. Emphasize the positives. Instead of saying, "don't get out of your chair," one might say, "please sit down" or "please stay in your seat."
2. Praise more and criticize less. Make three positive statements for each negative comment.
3. Give simple, direct instructions, in writing if possible.
4. Decrease distraction.
5. Be calm and logical; don't "lecture."

6. Give the bipolar child leadership opportunities, such as taking attendance sheets to the office, cleaning the blackboard, or keeping the class calendar.
7. Give many opportunities for bathroom breaks, time-outs, and visits to the school nurse, and follow through on any other agreed-upon accommodations.
8. Reward good behavior with positive feedback rather than tangible objects.
9. Keep expectations realistic and tailored to the child's strengths.
10. Give frequent pep talks of 10 to 15 minutes one to seven times a week based on needs.

Other authors provide additional suggestions that may be of benefit. According to Kutscher (2005), the key when teaching a student who has bipolar disorder is to underwhelm the student, which can be done by providing the student with a predictable, calm, and secure environment. Cooley (2007), and Kutscher (2005), both suggest the teacher develops a set of hand signals that a student may use to communicate confidentially with the teacher about how the student is currently feeling.

Not every child with bipolar disorder will require every suggested accommodation (Child and Adolescent Bipolar Disorder, 2008). Each case should be scrutinized and accommodations provided as appropriate (Fristad & Goldberg Arnold, 2004). For a student with bipolar disorder who is experiencing rapid cycling, the teacher must be remarkably flexible in the classroom routine (Child and Adolescent Bipolar Foundation, 2007).

Recognizing and Helping Suicidal Students

Any child suffering from a mental health disorder is at increased risk of committing suicide (Kutscher, 2005). If a school professional hears a student talking about suicide or hears other students say someone is talking about suicide, there are steps that should be taken (Naparstek,

2002). For a list of the questions that a school professional should ask refer to chapter two. If a teacher believes a student is suicidal and does not feel comfortable discussing the situation with the student directly, the teacher must seek out another staff member who can take control of the situation and ensure the child's safety, as well as the safety of others. This may require the school counselor or other school professional to call the police department (Fristad & Goldberg Arnold, 2004).

Recommendations

I know from watching my own son that many of the symptoms are well beyond Austin's control but when a child receives proper treatment a child can overcome many of the obstacles the child must face. Teachers and other school professionals need to know more about bipolar disorder as well as other mental health disorders for the sake of today's youth and future generations.

It is important to understand that the information on bipolar disorder in children is limited as of today, largely due to the short period of time for which bipolar disorder has been recognized in children. As I was doing research for this paper, the material I was able to locate tended to be rather limited and extremely repetitive. I also found many of the items I used for the paper were published in the late 1990s and early 2000s, indicating that researchers are currently conducting extensive research in this area. There is still much to learn about mental health disorders, especially bipolar disorder. The research being conducted on the human brain appears to be shedding light on how bipolar disorder affects children and provides the opportunity for the development of a genetic test in the future to determine if a child has bipolar disorder or not.

Due to the dedication of researchers and doctors, bipolar disorder and other mood disorders are now being recognized in children. However, there is still much to do in order for society

to accept that mental health disorders are truly present in our children. For example, one of the myths states that children do not suffer from depression. If people who are knowledgeable about mental health disorders begin to discuss what they know about childhood mood disorders and the genetics behind them people will begin to see the truth. However, the future needs to see the continuation of the research that is currently being conducted on the brain.

In the classroom teachers need to continue developing new methods for classroom management, testing to see if the methods are helpful, and if the methods cause problems for other students. Only then will other teachers be able to incorporate these new methods successfully into other classrooms. Also it is important for all school professionals to stay up to date on how mental health illnesses affect students both academically as well as socially. Children need to be diagnosed correctly, and mental health professionals need to establish diagnostic guidelines specific to children in regards to bipolar disorder.

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Appendix A: Child Mania Rating Scale- Teacher Version

Child Mania Rating Scale- Teacher Version (CMRS-T)

Child's Name _____ **Date of Birth** _____ **Case #/ ID #** _____

Instructions: The following questions concern the child's mood and behavior. Please place a check mark or an x for each item. Please consider it a problem if it is causing trouble and is beyond what is normal for the child's age. Check "Never/rarely" if the behavior is not causing trouble.

Does the child	Never/ Rarely	Some-times	Often	Very Often
Have periods of feeling super-happy for hours or days at a time and being extremely wound up and excited, such as feeling "on top of the world"?	0	1	2	3
Feel irritable, cranky, or mad for hours or days at a time?	0	1	2	3
Think that he or she can be anything or do anything (e.g. leader, best basketball player, rapper, millionaire, princess) beyond what is usual for that age?	0	1	2	3
Believe that he or she has unrealistic abilities or powers that are unusual, and may try to act upon them, which causes trouble?	0	1	2	3
Have periods of too much energy?	0	1	2	3
Have periods when he or she talks too much, too loud, or a mile a minute?	0	1	2	3
Have periods of racing thoughts that his or her mind cannot slow down (it seems that the child's mouth cannot keep up with his or her mind)?	0	1	2	3
Talk so fast that he or she jumps from topic to topic?	0	1	2	3
Rush around doing things nonstop?	0	1	2	3
Have trouble staying on track and is easily drawn to what is	0	1	2	3

happening around him or her?				
Do many more things than usual or is unusually productive or highly creative?	0	1	2	3
Behave in a sexually inappropriate way (e.g., talks dirty, exposes him- or herself, plays with private parts, masturbates, makes sex phone calls, humps on dogs, plays sex games, touches others sexually)?	0	1	2	3
Go and talk to strangers inappropriately or is more socially outgoing than usual?	0	1	2	3
Do things that are unusual for him or her that are foolish or risky (e.g. jumping off heights, giving things away)?	0	1	2	3
Have rage attacks or intense and prolonged temper tantrums?	0	1	2	3
Crack jokes or pun more than usual, laugh loud, or act silly in a way that is out of the ordinary?	0	1	2	3
Experience rapid mood swings?	0	1	2	3
Have any suspicious or strange thoughts?	0	1	2	3
Hear voices that nobody else can hear?	0	1	2	3
See things that nobody else can see?	0	1	2	3

(Courtesy of Pavuluri, pg. 242-243, 2008)

Appendix B: Pediatric Side Effects Checklist

Pediatric Side Effects Checklist (P-SEC)

This checklist is to be completed by parent, child, or patient. This will help identify the adverse effects of the medication(s). Please read through the list and check (✓) in the appropriate box.

Patient name: _____ ID: _____ Date: _____

Problems	**None**	**Mild/ sometimes but tolerable**	**Moderate/ interferes somewhat**	**Severe/ interferes a lot**
Gastrointestinal System				
Discomfort in the stomach				
Constipation				
Diarrhea				
Increased appetite				
Decreased appetite				
Nausea/vomiting				
Central Nervous System				
Muscle trembling/shaking				
Sleepiness				
Difficulty falling asleep				
Muscle stiffness				
Stiff jaw				

Problems with concentrating				
Problems with memory				
Restlessness/wanting to pace				
Irritation/agitation				
Problems with speech				
Dizziness/lightheadedness				
Headache				
Seizures				
Nightmares/vivid dreams				
Blurring of vision				
Excessive drooling				
Increased sweating				
Increased thirst				
Dry mouth/eyes				
Endocrine System				
Feeling cold/hot				
Weight gain				
Weight loss				
Fatigue/tiredness				
Breast cyst				
Changes in menstrual periods				

Problems	**None**	**Mild/ sometimes but tolerable**	**Moderate/ interferes somewhat**	**Severe/ interferes a lot**
Mood/behavior Changes				
Depression/feeling sad				
Excitability				
Feeling Anxious				
Aggression				
Panic attacks				
Cardiovascular System				
Palpitations				
Blackouts/loss of consciousness				
Chest pain				
Immune System				
Frequent Infections				
Skin				
Rash				
Acne				
Hair Loss				
Renal System				
Increased urination				
Bed Wetting				

Frothy urine/red urine				
Sexual Concerns/Problems				
Sexual concerns/problems				
Other				
Allergic reaction				
Other, please specify:				

Please indicate your current medications here.	
Medication	Dose

(Courtesy of Pavuluri, pg. 246-248, 2008)

Appendix C: Symptoms of Basic Mood States

Depression **Down, sad, blue**	**Well (Euthymia)** **Normal Mood**	**Mania** **Euphoric, irritable**
Low self-esteem	Normal self-esteem	High self-esteem
Slow thoughts	Normal thoughts	Racing, crowded thoughts
Lacks interest	Normal interest	Many interests
Needs more sleep	Normal sleep	Needs less sleep
Low energy	Normal energy	High energy
Low activity	Normal activity	Hyperactivity
Procrastinates	Normal impulse control	Impulsive
Fair to poor judgment	Good judgment	Poor judgment
Faedda, & Austin, pg. 20, 2006		

Appendix D: Clinical Symptoms of Bipolar Disorder in Children

Dysthymia/Depression	Hypomania/Mania
Physical/ Behavioral	**Physical/ Behavioral**
Increased sleep, tired, inhibited	Energetic, hyper, tireless, over talkative, loud
Slow movements, quiet, withdrawn	Impulsive, aggressive, violent
Does not feel well, aches, withdrawn	Feels "great", decreased sleep
Appetite, increase, weight gain	Appetite decrease, weight loss
Emotional	**Emotional**
Sadness, guilt, hopelessness, melancholy	Euphoric, humorous, giddy
Irritable, passive-aggressive, easily annoyed	Moody, labile, easily frustrated, explosive
Avoidant, dependent, passive, needy	Irritable, angry, sarcastic, defiant
Insecure, indecisive, cries easily	Argumentative, demanding
Shy, fearful, separation anxiety	Tense, wired, wound-up
Cognitive	**Cognitive**
*Anhedonia, lacks interest, motivation	Racing, crowded thoughts; many plans
Poor memory and/or concentration	Distractible, inattentive, daydreaming
Low self-esteem	Grandiose, over confident, willful, bossy
*Anhedonia means the inability to enjoy normally pleasurable activities.	

Courtesy of Faedda, & Austin, pg. 40, 2006

Appendix E: Student Coping Plan

Student Coping Plan

_____ Coping Plan

(Student's Name)

When I am feeling upset or overwhelmed, I will:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

Date: _____

Student signature: _____

Guardian signature: _____

Teacher Signature: _____

(Courtesy of Cooley, pg. 30, 2007)

Appendix F: Behavior Modification Plan

Behavior Modification Plan

_____ Behavior Modification Plan

(Student's Name)

What did I do that is against the rules? _____

_____

What rule did I break? _____

_____

Why did I break this rule? _____

_____

How did my behavior affect others? _____

_____

What will I do the next time I face a similar situation? _____

_____

How can my teacher help me to do this? _____

_____

Date: _____

Student Signature: _____

Guardian Signature: _____

Teacher Signature: _____

(Figure courtesy of Cooley, pg. 29, 2007)

Appendix G: Behavior Contract

Behavior Contract

This behavior contract between _____ and _____.

(Student's name) (Teacher's name)

Is for the period of _____ through _____.

The behavior(s): _____ agrees to show:

_____

_____

_____

If _____ is able to show these behavior(s): _____ will earn:

_____

_____

_____

Date: _____

Student's signature: _____

Guardian's signature: _____

Teacher's signature: _____

(Courtesy of Cooley, pg. 27, 2007)

Appendix H: Self-Monitoring Checklist

Self-Monitoring Checklist

_____ Self-Monitoring Checklist

The behavior I am trying to stop is: _____

_____

_____

I will make a checkmark each time I make a mistake.

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Notes: _____

_____

_____

_____

(Courtesy of Cooley, 2007, pg. 28)

Appendix I: Daily Mood Calendar

Daily Mood Calendar

Name _____ Month: _____

Color in the square using a color that best describes your overall mood for each part of the day.

Key:

Blue = Sad Red = Angry/explosive Gray = Crabby/ irritable

Yellow = Happy Orange = Silly Green = Neutral/ fair Purple = Worried

Week 1 Date: _____ To: _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Week 2 Date: _____ To: _____

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

(Courtesy of Pavuluri, 2008, pg. 252)