Swimming in Deep Water: Childhood Bipolar Disorder

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ABSTRACT: The authors focused on one parent’s struggles in finding a diagnosis and intervention for a child who had bipolar disorder. The authors explain the process of identification, diagnosis, and intervention of a child who had bipolar disorder. In addition to the personal story, the authors provide information on the disorder and outline strategies that have worked with one child both at home and school. They call attention to a little-known disability and provide some insight on the disorder for educators and families. Also, they provide a list of resources for further reading.

KEYWORDS: childhood bipolar disorder, diagnosis, intervention, strategies

SEVERAL YEARS AGO on Oprah Winfrey’s booklist, there was a book called The Deep End of the Ocean (Mitchard, 1999). This book was later made into a movie starring Michelle Pfeiffer. In the book, a woman loses her 3-year-old son in a hotel in Chicago, and he is missing for over 10 years before he is reunited with his family. Throughout this mother’s journey, she must find the courage to go on with her life and raise her other two children. At times, she feels like she is swimming in the deep end of the ocean.

That is exactly how I (G. W. Senokossoff) felt 2 years ago when my youngest son, Matthew, began to struggle and exhibit extreme—and sometimes unusual—behaviors in school and home. I have always loved children and waited a long time to have my own. Being an educator, I am supposed to be good with kids, yet I did not know how to fix Matthew’s problems. I hope that sharing our story will help other children, parents, and teachers who are dealing with similar situations to get the support that they desperately need.

Also, 2 years ago, my sons and I moved into our new home, at which time they enrolled in new schools. Matthew was starting first grade and his teacher was my friend and former colleague. As the year progressed, I began to receive notes about Matthew’s work and behavior. His teacher indicated that he was often off-task, did not complete his work, and wandered around the classroom disturbing the other children. When the teacher asked him to return to his seat or when his classmates complained, he would roar like his favorite dinosaur. At other times, Matthew would sit at his desk and destroy school supplies or draw on himself. When the teacher confronted him, according to Matthew, it was always someone else’s fault. He often said that his classmates were bothering or teasing him. Also, Matthew is very sensitive to and stimulated by noise. When his teacher raised her voice or the classroom became noisy, he would become agitated.

At the first parent–teacher conference, Matthew was given an academic instructional plan because he was not performing on grade level. He refused to complete the writing assessment. My son, who learned to read during the first few months of kindergarten and absorbed facts and could repeat them at will, was struggling in the first grade.

At the same time, we were dealing with unusual behaviors at home. Matthew was getting up at all hours of the night. Sometimes, he would wake me up; at other times, I would hear him and check on him. A few times, he climbed out of his bedroom window to wander around or look for things such as bats. Also, Matthew was fascinated by fire. One morning, my other son and I awoke to the fire alarm. Matthew had taken out the grill lighter from the top shelf of a closet where I had hidden it, and he had set his behavior chart on fire.

In addition to his sleeplessness, Matthew became angry when he made a poor choice and was given consequences or when he felt misunderstood. His temper tantrums grew; he became increasingly aggressive and went into rages that often lasted hours.
In September, a psychiatrist diagnosed Matthew with Attention Deficit with Hyperactivity Disorder (ADHD) and prescribed a stimulant and eventually an antidepressant to combat his anger; however, the tantrums continued. Also, Matthew had trouble making and keeping friends in our neighborhood and at school. Several times, I had to apologize to other parents for his behavior. Although Matthew’s tantrums started at home with his family, he soon began to act out in public and at school. During this time, I could not figure out what was wrong. My child was out of control and I did not know how to help him. Then, during one session with our therapist, she asked me if I had read the book The Bipolar Child (Papolos & Papolos, 2002). I had not, so I bought the book and, after reading the first few chapters, knew that my son had childhood bipolar disorder (CBD).

As the year progressed, Matthew continued to have trouble at school, especially during less structured times, such as physical education and lunch. Although he was reading on a fourth-grade level and able to complete all of his assessments successfully, he was still off-task for a large part of the day. Then, in April, we found a pediatric psychiatrist who specialized in ADHD and bipolar disorder. During our first meeting, he gave us the diagnosis that we needed to get the proper medication for Matthew. Since then, Matthew qualified for the gifted program, which he attends once a week. He is currently in a third-grade inclusion classroom. With his current medication, Matthew’s behavior has stabilized and I continue to work with a therapist on various behavior intervention strategies.

Bipolar Disorder

The challenges that Matthew and his family face because of his bipolar disorder affect more than 750,000 children a year. Unfortunately, many children go undiagnosed as ADHD (Robertston, Kutzer, Bird & Grasswick, 2001), conduct disordered, oppositionally defiant, and depressed (Hellander, 2000). As many as 80% of children with bipolar condition are undiagnosed for up to 10 years before receiving appropriate services to treat it (Depressional Bipolar Support Alliance, 2002). The discipline strategies that most schools use—repeated detentions with a final result of suspension—are ineffective for most children, especially for those with bipolar condition. Many school personnel lack an understanding of the condition, whereas the child and family continue to feel the stigma and guilt associated with the child’s behavior problems.

Researchers first identified bipolar disorder in the early 1800s. Although bipolar disorder is the most prevalent psychotic disorder in adults, most professionals consider the onset of the condition to rarely occur before puberty. The research for CBD is in its infancy (Faedda et al., 1995). The first diagnostic criteria for CBD occurred in the early 1960s with the use of adult criteria. As professionals began to apply the same diagnostic criteria and treatment for children, they realized adult onset and CBD manifest themselves in different ways. In addition, researchers found that treatment that is considered effective for adults can actually exacerbate the condition in children (McClellan & Werry, 2000), which has prompted more specific investigation into childhood and adolescent bipolar disorder as separate conditions from adult onset.

CBD

CBD occurs before adolescence and, in many cases, results in more severe behavior problems (Child & Adolescent Bipolar Foundation [CABF], 2001). Although CBD is considered a low-incidence disability, it occurs more often than the combined incidence of common childhood illnesses such as juvenile diabetes, cancer, AIDS, and epilepsy (Hellander, 2000). Furthermore, the disorder is more difficult to diagnose in children because of the infancy of the field and overlap of other mitigating conditions such as ADHD (Faedda et al., 1995).

Those who manifest early-age onset often have mood changes that shift from manic to depressive (referred to as rapid cycling), which often result in irritable behavior and frustrating tantrums. Also, delusions and hallucinations occur more frequently in childhood onset than in adult or adolescent onset (Weller & Weller, 1995). Misdiagnosis of CBD often occurs because the overt behaviors of the student are so disruptive that educators view it as a behavioral rather than a medical issue (Pavaluri, Naylor, & Janicak, 2002). In addition, 70–90% of children with CBD also have ADHD (Geller, Sun, Zimerman, Luby, & Frazier, 1995), whereas 19% of children with ADHD are also identified as having CBD (Hellander, 2000). Both conditions may result in hyperactivity, irritability, and distractibility. However, the child with CBD may also exhibit behaviors such as grandiosity, flight of ideas, racing thoughts, and a decreased need for sleep (Pavaluri et al.). The stimulant medication prescribed for children with ADHD often exacerbates the bipolar condition, which results in an acceleration of the cycling behavior (Kowatch et al., 2005). Unfortunately, professionals often look at the children’s environment and blame poor parenting skills and a lack of discipline in the home (Geller & Luby, 1997). Among parents of adopted children, behavioral problems sometimes are attributed to attachment disorder and researchers have suggested psychotherapy for treatment (Hellander). Unfortunately, the probability of recovery from CBD also diminishes when there is too much time between the first symptoms and the actual treatment (Goodwin & Jamison, 1990).

The likelihood that a child will recover from CBD increases when educators and other professionals are knowledgeable of the condition and various variables that may affect a student with a predisposition for the disorder. Children with bipolar disorder may appear outgoing, personable, highly energetic, and goal directed in the manic phase (Geller & Luby, 1997).
Often, parents and teachers value and reinforce these characteristics during the early school years. The difference between appropriate and manic behaviors is the intensity and frequency of the behaviors. Children in the manic phase may not be able to stop their behavior. They must constantly be doing something and believe that they can do just about anything well. They also require little sleep. Children with ADHD seem to be in constant motion, involved in undirected behavior, and sleep through the night. Children with CBD need only 3–4 hr of sleep and when awake routinely perform multiple tasks that are all goal directed. When the depressive episode appears, an astute teacher may notice the change and begin to investigate why such a drastic change has occurred in the student. The depressive episode may include the following: lack of enjoyment in life, change in appetite, fatigue, feelings of worthlessness or guilt, poor concentration, and thoughts of death and suicide (Geller & Luby). Over 50% of individuals are diagnosed with bipolar disorder during a depressive episode (Carlson, 1995). Because most children exhibit rapid cycling, it may be difficult for teachers, parents, or other professionals to see a discrete completion of one phase and the beginning of the next. Most adults with bipolar disorder have episodes that last 1–3 months, followed by normal day-to-day functioning behavior between phases (CABF, 2001).

The quick interepisode recovery for children with bipolar disorder often results in disruptive behavior because of their irritability and frustration with the rapid changes in their mind and body. Children themselves refer to it as the inability to shut off their brain. It is a roller-coaster ride in which they have no control, so they act out because of frustration and anxiety over the situation. In most classrooms in which a child is disruptive, the teacher imposes consequences for inappropriate behavior. Therefore, a child who has CBD does not seem to have control over his or her behavior, so they act out because of frustration and may escalate the acting out behavior to a more significant degree.

Because of the frenzied and erratic behavior of children with CBD, many are socially rejected by their peers. Reports on children with bipolar disorder indicate that more than 50% of them have no friends, are made fun of by others, and have poor relationships with their siblings (Pavuluri et al., 2002). Furthermore, they may face academic challenges because of the increased risk for learning disabilities and a higher likelihood of deficits in cognitive functioning, math, and verbal memory (Kowatch et al., 2005). When children with CBD experience stress, their episodic behavior increases. Across the elementary grades, the stress that accompanies the increased academic demands seems to play a role in the increase in episodic behaviors or the triggering of bipolar behaviors (Hellander, 2000).

**Adolescent Onset Bipolar Disorder**

Although concerns for adolescent bipolar disorder are similar to adults, there are differences in the manifestation of the disorder. Adolescents with bipolar disorder have similar manic characteristics as children; however, the manifestation of the behavior may be slightly altered. Adolescents with bipolar disorder often feel a sense of grandeur and importance in life, believe that rules are for others and do not apply to them, and manifest cockiness in the classroom. They may continually question a teacher’s skills in the classroom and even extend this point by failing a class to prove that the teacher was incompetent (Geller & Luby, 1997). Adolescents show longer episodic behavior but still may cycle as in childhood onset. The challenges that adolescents with bipolar disorder face are similar to the challenges that all adolescents face, but with an increase in the intensity and severity of the problems. In addition, adolescents with bipolar disorder face a greater risk for drugs and alcohol abuse, as well as a higher rate of suicide (Carlson, Bromet, & Sievers, 2000). Also, 30% of adolescents with bipolar disorder attempt suicide by the age of 18, and many of them turn to drugs and alcohol to cope. Drug and alcohol addiction occurs in approximately 39% of adolescents with bipolar disorder (Geller & Luby). The hypersexuality of adolescents with bipolar disorder can have serious consequences that include increased risk of communicable diseases and pregnancy. Accordingly, it is important to develop a treatment plan that enables adolescents to maintain a degree of stability in overall emotional development.

**Treatment and Services**

In the beginning, the treatment for children and adolescents with bipolar disorder followed the same treatment plan as adult onset. However, as researchers studied the effects of pharmacological intervention, concerns arose over the effectiveness of the drugs, especially the exacerbation of manic behavior. Most experts believe the best long-term intervention includes a multimodal treatment plan involving psychosocial therapy, educational training, and maintenance medication (Kowatch et al., 2005). Most professionals support the practice of stabilizing the mood swings before treating other mitigating disorders such as ADHD, OCD, or depression (Pavuluri, Naylor, & Janicak, 2002). In addition, most professionals contend that each new disability should be treated in a sequential manner to determine interactive factors of multiple medications (Kowatch et al.).

The key to long-term effective treatment of CBD is monitoring the effects of each medication and the mix of multiple drug interactions (Kowatch et al., 2005); this monitoring must occur at home and in school. Teachers must report changes in students’ mood and overt behaviors. It is useful if teachers keep anecdotal charts to record the date, time of behavior, and duration of behaviors. In addition, the inclusion of a mood chart helps students and teachers identify the mood of students at particular times of the day (CABF, n.d.). Also, a mood chart may help professionals to
identify any correlations between behaviors and moods that occur throughout the school day. Researchers have not established any clear guidelines on the maximum length of pharmacological treatment for children and adolescents (Hirschfeld, 2002). For adults, the recommendation is to begin to taper drug use after 18 months when possible. In some cases, drug intervention is needed for a much longer period of time.

The unintended side effects of medication often hinder successful treatment of children and adolescents. For example, weight gain is a concern for all individuals, and some female adolescents refuse the medication despite the effectiveness of mood stabilization drugs (Hellander, n.d.). In addition, with medication, there can be increased difficulty with cognitive functioning, including problems with word retrieval and memory (Kowatch et al., 2005). Thus, it is important to monitor the effectiveness of the drug on the child’s mood and how the drug affects the child. A proper diet and exercise may help to reduce the negative side effects of the medication. Also, researchers have found that exercise assists with mood elevation in individuals who have been diagnosed with bipolar conditions (Pavuluri et al., 2002).

### Teachers’ Role

Teachers play a critical role in understanding students with bipolar disorder and assisting them in being successful in school. School personnel should have some knowledge on the characteristics that a child with bipolar behavior may convey, such as inappropriate emotional response (e.g., laughing hysterically, crying for no reason), inappropriate or precocious sexual behavior, rapidly changing moods in a short period of time, defiance of authority, daredevil behavior, excessive involvement in multiple projects, delusions and hallucinations, sleeping too little, extreme sadness or loneliness, and racing thoughts and speech patterns (CABF, 2004).

The distinguishing difference between bipolar disorder and situational behavior problems that are due to extenuating circumstances is the intensity and duration of the behavior. It would be normal for an individual to be extremely sad because of the loss of a loved one. However, it would be abnormal for an individual to be extremely sad because of being asked to sit at his or her desk to begin class.

After a student is diagnosed with bipolar disorder, an individual education plan (IEP) should be written under the other health impaired category. The IEP should cover accommodations for the student and a means to assess progress throughout the year. The following accommodations provide a student with the support to be successful in the classroom: (a) consistent scheduling of courses, (b) area for debriefing when emotions overwhelm the student, (c) notice of changes in the schedule beforehand, (d) a staff member in the school to talk with when emotions are overwhelming, and (e) flexibility in the length and difficulty of assignments when needed because of cycling of behavior.

A student with bipolar disorder is no different from a student with diabetes, asthma, or epilepsy. The overt behavior of a student with a bipolar disorder is often beyond his or her control even with medication. Assuring the student that he or she is a welcome part of the school community—as well as establishing an understanding of the needs of the child—will provide a stabilizer for the student and assist him or her in succeeding in the classroom.

### At-Home Support for a Child With Bipolar Disorder

There are several useful strategies that parents of children with bipolar disorder may use at home. Flexibility, patience, conflict-resolution skills, and consistency are essential. Flexibility, or the ability to adjust the schedule to the child’s needs, is important. For instance, if the parents are entertaining guests at home or going out to attend an event and the child becomes agitated or irritable, it is advantageous to have a quiet place at home where he or she can go to calm down. However, the parents may need to leave the event early to care for their child. The ability to exercise patience is essential, as is ignoring minor negative behaviors and focusing on more positive responses.

Also, strong conflict-resolution skills are important. Being able to deflate a growing tantrum is crucial. Often, parents deal with many stresses concurrently and lose patience with misbehavior; however, negative, loud behavior only stimulates and escalates the child’s behavior. Although people don’t want to excuse poor behavior, they have to de-escalate the situation first. After the child is calm again, they should discuss the consequences of his or her actions.

The final, most important strategy is consistency, which children with bipolar disorder need in addition to structure. Routines are critical. Parents should have a morning routine that the child follows and set a timer. Also, parents should have a homework and bedtime routine. In the 2 years that the doctors were diagnosing and stabilizing Matthew, he was frequently late to school and our mornings were often a battle. Matthew is very rigid, or black-and-white, in his thinking, and he has difficulty making quick transitions. Setting up routines has helped him to know exactly what to expect.

In addition to routines, I helped Matthew set goals, and he earned rewards for meeting his goals. Many times, his rewards centered around time spent doing a favorite task. Also, Matthew has strategies that he used when he began to feel frustrated or stressed. These strategies include taking deep breaths, unclenching his fists, and moving to a quiet area to regain control. These strategies have significantly helped Matthew learn to cope.

Family dynamics are also affected. Matthew has a teenage brother who has learned how to remain calm and be helpful to him. It has been difficult for his brother, though, because...
of the focus and constant care that is required for Matthew. I have tried to support our older son in other ways.

CONCLUSION

The first doctor that we worked with hesitated to diagnose Matthew. Many psychiatrists are reluctant to diagnose children. After many struggles, I found a pediatric psychiatrist who was willing and able to help Matthew. We were also working with a highly skilled therapist. Matthew’s rages have greatly diminished and he is learning to control his behavior and accept responsibility for his actions.

Current research (CABF, 2004) suggests that many children are born with bipolar disorder and may not be diagnosed until adolescence. Also, children with bipolar disorder may not exhibit severe behaviors until they experience a traumatic event that triggers the symptoms. With Matthew, it may have been our move. When I look back at Matthew’s behavior over the years, it is clear that he was always an active and headstrong child. As a baby, he often did not sleep through the night, and, as a toddler, he had tantrums. However, many toddlers go through similar stages, and Matthew did not display severe behavior problems until we moved to a new home.

Because CBD is not a well-known problem, there is limited support for children with a bipolar disorder and each family’s story may differ. Parents should seek medical treatment and academic support for their children. Many professionals are not well informed on how to deal with these children. Yet, the incidence of pediatric bipolar disorder has been increasing steadily since World War II (CABF, 2004), and schools will need to learn to support these children and their families.

Remember the voice of one child with bipolar disorder:

Hi, I’m Matthew. I’m going to tell you what it feels like to have Bipolar disorder. I’ve been made fun of by other children. If you have this problem don’t attempt to fix it yourself. Instead go find an adult and tell them what happened. When I’m angry I feel like I want to hurt the person who made fun of me but I don’t. School was the hardest. Almost everyone in my class was making fun of me. At P.E. my classmate was making fun of me. Then he ran off laughing. It was hard to listen to my teacher I was off task and thinking about other things then I wouldn’t hear the teacher. Well... I’m on Summer Brake and I’m out of school so I don’t need that much medicine oh! Did I mention that I took medicine? Nope guess not. The medicine helps me focus, calm down a little and go to sleep. Well that’s it for me. [sic].

AUTHOR NOTES

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REFERENCES


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