

WELCOME TO “Are you talking to me?”



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Chloe is 16 and recently **moved** to Hampshire. Chloe feels **isolated** at her new home that she shares with her Mother, **step-father and 2 younger step-siblings**.

She is to **start** at Sparsholt College in Animal Management although she had a bad bout of flu and was **unable to start** at the beginning of term. She has had to leave her **horse behind** in Wiltshire and also a **boyfriend** who has promised to come up and visit her.

College has **not worked out** as she hoped. She lives on-site and has **not yet made any friends**. The **course is harder** than she thought and Chloe is finding it **difficult to learn** all the new terminology along with **preparing for weekly tests**.

Her boyfriend has said that he is **no longer able to come up** to Sparsholt as he is busy with a new job. Someone has told Chloe that he has a **new love** – a male.

Going home for the weekend, Chloe is informed that her belongings are being stored in the garage and that one of her younger siblings has been **given her room**.

Whilst bemoaning this to her mother, her step-father says that she **is a spoilt brat** and it is not reasonable to keep a spare room for her on the odd occasion she will visit from college.

Chloe meets up with some old friends who take her to Southampton where she finds **solace** in drink. Peace at last – the drink makes everything seem better for a while. On leaving the nightclub, Chloe **finds her mood darkening**. She **picks a fight** with a couple outside who have been jeering because they **know her ex and his new love**.

Police pick up Chloe and she spends the **night in the cells**. She is charged with **disturbing the peace, threatening behaviour** and is fined **£350**.

Her mother says she is **not allowed back home** in the holidays unless her behaviour improves and on returning to College, Chloe goes to MJ's club to **drown her sorrows**. Whilst in the toilets she overhears two girls talking about her and saying what **a minger** she is and **laughing about her** style of clothes and boyfriends. She is mortified and goes back to her room and takes **some pills to help her sleep**.

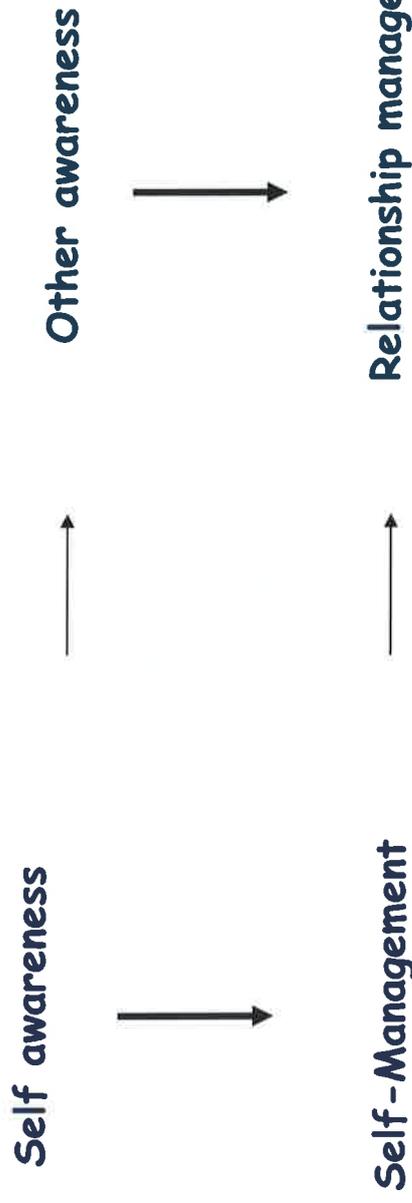
She **misses 3 days of lessons** and is put on formal review. Her parents are informed. Chloe feels **angry and hurt** and **cannot see a reason for staying**. She **hates her course, her tutor doesn't like her** and **she has no friends**.

Further, she has spent **all her money on drink** that was needed to **repay a loan** on her car. The car is to be **repossessed**. To top it all she has failed her exam and **cannot find the latest piece of work** that needs to be handed in today. Her mother phones to say she is **expecting a new baby**. What is the point of

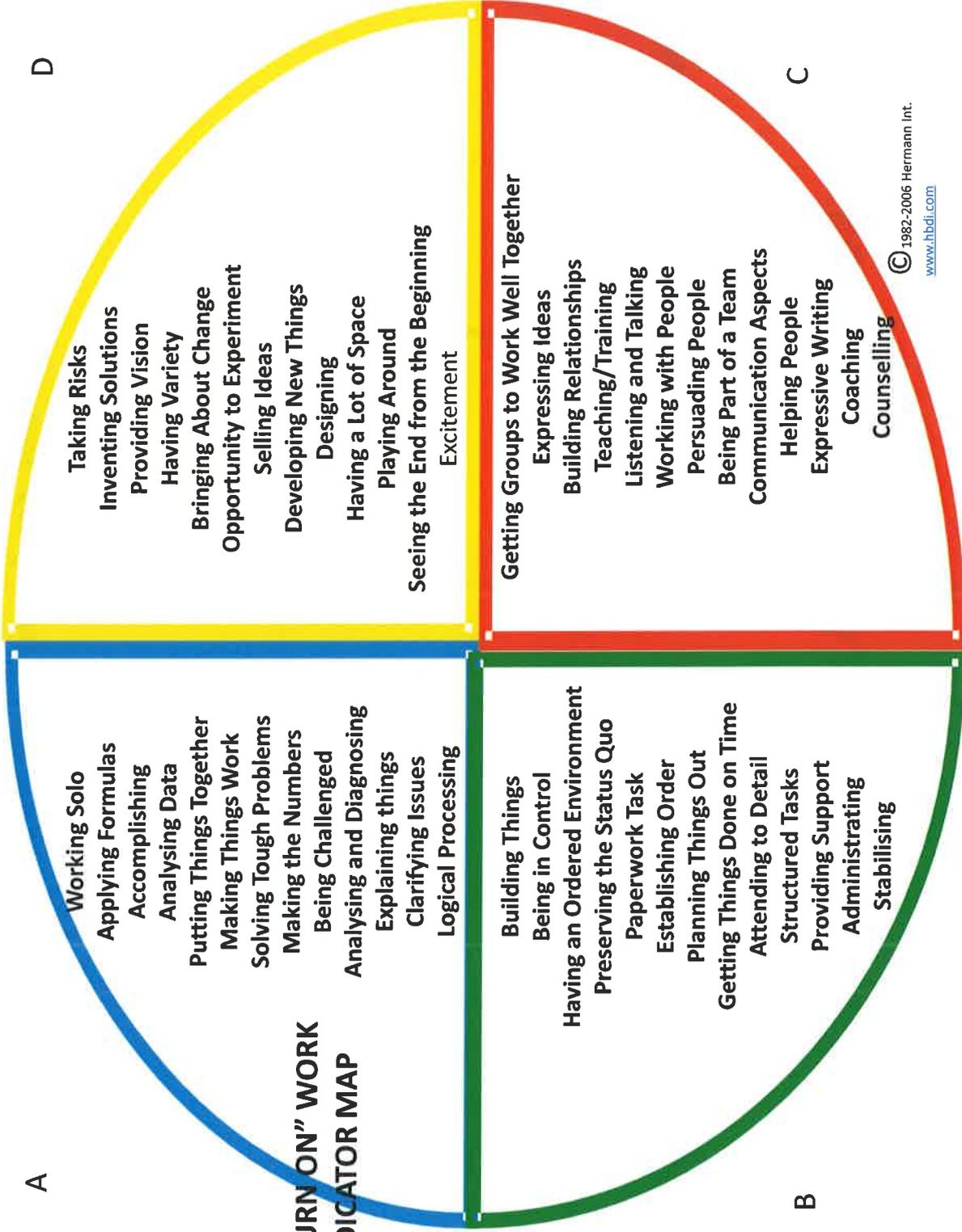
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Connexions between EI processes

Intrapersonal Intelligence Interpersonal Intelligence



A



**“TURN ON” WORK
INDICATOR MAP**

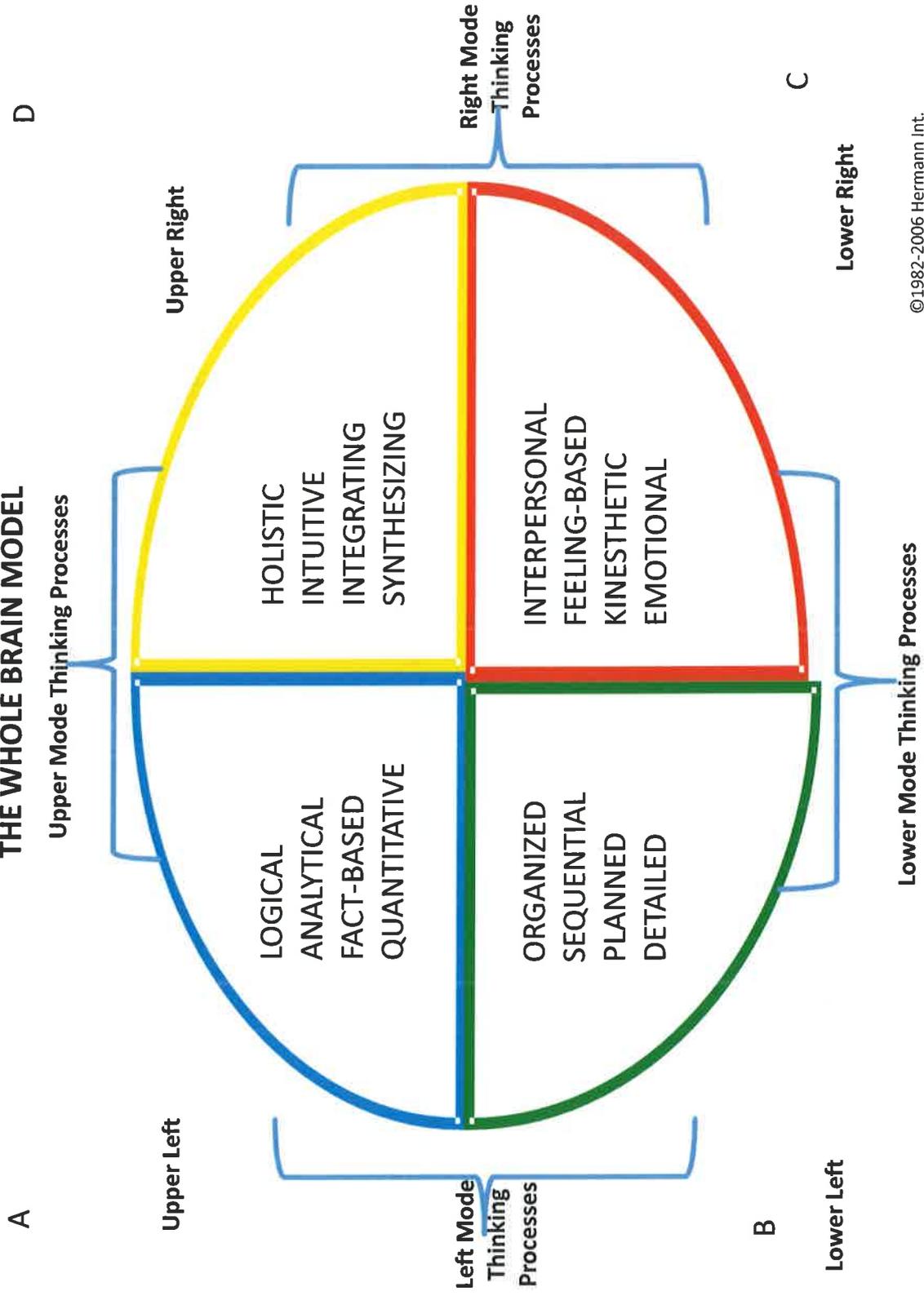
- Working Solo
- Applying Formulas
- Accomplishing
- Analysing Data
- Putting Things Together
- Making Things Work
- Solving Tough Problems
- Making the Numbers
- Being Challenged
- Analysing and Diagnosing
- Explaining things
- Clarifying Issues
- Logical Processing

- Building Things
- Being in Control
- Having an Ordered Environment
- Preserving the Status Quo
- Paperwork Task
- Establishing Order
- Planning Things Out
- Getting Things Done on Time
- Attending to Detail
- Structured Tasks
- Providing Support
- Administrating
- Stabilising

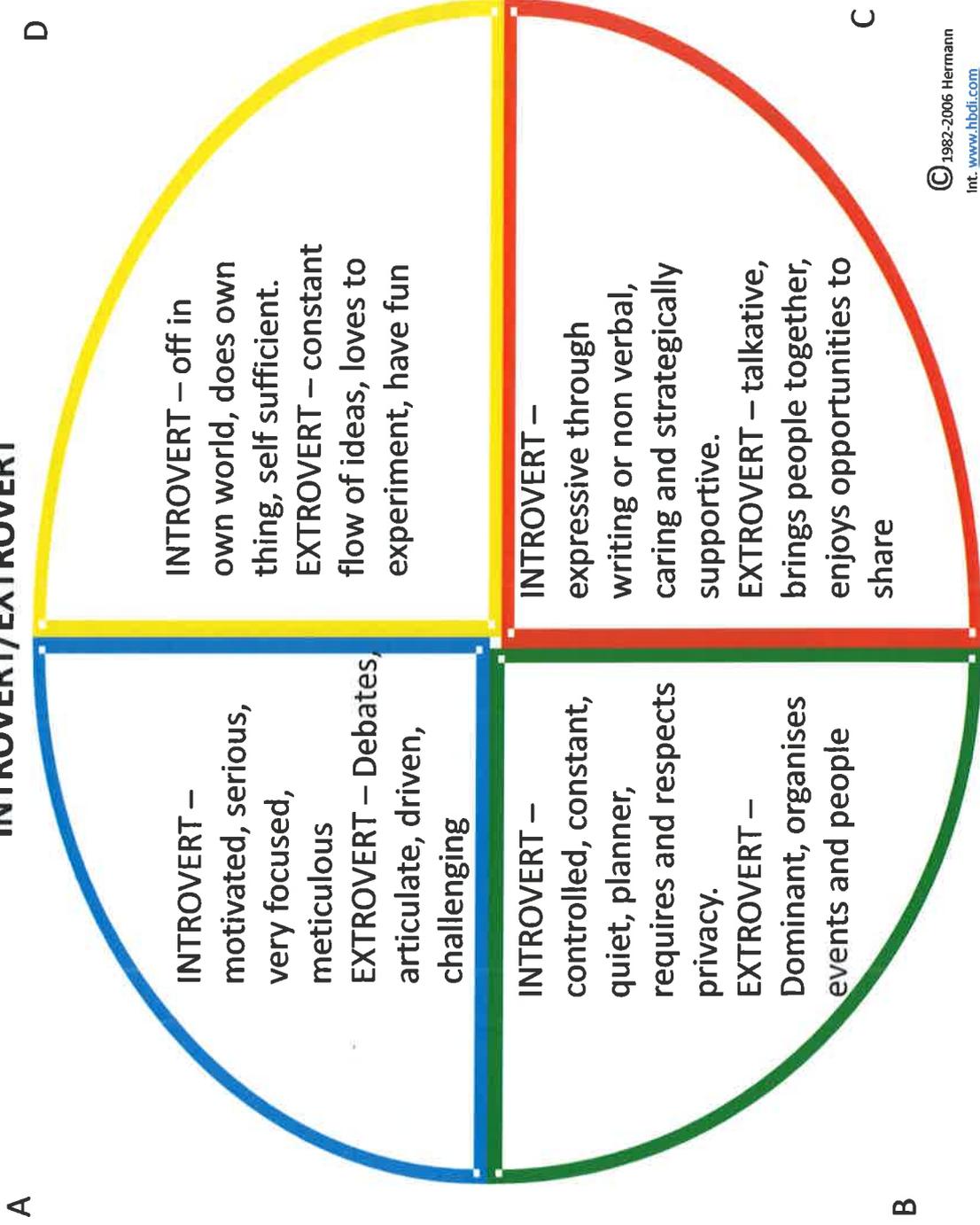
- Taking Risks
- Inventing Solutions
- Providing Vision
- Having Variety
- Bringing About Change
- Opportunity to Experiment
- Selling Ideas
- Developing New Things
- Designing
- Having a Lot of Space
- Playing Around
- Seeing the End from the Beginning
- Excitement

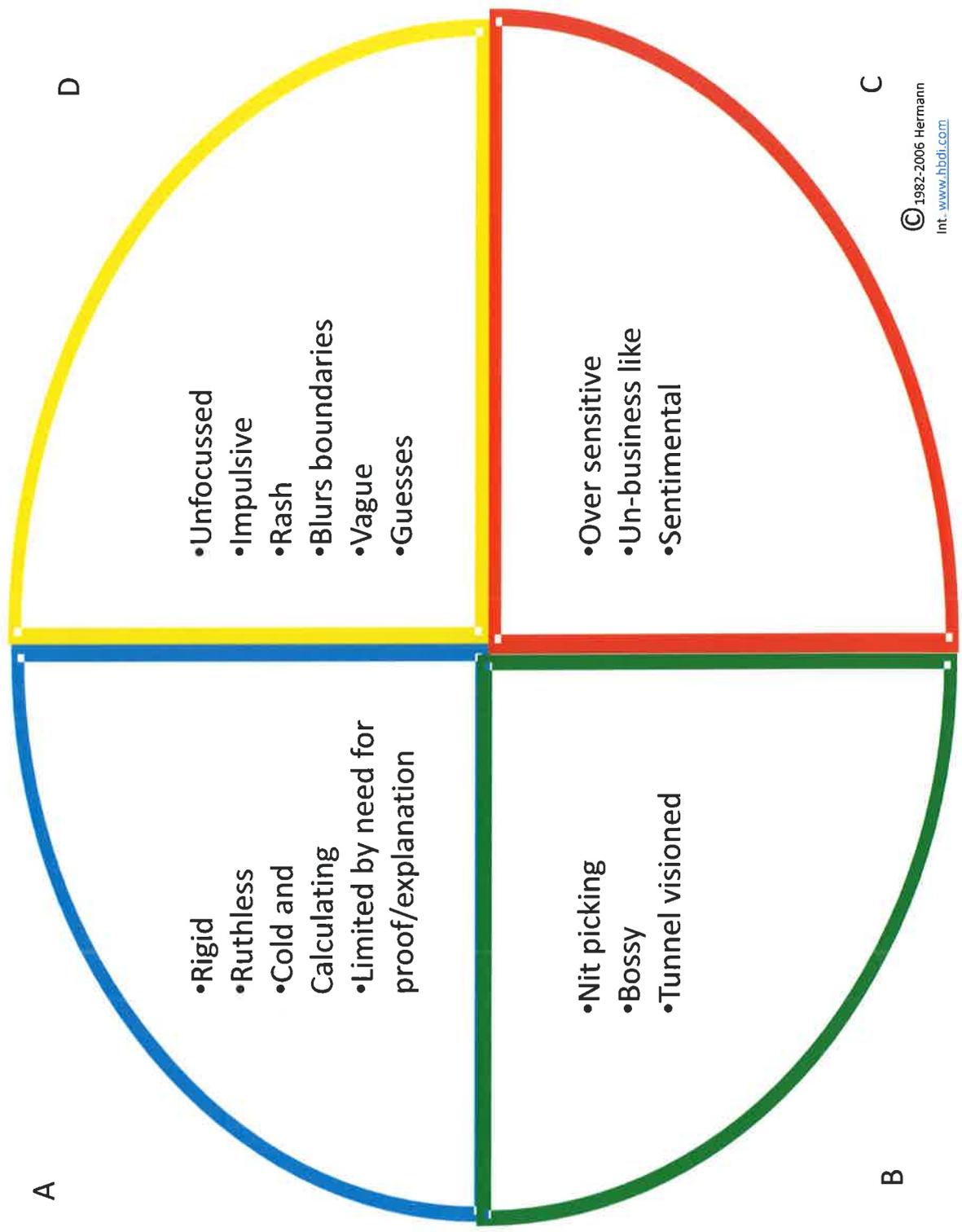
- Getting Groups to Work Well Together
- Expressing Ideas
- Building Relationships
- Teaching/Training
- Listening and Talking
- Working with People
- Persuading People
- Being Part of a Team
- Communication Aspects
- Helping People
- Expressive Writing
- Coaching
- Counselling

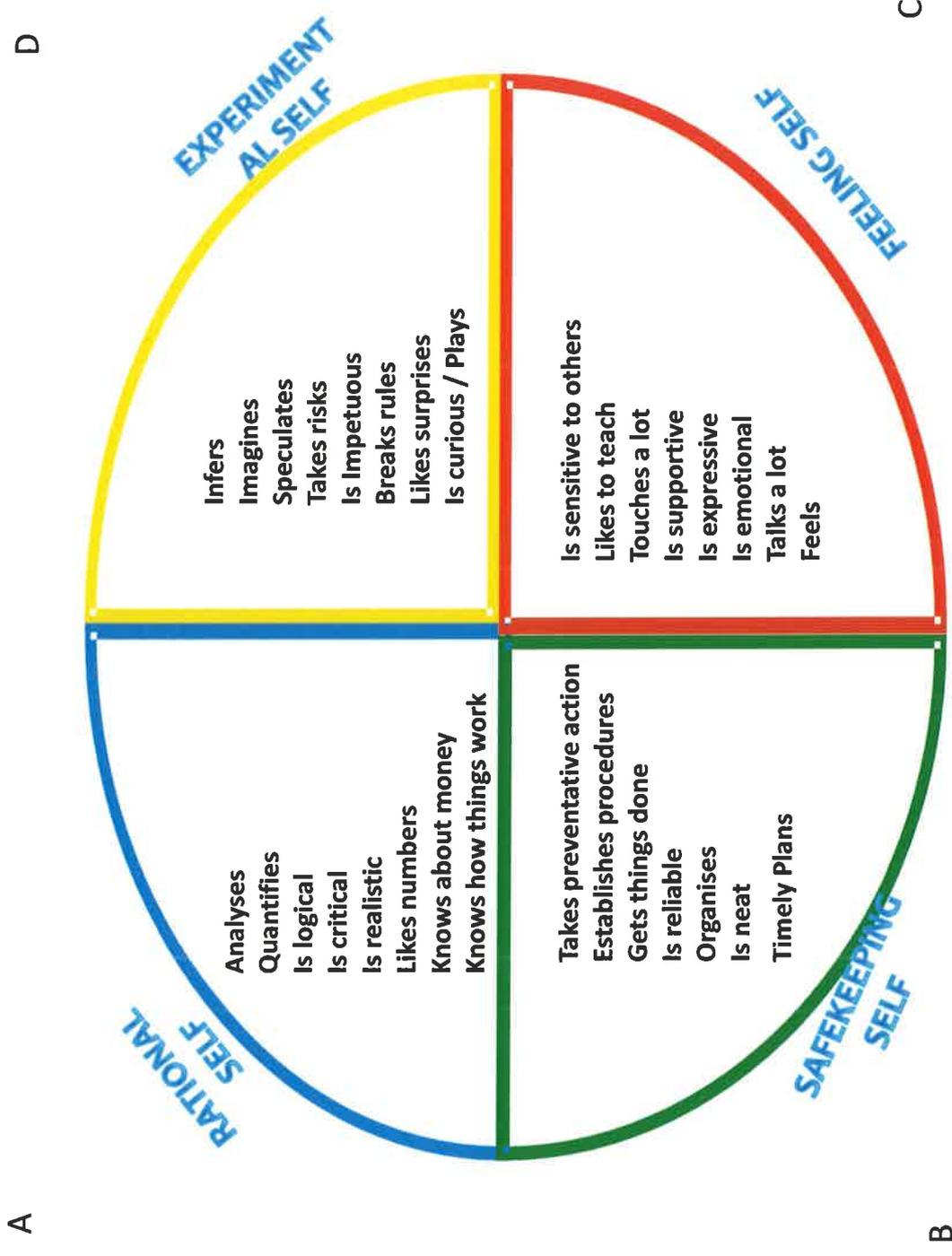
THE WHOLE BRAIN MODEL



INTROVERT/EXTROVERT







A Expects

- Brief, clear & precise information
- Materials that are direct and to the point
- Well articulated ideas presented in a logical format
- Data and fact-based charts
- Technical accuracy
- Presentation in alignment with corporate goals and objectives

Appreciates

- Critical Analysis
- A good debate
- Efforts to spend time wisely

D Expects

- An overview, a conceptual framework
- Frequent and spontaneous tasks
- Idea Chunks
- Freedom to explore
- Metaphorical examples
- Visuals
- Long-term objectives
- Connections to the big picture

Appreciates

- Initiative and imagination
- Connections to other approaches
- Newness and “fun” approach
- Minimal details

B Expects

- Step- By Step unfolding of the topic
- A written schedule & action plan
- Thorough, timely and reliable follow through
- Consistency
- Alignment with well established procedures
- Assurance that this has been done before
- Explanation of how it will happen
- References and background information

Appreciates

- Very low risk
- A written communication before session

C

- Empathy & consideration of their needs
- Involvement with others
- A good attitude & personal relationship
- Personal touch & informality
- Eye-to eye contact
- References to people involved
- To know how “others will react”
- Far all to have equal consideration
- Their feelings to be respected

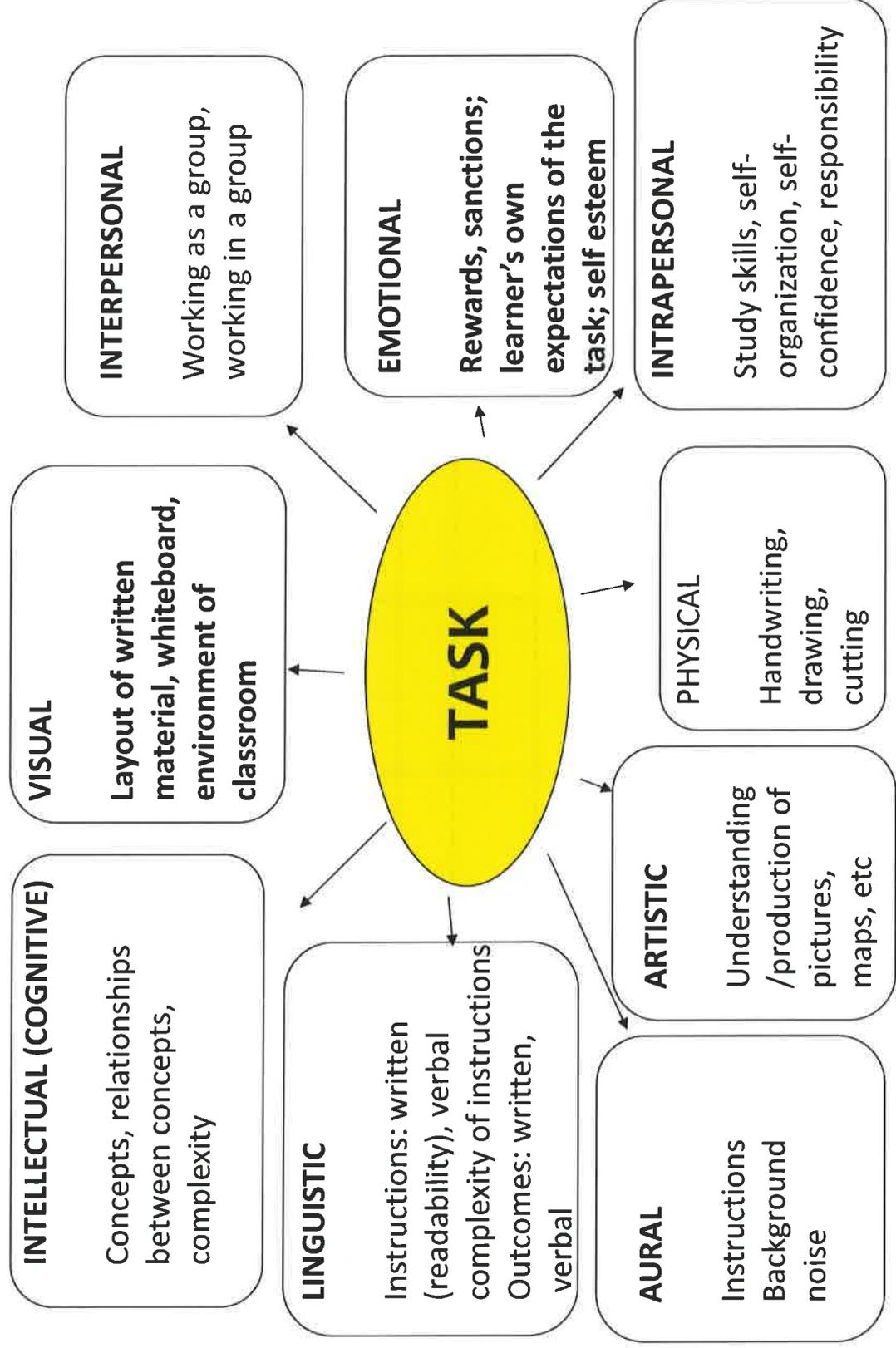
Appreciates

- The personal touch/sensitive to feelings
- Group discussion and consensus
- A harmonious approach

Herrmann Communication

A Facts, logic and theory	D The Big Picture, the future
B How, When, Where, Who?	C People, feelings, Participation

Components of Task Complexity



Scenarios –

In small groups look at the following scenarios – each contains a student with bipolar - and consider the following:

What is the behaviour perceived to be challenging?

Why is it challenging?

Who is it challenging for?

Why might it be happening?

How can you address the behaviour?

Scenario 1

You are teaching a maths revision class that requires you to explain a particularly important calculation to the class. Much of the learning for the unit hinges upon the students' understanding of this point. At the back of the class 2 boys are whispering to each other, student – who is known to distracting others. The is explaining to another wrong and he is getting you try to quieten him he abusive and bounces clearly struggling to sit and his voice becomes strident and incoherent as his thoughts and conversation begin to race. Although you are aware the student has bipolar and has difficult home circumstances, he makes it quite clear that he thinks your classes are irrelevant, boring and a waste of his time and he could teach better himself. When you respond to this, he tells you to f*** off. The rest of the class are hushed, waiting for your response.



Scenario 2

The class is working in groups, using worksheets which have been distributed to them. The students are required to discuss the material and then to solve the problems with which they are presented in a collaborative manner. As the lesson progresses, you become aware that within one of your groups a student is doing nothing at all. She has an EHCP that states she has bipolar and after 15 minutes on the task even begun to address the material but is staring aimlessly into space. When questioned she says that she has a headache and feels sick and is really tired. In fact, she states that she can't be bothered to do any of it, it's pointless and she wants to go home. The last time this happened the student was away for 3 weeks.



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Scenario 3

You are teaching a mixed group. The class has just come back from a canoeing activity and it is a Friday afternoon, last period of the day. There is a bit of difficulty settling one student down. You have a note from the previous teacher to say that the student has been very 'difficult'. They have not responded to instructions, become very irritable with and distracted by other students who are talking about their forthcoming night out in the student bar. All students are over 18.

Students are needed to attend a canoe practice on Saturday morning before a race on Sunday afternoon.

The night can go in one of three ways for the student -.

- 1) I don't drink and I have a good time with only mild mood shifts.
- 2) I drink (a lot) and I have a great and manic time.
- 3) I drink (a lot) and become super depressed and regret everything.



Let's Talk

Active Listening, non-judgemental listening

- Use body language to show that you are listening and interested
- Often the child/young person will feel somewhat better just for being listened to
- Silence can be useful

Ask open, straightforward questions to clarify situation

- How? Who? Where? When? What? Be careful of using 'Why'
- Often the person will have their own answers, but be unable to access them due to their distress
- Having to think in this way will help to reduce distress levels

Ask who they would like you to contact

Let's Talk

- **What is the most useful thing I can do right now?**
- **What would you like to happen next?**
- **Who would you like me to contact?**
- **Where would you feel most comfortable?**
- **You said this has happened before. What helped on that occasion?**

Look after yourself!

DO	DON'T
Have a conversation in a private space	Don't attempt to start a conversation in front of everyone else
Make sure there are no interruptions. Switch your mobile phone off.	Don't start a conversation if you don't have time
Be focussed. You only need information that will help you achieve the goal of supporting your student	Don't attempt to diagnose.
Ask open, non-controlling questions. E.G "I was wondering how you are doing"	Don't ask questions that could create pressure like "what's wrong with you then"
Use neutral language	Don't use medical language –E.G "You seem depressed"
Allow student time to answer	Don't tell the person what to do
Try and put yourself in the other person's position and see things from their perspective	Don't leave things up in the air.
Make arrangements for a follow-up meeting to review situation	

Depression

During a period of depression, your symptoms may include:

- feeling sad, hopeless or irritable most of the time
- lacking energy
- difficulty concentrating and remembering things
- loss of interest in everyday activities
- feelings of emptiness or worthlessness
- feelings of guilt and despair
- feeling pessimistic about everything
- self-doubt
- being delusional, having hallucinations and disturbed or illogical thinking
- lack of appetite
- difficulty sleeping
- waking up early
- suicidal thoughts

Mania

The manic phase of bipolar disorder may include:

- feeling very happy, elated or overjoyed
- talking very quickly
- feeling full of energy
- feeling self-important
- feeling full of great new ideas and having important plans
- being easily distracted
- being easily irritated or agitated
- being delusional, having hallucinations and disturbed or illogical thinking
- not feeling like sleeping
- not eating
- doing things that often have disastrous consequences – such as spending large sums of money on expensive and sometimes unaffordable items
- making decisions or saying things that are out of character and that others see as being risky or harmful

Patterns of depression and mania

If you have bipolar disorder, you may have episodes of depression more regularly than episodes of mania, or vice versa.

Between episodes of depression and mania, you may sometimes have periods where you have a "normal" mood.

The patterns are not always the same and some people may experience:

- rapid cycling – where a person with bipolar disorder repeatedly swings from a high to a low phase quickly without having a "normal" period in between

- mixed state – where a person with bipolar disorder experiences symptoms of depression and mania together; for example, overactivity with a depressed mood

If your mood swings last a long time but are not severe enough to be classed as bipolar disorder, you may be diagnosed with a mild form of bipolar disorder called cyclothymia.

Symptom: Children with bipolar disorder often have a reversal in their sleep/wake cycle and it is extremely difficult for them to get to sleep at night and to wake up early in the morning. He or she seems half comatose or extremely grumpy and sleeps through first and possibly second period, often missing important class material and doing poorly on tests in the first two periods.

Accommodations:

- Schedule academic classes later in the day when the student is more alert and emotionally available for learning.
- Allow the student to take important tests later in the day when the student may be able to focus better.
- Allow the student to begin the school day a little later.

Symptom: The student has daily and seasonal fluctuations in mood and energy and is therefore more attentive to classwork at certain times and less attentive at others.

Accommodations:

- Create formal contingency plans when the student is unstable and is experiencing periods of withdrawal or fatigue (a symptom of the illness and often a side effect of the medications).

Symptom: The student can experience great irritability, building to a rage if not recognized and dealt with in an appropriate and timely manner.

Accommodations:

- Assign a staff/school person who the student can go see when he or she feels unable to cope. This can be a counselor, school therapist, teacher, or any other person (campus monitor, school nurse, etc.) with whom the student feels safe and whom the student trusts and chooses. Give the student a permanent pass and a private signal that only he and the teacher understands so that he can make a private exit in front of the rest of the class.
- Offer the student a private place to go to calm down when feelings are overwhelming.

Symptom: The student has difficulty with peers. The student may have poor social skills, be bossy, misperceive the behaviors and intentions of others, and be socially inappropriate at times.

Accommodations:

- Arrange for the student to learn social skills and group behavior by meeting with the school social worker, school psychologist, or the guidance counselor.
- Develop a social skills class and have the student participate in it.
- Place an aide in the classroom who can monitor social interactions and report incidents of social conflict. The aide can interpret and explain to the student how things occurred which may be outside the student's perception. This aide can advocate for the child, act as a friend, make the child feel safe, and alert the school if there are any incidents of bullying going on.

Symptom: The student becomes overheated and overstimulated in gym classes and begins to suffer discomfort or to cut class.

Accommodations:

- If the student participates, he or she must always have access to water and rest.
- The student should have the option of less competitive physical activity such as Yoga, Tae Kwan Do, weight training, aerobics, etc.
- The student should be graded based on attendance rather than participation.
- If necessary for the student's emotional well-being, have an Adaptive P.E. written into the IEP until such time as the student is ready for mainstream physical education.
- If inclusion is an issue or a desire on the student's part, the student could be appointed score keeper or equipment manager.

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1. Talk to your child about anxiety, what is happening in their body and why it happens. Many children and young people don't know what they are feeling when they are anxious, and it can be very frightening and overwhelming. They might even think they are very ill or that they are having a heart attack.
2. Help them to recognise anxious feelings so they can tell when they are becoming anxious and can ask for help.
3. Tell your child/young person it will be okay, and the anxiety will pass. It can be helpful to describe the anxiety as a wave to ride or surf that gets smaller after it peaks.
4. Get your child to breathe deeply and slowly, in through their nose for three counts and out through their mouth for three counts.
5. Distract them by focusing on something else.
6. **Cognitive Behavioural Therapy (CBT):** The approach of CBT is about thinking more positively about life, looking at how you can get stuck in patterns of behaviour and ways of changing these rather than dwelling on past events. There are typically six or 12 weekly sessions and the therapist sets goals with the young person, often with 'homework' to do in between.
7. **Mindfulness:** Mindfulness is often combined with CBT and helps a young person to focus on difficult thoughts and feeling, rather than avoiding them, so that the fear of them gradually lessens. Therapists can also include meditation, yoga and breathing exercises.
8. **Psychotherapy:** This is a more long-term therapy and involves talking about the effects of past events and can be more helpful with long-term problems such as depression or eating disorders. NHS psychotherapists work in clinics or hospitals; some private psychotherapists work from home.

9. **Family Therapy:** The whole family works with the family therapist to try and understand the problems they are all having. It can help improve communications between family members and issues such as children's behavioural problems, disability, family breakdown, addiction and domestic violence.

Case Study

Alarm goes off. It's hard to get up, the effects of my mood-stabilizing medications causing me to feel more drowsy than the average college student – after nine hours of sleep.

I have plenty of friends who sleep only a few hours a night and skip breakfast. I can't afford these things. I make myself a bowl of oatmeal and peanut butter, knowing if I don't start off with a balanced breakfast, I'm more likely to restrict or binge later, the lingering habits of my past eating disorder still threatening to ruin my day if I'm not careful.

Next, I go to class. I struggle to focus, the professor's words often in one ear and out the other. If I'm stressed, intrusive thought obsessions and mental compulsions distract me during the seminar, causing me to be in another world of my own. One filled with anxiety.

Other days, I'll be launched into the past, where I ruminate on prior events and feelings, almost as if they were a part of my present. I might even dissociate out of the room, the obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) making learning a lot harder.

Not to mention there are my emotions — if I'm feeling hypomanic I bounce in my seat and my thoughts race. I struggle to sit. If I'm feeling depressed, negative thoughts bombard my psyche as well as physical exhaustion. Occasionally, all is calm in my mind. But most of the time, there's some sort of distraction that takes me far away from the classroom internally.

After class, I know it's time to do some homework, but I can't bring myself to focus, not when my mind has worn me out. I want to just draw in my notepad, using markers to take my stress away. So usually, that's what I do for a little bit.

I later grab a meal with friends, the socialization always a mood booster for an extrovert like me. Eating is sometimes a struggle though with my eating disordered past. I struggle with under-eating and sometimes even over-eating since entering recovery from anorexia. It's easy to end up on the other end of the spectrum, but I try my best to focus on enjoying time with my friends rather than the food.

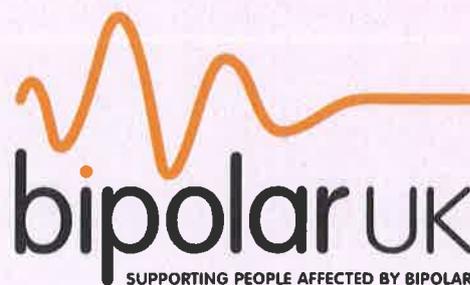
I give homework another shot, pushing my obsessive thoughts away. I'm successful for a little bit, but if my energy is high because of my bipolar disorder, I must take frequent breaks to focus.

Next, I see my therapist for the second time this week. We have a good session, but I leave feeling overwhelmed by my own thoughts and emotions, yet at the same time I feel relieved to have gotten away from campus and worked through certain issues. She gives me coping skills to get through the next trigger or intense wave of emotion.

1. Notice changes in your child's/young person's mood. Your instinct will probably tell you if your child/young person is not feeling their best.
2. Your child/young person may feel that you won't understand but you can often surprise them... and yourself!
3. It is important to let them know that you care about them, want what's best for them and are willing to help if you can.
4. Be open and available for them to talk over problems, things that are bothering or stressing them or how they are feeling.
5. Pick a time that is good for you both, where you have enough time to have a proper conversation without being interrupted.
6. Ask what you can do to help. Stay calm and positive and try to be the 'strong one'.
7. Make it clear you will not say anything to anybody else if they don't want you to. (An exception will be if you have a **significant concern** for their safety).
8. Help with practical support; for example, if your child/young person has to go for an appointment but feels uncomfortable about going on their own, go with them, even if you wait outside.
9. Provide emotional support; this is often a case of listening and being empathetic, rather than trying to find answers or solutions.

10. Suggest people your child/young person might be safe to confide in (e.g. mum, dad, sibling, other relative, friend, GP, helpline).

Mood Scale



This scale is not meant to be definitive but is an indicator of possible behaviours

MANIA	10	Total loss of judgement, exorbitant spending, religious delusions and hallucinations.
	9	Lost touch with reality, incoherent, no sleep, paranoid and vindictive, reckless behaviour.
HYPOMANIA	8	Inflated self-esteem, rapid thoughts and speech, counterproductive simultaneous tasks.
	7	Very productive, everything to excess (phone calls, writing, smoking, tea), charming and talkative.
BALANCED MOOD	6	Self-esteem good, optimistic, sociable and articulate, good decisions and get work done.
	5	Mood in balance, no symptoms of depression or mania. Life is going well and the outlook is good.
	4	Slight withdrawal from social situations, concentration less than usual, slight agitation.
MILD TO MODERATE DEPRESSION	3	Feelings of panic and anxiety, concentration difficult and memory poor, some comfort in routine.
	2	Slow thinking, no appetite, need to be alone, sleep excessive or difficult, everything a struggle.
SEVERE DEPRESSION	1	Feelings of hopelessness and guilt, thoughts of suicide, little movement, impossible to do anything.
	0	Endless suicidal thoughts, no way out, no movement, everything is bleak and it will always be like this.

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Bipolar UK Mood Diary

Use the calendar below to record your daily notes. This could include information or reminders about your mood, behaviour, sleep, nutrition, exercise, etc.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Frequently Asked Questions

The answers to the following questions do not represent the views of all mental health professionals; they reflect the academic, clinical and professional expertise of investigators supported by JBRF and other like-minded experts.

Please note: although you will read much on this site about how bipolar disorder per se is just an idea which is losing credibility, we will nevertheless use the term here as a shortcut because it is one which has a familiar meaning and because it fits with the nature of the questions.

What is “early-onset”/ “pediatric”/ “juvenile” bipolar disorder and why are we suddenly hearing so much about it?

Although the terms “early-onset”, “pediatric” and “juvenile” bipolar disorder actually mean slightly different things, they are often used interchangeably as labels for a manic-depressive disorder that appears early –very early—in life. For many years it was assumed that children could not suffer the mood swings of mania or depression, but researchers are now reporting that bipolar disorder (or early temperamental features of it) can occur in very young children, and that it is much more common than previously thought.

Is bipolar disorder in children the same thing as bipolar disorder in adults?

Adults diagnosed with bipolar disorder seem to experience abnormally intense moods for weeks or months at a time, but children appear to experience such rapid shifts of mood that they commonly cycle many times within the day. This cycling pattern is called ultra-ultra rapid or ultradian cycling and it is most often associated with low arousal states in the mornings (these children find it almost impossible to get up in the morning) followed by afternoons and evenings of increased energy.

It is not uncommon for the first episode of the disorder to be a depressive one. But as clinical investigators have followed the course of the disorder in children, they have reported a significant rate of transition from depression into bipolar mood states.

It is important to note that there are many adults whose symptom profiles look much more similar to the pediatric profile. However, just like those children, they would not qualify for a bipolar I or II diagnosis.

Additionally, even those people who *do* qualify for a bipolar I or II diagnosis spend most of their time in a sub-syndromal state; that is, their symptoms do not meet criteria.

What are the symptoms in childhood, and how early can they begin?

We have interviewed many parents who report that their children seemed different from birth, or that they noticed that something was wrong as early as 18 months. Their babies were often extremely difficult to settle, rarely slept, experienced separation anxiety, and seemed overly responsive to sensory stimulation.

In early childhood, the youngster may appear hyperactive, inattentive, fidgety, easily frustrated and prone to terrible temper tantrums (especially if the word “no” appears in the parental vocabulary). These explosions can go on for prolonged periods of time and the child can become quite aggressive or even violent. (Rarely does the child show this side to the outside world.)

A child with bipolar disorder may be bossy, overbearing, extremely oppositional, and have difficulty making transitions. His or her mood can veer from morbid and hopeless to silly, giddy and goofy within very short periods of time. Some children experience social phobia, while others are extremely charismatic and risk-taking.

If the child is fidgety and inattentive and hyperactive, isn't the correct diagnosis attention-deficit disorder with hyperactivity (ADHD)? Or, if the child is oppositional, wouldn't oppositional-defiant disorder (ODD) be the correct diagnosis?

Several studies have reported that over 80 percent of children who have early-onset bipolar disorder will meet full criteria for ADHD. It is possible that the disorders are co-morbid—appearing together—or that ADHD-like symptoms are a part of the bipolar picture. JBRF sponsored investigators identified measures on several neurocognitive tests which are able to differentiate between ADHD and bipolar disorder. The published study can be seen here: [Neuropsychological factors differentiating treated children with pediatric bipolar disorder from those with attention-deficit:hyperactivity disorder.](#)

In addition to these subtle neurocognitive differences, children with bipolar disorder exhibit more irritability, labile mood, grandiose behavior, and sleep disturbances— often accompanied by night terrors (nightmares

filled with gore and life-threatening content)—than do children with ADHD.

Because stimulant medications may exacerbate an underlying mood disorder, bipolar disorder should be ruled out before a stimulant is prescribed.

In another JBRF sponsored study, almost all of the 120 boys and girls diagnosed with bipolar disorder met criteria for oppositional defiant disorder (ODD). You will find extensive information about how oppositional behaviors fit into the mood disorder called Fear of Harm in the following postings: [Fear of harm, a possible phenotype of pediatric bipolar disorder: A dimensional approach to diagnosis for genotyping psychiatric syndromes](#) and [More About Fear, Aggression, Anxiety](#). The child should be evaluated for a possible bipolar disorder.

So how would a doctor diagnose early-onset bipolar disorder?

The family history is an important clue in the diagnostic process. If the family history reveals mood disorders or substance abuse coming down one or both sides of the family tree, red flags should appear in the mind of the diagnostician. The illness has a strong genetic component, although it can skip a generation.

Many parents are told that a proper diagnosis cannot be made until the child grows into the upper edges of adolescence—between 16 and 19 years old. This reflects outdated ideas. However, even among doctors who acknowledge that children can and should be diagnosed earlier; there is a reluctance to do so. The seriousness of the diagnosis, the effects of the medications used to treat the condition and the difficulty to tease out normal, albeit difficult, developmental behavior from behavior which warrants medical attention, often delays proper diagnosis.

Objective criteria or tests would be a welcome relief. Unfortunately, the field of psychiatry is not at that point.

That said, as you will read in postings under the tab “Information from JBRF Sponsored Research”, there are some very important and easily recognizable signs of the condition which JBRF investigators call Fear of Harm (FOH). Studies have shown that approximately 2/3 of children who are diagnosed with bipolar disorder or who are at risk for bipolar disorder may actually have this condition. The symptom profile of FOH is well described in this website. If you recognize your child in this description, we strongly advise you to bring the information to the attention of your

child's doctor. Several of the symptoms of FOH appear very early in life making early diagnosis and intervention more likely. To read an article which discusses those early warnings, click [here](#) .

If a child hears voices or sees things, does that mean he or she is schizophrenic?

Absolutely not. Psychotic symptoms such as delusions (fixed, irrational beliefs that could not possibly exist) and hallucinations (seeing or hearing things not seen or heard by others) can occur during both phases of bipolar disorder. In fact, they are not uncommon. Sometimes the voices and visions are compelling; often they are threatening. Quite a few children report seeing bugs or snakes or say that they see and hear satanic figures. The hallucinations can be either well formed or vague, such as a dark wind. The hallucinations often occur shortly before sleep or upon waking up.

What are the treatments for early-onset bipolar disorder?

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

Mood stabilizers are the mainstay of treatment for a bipolar disorder, but many of these medications have only recently begun to be used in children with the condition, so not a lot of data about their use in childhood bipolar disorder exists. (However, the anticonvulsant mood stabilizers such as Depakote and Tegretol, etc. have been used to treat young children with epilepsy for quite some time, so there is a literature about these drugs in the pediatric population.)

Many psychiatrists simply adapt what they know about the treatment of adults to the pediatric and adolescent population. Our experience tells us that, because they are treating children and there is not much literature on the subject, many psychiatrists prescribe the drugs very cautiously. This often causes them to discount the efficacy of the treatment before it is able to reach a therapeutic dose. The result is to either pass-up an effective treatment or to question the diagnosis altogether.

Commonly prescribed mood stabilizers include lithium carbonate (Lithobid, Lithane, Eskalith), divalproex sodium (Depakote, Depakene),

carbamazapine (Tegretol), and Oxcarbazapine (Trilepta). Newer agents such as gabapentin (Neurontin), lamotrigine (Lamictal), topiramate (Topomax), and tiagabine (Gabitril) are currently under clinical investigation for the treatment of bipolar disorder and are being used in children. (Lamictal is Black Label for those under the age of 16.)

If a child is experiencing psychotic symptoms and/or aggressive behavior, the newer antipsychotic drugs, risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), and Aripiprazole (Abilify) are commonly prescribed. Older antipsychotics such as thioridazine (Mellaril), haloperidol (Haldol), and molindone (Moban) are old standbys. Clonazepam (Klonopin) and lorezapam (Ativan) are also used to treat anxiety states, induce sleep, and put a break on rapid-cycling swings in activity and energy.

Research pursued by JBRF-sponsored investigators has accumulated impressive results by treating children characterized by Fear of Harm with intranasal ketamine. To the best of our knowledge there is nobody else in the country using this treatment regimen at this time. Upon conclusion of the Ketamine Clinical Study, we will prioritize distributing this information.

Should antidepressants be used?

It's very risky. Several studies have reported high rates of the induction of mania or hypomania and rapid-cycling in children with bipolar disorder who are exposed to antidepressant drugs of all classes. In addition, the child may experience a marked increase in irritability and aggression. Many parents on the BPParents listserv (an on-line community of parents who communicate with each other from all over the world via E-mail) reported that their children experienced psychosis and were hospitalized subsequent to their treatment with antidepressants. Some children did well for weeks or even for three months before a switch into mania and ultra-rapid mood shifts began.

Can a child take antidepressants for the depressive periods after he or she is stabilized on a mood stabilizer?

Maybe. Some children may be able to take an antidepressant for a brief period if it is opposed by a mood stabilizer. More studies need to be done so that treatment recommendations can be made.

