Bi-Polar

Bi-Polar is the new name given to what was called manic depressive illness. Bi-polar affects two in every hundred of the Australian population. Both male and females are equally likely to have Bi-polar however males tends to be diagnosed earlier. Bi-polar is believed to be caused by a combination of factors including genetics, biochemistry, stress and seasons. There appears to be a chemical imbalance in the brain which can be corrected by medication. People suffering from Bi-polar can experience recurrent episodes of depressed and elated moods from mild to severe. Some people do not experience depressive episodes. As Bi-polar is normally associated with adults with the diagnosis occurring around 22 years doctors are reluctant to diagnose young children. Bipolar disorders can begin from childhood through to about 50 years of age. The average age of onset is about 30 years.

Effects on Developmental Areas

Social and Emotional

- May get angry or irritable with people who disagree or dismiss their ideas
- May withdraw from others in social situations
- Has prolonged periods of depressive or manic behaviours

Motor and Physical Development

- May have increased energy and over activity
- May have reduced need for sleep
- May have loss of appetite and thus loss of weight
- May be extremely sensitive to certain stimuli

Language and Communication Development

- May speak quickly and jump from subject to subject

Cognitive

- May have rapid thinking which then can affect language
- May have grandiose concepts of themselves
- May have their attention easily drawn to irrelevant or unimportant things
- May not have the insight that their behaviour, actions are inappropriate
- May have depression triggered by a stressful/unhappy event
- May have difficulty concentrating

- May have false beliefs or feelings of guilt
- May have deep sadness and have a tendency towards suicidal thoughts
- May lose interest in activities once enjoyed before

Bi- Polar

Inclusion Strategies

Each child diagnosed with Bi-Polar will be different and individual. It is important to gain information from the parents as to what characteristics of Bi-Polar their child displays. It is important to work closely with the parents as well as any additional support specialists e.g. therapists who may be involved with the child. It is also important to gain an understanding from the parent as to what is the most important aspect of their child attending your service. What is it that parents hope to gain from using your service? The following inclusion strategies are just some examples which may be applied to support the inclusion process. This list is only the start and it is dependant on a variety of factors such as environment, length of time child is in care, child's interest, likes, dislikes, skills already achieved. The strategies are divided into developmental areas however some strategies overlap and assist in a variety of developmental areas.

Social development

- On arrival and farewell and when wanting child's attention say the child's name first to catch his attention e.g. "Jack, good morning" rather than "Good morning, Jack".
- Allow for plenty of breaks. Provide a quiet area with objects for child to explore independently.
- Be supportive and acknowledge the child's emotions. Allow the child to retreat when they're feeling overwhelmed. Prearrange appropriate activities for the child to retreat to, such as going to the toilet, getting a drink of water or to a quiet area.
- Explain what you are doing when you are doing it when presenting an activity, giving instructions or encouraging turn taking/sharing.
- Provide time for the child to make a choice. Encourage them to take a minute to reflect.
- Let other children know what child is doing to reinforce the concept of him being part of the group. Do this with all children e.g. "Look Jack is doing a puzzle as well".
- Offer small group activities without the pressure for the child to participate. Do not blame or try to help by suggesting that the child "try harder".
- Try to not become over involved or withdraw from the individual.
- Find regular (as often as possible) opportunities to provide positive praise. Proactively identify and praise situations where the child was able to regulate

their behaviour including using problem solving, calm down strategies or even reacting with less aggression.
- Do not participate in the escalation of excitement. When child is able to take feedback provide feedback e.g. “You are a little high/noisy/over excited at the moment, what about listening to some music” in a gentle manner.
- Validate and express understanding of the child's feelings. For example: "I can understand how you might feel that way".
- Be aware that you cannot “jolly” the child out of a depressive state.
- Try to sit beside the child without expecting a two way conversation. Often child just needs you there.

Physical development

- Allow child to practice his/her physical skills but reinforce the rules for turn taking, quiet times etc.
- Encourage child to eat but do not push the matter, however, be aware of hydration and nutrition issues.

Language

- Utilise the use of large clear pictures to reinforce what you are saying and encourage child to use these as well.
- Para-phrase back what the child has said.
- Clarify types of communication methods the child may use e.g. Key Word Sign.
- Provide puppets/pictures as an extra prop when using finger plays and songs.
- Reduce the amount of instructions in one statement to allow time for the child to gain an understanding of what is been said e.g. “Hold the puppet up high” rather than “hold the puppet up high and wave it around so that all the children can see it.” Once child understands to “hold the puppet up high” you can then add “Good, now all the children can see it”.
- Ascertain from parents words that are familiar with the child e.g. family words that represent aspects of child life, and use these in your program.
- Keep up good levels of communication even when not reciprocated.

Cognitive

- Make routines consistent where possible and predictable. Inform parents and child of any changes.
- Give child advanced notice of transitions about to take place. More time may be needed for these transitions to occur to allow the child to finish the task they were on.
- Encourage use of a bright, easily recognisable bag for child to be able to recognise his hook/locker.
- Gain information from parents about child’s likes, interests and dislikes and incorporate these in your program.

- Break tasks down to smaller steps e.g. placing one puzzle piece in a time rather than expecting the puzzle to be completed.
- Allow the child time to complete tasks and practice skills at own pace.
- Attend to safety issues that poor concentration can cause.
- Set realistic tasks.
- Have realistic expectations.
- When child's thoughts are racing reduce stimulation and loud noise.

References:

Kutscher, M.L. (2005) ***Kids in the Syndrome Mix of ADHD, LD, Asperger's, Tourette's, Bipolar, and More!*** Jessica Kingsley Publishers: London

Mental Illness Fellowship Victoria
www.mifellowship.org/documents/understandingbipolar.pdf

Association of relatives & Friends of the mentally Ill
884 Brunswick St
New Farm
www.arafmiqld.org
24hrs support line 1800351881

www.healthinsite.gov.au/topics/Bipolar_disorder