Educator's Guide to Reacclimation of Bipolar Students After Hospitalization

(2000) by Tracey Trudeau.

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1. Erratic school attendance makes it difficult to assess academic potential or impairment, therefore awareness of lack of opportunity to learn as opposed to the inability to learn is important. Students require flexibility in their academic programming, including those capable of learning core subjects when well and stable. This ultimately becomes an attendance issue rather than a problem defined by a deficit in potential.

2. Premorbid cognitive assessment data provide a good baseline measure for illness-related changes, particularly when qualitative analyses of subtests are employed.

3. A strong supportive partnership between the disciplines of psychiatry and education where there is some common understanding of each other's roles, needs, and language is a prerequisite of successful transitioning. Information sharing that is full of discipline-related jargon confounds the end purpose - student well-being.

4. A special effort should be made by inpatient facilities to connect with rural school districts to minimize any feelings of geographical disconnection by receiving school staff or perception of diminished support.

5. Inpatient staff roles should include finding a supportive school and a primary liaison for the student, providing initial teacher education, program planning assistance, and post-placement support to the receiving school.

6. Predictable and consistent daily routines are ideal for recovering students - the idea of one room, one teacher, might be explored with appropriate students. Gradual or partial re-integration is usually recommended rather than returning with a full academic load.

7. Importance of finding a student's optimum learning style is stressed (i.e. auditory, visual, kinesthetic), as is the willingness of teachers to allow flexibility of the format of work product that would best represent the student's understanding of concepts.

8. Medication and treatment non-adherence difficulties are often timed around school and holiday transitions. Is there a role here for the school counselor in proactively seeking out the student and checking in?

9. Some students will struggle with learning in two languages after recovery despite excelling previously in bilingual education. Careful evaluation of student ability to continue in a demanding bilingual program will ensure that possible pressure to please parents or teachers does not sabotage the total academic program.

10. Students have a strong desire to return to community schooling. This is complicated by worry of ostracism or harassment by peers. These concerns should be raised proactively by parents, therapists, and school staff. Instances of bullying or ridicule about psychiatric hospitalization or diagnosis should be dealt with swiftly and seriously in a manner consistent with racial or sexual harassment.

11. Mental health units should be taught in the upper grades in the context of regular biology or health courses. It is important to begin to demystify these illnesses to the general public and to peers of recovering students rather than solely directing this information to educators, service providers and other helpers.

12. Hospital staff is encouraged to develop a personalized checklist for cues of illness relapse (such as particular symptom emergence) based upon an individual student's past history and current presentation. The student should collaborate in the creation of the checklist and know the steps a school staff member will take on his/her behalf. The use of a contract in the event of acute illness onset facilitates more efficiently timed emergency psychiatric services. Emergence of psychotic symptoms in school should be handled (if possible) discretely.

13. Medication education (especially the side effect profile and level of efficacy in controlling symptoms) should be provided to teachers. Evaluation of work product and performance must consider the limitations of residual illness symptoms and medication side effects: Poor penmanship due to hand tremor, awkward gait or rapid weight gain in physical education, dry mouth and increased fluid intake necessitating frequent bathroom trips, heightened sensitivity to noise and light, are all common in students treated with psychotropic medications.

14. Public school reintegration should be gradual (starting with half days) and working gradually towards a full load if the student is capable. Curriculums should be flexible and the preferred learning methods are co-operative learning and a module format. Mastery learning through module format will ensure that cognitive instability has not interfered with concepts previously taught. A module format may be helpful where a student can work at his or her own pace, or perhaps come back to the module after a hospitalization. Emphasis on mastery learning may be appropriate for students who have lost previous academic achievements/gains. Learning gaps (including concurrent high competencies and clear deficits) are common in bipolar students.

15. A peer mentor (ideally one grade older) may be assigned to the student at a new school. Conversely, a recovering bipolar student wishing to mentor younger peers may be important in developing self-competency. A peer mentor from a self-help or advocacy group may be one important step in understanding that it is possible to grow beyond persistent psychiatric illness, or conversely, share the realistic experiences of being treatment non-adherent and self-destructive.

16. Teachers and other staff should encourage a self-help philosophy with students through advocating for a life-management perspective. Such a philosophy includes self-challenge, self-acceptance, honesty, and especially humor. Typical classroom behavior management strategies are appropriate to use when the student is stable and in remission - they do not work when the student is becoming ill or is still in recovery. For example, during the depressive phase of the illness, bipolar students experience phenomena called 'anhedonia' or flat affect - the inability to experience pleasure or happiness. Consequently, the student has lost the reinforcement of satisfaction which comes from learning something new, so being praised and encouraged by teachers and parents may be ineffectual for behavioral reinforcement.

17. Special education staff are encouraged to design IEPs for students with bipolar disorder that allow for equal time to develop strengths and to follow creative projects as is given for addressing identified academic shortcomings. Students who see themselves as spending more time 'making up' and less time 'getting ahead' may not develop an area of perceived competence. For example, these students show decline in math performance when comparing work pre- and post-illness. Remedial work in math is necessary, however bipolar disorder also increases the tendency of creative excellence in the visual and written arts. These strengths must be developed and even become a primary focus in an IEP.

18. Below average adaptive behavior skills (communication, daily living skills, socialization, motor skills) as measured by tools like the Vineland Adaptive Behavior Scale may identify target areas missed in more 'intellect-based' assessments (Shole-Martin & Alessi, 1988). Many students who are hospitalized frequently or for extended periods with serious psychiatric illnesses show significant to serious deficits in adaptive behavior skills. Consulting with an occupational therapist may identify problems which parents and/or teachers have attributed to 'motivational' factors.

19. If a student is capable or doing all academic work, but at a slower pace, or, in chunks due to regular and protracted school absences, an IEP that realistically plans for 1.5 academic years to complete each grade might be more helpful than a plan that 'hopes' the student will complete the work if he or she would just remain stable. This also brings forth the serious question of mandatory grade promotion. If the student can understand the work but simply requires the time to complete it, are educators creating ever-increasing cumulative deficits and setting these bipolar students up for later failure? Promoting these students just so that they may remain with their peers may not be a) what the student wants, b) an academically sound decision, or c) the best way to ensure that the student is given a chance to learn to his or her potential.

20. Inpatient staff must ask themselves if parents are making 'informed' decisions regarding educational and health concerns for their children. Parents must know, however hard it may be, the full extent of current and future impairment given what is know about the student's course of illness and history. This is neither the time to 'understate' the case nor to protect the student and the family from the expectation that relapse is not only likely but highly probable. The goal is to frankly communicate the serious nature of the disorder while ensuring that some optimism may be maintained. Contingency planning helps reduce the anxiety of impending relapse.

21. The most important goal for an educator of a bipolar student is to keep that student interested in learning and feeling welcome at school. This is even more important that teaching a prescribed number of concepts by June or in a manner that does not appear to 'bend the rules' too much for a particular child. If the primary measure of success in educating these students is how well they have been molded into the routine and rules of the school, then it is likely that the student's best interests have come second. This illness will go on far longer than the years spent in school. If the student leaves school loving to learn, (s)he will come back to it throughout the lifespan when well enough.

22. Remember that the student did not choose to have bipolar disorder any more than a child chooses to have Down's syndrome or profound deafness. The transition planning process and educational programming should be governed by compassion.

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