



Georgia Childhood Bipolar Foundation

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“Childhood’s Most Misunderstood Disorder”

by Julie Ward

Childhood Onset Bipolar Disorder (COBD) was virtually unrecognized until the late 1980’s and not commonly diagnosed until the mid 1990’s, yet it has many similarities to its adult counterparts. Children can exhibit the same symptoms as adults do including hypersexuality, suicidal ideation and planning, risk-taking behaviors, poor decision-making, lack of impulse control, depression and psychosis. The differences, mainly in how symptoms are manifested, are what make COBD difficult to recognize, diagnose and treat.

A typical adult with normal bipolar cycles may have long durations of manias, depressions and euthymic states. Mania in non-rapid cyclers can last for weeks to months at a time, even longer for depressions. Even rapid cycling adults have manic cycles that last for days with extended euthymic states that allow adults to mask or hide their condition.

By definition, a person has rapid cycles if their moods switch from one state to another more than *four times per year*. Children typically present with switching *four times or more per day*. It is not uncommon for a child with bipolar to wake in an irritable, sullen mood, arrive to school in a pleasant mood, become manic and hyperactive in the early afternoon, crash into anger and rage in the late afternoon, then complete the cycle by acting as if nothing happened at bedtime. Even when on medication to control mood swings, children can exhibit drastic swings, after which they may claim to have no recollection of their feelings, emotions or even actions.

My own son, now age 12, has exhibited extreme rapid cycling at times. During the course of a day, I have counted as many as twelve distinct cycles. A typical morning of rapid cycling might look like this:

6:00 a.m. (sometimes earlier) – Child awakens manic, calls relatives and friends on the phone to discuss plans for a party (relatives and friends are still asleep).

7:30 a.m. – Child is despondent and crying, proclaiming his world is at an end. Reason undetermined by mom.

8:00 a.m. – Child is raging and throwing objects because mom tried to console him

9:30 a.m. – Child has fallen asleep, exhausted from raging

11:00 a.m. – Child re-awakens in a good mood, as if nothing happened just hours earlier.

12:00 noon – Child begs to be taken to the store to buy party supplies (for the party he organized at 6:00 a.m. unbeknownst to mom). When mom tries to understand his feverish demands and tells him that she needs to be included in his plans, child proclaims “You hate me! You never want me to be happy! You’re a b*tch!” and begins to meltdown.

12:30 p.m. – Mom tries to fix lunch, but nothing suits the child. He is only satisfied after 30 minutes of crying, whining and arguing about what he wants to eat.

1:30 p.m. – Child is in a good mood, having eaten, and says “Mom, I love you. You’re the best mom ever.”



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While children do exhibit classic manic symptoms, they can differ in presentation from adult forms. Grandiosity or inflated sense of self-esteem may cause a child to believe that he can order his teacher or principal around without consequence. Lack of impulse control can result in fistfights or verbal threats involving peers. Poor decision-making can affect a child's ability to make friends.

Adult mania is famous for depleting bank accounts and running up credit limits; children also obsess about money, but this usually manifests as stealing, hoarding or begging for money (or clothes, CD's, toys, video games, etc.). My son's obsession with money often means that he will spend countless hours counting quarters from a jar planning how he'll spend them. Or he'll come to me several times an hour to ask me if I will pay him for various tasks (sometimes he even demands money just for "staying out of your way, mom").

Depression is an even more different animal in children than mania. Anger and irritability are key childhood depressive symptoms. Rarely does a child break down and cry, refuse to get out of bed for days or wax poetic about the meaning of life. Children are quite primal in their expression of low mood. Rage often ensues. Parents often talk about "the look" – a child's eyes will glaze over and it's as if he is not the same person anymore. It is this phenomenon accompanied by the fact that most children have no recollection of their own rages that justifies the comparison of bipolar disorder to epileptic seizures. Some children actually do have measurable seizure activity, although not all.

The age of onset can vary in children from birth (yes, birth) to pre-teen years. Most parents notice a difference in their child from a young age. Some children's behaviors are severe enough that the parent seeks early intervention (before the child starts school). Although not typical, my son was diagnosed with bipolar disorder in 1995 at the age of three and a half. I sought treatment because as early as age two, he expressed disturbing emotional instability, including suicidal tendencies. He once asked for a gun for Christmas. Thinking he meant a toy gun, I asked him why. He replied, "So I can make myself be dead." Shocked, but maintaining composure, I asked him why again. He replied, "Because my daddy ran away and hurt my feelings."

Some parents are not even aware of the differences in their child until they start public school. Regardless of the age of onset, diagnosing a child with bipolar disorder can be a difficult thing, and many times, the diagnosing physician will label the symptoms of mania as attention deficit hyperactivity disorder or ADHD. Many children do also have symptoms of ADHD, as mania and hyperactivity are quite similar. But problems can arise when the physician tries to treat the mania as if it were hyperactivity. Psychostimulants, especially when given as mono-therapy, can drastically alter a bipolar child's mood state. Drugs like Ritalin, Adderall and Concerta often cause bipolar children to exhibit extreme mania, aggression and even psychosis. If ADHD is suspected and a child worsens on ADHD treatment and medication, this could be an indication that the child actually has bipolar disorder.

Such an occurrence, accompanied by a strong family history of mental illness, is how the psychiatrist arrived at my son's diagnosis of bipolar disorder. Prior, he was being treated for suspected ADHD and was placed on psychostimulants. After a small dose of such a drug caused my 3 ½-year-old son to go for 45 days with only catnaps and no substantial sleep, the doctor changed the diagnosis and later the medication.



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Other medications can also be particularly hazardous when treating children with bipolar disorder. Certain antidepressants have been known to induce mania, mixed states and even suicidality in children and adolescents, *even in the presence of a mood stabilizer*. Many bipolar children cannot tolerate the power of adult depression medications. The typical “cocktail” for a bipolar child usually consists of one or more mood stabilizers and possibly one or more antipsychotic medications. My son experienced aggression, auditory and visual hallucinations and paranoid delusions as a result of taking such a drug. He now takes anticonvulsant mood stabilizers and a novel, third-generation antipsychotic.

While adults typically find therapy and support groups helpful, children often do poorly in social situations and individual therapy due to their immaturity level—which can be as much as 3 to 5 years behind their chronological age. Most of the therapeutic interventions for bipolar children come from positive parenting and school. Children with bipolar disorder may need an IEP (individual education plan) to receive accommodations and services available in the public school setting. In extreme cases, the child may even need a special education setting with smaller class sizes, fewer transitions and reduced stressors. As the child grows older, he often develops coping skills and insight with help from these sources, hopefully preparing him for a successful, functional adulthood.

In many ways, diagnosing bipolar disorder early is devastating to the family. No parent ever desires to hear that their child has a life long affliction that has a mortality rate higher than some forms of cancer. However, early discovery and treatment can bode for a more positive, healthier prognosis. Children, being quite resilient and malleable, have a better chance at maintaining medication compliance, fostering self-awareness and becoming a self-advocate.

We are just beginning to see the first generation of children diagnosed with bipolar disorder come into young adulthood. But, all indications are that children with a solid medication regimen, a strong support system and a healthy self-image are developing into strong, positive, functional adults... who just happen to also have an illness called bipolar disorder.



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Some ways Childhood Onset Bipolar Disorder differs from adult Bipolar Disorder:

- Children have much faster and more frequent cycles than adults
- Children rarely have pure euphoric mania as defined by the DSM-IV. Children are more likely to have dysphoric mania or mixed states.
- Depression in children often manifests as anger and aggression instead of sensitivity and withdrawal.
- Children often have co-morbid conditions accompanying the bipolar disorder that are commonly found in childhood: ADD, ADHD, Tourette's Syndrome, OCD (Obsessive Compulsive Disorder), ODD (Oppositional Defiant Disorder) and Autism, to name a few.
- The co-morbidity of other disorders can make medical treatment very difficult in children. Children are more likely to be activated by certain medications, namely antidepressants and psychostimulants, than adults.
- Bipolar in children is very often misidentified as unipolar depression with hyperactivity. Treatment for unipolar depression is vastly different from treatment for bipolar in children, and can result in severe problems.
- Children are not "little adults", i.e., their metabolisms run differently than adults, so merely prescribing smaller doses of adult medications do not sufficiently treat bipolar disorder. Many times, the rate of metabolism in children is so great that doses larger than typical for adults need to be used.

Some ways Childhood Onset Bipolar is similar to adult Bipolar Disorder:

- Children can be suicidal, even as young as 2 years of age. These ideations can quickly develop into plans and actions because of the impulsive nature of Bipolar Disorder and the inability to weigh consequences of actions.
- Children with mania have the same urges that adults do in the sense that they also become hypersexual, grandiose, obsessive and desire to spend money.
- Children with depression also have the same tendencies as adults to avoid talking about their situation, to withdraw from activities and people once enjoyed, to require extraordinary amounts of sleep in order to function, and have a decreased stress threshold making daily functioning nearly impossible.
- Children, like adults, require medication to stabilize, but cognitive behavior therapy (CBT) has been shown quite successful in helping the child with bipolar to develop insight and control over their moods and actions.
- Stress, just as with adults, can trigger a relapse of the bipolar condition.

For more information about Childhood Onset Bipolar Disorder, please visit these websites:

<http://www.gcbf.org> – The Georgia Childhood Bipolar Foundation

<http://www.jbrf.org> – The Juvenile Bipolar Research Foundation

<http://www.bpkids.org> – The Child and Adolescent Bipolar Foundation

About the author: Julie Ward is the divorced mother of one son diagnosed with Childhood Onset Bipolar Disorder and Asperger's Syndrome. Julie serves as the president of the Georgia Childhood Bipolar Foundation, a parent-led foundation that provides support and education to families with children diagnosed with or at risk for bipolar disorder in the state of Georgia. Julie also has bipolar disorder. She and her son live in McDonough, Georgia.

Edited by Steve Propst. This article appears in the Spring newsletter of the Atlanta Chapter of DBSA, the Depression and Bipolar Support Alliance.