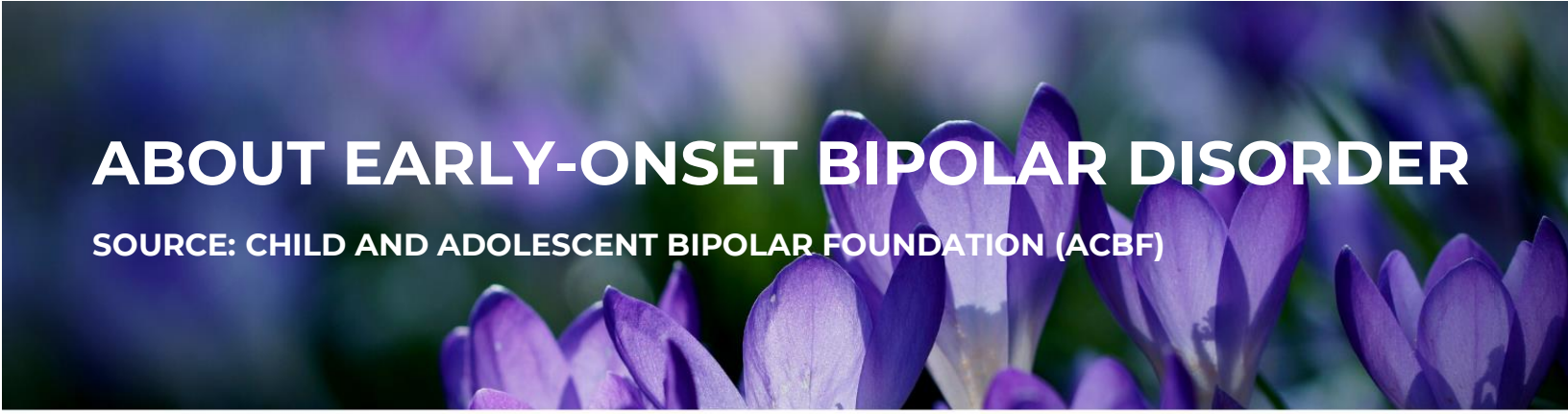

ABOUT EARLY-ONSET BIPOLAR DISORDER

SOURCE: CHILD AND ADOLESCENT BIPOLAR FOUNDATION (ACBF)

Bipolar disorder (also known as manic depression) is a serious but treatable medical illness. It is a disorder of the brain marked by extreme changes in mood, energy, and behavior.

Symptoms may be present since infancy or early childhood or may suddenly emerge in adolescence or adulthood. Until recently, a diagnosis of the disorder V11as rarely made in childhood. Doctors can now recognize and treat bipolar disorder in young children.

Early intervention and treatment offer the best chance for children with emerging bipolar disorder to achieve stability, gain the best possible level of wellness, and grow up to enjoy their gifts and build upon their strengths. Proper treatment can minimize the adverse effects of the illness on their lives and the lives of those who love them.

Families of affected children and adolescents are almost always baffled by early-onset bipolar disorder and are desperate for information and support. This information will offer answers to some of the most common questions asked about this disorder.

How common is bipolar disorder in children?

It is suspected that a significant number of children diagnosed with attention-deficit disorder with hyperactivity (ADHD) have early-onset bipolar disorder instead of, or along with, ADHD.

According to the American Academy of Child and Adolescent Psychiatry, up to one third of the 3.4 million children and adolescents with depression may be experiencing the early onset of bipolar disorder.

What are the symptoms of bipolar disorder in children?

Bipolar disorder involves marked changes in mood and energy. In most adults with the illness, persistent states of extreme elation or agitation accompanied by high energy are called mania. Persistent states of extreme sadness or irritability accompanied by low energy are called depression.

However, the illness looks different in children that it does in adults. Children usually have an ongoing, continuous mood disturbance that is a mix of mania and depression. This rapid and severe cycling between moods produces chronic irritability and few clear periods of wellness between episodes.
Symptoms may include:

- An expansive or irritable mood
- Depression
- Rapidly changing moods lasting a few hours to a few days
- Explosive, lengthy, and often destructive rages
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation, distractibility
- Sleeping little or, alternatively, sleeping too much
- Bed-wetting and night terrors

- Strong and frequent cravings, often for carbohydrates and sweets
- Excessive involvement in multiple projects and activities
- Impaired judgment, impulsivity, racing thoughts, pressure to keep talking
- Dare-devil behaviors
- Inappropriate or precocious sexual behavior
- Delusions and hallucinations
- Grandiose belief in own abilities that defy the laws of logic
- (Ability to fly, for example)

Symptoms of bipolar disorder can emerge as early as infancy. Mothers often report that children later diagnosed with the disorder were extremely difficult to settle and slept erratically. They seemed extraordinarily clingy, and from a very young age often have uncontrollable, seizure-like tantrums or rages out of proportion to any event. The word 'no' often triggered these rages.
Several on-going studies are further exploring characteristics of affected children. Researchers are studying, with promising results, the effectiveness and safety of adult treatments in children.

What are the symptoms of bipolar disorder in adolescents?

In adolescents, bipolar disorder may resemble any of the following classical adult presentations of the illness.
Bipolar I. In this form of the disorder, the adolescent experiences alternating episodes of intense and sometimes psychotic mania and depression.

Symptoms of mania include:

- Elevated, expansive, or irritable mood
- Decreased need for sleep
- Racing speech and pressure to keep talking
- Grandiose delusions
- Excessive involvement in pleasurable but risky activities
- Increased physical and mental activity
- Poor judgment
- In severe cases, hallucinations

Symptoms of depression include:

- Pervasive sadness and crying spells
- Sleeping too much or inability to sleep
- Agitation and irritability
- Withdrawal from activities formerly enjoyed
- Drop in grades and inability to concentrate
- Thoughts of death and suicide
- Low energy
- Significant change in appetite

Periods of relative or complete wellness occur between the episodes.

Bipolar IT. In this form of the disorder, the adolescent experiences episodes of hypomania between recurrent periods of depression. Hypomania is a markedly elevated or irritable mood accompanied by increased physical and mental energy. Hypomania can be a time of great creativity.

Cyclomania. Adolescents with this form of the disorder experience periods of less severe, but definite, mood swings.
Bipolar Disorder NOS (Not Otherwise Specified). Doctors make this diagnosis when

it is not clear which type of bipolar disorder is emerging.

For some adolescents, a loss or other traumatic event may trigger a first episode of depression or mania: Later episodes may occur independently of any obvious stresses or may worsen with stress. Puberty is a time of risk. In girls, the onset of menses may trigger the illness, and symptoms often vary in severity with the monthly cycle.

Once the illness starts, episodes tend to recur and worsen without treatment. Studies show that after symptoms first appear, typically there is an IO-year lag until treatment begins.

Parents are encouraged to take their adolescent for an evaluation if four or more symptoms persist for more than two weeks. Early intervention and treatment can make all the difference in the world during this critical time of development.

Is substance abuse and addiction related to bipolar disorder?

Most teens with untreated bipolar disorder abuse alcohol and drugs. Any child or adolescent who abuses substances should be evaluated for a mood disorder.

Adolescents who seemed 'normal' until puberty and experience a comparatively sudden onset of symptoms are thought to be especially vulnerable to developing addiction to drugs or alcohol. Substances may be readily available among their peers and teens may use them to attempt to control their mood swings and insomnia. If addiction develops, it is essential to treat both the bipolar disorder and the substance abuse at the same time.

What role does genetics or family history play in bipolar disorder?

The illness tends to be highly genetic, but there are clearly environmental factors that influence whether the illness will occur in a particular child. Bipolar disorder can skip generations and take different forms in different individuals.

The small group of studies that have been done vary in the estimate of risk to a given individual:

- For the general population, a conservative estimate of an individual's risk of having full-blown bipolar disorder is 1 percent. Disorders in the bipolar spectrum may affect 4 - 6 %.
- When one parent has bipolar disorder, the risk to each child is 15 to 30%. When both parents have bipolar disorder, the risk increases to 50 to 75%. The risk in siblings and fraternal twins is 15 to 25%.
- The risk in identical twins is approximately 70%.

In every generation since World War II, there is a higher incidence and an earlier age of onset of bipolar disorder and depression. On average, children with bipolar disorder experience their first episode of illness 10 years earlier than their parents' generation did. The reason for this is unknown.

The family trees of many children who develop early-onset bipolar disorder include individuals who suffered from substance abuse and/or mood disorders (often

undiagnosed). Also, among their relatives are found highly accomplished, creative, and extremely successful individuals in business, politics, and the arts.

Historical Perspective
Bipolar disorder has left its mark on history. Many famous and accomplished people had symptoms of the illness, including:

- Abraham Lincoln
- Winston Churchill
- Theodore Roosevelt
- Goethe
- Balzac
- Handel
- Schumann
- Berlioz
- Tolstoy
- Virginia Woolf
- Hemingway
- Robert Lowell
- Anne Sexton

The biographies of Beethoven, Newton, and Dickens reveal severe and debilitating recurrent mood swings beginning in childhood.

Diagnosing Bipolar Disorder in Children

Healthy children often have moments when they have difficulty staying still, controlling their impulses, or dealing with frustration. Some behaviors by a child should raise a red flag.

- Destructive rages that continue past the age of four
- Talk of wanting to die or kill themselves
- Trying to jump out of a moving car

How does bipolar disorder differ from other conditions?

Even when a child's behavior is unquestionably not normal, correct diagnosis remains challenging. Bipolar disorder is often accompanied by symptoms of other psychiatric disorders. In some children, proper treatment for the bipolar disorder clears up the troublesome symptoms thought to indicate another diagnosis. In other children, bipolar disorder may explain only part of a more complicated case that includes neurological, developmental, and other components.

Diagnoses that mask or sometimes occur along with bipolar disorder include:

- Depression
- Conduct Disorder (CD)
- Oppositional-Defiant Disorder (ODD)
- Attention-Deficit Disorder with Hyperactivity (ADHD)
- Panic disorder
- Generalized Anxiety Disorder (GAD)
- Obsessive-Compulsive Disorder (OCD)
- Tourette's Syndrome (TS)
- Intermittent explosive disorder
- Reactive Attachment Disorder (RAD)

In adolescents, bipolar disorder is often misdiagnosed as:

- Borderline Personality Disorder (BPD)
- Post-Traumatic Stress Disorder (PTSD)
- Schizophrenia

The need for prompt and proper diagnosis

Tragically, after symptoms first appear in children, years often pass before treatment

begins, if ever. Meanwhile, the disorder worsens and the child's functioning at home, school, and in the community is progressively more impaired.

The importance of proper diagnosis cannot be overstated. The results of untreated or improperly treated bipolar disorder can include:

- An unnecessary increase in symptomatic behaviors leading to removal from school, placement in a residential treatment center, hospitalization in a psychiatric hospital, or incarceration in the juvenile justice system
- The development of personality disorders such as narcissistic, antisocial, and borderline personality
- A worsening of the disorder due to incorrect medications
- Drug abuse, accidents, and suicide

It is important to remember that a diagnosis is not a scientific fact. It is a considered opinion based upon the behaviour of the child over time, what is known of the child's family history, the child's response to medications, his or her developmental stage, the current state of scientific knowledge and the training and experience of the doctor making the diagnosis.

These factors (and the diagnosis) can change as more information becomes available. Competent professionals can disagree on which diagnosis fits an individual best. Diagnosis is important, however, because it guides treatment decisions and allows the family to put a name to the condition that affects their child. Diagnosis can provide answers to some questions but raises others that are unanswerable given the current state of scientific knowledge.

How can I help my child?

Parents concerned about their child's behavior, especially suicidal talk, and gestures, should have the child immediately evaluated by a professional familiar with the symptoms and treatment of early-onset bipolar disorder.
There is no blood test or brain scan, yet that can establish a diagnosis of bipolar disorder.

Parents who suspect that their child has bipolar disorder (or any psychiatric illness) should take daily notes of their child's mood, behaviour, sleep patterns, and unusual events, and statements by the child of concern to the parents. Share these notes with the doctor making the evaluation and with the doctor who eventually treats your child. Some parents fax or email a copy of their notes to the doctor before each appointment.

Because children with bipolar disorder can be charming and charismatic during an appointment, they initially may appear to a professional to be functioning well. Therefore, a good evaluation takes at least two appointments and includes a detailed family history.

Finding the right doctor

If possible, have a board-certified child psychiatrist diagnose and treat your child. A child psychiatrist is a medical doctor who has completed two to three years of an adult psychiatric residency and two additional years of a child psychiatry fellowship program. Unfortunately, there is a severe

shortage of child psychiatrists, and few have extensive experience treating early-onset bipolar disorder.

If your community does not have a child psychiatrist with expertise in mood disorders, then look for an adult psychiatrist who has:

1. a broad background in mood disorders, and
2. experience in treating children and adolescents.

Other specialists who may be able to help, at least with an initial evaluation, include pediatric neurologists. Neurologists have experience with the anti-convulsant medications often used for treating juvenile bipolar disorders. Pediatricians who consult with a psychopharmacologist can also provide competent care if a child psychiatrist is not available.

Some families take their child to nationally known doctors at teaching hospitals for diagnosis and stabilization. They then turn to local professionals for medical management of their child's treatment and psychotherapy. The local professionals consult with the expert as needed.

Experienced parents recommend that you look for a doctor who:

- Is knowledgeable about mood disorders, has a strong background in
- psychopharmacology, and stay up to date on the latest research in the field
- Knows he or she does not have all the answers and welcomes information discovered by the parents
- Explains medical matters clearly, listens well, and returns phone calls promptly
- Offers to work closely with parents and values their input
- Has a good rapport with the child
- Understands how traumatic a hospitalization is for both child and parents, and keeps in touch with the family during their period
- Advocates for the child with managed care companies, when necessary, Advocates for the child with the school to make sure the child receives services appropriate to the child's educational needs

Treatment

Although there is no cure for bipolar disorder, in most cases treatment can stabilize mood and allow for management and control of symptoms.

A good treatment plan includes medication, close monitoring of symptoms, education about the illness, counseling, or psychotherapy for the individual and family, stress reduction, good nutrition, regular sleep and exercise, and participation in a network of support.

The response to medications and treatment varies.

Factors that contribute to a better outcome are:

- Access to competent medical care
- Early diagnosis and treatment
- Adherence to medication and treatment plan
- A flexible, low-stress home and school environment

- A supportive network of family and friends

Factors that complicate treatment are:

- Lack of access to competent medical care
- Time lag between onset of illness and treatment
- Not taking prescribed medications
- Stressful and inflexible home and school environment
- The co-occurrence of other diagnoses
- Use of substances such as illegal drugs and alcohol

The good news is that with appropriate treatment and support at home and at school, many children with bipolar disorder achieve a marked reduction in the severity, frequency, and duration of episodes of illness. With education about their illness (as is provided to children with epilepsy, diabetes, and other chronic conditions), they learn how to manage and monitor their symptoms, as they grow older.

The parent's role in treatment

As with other chronic medical conditions such as diabetes, epilepsy, and asthma, children and adolescents with bipolar disorder and their families need to work closely with their doctor and other treatment professionals. Having the entire family involved in the child's treatment plan can usually reduce the frequency, duration, and severity of episodes. It can also help improve the child's ability to function successfully at home, in school, and in the community.

Parents: Learn all you can about bipolar disorder. Read, join support groups, and network with other parents. There are many questions still unanswered about early onset bipolar disorder, but early intervention and treatment can often stabilize mood and restore wellness. You can best manage relapses by prompt intervention at the first re-occurrence of symptoms.

Medication

- Few controlled studies have been done on the use of psychiatric medications in children.
- Only a handful for pediatric use has been approved. Psychiatrists must adapt what they know about treating adults to children and adolescents.
- Medications used to treat adults are often helpful in stabilizing mood in children. Most doctors start medication immediately upon diagnosis if both parents agree. If one parent disagrees, a short period of watchful waiting and charting of symptoms can be helpful.
- Treatment should not be postponed for long; however, because of the risk of suicide and school failure.
- A symptomatic child should never be left unsupervised. If parental disagreement makes treatment impossible, as may happen in families undergoing divorce, a court order regarding treatment may be necessary.
- Other treatments, such as psychotherapy, may not be effective until mood stabilization occurs. In fact, stimulants and antidepressants given without a mood stabilizer (often the result of misdiagnosis) can cause havoc in bipolar children, potentially inducing mania,

more frequent cycling, and increases in aggressive outbursts.

No one medication works in all children. The family should expect a trial-and-error process lasting weeks, months, or longer as doctors try several medications alone and in combination before they find the best treatment for your child. It is important not to become discouraged during the initial treatment phase. Two or more mood stabilizers, plus additional medications for symptoms that remain, are often necessary to achieve and maintain stability.

Parents often find it hard to accept that their child has a chronic condition that may require treatment with several medications. It is important to remember that untreated bipolar disorder may lead to suicide. The untreated disorder carries the risk of drug and alcohol addiction, damaged relationships, school failure, and difficulty finding and holding jobs. The risks of not treating are substantial and must be measured against the unknown risks of using medications whose safety and efficacy have been established in adults, but not yet in children.

The following is a brief overview of medications used to treat bipolar disorder. This brief overview is not intended to replace the evaluation and treatment of any child by a physician. Be sure to consult with a doctor who knows your child before starting, stopping, or changing any medication.

Mood Stabilizers

- Lithium (Eskalith, Lithobid, lithium carbonate) -A salt that occurs naturally in the earth, lithium has been used successfully for decades to calm mania and prevent mood cycling. Lithium has a proven anti-suicidal effect. An estimated 70 to 80 percent of adult bipolar patients respond positively to lithium treatment. Some children do well on lithium, but others do better on other mood stabilizers. Lithium is often used in combination with another mood stabilizer.
- Divalproex sodium or valproic acid (Depakote) -Doctors frequently prescribe this anti-convulsant for children who have rapid cycling between mania and depression.
- Carbamazepine (Tegretol) - Doctors prescribe this anti-convulsant because of its anti-manic and anti-aggressive properties. It is useful in treating frequent rage attacks.
- Gabapentin (Neurontin) - This is a newer anti-convulsant drug that seems to have fewer side effects than other mood stabilizers. However, doctors do not know how effective this drug is, and some parents report activation of manic symptoms in young children.
- Lamotirigine (Lamictal) - This newer anti-convulsant can be effective in controlling rapid cycling. It seems to work well in the depressive, as well as the manic, phase of bipolar disorder. Any appearance of rash must be immediately reported to the doctor, as a rare but severe side effect may occur (for this reason Lamictal is not used in children under 16).
- Topiamate (Topamax)-This newer anti-convulsant drug may control rapid-cycling and mixed bipolar states in patients who have not responded well to divalproex sodium or carbamazepine.

Unlike other mood stabilizers, it does not have weight gain as a side effect, but its efficacy in children has not been established.
- Tiagabine (Gabitnil)-This newer anti-convulsant drug has FDA approval for use in adolescents and is now being used in children as well.

Other Medications

Doctors may prescribe **antipsychotic medications** (Risperdal, Zyprexa, Seroquel) for use during manic states, particularly when children experience delusions or hallucinations and when rapid control of mania is needed. Some of the newer antipsychotic medications are very effective in controlling rages and aggression. Weight gain is often a side effect of antipsychotic medications.

Calcium channel blockers (verapamil, nimodipine, isradipine) have recently received attention as potential mood stabilizers for treating acute mania, ultra-ultra-rapid cycling, and recurrent depression.

Anti-anxiety medications (Klonopin, Xanax, Buspar, Activan) decrease anxiety by diminishing activity in brain arousal systems. They reduce agitation and over-activity and help promote standard sleep. Doctors commonly use these medications as add-ons to mood stabilizers and antipsychotic drugs in acute mania.

Alternative and Supplemental Treatments

There are reports on alternative and supplemental treatments, such as light therapy, electroconvulsive therapy, transcranial magnetic stimulation, and nutritional supplements, such as Omega-3 oil (fish oil) and St. John's Wort, working in some cases. (Some reports indicate that St. John's Wort can trigger mania; it should not be administered to children.)

Psychotherapy

In addition to seeing a child psychiatrist, the treatment plan for a child with bipolar disorder usually includes regular therapy sessions with a licensed clinical social worker, a licensed psychologist, or a psychiatrist who provides psychotherapy. Cognitive behavioral therapy, interpersonal therapy, and multi-family support groups are an essential part of treatment for children and adolescents with bipolar disorder. A support group for the child or adolescent with the disorder can also be beneficial, although few exist.

Therapeutic Parenting

Parents of children with bipolar disorder have discovered numerous techniques referred to as therapeutic parenting. These techniques help calm their children when they are symptomatic and can help prevent and contain relapses. Such techniques include:

- Practicing and teaching their child relaxation techniques
- Using firm restraint holds to contain rages
- Prioritizing battles and letting go of less important matters
- Reducing stress in the home, including learning, and using good listening and communications skills
- Using music and sound, lighting, water, and massage to assist the child with waking, falling asleep, and relaxation

- Becoming an advocate for stress reduction and other accommodations at school Helping the child anticipate and avoid, or prepare for stressful situations by developing coping strategies beforehand
- Engaging the child's creativity through activities that express and channel their gifts and strengths
- Providing routine structure and a great deal of freedom
- Removing objects from the home (or locking them in a safe place) that could be used to harm self or others during a rage, especially guns, keeping medications in a locked cabinet or box.

What are the educational needs of a child with bipolar disorder?

A diagnosis of bipolar disorder means the child has a significant health impairment (such as diabetes, epilepsy, or leukemia) that requires ongoing medical management. The child needs and is entitled to accommodations in school to benefit from his or her education. Bipolar disorder and the medications used to treat it can affect a child's school attendance, alertness and concentration, sensitivity to light, noise and stress, motivation, and energy available for learning. The child's functioning can vary greatly at different times throughout the day, season, and school year.

The special education staff, parents, and professionals should meet as a team to determine the child's educational needs. An evaluation, including psycho-educational testing, will be done by the school (some families arrange for more extensive private testing). The educational needs of a particular child with bipolar disorder vary depending on the frequency, severity, and duration of episodes of illness. These factors are difficult to predict in an individual case. Transitions to new teachers and new schools, return to school from vacations and absences, and changing to new medications are common times of increased symptoms for children with bipolar disorder. Medication side effects that can be troublesome at school include increased thirst and urination, excessive sleepiness, or agitation; at school include increased thirst and urination, excessive sleepiness or agitation, interference with concentration. Weight gain, fatigue, and a tendency to become easily overheated and dehydrated impact a child's participation in gym and regular classes.

These factors and any others that affect the child's education must be identified. A plan will be written to accommodate the child's needs. It should include accommodations for periods when the child is relatively well (when a less intense level of services may suffice), and accommodations available to the child in the event of relapse. Specific accommodations should be backed up by a letter or phone call from the child's doctor to the director of special education in the school district. Some parents find it necessary to hire a lawyer to obtain the accommodations and services that federal law requires public schools to provide for children with similar health impairments.

Examples of accommodations helpful to children and adolescents with bipolar disorder include:

- Preschool special education testing and services
- Small class size (with children of similar intelligence) or self-

contained classroom with other emotionally fragile (not 'behavior disorder') children for part or all day
- One-on-one or shared special education aide to assist child in class
- Back-and-forth notebook between home and school to assist communication Homework reduced or excused and deadlines extended when energy is low Late start to school day if fatigued in morning
- Recorded books as an alternative to self-reading when concentration is low Designation of a "safe place" at school where child can retreat when overwhelmed Designation of a staff member to whom the child can go as needed
- Unlimited access to bathroom
- Unlimited access to drinking water
- Art therapy and music therapy
- Extended time on tests
- Use of calculator for math
- Extra set of books at home
- Use of keyboard or dictation for writing assignments
- Regular sessions with a social worker or school psychologist
- Social skills groups and peer support groups
- Annual in-service training for teachers by child's treatment professionals (sponsored by school)
- Enriched art, music, or other areas of strength
- Curriculum that engages creativity and reduces boredom (for highly creative children)
- Tutoring during extended absences
- Goals set each week with rewards for achievement
- Summer services such as day camps and special education summer school
- Placement in a day hospital treatment program for periods of acute illness that can be managed without inpatient hospitalization
- Placement in a therapeutic day school during extended relapses or to provide a period of extra support after hospitalization and before returning to regular school Placement in a residential treatment center during extended periods of illness if a therapeutic day school near the family's home is not available or is unable to meet the child's needs

A Turning Point

Learning that one's child has bipolar disorder can be traumatic. Diagnosis usually follows months or years of the child's mood instability, school difficulties, and damaged relationships with family and friends. However, diagnosis can and should be a turning point for everyone concerned. Once the illness is identified, energies can be directed towards treatment, education, and developing coping strategies.

"There is hope and there is help."