FACTS ABOUT CHILDHOOD-ONSET BIPOLAR DISORDER

SOURCE: NATIONAL ALLIANCE FOR THE MENTALLY ILL (NAML)

What is Childhood-Onset Bipolar Disorder (COBPD)? How does it differ from bipolar disorder (Manic-Depression) in adults?

Those with bipolar disorder experience mood swings that alternate from periods of severe highs (mania) to severe lows (depression). However, while these abnormally intense moods usually last for weeks or months in adults with the illness, children with bipolar disorder can experience such rapid mood swings that they commonly cycle many times within a day. The most typical pattern of cycling among those with COBPD, called ultra-ultra-rapid or ultradian, is most often associated with low arousal states in the mornings followed by increases in energy towards late afternoon or evening.

It is not uncommon for the initial episode of COBPD to present itself as major depression. But as clinical investigators have followed the course of the disorder in children, they have observed a significant rate of transition from depression into bipolar mood states.

Is COBPD usually inherited?

Yes. One of the most important factors in establishing the diagnosis is family history. According to several recent studies, a history of mood disorders (particularly bipolar disorder) and/or alcoholism on both the maternal and paternal sides of a family appear to be commonly associated with COBPD.

How early in childhood does the disorder start? What are some common early symptoms?

Many parents report that their children have seemed different since early infancy. They describe difficulty settling their babies, and they note that their children are easily over-responsive to sensory stimulation. Sleep disturbances and night terrors are also commonly reported.

Later in a child's development, other symptoms are seen.

Very common

- Separation anxiety
- Rages and explosive temper tantrums (lasting up to several hours)
- Marked irritability Oppositional behaviour
- Frequent mood swings
- Distractibility
- Hyperactivity
- Impulsivity
- Restlessness / fidgetiness
- Silliness, goofiness, giddiness
- Racing thoughts
- Aggressive behaviour
- Grandiosity
- Carbohydrate cravings
- Risk-taking behaviours
- Depressed mood
- Lethargy
- Low self-esteem
- Difficulty getting up in the morning
- Social anxiety

- Oversensitivity to emotional or environmental triggers

Common

- Bed-wetting (especially in boys)
- Night terrors
- Rapid or pressured speech
- Obsessional behaviour
- Excessive daydreaming
- Compulsive behaviour
- Motor and vocal tics
- Learning disabilities
- Poor short-term memory
- Lack of organization
- Fascination with gore or morbid topics
- Hypersexuality
- Manipulative behaviour
- Bossiness
- Lying
- Suicidal thoughts
- Destruction of property
- Paranoia
- Hallucinations and delusions

Less common

- Migraine headaches
- Bingeing
- Self-mutilating behaviour
- Cruelty to animals

Are there other childhood psychiatric conditions that can co-occur with bipolar disorder?

Yes. Rarely does bipolar disorder in children occur by itself; rather, it is often accompanied by clusters of symptoms that, when observed at certain points of the child's life, suggest other psychiatric disorders such as attention-deficit/ hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), oppositional defiant disorder, and conduct disorder.

An estimated 50 to 80 percent of those with COBPD have ADHD as a co-occurring diagnosis. Since stimulant medications often prescribed for ADHD (Dexedrine, Adderall, Ritalin, Cylert) have been known to escalate the mood and behavioural fluctuations in those with COBPD, it is important to address the bipolar disorder before the attention-deficit disorder in such cases.

Some clinicians suggest that the prescription of a stimulant for a child genetically predisposed to bipolar disorder may induce an earlier onset or negatively influence the cycling pattern of the illness.

What is the difference between ADBD and COBPD?

Several studies have reported that more than 80% of children who go on to develop COBPD have five or more of the primary symptoms of ADHD -- distractibility, lack of attention to details, difficulty following through on tasks or instructions, motor restlessness, difficulty waiting one's turn, and interrupting or intruding upon others. In fact, difficulties with attention are so common in children that ADHD is often diagnosed instead of bipolar disorder. Actually, ADHD often appears before a clear development of the frequent alternating mood swings and prolonged temper tantrums associated with COBPD.

While the symptoms of COBPD and ADHD may be similar, their origins differ. For instance, destructiveness and misbehaviour are seen in both disorders, but these behaviours often seem intentional in those with COBPD and are caused more by carelessness or inattention in those with ADHD. Physical outbursts and temper tantrums, also features of both disorders, are triggered by sensory and emotional overstimulation in those with ADHD but can be caused by limit setting (e.g., a simple "no" from a patent) in those with COBPD. Furthermore, while those with ADHD seem to calm down after such outbursts within 15 to 30 minutes, those with COBPD often continue to feel angry, sometimes for hours. It is important to note that children with COBPD are often remorseful following temper tantrums and express that they are unable to control their anger.

Other symptoms, such as irritability and sleep disturbances often accompanied by night terrors with morbid, life-threatening content (e.g., nuclear war or attacking animals), are commonly seen in those with COBPD but rarely associated with ADHD.

How does the illness affect school performance and social relationships?

Deficits in shifting and sustaining attention, as well as difficulties inhibiting motor activity once initiated can strongly influence both classroom behaviour and the establishment of stable peer relationships. Distractibility, daydreaming, impulsiveness, mischievous bursts of energy that are difficult for the child to control, and sudden intrusions and interruptions in the classroom are also common features of the COBPD.

Stubborn, oppositional, and bossy behaviour, usually appearing between the ages of six to eight, pose significant problems for parents, educators, and peers. Risk-taking, disobedience to authority figures, and the likelihood of becoming addicted to psychoactive drugs such as marijuana and cocaine also present serious concerns. Furthermore, a high percentage of children with COBPD have co-occurring learning disabilities, a problem that can negatively affect school performance and self-esteem.

Should parents tell teachers?

Teachers need to be educated about the common behaviours, symptoms, and nature of COBPD. Most families have found that many teachers can be sympathetic allies when they fully understand the day-to-day problems of the child. A teacher's view of a child is limited to the period of day when most bipolar children are less easily aroused and can tolerate and be responsive to social rules set by the teacher. Teachers often see only the child's attention problems, fidgetiness, and occasional abundance of mischievous energy, not the explosive tantrums.

How is COBPD treated?

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, therapy that helps him or her understand the nature of the illness and how it affects his or her emotions and behaviour is

a critical component of a comprehensive treatment plan.

Some medications have also proved useful. Since few treatment studies have been conducted in children, though, most clinicians use drugs that have been tested and proved successful in adult forms of bipolar disorder. For mood stabilization these include lithium carbonate (Lithobid, Lithane, Eskalith), divalproex sodium (Depakote, Depakene), and carbamazepine (Tegretol).

New agents such as gabapentin (Neurontin), lamotrigine (Lamictal), and topiramate (Topomax) are currently under clinical investigation and being used in children. (Lamictal is not recommended for those under the age of 16.)

For the treatment of psychotic symptoms and aggressive behaviour, risperidone (Risperdal) and olanzapine (Zyprexa) are commonly used newer agents, while thordazine (Mellaril), perphenazine (Trilafon), and haloperidol (Haldol) are old standbys. Clonazepam (Klonopin) and lorazepam (Ativan) are also used to treat anxiety states, induce sleep, and put a brake on rapid cycling swings in activity and energy.

What about the use of antidepressant drugs?

It's very risky. Several studies have reported very high rates of the induction of mania or hypomania (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. The course of the disorder may be altered if antidepressants are prescribed without mood stabilizers.

"There is hope and there is help."