
BIPOLAR SPECTRUM DISORDERS: EARLY ONSET



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Bipolar disorder (previously known as manic depression) in children has been receiving increasing attention from both the scientific community and the general public. Various terms have been used to describe bipolar disorder in children, including pediatric, juvenile, early-onset, childhood, and prepubescent. Because children can be diagnosed with any one of these bipolar diagnoses, we will use the term early-onset bipolar spectrum disorder in this handout (Early-Onset BP).

Characteristics of Early-Onset Bipolar Spectrum Disorder

Early-Onset BP involves episodes of mania and depression. A *manic* episode is defined as a distinct period of excessively elevated (i.e., inappropriately happy) or irritable (i.e., temper tantrums and rages out of proportion to events) mood.

Altered mood is defined by three or more (four or more, if mood is irritable and not elated) other symptoms. Among these are inflated self-esteem (e.g., a child thinks he is smarter than everyone else despite failing grades); grandiosity (e.g., a child believes and tells others he is able to fly); decreased need for sleep (e.g., a child feels rested after three hours sleep); rapid, loud, or uninterruptible speech; racing thoughts, increased distractibility (beyond the child's baseline attentional capacity), increased goal-directed activity/psychomotor agitation (e.g., a child starts to rearrange the school library, cleans everyone's desks, and plans to build an elaborate fort in the playground, but never finishes any of these projects); and excessive involvement in pleasurable or dangerous activities (e.g., a previously mild-mannered child writes dirty notes to other children in class or attempts to jump out of a moving car).

An episode of *depression* is defined as a distinct period of sad or irritable mood or markedly diminished interest/pleasure in most activities. This low is accompanied by four or more symptoms including significant appetite change, sleep problems, restlessness or slowed movement, fatigue, feelings of worthlessness or excessive guilt, problems concentrating, and recurrent thoughts of death and/or recurrent suicidal thoughts, plans, or attempts.

Mood symptoms wax and wane, are often unrelated to environmental triggers, and represent a significant change from the child's typical functioning. In addition, severe mania or depression may lead to psychotic symptoms such as paranoia (e.g., a child truly believes someone is spying on him), delusions (e.g., a child believes the war in Iraq was his fault), and auditory or visual hallucinations (e.g., a child hears voices telling him to do bad things or sees skeletons playing basketball). Psychotic symptoms in the presence of manic or depressive symptoms do not mean the child has schizophrenia or a related psychotic disorder. Typically, these psychotic symptoms disappear when mood symptoms improve.

In contrast to adults, who are more likely to present with discrete cycles of depression and mania, children with Early-Onset BP may exhibit both manic and depressive symptoms at the same time or within the same day. Mood shifts in children are characterized by mixed states (i.e., simultaneous manic and depressive symptoms), rapid cycling (i.e., four or more mood episodes per year), ultra-rapid cycling (i.e., between 5 and 364 mood episodes per year) or ultradian cycling (i.e., multiple episodes per day). Finally, whereas mood changes in adults with bipolar disorder are often expressed as a euphoric or sad mood, manic and depressive moods in children often are expressed as intense irritability.

Assessment and Diagnosis of Early-Onset BP

If a child is suspected of having Early-Onset BP, then the child should be referred to a mental health professional with experience in childhood mood disorders for a thorough assessment. This is essential in ensuring that behaviors possibly resulting from poor child rearing, medication side effects, medical conditions, learning disabilities, developmental delays, and/or other disorders are not erroneously

labeled (and therefore incorrectly treated) as manic or depressive symptoms.

Mental health professionals use a diagnostic guide called *The Diagnostic and Statistical Manual of Mental Disorders 4th ed.* (DSM-IV-TR; see “Resources”) to make psychiatric diagnoses. This manual includes four types of bipolar disorder (Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder—Not Otherwise Specified) that vary in terms of symptom severity and duration. Commonly, children diagnosed with Early-Onset BP also meet diagnostic criteria for additional or “co-occurring” disorders, such as Attention Deficit Hyperactivity Disorder (ADHD) (dysfunctional levels of inattention, impulsivity, and activity), Oppositional Defiant Disorder (severe and impairing noncompliant and hostile-irritable behaviors), Conduct Disorder (serious and delinquent antisocial behavior such as stealing, vandalism, and physical violence), various anxiety and learning disorders, and substance abuse.

Causes of Early-Onset BP

While the exact cause(s) of Early-Onset BP is not presently known, substantial evidence suggests a biological basis. Genetic studies show the risk of having bipolar disorder increases if there is a family history of bipolar disorder, depression, and substance abuse. An imbalance of neurotransmitters (i.e., chemicals responsible for sending messages) within the brain have been implicated in bipolar disorder, as have various areas of the brain responsible for controlling thoughts, behaviors, and emotions. Therefore, because Early-Onset BP appears to have biological origins, it can be considered a no-fault brain disorder.

Development of Early-Onset BP

The clinical history of children with Early-Onset BP, from toddler years or even infancy, often includes reports of intense colic that evolve into ongoing extreme irritability and terrible twos that morph into terrifying threes and beyond. Many of these children have pre-existing problems with ADHD, Oppositional Defiant Disorder, Conduct Disorder, anxiety, and depression long before they are actually diagnosed with Early-Onset BP. Most children with colic and difficulties at age 2 and 3, though, do *not* develop Early-Onset BP. Over time, Early-Onset BP is often associated with significant psychosocial impairment, such as school failure and substance abuse, increased use of mental health services, multiple hospitalizations, and suicidal behavior. In short, children with Early-Onset BP tend not to grow out of it. Finally, whereas Early-Onset BP appears to have a biological cause, its development over time, or its course, may be exacerbated by environmental

factors such as family, teacher, and peer conflict; academic stress; and disruption in the sleep-wake cycle.

Treatment of Early-Onset BP

Much like another chronic illness, diabetes, there is no cure for Early-Onset BP. However, its symptoms can be managed and often prevented from recurring, and their impact lessened, by a combination of effective pharmacological, psychosocial, and school-based interventions.

Pharmacological Treatments

Pharmacological intervention is the foundation of effective treatment for Early-Onset BP. Research and clinical practice indicate that most children require multiple medications to alleviate symptoms of mania, depression, and co-occurring conditions. Although medications have not been adequately studied in children with Early-Onset BP, there is clinical evidence of effectiveness of the medication. Physicians should prescribe these medications only in close partnership with families, should carefully monitor their young patients for potentially dangerous side effects, and should attend to ongoing research regarding the most appropriate, safe treatments.

Not all medications that are discussed below will be appropriate (or needed) for all children with an Early-Onset BP diagnosis.

Mood stabilizers are considered the first line of pharmacological intervention. *Anti-psychotic* medications may help reduce aggressive or psychotic symptoms, and *anti-hypertensive* medications are sometimes used to improve the sleep-wake cycle.

After a child’s mood has been stabilized with a mood stabilizer, low dose *anti-depressant* medications may reduce depressive and anxiety symptoms and psychostimulants may reduce ADHD symptoms of inattention, impulsivity, and hyperactivity. However, both anti-depressants and psychostimulants pose a risk of activating manic symptoms, so must be monitored carefully.

While *dietary interventions* (omega-3 fatty acids, high intensity vitamin-mineral complexes) have been tried in children, their effectiveness is still being tested. A list of commonly used medications for the treatment of Early-Onset BP and associated symptoms follows:

- *Mood stabilizers:* Depakote, Lithium, Tegretol, Gabitril, Lamictal, Topamax, Trileptal.
- *Anti-psychotics:* Abilify, Clozaril, Geodon, Risperdal, Seroquel, Zyprexa.
- *Anti-hypertensives:* Clonidine and Tenex.
- *Anti-depressants:* Celexa, Lexapro, Luvox, Prozac, Remeron, Serzone, Wellbutrin, Zoloft.

- *Psychostimulants:* Adderal, Concerta, Dexedrine, Focalin, Metadate, Ritalin; Strattera (a nonstimulant) may also be helpful for ADHD symptoms.

Psychosocial Treatments

Children with Early-Onset BP may experience significant impairment in family life, peer relationships, academic functioning, and home/school behavior, all of which require psychosocial treatment.

Interventions might include some combination of family therapy, individual therapy, parent guidance, group therapy, school-based intervention, home-based treatment, respite, out-of-home placement, and web-based support.

Treatment components might include mental health support, education, and skills development (a) to teach parents and children about the disorder, co-occurring symptoms, and medications, and mental-health and community/school-based treatment teams and services and (b) to build skills such as feelings management, principles of basic cognitive-behavioral therapy, communication, problem solving, dealing with negative family interactions, coping with the stress of parenting a child with a mood disorder, and specific issues in managing manic and depressive symptoms.

School-Based Treatments

Children with Early-Onset BP have varying degrees of academic, behavioral, and social-emotional problems in the school environment, with some problems being very severe. They may be identified as “students with a disability” and therefore eligible for special education services. Among these educational disabilities (using federal classifications) are Serious Emotional Disturbance, Specific Learning Disability, and Other Health Impairment.

No research-supported school-based interventions currently exist for Early-Onset BP; however, a number of potentially beneficial clinical and educational recommendations for school difficulties are available (see “Resources”).

In addition to providing an organized, predictable classroom with clear expectations and a positive discipline strategy (good for all learners), the following specific recommendations are adapted from the website of the Child and Adolescent Bipolar Foundation (see “Resources”):

Maintain flexibility as symptoms wax and wane:

- Modify expectations regarding the amount, content of, and time allowed for activities, assignments, and tests, based on the child’s fluctuations in mood, attention, energy, and motivation.

- Accept late assignment when parents agree best effort was made to complete work on time.
- Be aware of medication side effects (increased thirst and urination, drowsiness, sluggishness, etc.).
- Allow unlimited access to fluids and restroom, and establish a private signal to covertly communicate these needs to the teacher during class.
- Provide privacy for taking medications.
- Inform all relevant staff members of potentially serious side effects and of other interfering side effects.

Be prepared for episodes of intense emotion (sadness, rage, tearfulness):

- Identify a safe/private place for the child to go to regain control (e.g., guidance office, resource room).
- Establish a private signal to covertly communicate the need to take a brief time-out during class.
- Develop methods for parents and teachers to communicate daily about problems *and* positive behaviors (e.g., daily report card, writing in assignment notebook).
- Arrange for a functional behavior assessment (usually completed by a clinical psychologist or school psychologist) to identify triggers and events that precede losses of control, and develop a behavior plan to teach the child new ways to prevent or cope with stressors and frustrations. If episodes are due to boredom, provide enrichment activities; if episodes are due to hunger or low blood sugar, allow the child to eat a mid-morning/afternoon snack; and if episodes occur during particularly difficult activities, reduce demands to a level the child can manage.
- Identify an emergency contact person who can pick the child up if parents are not available.

Recognize social skills difficulties (misinterpreting jokes, acting shyly, being bossy or bullying, or being a victim of bullying):

- Have the child work with the guidance counselor, school psychologist, or school social worker regularly to improve social skills.
- Place the child in a group that addresses development of social skills.
- Increase staff supervision to avert problems.
- Establish a zero-tolerance policy in regard to bullying, and apprise parents of bullying (i.e., who, what, when, where, why, and how) in case bullying persists outside of school.

Prepare for transitions back to school following hospitalization (or after an upsurge in symptoms that precludes success in negotiating an entire school day):

- Arrange for temporary homebound instruction followed by gradual transition back to school if needed or arrange for partial days at school.

If symptoms escalate and become potentially harmful to the child and others, consider the temporary or even permanent support of more restrictive educational environments. These may include:

- Regular classroom with resource room support.
- Self-contained classroom.
- Home schooling.
- Therapeutic day school.
- Hospital day treatment program.
- Residential treatment center.
- Therapeutic boarding school.

Conclusion

Although Early-Onset Bipolar Spectrum Disorder is a chronic but variable disorder that often inflicts chaos on family life, peer relationships, and school functioning, it is important not to lose hope. Many effective treatment tools exist and continue to become available at a rapid rate.

Resources

- American Psychological Association. (2000). *The diagnostic and statistical manual of mental disorders* (4th ed.) (text revision). Washington, DC: Author. ISBN: 0890420254.
- Anderson, M., Kubisak-Boyd, J., Field, R., & Vogelstein, S. (2003). *Understanding and educating adolescents with bipolar disorder: A guide for educators*. Northfield, IL: The Josselyn Center. (Available: www.josselyn.org)
- Fristad, M., & Arnold, J. G. (2003). *Raising a moody child: How to cope with depression and bipolar disorder: A book for parents*. New York: Guilford. ISBN: 1572308710.
- Fristad, M., & Arnold, J. G. (2004). *Taking charge of the mad, bad, sad feelings: A companion guide to raising a moody child—A book for children and parents*. New York: Guilford.

Websites

- IDEA Practices—www.ideaactivities.org
Funded by the U.S. Department of Education.
Provides up-to-date information about special education laws and regulations and court rulings, as

well as a resource materials for a wide range of disabilities.

The Child and Adolescent Bipolar Foundation—
www.bpkids.org/learning
Provides information on school and classroom adaptations and accommodations.

Wrightslaw—www.wrightslaw.com
Provides up-to-date information about special education law and advocacy for children with disabilities.

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