

# *The Bipolar Child Newsletter*

## *November, 1999 Vol. 1*

–Demitri and Janice Papolos

Thank you for visiting our web site and for subscribing to our newsletter. We thought an E-mail newsletter would be a good forum in which to keep parents, educators, and mental health professionals abreast of the newest findings in the fields of psychopharmacology, genetics and neurobiology as they relate to early-onset bipolar disorder. We also plan, in future issues, to focus on strategies and ideas which will make family life a bit easier for all. Next month we intend to spotlight the stress of the holidays and how they impact a child with bipolar disorder, and offer some explanations and suggestions that might make the holidays pass more smoothly. Naturally, we hope that you, our subscribers, will write us ([info@bipolarchild.com](mailto:info@bipolarchild.com)) with questions or topics that you would especially like to see covered.

Although [The Bipolar Child](#) will not be published until next month, we do not want to wait to discuss a subject that is of great concern. Throughout this country, children with bipolar disorder are being diagnosed with an alphabet soup of childhood conditions--attention-deficit disorder (ADHD), oppositional defiant disorder (ODD), obsessive compulsive disorder (OCD), conduct disorder (CD), intermittent explosive disorder, and Tourette's syndrome (TS)--while bipolar disorder is overlooked or considered only as a last resort. As a result, these children are being treated with medications that are causing more rapid cycling, manic and hypomanic states, increased aggression and even violence. Antidepressants in particular, can induce mixed states in which suicidal feelings and behaviors can emerge.

Therefore, we'd like to talk about the difficulties of diagnosis and sound some alarms about treatment strategies when co-occurring or co-morbid symptoms are present.

### **Bipolar Disorder, Co-occurring Conditions, and the Need for Extreme Caution Before Initiating Drug Treatment**

Rarely does bipolar disorder in children occur as a pure entity by itself. Rather it is often accompanied by clusters of symptoms that--when observed at certain points in a child's life--suggest other psychiatric disorders, such as attention-deficit disorder with hyperactivity, depression, obsessive-compulsive disorder, oppositional defiant disorder, generalized anxiety disorder, conduct disorder, eating disorders, or Tourette's syndrome.

The questions researchers are attempting to resolve are:

1. Does bipolar disorder occur simultaneously with other psychiatric disorders making it possible for a child actually to have three or four diagnoses?
2. Are these clusters of symptoms that suggest distinct disorders merely early precursors on a developmental continuum that eventually expresses itself as full-blown bipolar?
3. Are all these symptoms merely a more apt description of early-onset bipolar disorder?

The truth is no one knows for certain. And until research can provide clarification, parents are going to have to tolerate a great deal of diagnostic ambiguity. Yet a correct diagnosis is vital to a child's well-being, for it is the proper diagnosis that guides the treatment and--equally important--prevents the child from being placed on medications that can considerably worsen the course of the disorder.

It is not uncommon for physicians to focus narrowly on one cluster of symptoms--often the ones that are most recognizable such as a depressed mood or hyperactive behavior. As a result, a child may be prescribed antidepressants such as Prozac, Paxil, Zoloft, Celexa and so on to treat the depressive symptoms, and stimulants such as Ritalin, Adderall and Cylert to treat what appears to be attention-deficit

disorder with hyperactivity. Luvox, an antidepressant also in the selective serotonergic reuptake inhibitor (SSRI) category is commonly prescribed for symptoms of obsessive-compulsive disorder.

Yet data is emerging that is beginning to demonstrate the dangers of treating only the attentional, depressive, or obsessional symptoms, meantime overlooking the possibility of a bipolar condition.

## **The Overlap With ADHD**

Perhaps the greatest source of diagnostic confusion in childhood bipolar disorder is that its symptoms overlap with many of the symptoms of attention-deficit disorder with hyperactivity. At first glance, any child who can't sit still, who is fidgety, impulsive, easily distracted or emotionally labile is more likely to receive a diagnosis of ADHD than bipolar disorder. However, since over 80 percent of children with a bipolar disorder will meet full criteria for attention-deficit disorder with hyperactivity, ADHD should be diagnosed only after bipolar disorder is ruled out. While these two conditions seem highly co-morbid, stimulants unopposed by a mood stabilizer can have an adverse effect on the bipolar condition. 65 percent of the children in our study had hypomanic, manic and aggressive reactions to stimulant medications. Parents wrote to us and described some of their children's reactions to stimulants. They said things like: "He got sky-high on Ritalin and then violent"; "Ritalin caused physical aggression"; "She got psychotic on stimulants"; "He got suicidal and tried to get run over by a car"; "He went bonkers..."

This past May, in a letter to the editor of the Journal of the American Academy of Child and Adolescent Psychiatry, Tomie Burke, founder of Parents of Bipolar Children, and Martha Hellander, Executive Director of the Child and Adolescent Bipolar Foundation addressed the issue of whether mania is mistaken for attention-deficit disorder with hyperactivity in children. They wrote: "Most of our children initially received the ADHD diagnosis, were given stimulants and/or antidepressants, and either did not respond or suffered symptoms of mania such as rages, insomnia, agitation, pressured speech, and the like. In lay language, parents call this 'bouncing off the wall.'" First hospitalizations occurred often among our children during manic or mixed states (including suicidal gestures and attempts) triggered or exacerbated by treatment with stimulants, tricyclics, or selective serotonin reuptake inhibitors. Many of these same children are now doing well on lithium or other mood stabilizers, along with cautiously monitored adjunctive medications."

## **A First Episode of Depression**

It is also not uncommon for the initial episodes of a developing mood disorder to present as major depression. But as clinical investigators follow the course of the disorder in children, a significant rate of switching to bipolar symptoms occurs. According to the American Academy of Child and Adolescent Psychiatry, a third of the 3.4 million children who first seem to be suffering with depression will go on to manifest the bipolar form of a mood disorder.

The only major epidemiological study of bipolar disorders in youth was conducted by Dr. Peter Lewinson and colleagues at the Oregon Research Institute, and they found that a significant percentage ( 61.1 percent) of the bipolar adolescents began their course of illness with either minor or major depressive episodes.

What are the possible predictors of a switch from a major depressive disorder to a manic-depressive course of illness? In the survey we conducted for our book, some of the common symptoms that preceded a bipolar course were depressions marked by a craving for sweets and carbohydrates, prolonged and aggressive temper tantrums, lethargy, oversleeping, separation anxiety, self-consciousness with others, and phobic anxiety.

While it is so tempting to want to rescue a child from depression with an antidepressant, bipolar children often have terrible and bizarre reactions to these medications. In our study, over 80 percent of the children now diagnosed as bipolar had manic, hypomanic, violent, and suicidal reactions to these medications. Often

the child seemed to do well at first, but after weeks and even months of treatment (we heard the time period three months quite often) a deterioration seemed to take place and the child became: "nasty and had vicious"; "giddy and silly"; "activated, aggressive, and agitated"; and we heard reports of "increased cycling"; "She began to cut herself"; "He destroyed my entire porcelain collection with a baseball bat and then came at me with a knife. I had to call the police and they put my beloved 13-year-old in jail."

## **Obsessive-Compulsive Symptoms**

Obsessive-compulsive symptoms may also occur in tandem with a bipolar disorder and, again, it is risky to treat just the obsessional symptoms. Last year, Dr. Frances S. Go and colleagues at the Department of Psychiatry at the University of Pittsburgh Medical Center treated a sample of 20 adolescents (ages 11-17) diagnosed with OCD and mood disorders and reported that 30 percent of the patients--6 out of the 20--treated with SSRIs developed mania or hypomania. The symptoms included impulsivity, grandiosity, pressured speech, and disinhibition and emerged despite a gradual dose elevation and conservative dosing. The authors advise clinicians to "be aware of the risk and to be vigilant in monitoring manic and hypomanic behaviors when using SSRIs to treat OCD in youth..."

## **The Big Picture**

How, then, does a clinician make a diagnosis of bipolar disorder with all the co-morbid conditions? The family history is an important clue. If the family history reveals mood disorders, suicide, or alcoholism coming down one or both sides of the family tree, red flags should appear in the mind of the diagnostician. The illness has a strong genetic component although it can skip a generation.

It is obvious that the diagnosis of mood disorders in children is extremely complex. While the perplexing questions raised by the frequency of co-morbid diagnoses cannot be resolved at this time, researchers have begun to define a syndrome that encompasses symptoms of a number of childhood psychiatric disorders but also has unique features of its own. Ranging from "very common" to "common," the symptoms and behavioral traits that have consistently observed in children with early-onset bipolar disorder include:

## **VERY COMMON**

- Separation anxiety
- Rages and explosive temper tantrums lasting up to several hours
- Irritability
- Oppositional behavior
- Rapid cycling (frequent mood swings, occurring within an hour, a day, or several days)
- Distractibility
- Hyperactivity
- Impulsivity
- Restlessness/fidgetiness
- Silliness, giddiness, goofiness
- Racing thoughts
- Aggressive behavior
- Grandiosity
- Carbohydrate cravings
- Risk-taking behaviors
- Depressed mood
- Lethargy
- Low self-esteem
- Difficulty getting up in the morning
- Social anxiety
- Oversensitivity to emotional or environmental triggers

**COMMON**

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

**Final Thoughts**

Now understanding that early-onset bipolar disorder is frequently co-morbid with other childhood psychiatric conditions, doctors and parents should be concerned that a medication used to treat these other conditions may "flush out" a previously quiescent bipolar gene that can significantly worsen the course of illness and potentially wreak havoc with that child's life. It is therefore vitally important that parents learn everything they can about their family histories, and if mood disorders (depression or manic-depression), suicide, or alcoholism come to light, treatment should proceed very cautiously. Mood stabilizers should perhaps be the first line of treatment (and it may take two such medications to stabilize the child), and attentional, obsessional, or depressive symptoms be treated only after a therapeutic dose of the mood stabilizer is achieved.

**References:****Books:**

Papolos, Demitri and Janice Papolos. *The Bipolar Child* New York: Broadway Books, December, 1999.

**Articles:**

Go, Frances S. Erin E. Malley et al. "Manic Behaviors Associated with Fluoxetine in Three 12-18-year-olds with Obsessive Compulsive Disorder." *Journal of Child and Adolescent Psychopharmacology* 8 (1998):73-80.

Hellander, Martha E. and Tomie Burke. "Children With Bipolar Disorder (letter to the editor)" *Journal of the Academy of Child and Adolescent Psychiatry* 38 (May 1999): 495.

Lewinson, Peter M, Daniel N. Klein, and John R. Seely. "Bipolar Disorders in a Community Sample of Older Adolescents: Prevalence, Phenomenology, Comorbidity, and Course." *Journal of the Academy of Child and Adolescent Psychiatry* 34 (April 1995):454-463.

This newsletter will be published regularly and will attempt to be responsive to specific questions that are

pertinent to families. Please send in your comments and suggestions to [info@bipolarchild.com](mailto:info@bipolarchild.com) which can also be reached through our web site at [www.bipolarchild.com](http://www.bipolarchild.com). Please feel free to forward the newsletter to others you think may find it helpful.

We continue to collect research data on clinical symptomatology and ask that those that are interested and have not already enrolled in the research program you may do so at the web site.

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