



San Diego's Voice On Mental Illness

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, hyperactivity, fidgetiness, difficulties making changes, and high levels of anxiety (particularly in response to separation from the child's mother) are commonly seen. Additionally, being easily frustrated, having difficulty controlling anger, and impulsiveness (difficulty waiting one's turn, interrupting others) often result in prolonged and violent temper tantrums.

Childhood-Onset Bipolar Disorder

All 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.

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 appears to be commonly associated with COBPD.

An estimated 50% to 80% of those with COBPD have attention-deficit/hyperactivity disorder (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 behavioral 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 develop bipolar disorder may induce an earlier onset or negatively influence the cycling pattern of the illness.

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 behavior 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 behavior, usually appearing between the ages of six to eight, poses significant problems. Risk-taking, disobedience to authority figures, and the likelihood of becoming addicted to psychoactive drugs such as marijuana and cocaine also present serious concerns. A high percentage of children with COBPD have co-occurring learning disabilities.

What is the difference between ADHD 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 misbehavior are seen in both disorders, but these behaviors often seem intentional in those with COBPD and 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 over-stimulation in those with ADHD but can be caused by limit-setting (e.g., a simple "No" from a parent) 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 (nuclear war, attacking animals), are commonly seen in those with COBPD but are rarely associated with ADHD.

Open Your Mind



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Are Brain Disorders*

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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 behavior 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*). Newer agents such as gabapentin (*Neurontin*), lamotrigine (*Lamictal*), and topiramate (*Topomax*) are currently under clinical investigation and are being used in children.

For the treatment of psychotic symptoms and aggressive behavior, risperidone (*Risperdal*) and olanzapine (*Zyprexa*) are commonly used newer agents. 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. The use of antidepressant drugs is very risky, as it may induce mania or hypomania. The child may also experience a marked increase in irritability and aggression.

NAMI San Diego

NAMI San Diego, a non-profit organization, provides education, support services, and advocacy to improve the quality of life of everyone affected by mental illnesses. It is an affiliate of the National Alliance on Mental Illness (NAMI) and NAMI California. Its membership includes persons with brain disorders, their families, friends, mental health professionals and supportive members of the community.

NAMI offers monthly informational meetings, a monthly newsletter, free educational programs, a lending library of books and video-tapes, and support meetings for consumers and families throughout the county.

For information and support
call:

**NAMI San Diego
Helpline**

(800) 523-5933

(619) 543-1434

**www.namisaniego.org
information@namisd.org**

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