

Early-Onset Bipolar Disorder, and Bipolar Disorder in Adults

Summarized by Thomas T. Thomas

What do the early stages of bipolar disorder look like? What should a family be aware of in dealing with a child's suddenly disordered behavior? And what measures are available—behavioral intervention, educational testing and intervention, psychotherapy, medical treatment—for a youth exhibiting bipolar disorder? The speaker at our July 28 meeting, **Bradley Engwall, MD**, addressed the issue of early-onset bipolar disorder and its occurrence in adults. Dr. Engwall is fully trained in pediatric and adult psychiatry and board certified in psychiatry. He teaches on the clinical faculty of the University of California–San Francisco Department of Psychiatry and is on staff at Lincoln Children's Center, as well as having a private practice in Albany.



BRADLEY ENGWALL, MD

“The topic of bipolar disorder—the newer term for manic depression—in children and adolescents is one of the most difficult in psychiatry,” Dr. Engwall said. “It is only in the last twenty years that we have thought children could even be diagnosed as bipolar.”

Bipolar is well recognized in adults, and many famous people have suffered from it: Abraham Lincoln, Vincent Van Gogh, and Edgar Allan Poe, to name a few. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV, which is the handbook of psychiatry) defines the bipolar disorder as characterized by high, low, and mixed moods.

Depression, or the low mood, is common enough, but only when it is combined with periods of elevated mood does it become bipolar. If the high is pronounced—with elements of psychosis, divorce from reality, grandiosity, delusions and hallucinations, lack of a need for sleep, excessive involvement in pleasurable activities like sex, gambling, or spending, and lasts for at least seven days—then the condition is called “mania” and the diagnosis is Bipolar Type I. The author Virginia Woolf was diagnosed with Type I.

If the high is milder—that is, characterized by three or more symptoms of mania, with a distinct personality change and signs of irritability, but persisting for only three days and not life impairing—then the condition is called “hypomania” and the diagnosis is Bipolar Type II.

There is also a diagnosis of Bipolar Type III, which Dr. Engwall identified as an informal diagnosis used in the field to distinguish someone who has only experienced episodes of major depression before initiation of antidepressant treatment but who, while taking an antidepressant, experiences mania or hypomania. Since this is not in the formal DSM nomenclature, it is not well known outside of

expert circles. In the DSM nomenclature, this would be closest to the category Bipolar, Not Otherwise Specified (NOS), which is a catchall category for all forms of bipolar disorder that don't fit under Type I, Type II, or cyclothymia.

He noted that 1.5% of the population has Bipolar I with extreme highs and lows, and about 3% has Bipolar II with extreme lows and mild highs. So bipolar disorder is much more prevalent than schizophrenia, from which 0.8 to 1% of the population suffers.

The genes that appear to affect bipolar disorder overlap with those responsible for many of the personality disorders, Dr. Engwall said. However, in the latter, symptoms are chronic or ongoing, while bipolar is characterized by periods where the person sometimes feels fine and other times not. This makes the diagnosis for an adult difficult enough. "A retrospective study showed that on average a person will be in the mental health system for ten years from the first time he or she asks for help before getting a correct diagnosis," Dr. Engwall said. "This takes much less time if family members contribute information to the treating psychiatrist," he noted.

The disorder normally starts with a period of depression but soon includes mania or mood swings. "The diagnostic boundaries of bipolar disorder were discovered through treatment," he said, "because bipolar responds to lithium. Many African-Americans were misdiagnosed with schizophrenia prior to the 1970s and treated with antipsychotics. It was only when they were treated with lithium, which came into more common use in the '70s, that clinicians recognized the number who had been misdiagnosed. A similar phenomenon has occurred in children, in which the lithium treatment has revealed the way bipolar disorder manifests itself in children."

Psychologist Janice Egeland performed a study of bipolar among the Amish. This group is an excellent study population because they have little alcohol or substance abuse, a fairly controlled gene pool with good genealogies, well defined social roles with little room for acting out, and stable communities where participants are available for follow-up studies. Egeland examined 100 children who had one or more parent with Bipolar Type I, 100 children with an aunt or uncle with the disorder, and 100 children with no disorder among their parents, aunts or uncles, or grandparents. None of the children had a diagnosis of mental illness according to DSM-IV criteria. She followed the study group for seven years and found the children with bipolar parents much more likely to manifest behavioral problems compared to those without bipolar disorder in a first-degree relative. The Amish themselves seem to know of a genetic relationship, speaking of this illness as "in the blood."

Symptoms of bipolar disorder in children, Dr. Engwall said, include being sensitive to the environment, having high energy or low energy, inability to control anger, being stubborn and determined, having trouble falling asleep, attention problems or hyper alertness, being anxious or overly excitable, and presenting somatic symptoms such as stomach ache.

"However," he said, "so many of the symptoms could also be something else, such as attention deficit hyperactivity disorder [ADHD] or oppositional defiant disorder [ODD]. Ninety percent of bipolar children are diagnosed with

ODD—and not all of them are boys. When reflecting on these symptoms in light of DSM-IV, it's possible that such symptoms could place a child in many different categories, making bipolar disorder in children difficult to recognize.”

Pediatric bipolar disorder is often difficult to distinguish from ADHD in some children because the diagnostic criteria overlap significantly. A child who has bipolar disorder may exhibit ADHD-like inattention and hyperactivity during many observations but, unlike ADHD, manifest good attention for long periods on other occasions. Other symptoms that can distinguish bipolar from ADHD are grandiosity, auditory or visual hallucinations, and euphoria. “Some children may jump off a roof because they’re too young to know they can’t fly,” Dr. Engwall said, “but some do because they’re under the delusion that they can.”

Euphoria ranges from merely feeling good and positive about life to feeling unstoppable, having overblown ideas about a person’s own potential or future, having trouble stopping talking or talking too fast, being overly sociable with strangers, and having lots of energy.

Fifty percent of children who develop early-onset major depression—which Dr. Engwall called a red flag—actually have bipolar disorder. “We often learn the truth about the diagnosis through treatment, as oftentimes there are no signs of mania until antidepressant treatment is started, which may result in clear manic symptoms, or no benefit, or—often—agitated, worsening depression.”

Twenty-five percent of bipolar children are misdiagnosed with conduct disorder, whose symptoms include bedwetting, playing with fire, abusing animals, showing no remorse, and having trouble distinguishing other people’s feelings. Bipolar also has co-morbidity with tick disorders such as Tourette syndrome.

Twenty-five percent of bipolar children have post traumatic stress disorder (PTSD) as well, because the child is more vulnerable to being emotionally overwhelmed. What may be very difficult for one child may seem cataclysmic for a child with bipolar disorder. There is also the factor that many times a parent or sibling is also afflicted with bipolar disorder, which may lead to a greater chance of physical or sexual abuse.

“It’s difficult to separate the environment from the biology,” Dr. Engwall said. “The psychiatrist needs to push through the forest of symptoms to find the biological element of the illness.”

Pharmacological treatment of children with bipolar disorder has been the subject of very few studies. Lithium has been helpful, Dr. Engwall said. So have Depakote and Seroquel. All are mood stabilizers and have their role in treating bipolar children. Antipsychotic medications have their place as well, but the older medications have risks of movement disorders. Antidepressants can be used with severe depression but can also trigger mania.

In addition to medication, Dr. Engwall suggested that parents of bipolar children first get educated about the disorder. He recommended the Child & Adolescent Bipolar Foundation at www.bpkids.org or the Depression and Bipolar Support Alliance at www.dbsalliance.org. The National Institute of Mental Health at www.nimh.nih.gov is another good resource. He also recommended the book *The Bipolar Child* by Demetri and Janice Papolos.

Second, parents can learn behavioral techniques for dealing with bipolar children. When the child is having a tantrum, disengage to short-circuit the behavior instead of staying in contact and escalating the mood. Let the child have time to recover. It's also important to develop routines around bedtime or waking up that will give the child help in regulating his or her mood, because bipolar children feel out of control. In school, the teacher should be aware of the diagnosis and can help set up routines and structure.

Third, once the child's moods are contained, get him or her into individual therapy. When the child's moods are uncontained, the psychiatrist tends to focus more on supporting the family than on providing therapy.

Fourth, address the bipolar child's diet. Sugar—which he or she will crave—only makes the child more irritable and hyper, followed by an inevitable drop in blood sugar. A diet high in protein is better. Avoid caffeinated drinks, such as colas, which can rev up the child, make him or her irritable, and sometimes cause depression.

Dr. Engwall mentioned that there had been some study of the use of fish oil in treating bipolar disorder, but the substance in question was a highly purified form and the amounts were unrealistically high. Other supplements that have been studied include zinc—which changes liver metabolism and may interfere with response to medication—and branch chain amino acids. “These treatments look promising but are not proven,” he said.

Q: Are you manic if you feel like you're plugged into an electric socket?

A. That would be one symptom, but such a feeling might also have a medical cause—a viral illness, stroke, or hyperthyroidism.

Q. Is there a connection between bipolar and math or music talent?

A. Many famous musicians and mathematicians have suffered from bipolar, but with children the disorder seems to cause math problems instead, because of distraction and lack of focus.

Q. Is there a relationship between bipolar and migraine?

A. Not that we know of. Migraines are fairly common and may have something to do with serotonin. Bipolar is also associated with serotonin, but that's not what drives the disorder. Hormones such as progesterone can have an effect on both migraines and bipolar disorder.

Q. Does the incidence of bipolar disorder increase at puberty?

A. We don't know enough to state this. We do see the rate of depression in girls increasing—doubling, actually—after puberty and remaining much higher than in boys.

Q. Is Lamictal useful for bipolar children?

A. This medication has been around eight or nine years and has been demonstrated for treating depression with bipolar and can be as good as lithium. However, there is a 1% chance of developing a severe, sometime fatal rash with this medication, and so the dosage must be monitored closely and increased slowly.

While we do have developed treatment algorithms—that is, agreed medical approaches, including the order in which certain medications should be tried or

combined—for adults with a diagnosis of Bipolar Type I, they do not exist for Bipolar Type II or for bipolar in children.