Bipolar in Children and Young People

Introduction

This leaflet is aimed at the relatives, friends and support professionals of younger people and children with bipolar (also known as manic depression). It focuses on the very specific needs of children and young people with bipolar disorder, which can be quite different to those experienced by older people. Bipolar UK publishes a wide variety of other information about bipolar which you may also find helpful, which can all be found online at www.bipolaruk.org.

The average age of diagnosis for bipolar used to be 32 years old but in the last decade this has dropped dramatically to an average of 21 years old, and is likely to go even lower. The reason for this is not known but could be due to a number of factors including: increased awareness and education amongst the public and mental health professionals, increased substance abuse, changing life stressors and increasing prescribing of anti-depressants. There is understandably much debate about the ethics of labelling children and young people with a diagnosis of bipolar but one of the advantages of a correct diagnosis is that it may allow for more effective treatment which will hopefully reduce the impact of bipolar in the longer term.

There is no definite answer as to why some people experience bipolar but it seems to be a combination of:

> **Biological factors:** genetic inheritance, disrupted brain chemistry, and disrupted circadian (daily) rhythms.
>
> **Psychological factors**: how different people react to, and cope with: life events, stress, physical factors (including medical disorders but also excessive alcohol or stimulant use), and social relationships.

These factors may increase the risk of developing bipolar but they do not cause it. 1% to 2% of the population experience a lifetime prevalence of bipolar and recent research suggests as many as 5% of us are on the bipolar spectrum. Men and women are affected equally, and an estimated 0.5% of children or young people are affected by the disorder.

Symptoms and Types of Bipolar

Bipolar in adults is characterised by episodes of depression, mania, mixed state, or hypomania that typically recur. Some people may also experience psychosis or rapid cycling whilst experiencing one of these episodes. In order for someone to receive a diagnosis of bipolar they need to display certain symptoms over a certain period of time. You may come across diagnoses such as Bipolar I or Bipolar II. The categories reflect difference in the severity and duration of episodes of mania or depression.

Depression: Symptoms include: a persistent sad mood; loss of interest or pleasure in activities that were once enjoyed; significant change in appetite or body weight; difficulty sleeping or oversleeping; physical slowing or agitation; loss of energy; feelings of worthlessness or inappropriate guilt; difficulty thinking or concentrating; and recurrent thoughts of death or suicide. The depressive episodes of people with bipolar are often indistinguishable from those of people with unipolar major depressive disorder. Some people suffer sever, incapacitating depressions, with or without psychosis, that prevent them from working, going to school, or interacting with family or friends. Others experience more moderate depressive episodes, which may feel just as painful but impair functioning to a lesser degree.

Mania: Symptoms include abnormally and persistently elevated (high) mood or irritability occurring with at least three of the following: overly-inflated self-esteem; decreased need for sleep; increased talkativeness; racing thoughts; distractibility; increased goal-directed activity or physical agitation; and excessive involvement in risky behaviours or activities (e.g. spending sprees, reckless driving, sexual affairs).

Psychosis: Sometimes severe mania or depression is accompanied by periods of psychosis. Psychotic symptoms include hallucinations (hearing, seeing, or otherwise sensing the presence of stimuli that are not actually there) and delusions (false fixed beliefs that are not subject to reason or contradictory evidence and are not explained by a person’s usual cultural concepts. Psychotic symptoms associated with bipolar typically reflect the extreme mood state at the time (e.g. grandiosity during mania, worthlessness during depression).

Hypomania: Episodes are characterised by low-level, non-psychotic symptoms of mania such as: increased energy, euphoria, irritability, and intrusiveness. These may cause little impairment in function but are noticeable to others. People who meet criteria for bipolar or

unipolar depression and who experience chronic psychotic symptoms which persist even with clearing of the mood symptoms, may be diagnosed with schizoaffective disorder.

Other terms you may come across:

Euphoric mania: person is elated and full of optimism.

Dysphoric mania: person is high but also irritable, impatient, agitated.

Euthymia: stable mood.

Unipolar depression: major depressive disorder, with no mania.

Dysthymia: less severe depression than unipolar depression but can be more persistent.

Bipolar diagnoses:

Bipolar I: people experience mania and major depression.

Bipolar II: people experience hypomania and major depression.

Cyclothymia: people experience hypomania and less severe depression.

Rapid cycling: This is defined as four or more episodes within a 12-month period This type of bipolar tends to be more resistant to treatment than non-rapid-cycling bipolar. Children and young people may be more prone to rapid cycling that adults, sometimes cycling several times a week or even a day (known as ultra-rapid cycling).

'Mixed' state: Symptoms of mania and depression are present at the same time which may result in agitation, trouble sleeping, significant change in appetite, psychosis, and suicidal thoughts.

Children and Bipolar

As yet there are no separate guidelines for diagnosing children with bipolar so medical professionals have to rely on adult criteria and their own judgement. Using adult criteria may cause problems as there do appear to be differences in the way bipolar appears in children compared to adults.

The main differences are that children are more likely to have continuous, mixed state mood cycles, with severe irritability. Also they may not have clear episodes with periods of wellness that are usually seen in adults. The Child and Adolescent Bipolar Foundation states that in children symptoms *may* include:

- An expansive or irritable mood
- Depression
- Rapidly changing moods lasting a few hours to a few days
- Explosive, lengthy, and often destructive rages
- Separation anxiety
- Defiance of authority
- Hyperactivity, agitation, and distractibility
- Sleeping little, or too much
- Bed wetting and night terrors
- Strong and frequent cravings, often for carbohydrates and sweets
- Excessive involvement in multiple projects and activities
- Impaired judgement, impulsivity, racing thoughts, and pressure to keep talking.
- Dare-devil behaviours
- Inappropriate or precocious sexual behaviour
- Delusions and hallucinations
- Grandiose belief in own abilities that defy the laws of logic (ability to fly, for example)

CABF also states that the '…symptoms of bipolar diagnosis can emerge as early as infancy. Mothers often report that children later diagnosed with the disorder were extremely difficult to settle and slept erratically… and often had uncontrollable, seizure-like tantrums or rages out of proportion to any event.'

It can be difficult to judge the extent to which behaviour might be due to developmental issues and part of growing up, and what may be due to a disorder such as bipolar. This can also be dependent on the appropriate context: for example, when a child's grandiose ideas, which are fine when playing with other children, constantly spill over into interactions with adults. As a friend of family member you may be well aware that these mood swings are outside the boundary of what would be considered 'ordinary'.

If you are concerned that your child is experiencing extreme mood swings it might be useful to keep a diary of day-to-day events to show how moods are fluctuating over time, and what impact they are having on your child's behaviour (a mood scale and diary are available on our website at www.bipolaruk.org). This can then be discussed with your medical professional, along with any family history of mental health problems or alcohol/substance misuse.

It can also be useful to check that your doctor is aware that children and young people can experience bipolar disorder as this is not always widely known; even amongst medical professionals as it is still thought of as only affecting adults.

Young people and bipolar

The onset of bipolar in young people can bring additional issues because it happens at a critical time developmentally when young people want to assert their independence and are developing a sense of self. It can be very difficult for a young person experiencing bipolar to separate themselves from their illness as there may be a great deal of emphasis placed on their mood swings, and the impact these have, both by the individual and their supporters. It can be important for a young person to be reminded that they are not their illness and have their own personalities and idiosyncrasies.

How and when certain life changes happen - changes which affect many young people such as starting work, college, university, romantic relationships, etc. – may be different for a young person experiencing bipolar. For example, a young person may need more support than friends of a similar age. If you are supporting a young person with bipolar it can also be hard to achieve a balance between being supportive and being hyper-vigilant about mood changes, which can lead to friction. This is difficult for the whole family and may need talking about in a non-critical, non-hostile way. It may also be useful to specify a list of warning signs, that have been mutually agreed, that would benefit from help or support from you. It is often helpful to keep a record of these by writing them down. More information on this topic is included in Bipolar UK's *Information for Family and Friends* leaflet, which can be found on the website.

Comorbidity

Comorbidity occurs when someone is diagnosed with more than one condition. This can be common in bipolar and is also known as dual

diagnosis. In particular, children and young people with bipolar disorder may also be diagnosed with:

ADHD (attention-deficit hyperactivity disorder): behaviour disorder which starts in childhood, the symptoms of which are developmentally inappropriate inattention, impulsivity, and hyperactivity. More frequent in boys. May be treated with the stimulant Ritalin (methylphenidate), which aims to improve attention and focus.

Asperger's syndrome: a developmental disorder that is possibly related to autism; children affected by this disorder have significantly impaired social interaction. However, the child is generally of average or above average intelligence with no significant delay in language development.

Autism: Characterised by impaired development of social skills, relationships and communication; a restricted range of activities and interest. How autism appears in an individual can vary greatly.

Dyslexia: Affects ability to comprehend written and printed words.

Oppositional defiant disorder (ODD): a disruptive disorder characterised by persistent fighting or arguing, being touchy, easily annoyed or intentionally annoying, vindictive or spiteful; up to 90% of children with bipolar may meet the full criteria for a diagnosis of ODD.

Anxiety disorder: group of disorders including generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia disorder, post-traumatic stress disorder, and separation anxiety disorder; this group of disorders is categorised as neurobiological conditions that are characterised by overwhelming and persistent feelings of worry and fear that drastically interfere with everyday life.

Substance misuse

Drug and alcohol misuse is significantly higher amongst people diagnosed with bipolar than amongst the general population. Some people may use non-prescribed substances to, in effect, 'self-medicate'. This can be to mask a symptom e.g. hallucinogens and psychosis; stimulants and depression. People may also use substances to offset side effects of prescribed drugs, or to trigger a desired aspect of bipolar, such as hypomania. There is some debate about whether substances may initially trigger bipolar but there is no conclusive evidence for this. Whatever the reasons, substance abuse can significantly increase the impact of bipolar.

If someone is experiencing bipolar disorder and a substance abuse problem it can be very difficult to get the correct professional help; drugs agencies are reluctant to treat people until their mental health problems have been stabilised and vice versa with mental health agencies. But because the two issues are likely to be closely linked, it is important, if at all possible, for the individual to be given concurrent support for both bipolar and substance abuse.

Delayed or Incorrect Diagnosis

Unfortunately many people with bipolar disorder are initially misdiagnosed. This may happen because someone is diagnosed with depression but they also have hypomania which has not been recognised, or because a person with severe psychotic mania is misjudged to have schizophrenia. In addition, a problem for children and young people is that they may be initially diagnosed with another similar disorder, such as one of those listed in the 'comorbidity' section above. ADHD can be easily confused with bipolar in children, and is much more widely known about. Misdiagnosis can cause problems with medication; there has been little research into the effect the stimulant Ritalin may have on children susceptible to mania but anecdotal evidence suggests it may trigger or increase the severity of a manic episode. Children who are diagnosed with comorbid ADHD and bipolar need to be medicated with particular care.

Managing Bipolar

There is no cure for bipolar but many people successfully manage the condition through a combination of medication, self-management (learning to recognise the triggers and early warning signs that precede a mood swing and taking action to prevent or limit this) and counselling or therapy. Bipolar UK publishes a variety of information on medication and self-management, which is available on our website.

There is a growing support for the effectiveness of family therapy for families with a family member diagnosed with bipolar. This combination of education and therapy appears to improve not only family communication but also increases periods of wellness for the person experiencing bipolar. Your medical professional may have information on whether family therapy is available locally.

Support in Education

School

Appropriate support at school or college can have a major positive impact. Making the school or college aware of how bipolar, and the possible side effects of medication, can affect performance in education will help teaching staff to offer support and increase their understanding of an area they may not have much experience with. For children of school age the following steps could be suggested:

- Unlimited access to toilet and unlimited access to drinking water.
- Classroom assistant for additional support in class.
- Joint parent-teacher notebook between home and school for better communication.
- Homework reduced or excused and deadlines extended when energy is low.
- Later start to the day if necessary.
- Designation of a ‘safe place’ at school where child can take time out.
- Designation of a staff member to whom the child can go as needed.
- Extended time on tests and exams.

College and University

A variety of support is available for people going to college or university. This, combined with careful planning, can help to make further or higher education more manageable and enjoyable.

Disabled Students’ Allowance (DSA) is a non-means tested benefit available through your Local Education Authority (LEA), but only for people who are in higher education. It is to provide additional support to students with disabilities (including mental health problems) to help them with:

- Specialist equipment allowance – e.g. a laptop for someone who is depressed and unable to use university computers, or needed to go home for a period of time.
- Non-medical helpers’ allowance – e.g. someone else to take notes when concentration is poor.
- General/other expenditure allowance – e.g. for photocopying or buying extra books if unable to study in a library for long periods.

Travel costs – e.g. paying for taxis if anxiety was preventing someone from using public transport to get to university.

Although DSA funding is not available for students in further education, individual colleges should have funds available to support disabled students. Funding may also be available from charitable trusts. For more information on this and DSA contact Skill (National Bureau for students with disabilities) at www.skill.org.uk.

Other points to consider:

Making sure there is a named personal tutor who is kept informed if someone is unwell, and who will be sympathetic in extending deadlines for assignments when necessary.

Considering the type of course applied for – some courses are highly unstructured which can cause difficulties in terms of self-management.

Contacting the student medical centre and student counselling service in advance and discussing what support is available. However, it is important to bear in mind that although the student counsellors may be extremely good, they may not have experience of bipolar and of what to do if someone is becoming unwell.

Setting up an advance agreement just in case of a crisis. This can be used to detail who should be informed at college/university and at home, preferred medications and treatments, and so on.

Contacting the National Union of Students (NUS) Students with Disabilities Officer at the university to find out what specific support may be available at an individual university.

Looking after yourself

It is also important to remember to look after your needs and health. Bipolar UK's leaflet 'Information for Friends and Family', which can be found on our website, gives more detailed advice about looking after your needs and how to support someone with bipolar disorder. If you are a parent with other children it is important to consider how their needs are being met and how the relationships between siblings can be maintained. Under the NHS's Care Plan Approach, you may be classified as a carer and therefore entitled to a written plan of how your needs will be met, as well as those of your friend or family member. To find out more about this speak to your medical professional.

Bipolar UK resources

Bipolar UK works to enable people affected by bipolar to take control of their lives. Founded in 1983, we have a store of expert knowledge to offer.

We produce a range of leaflets and information sheets, which are all available on our website. Our vibrant eCommunity provides members with a forum to express and share their views and experiences. We also provide a variety of services for individuals with bipolar, their carers and their families, including: our Support Groups up and down the country; our Support Line; Employment Support service; and our online blog, *Pendulum*.

For more information please call our Supporting Line on 0333 323 3880, email info@bipolaruk.org or visit our website at www.bipolaruk.org.

Further resources

National Union of Students

NUS HQ
4th Floor
184-192 Drummond St
London
NW1 3HP

0845 5210 262

www.nus.org.uk nusuk@nus.org.uk

Saneline

0845 767 8000

Carers UK

20 Great Dover Street
London
SE1 4LX

020 7378 4999

www.carersuk.org

Organisations which offer support for the disorders mentioned above:

ADHD: National ADD Information and Support Service (ADDISS)

020 8952 2800 http://www.addiss.co.uk/

Asperger's and Autism: The National Autistic Society

0808 800 4104 http://www.autism.org.uk/

Dyslexia: The British Dyslexia Association

0845 251 9003 http://www.bdadyslexia.org.uk/

Anxiety Disorder: Anxiety UK

08444 775 774 http://www.anxietyuk.org.uk/

Alcohol support: Alcoholics Anonymous

01904 644 026 www.alcoholics-anonymous.org.uk

Drugs support: Narcotics Anonymous

0300 999 1212 www.ukna.org