

Bipolar Mood Disorder in children and adolescents: in search of theoretic, therapeutic and diagnostic clarity

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I address early onset Bipolar Mood Disorder, exploring the ways in which the disorder manifests in the lives of children. Complications in current and past literature are clarified, and the dearth of substantive research into the area is noted. I clarify associated risk factors specific to paediatric bipolar disorder. A treatment procedure informed by cognitive-behavioural, narrative and family systems theories is proffered, and is considered in relation to the development of a pharmacological intervention. I highlight shortcomings in psychiatric interventions, and provide a framework for treatment which takes into account the complex variety of needs which bipolar children present.

Keywords: cognitive therapy; family systems therapy; narrative therapy; paediatric bipolar disorder; paediatric psychiatry; pharmacological intervention

Paediatric psychiatry has been plagued by controversy relating to the diagnosis, management, prognosis and prevalence of childhood-onset Bipolar Mood Disorder (Smith, 2007). What seems evident in the literature is a general underestimation of the prevalence of the disorder. This is coupled with a misdiagnosis of paediatric bipolar disorder as one of a variety of developmental disorders (Biederman, 1997). The literature also suggests that the attention afforded to paediatric Bipolar Mood Disorder has been insubstantial (Cummings & Fristad, 2007; Strober *et al.*, 2006).

In this paper my aim is twofold: I shall first describe the phenomenology, aetiology and neurology of paediatric bipolar disorder, coupled with an outline of the ways in which it may differ from adult-onset Bipolar Mood Disorder. Next I shall differentiate paediatric bipolar disorder from disorders that may be diagnosed more commonly and incorrectly. In conjunction with this, I shall expound the associated risk factors. The second aim is to explore methods of intervention. The behavioural manifestations of paediatric bipolar disorder are quite specific in comparison with adult bipolar presentations. The quality of explosiveness, rapid shifting in mood and intermittent aggressiveness characteristic of the disorder can be disruptive of development. The literature highlights specific interventions for the disorder, which I shall comment on in the final section.

PAEDIATRIC BIPOLAR DISORDER

Phenomenology

First to address the primary question: Is there a form of bipolar disorder specific to childhood? There is indeed much controversy regarding the phenomenology of paediatric bipolar disorder (Kowatch, 2005). The author states that reports published concerning its diagnosis and treatment contain different diagnostic criteria and methods. In this we see a methodological inconsistency in approaches to assessing mania in children. It is acknowledged that the term 'childhood onset' is relative, since the index episode could occur anywhere between early infancy and late adolescence. That aside, diverse statistics are noted in the literature, making it difficult to summarise them. The lowest statistic reflects 0.5% of bipolar disorder in childhood (Biederman, 1997), while the highest reflects an estimated 59% of childhood onset (Soutullo *et al.*, 2005). Apart from this variety in commentaries on paediatric bipolar disorder, the question remains as to whether the manifestation of bipolar disorder in childhood is phenomenologically different to that in adults.

Bipolar Mood Disorder is characterised by recurrent, discrete episodes of fluctuation in mood,

which can have a significant impact on functioning. Paediatric bipolar disorder is defined by chronic, non-episodic, ultra-rapid cycling (Faedda, Baldessarini, Glovinsky, & Austin, 2004; Vogel, 2000; Wosniak & McCallaghan 1985). This factor in particular renders paediatric bipolar disorder easily misdiagnosed as one of the disruptive behavioural disorders, including Oppositional Defiant Disorder (ODD), Conduct Disorder or AD/HD (Soutullo *et al.*, 2005). Presentations of bipolar disorder in children are defined by mixed dysphoria and lability, without discreet episodes. The frequency of mood fluctuations implies that children with Bipolar Mood Disorder are disabled by the disorder, should its course be improperly managed. Thus, the diagnostic outline of the disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) (American Psychiatric Association, 2000) is an inadequate description of its manifestation in children. With the DSM describing bipolar disorder as defined by distinct episodes of mania or depression with inter-episode return to healthy functioning, paediatric bipolar disorder, which manifests as a rapid cycle of fluctuating moods, falls into a nosological gap.

In children living with bipolar disorder, impairment is seen in school functioning, and in peer and family relationships. Mood oscillates rapidly from a depressive state to manic excitation. Among the potential symptoms of a depressive episode, the following may be observed: Persistent sad or irritable mood, loss of interest in previously pleasurable activities, fluctuations in appetite, psychomotor agitation or retardation, feelings of worthlessness and guilt, and suicidal ideation (Papolos & Papolos, 2002). On the manic spectrum, the following symptoms are likely: fluctuations in mood ranging from extreme irritability, elation and fatuousness; inflated self-esteem or grandiosity; increased energy with a decreased need for sleep; increased rate, volume and quantity of speech; distractibility; hyper sexuality; an elevation in the amount of goal-directed behaviour, and disregard for the dangers involved in high-risk activities (Kowatch, Youngstrom, Danielyan, & Findling, 2005).

The clinical description of paediatric bipolar disorder is discernibly different from adult-onset bipolar disorder. The presentation falls into nine symptom classes (Pavuluri & Bishop, 2005). Firstly there is *elated mood*, defined by silliness, giddiness and feeling invincible. Children in this state are easily overwhelmed, and their affect may oscillate quickly from excitation to a state of anxious distress. Secondly, *irritable mood* (one of the cardinal features of paediatric bipolar disorder) manifests in aggressive, hostile behaviours with intense, inconsolable responses to stressors. *Inflated self-esteem* or *grandiosity* is the next category of reported symptoms. The child may make unsupportable statements such as "I am the cleverest boy in the whole world", or "The teachers could learn a few lessons from me".

A decreased need for sleep is evident in children with bipolar mood disorder. They awaken from little sleep, feeling refreshed and energised. *Pressure of speech* is noted, with children constantly talking, dominating the interpersonal space, and seeking attention by being excessively entertaining. *Constant goal-directed activity* is observed by Pavuluri & Bishop (2004) as a central feature. Children may be overwhelmed by a frenzy of activity, with aims to achieve unrealistic goals. The constant *search for pleasurable activities* is also observed, a feature that often manifests in children showing little awareness of the social surroundings.

The emergence of *depression* in children living with bipolar disorder is age-specific in its manifestation. Depressed children may report feeling "crabby"; their parents may describe "excessive whining" in the child; they may cry for no apparent reason, withdraw and isolate themselves, exhibit fluctuations in mood from irritability to tearfulness, and may engage in minor self-injurious behaviours such as skin-pinching. These children may develop a painful sensitivity to rejection, due to the incongruity of their behaviours compared with their peers.

The final category of symptoms in bipolar children relates to the *psychotic spectrum*. Children presenting what could be called an atypical mania (Ballenger, Reus, & Post, 1982) could exhibit auditory and visual hallucinations, usually in relation to mood-congruent delusions of grandiosity. In terms of thought form, the significance of flight of ideas, tangentiality and excessive speed and production of thoughts has been noted.

Aetiology

I shall now discuss issues relating to the aetiology of the illness. First to mention the findings from neurology: Evidence exists confirming the presence of right ventricular enlargement, structural abnormalities in the orbito-frontal cortex, medial temporal lobe structures, striatum and cerebellum; structures that contribute to mood regulation and the modulation of behaviour (Monkul, Malhi, & Soares, 2005). With reference to abnormalities in the orbito-frontal cortex, Schore (1994; 2000) comments on the function of this structure in the auto-regulation of positive and negative emotional states. The orbito-frontal structure is elsewhere described as the senior executive of the emotional brain (Joseph, 1996), emphasising its role in the regulation of mood. The potential role of structural abnormality in this area has been clearly shown.

What is interesting to bear in mind in considering the aetiology of bipolar disorder and the documented diagnostic blurring of the borderline/bipolar classification is the notion that those right brain structures that function in the regulation of emotion develop in the first 18 months of life. Their normative development is promoted by the presence of a growth-facilitating emotional environment that is provided by a secure attachment relationship with a primary caregiver (Schore, 2000). This insight is interesting, considering the observation that borderline personality disorder is connected aetiologically with trauma in the context of early attachment relationships (Fonagy, Target, Gergely, Allen, & Bateman, 2003; Herman, Perry, & Van der Kolk, 1989; Holmes, 2004). Both bipolar and borderline presentations are characterised by instability of affect regulation; a feature which makes them appear quite similar. What is being suggested here is a structural neurological similarity in the aetiology of borderline personality disorder and bipolar mood disorder, mitigated by a secure attachment relationship in early infancy. It is suggested that further research is required to establish the neurological basis of this connection.

Monkul *et al.* (2005) investigated neuroanatomic and neurochemical abnormalities in people with bipolar mood disorder, attending to the possibility that such abnormalities may be progressive. What emerged from their study is the notion that there is a lack of evidence supporting the possibility of progressive neurological processes, but that there exist a variety of processes, including environmental, educational and nutritional processes, which could effect such progression of the pathology. The impact of medication on the correction or reversal of such neurological processes as seen in bipolar disorder is proposed as an untapped area of research.

An important consideration in relation to the neurochemistry of bipolar mood disorder is the extreme heritability of the illness, an element of the assessment process that features centrally in giving the diagnosis. The literature suggests that paediatric bipolar disorder is associated with a significantly greater genetic load with one or both parents being diagnosed with the illness (Strober *et al.*, 2006). Papolos and Papolos (2002) indicate that over 80% of bipolar children have parents on both sides with histories of mood disorder and/or alcoholism. Faedda *et al.* (2004) found a 90% chance of bipolar children having a family history of the illness.

Further on in this paper, when discussing recommended treatments for paediatric bipolar disorder, I shall comment on the importance of accurately diagnosing and promptly treating this disorder. I shall also highlight the possible dangers of misdiagnosis and delayed treatment.

THE PROBLEM OF COMORBIDITY

Confusion exists in the identification of paediatric bipolar disorder, given the variety of pathologies that may mimic the disorder or manifest comorbidly. Frequently, the histories of children with bipolar disorder will reflect a range of diagnoses including (in order of frequency) Attention Deficit/Hyperactivity Disorder (60%), Anxiety Disorders including Obsessive Compulsive Disorder (39%), Major Depressive Disorder (37%) and Oppositional Defiant and/or Conduct Disorder (21%) (Faedda *et al.*, 2004).

Four spectrums of pathology exist in relation to paediatric bipolar disorder. Firstly, the anxiety disorders: Biederman, Harpold, and Wozniak (2005) observed that paediatric bipolar disorder is

associated with an increased risk for developing anxiety disorders, with Obsessive Compulsive Disorder and Social Phobia being the most frequently observed. An important consequence of the bipolar/anxiety disorder comorbidity is the challenge that this poses to pharmacological interventions. Anxiety disorders in children occur far more frequently with bipolar disorder than they do in relation to AD/HD and other disruptive behavioural disorders such as Oppositional Defiant and Conduct Disorders (Biederman, 2005). The reason for the co-occurrence of anxiety disorders with bipolar disorders could be connected with the pervasive impairment in functioning seen in paediatric bipolar presentations. In children with the disorder, there is often a delay in time between the index episode and diagnosis of the illness. Faedda *et al.* (2004) have noted an average delay of seven years between onset and diagnosis. The consequences of this could be highly disruptive of the child's developing sense of self. Underperformance at school, tumultuous peer and family relationships, and feeling easily overwhelmed could cause the child to develop a sense of insecurity and isolation.

The second diagnosis in a cluster with paediatric bipolar disorder is Attention Deficit/Hyperactivity Disorder (Singh, DelBello, Kowatch, & Strakowski, 2006; Scribante, 2009). The magnitude of the AD/HD-bipolar correlation has led some researchers to postulate AD/HD as a developmental precursor of paediatric bipolar disorder. However, little evidence exists to confirm this hypothesis (Leibenluft, Charney, Towbin, Bhangoo, & Pine, 2003). The authors conceptualise the link between AD/HD and bipolar disorders as representing one of three possibilities: a) AD/HD as a true comorbidity, b) a phenotypic variant of bipolar disorder, or c) AD/HD as manifesting symptoms within the bipolar spectrum. Singh *et al.* (2006) propose AD/HD as a prodromal condition preceding the onset of paediatric bipolar disorder.

Given the implications of paediatric bipolar disorder for the child's development, personality could be significantly influenced by the bipolar process (Goldstein *et al.*, 2005). The authors comment on the prevalence of certain behaviours in the bipolar adolescent that may overlap with Cluster B personality pathologies, specifically Borderline and Histrionic Personality Disorders. The manic exuberance of bipolar children may be perceived in adolescence as an indication of histrionic traits. More frequently noted is self-injurious behaviour, often observed in adolescents with Bipolar Mood Disorder or borderline traits. Although insufficient research has been done to establish a link between the two, it has been postulated that Bipolar Mood Disorder and Borderline Personality Disorder exist on a spectrum of their own, with certain overlapping behavioural manifestations. The severity of affect dysregulation in both disorders is a diagnostic overlap that deepens the uncertainty regarding the diagnosis of paediatric bipolar disorder.

The final diagnostic correlates with paediatric bipolar disorder are Major Depressive Disorder and Dysthymic Disorder. Kovacs (1989) observes that more than half of children diagnosed with bipolar disorder were diagnosed initially with a depressive illness. Furthermore, depression in early childhood, coupled with evidence of a multi-generational family history of bipolar disorder, serves as a strong predictor of onset of the illness.

The vicissitudes of manic-depressive cycling in paediatric bipolar disorder are varied and complex. I have described the ultra-rapid cycling (Wosniak *et al.* 1985) that characterises paediatric presentations. This, coupled with the emphasis on irritability and aggressiveness in children with bipolar disorder, suggests that clinicians could well emphasise depressive features and thus downplay the manic component of the presentation. The consequence of this is seen in the pharmacological intervention in which depressed children are frequently treated with Serotonin Re-Uptake Inhibitors (SSRIs) (McShane, Mihalich, Walter, & Rey, 2006). Pavuluri *et al.* (2005) consider psychopharmacological treatments for paediatric bipolar disorder and emphasise prescription hygiene in which they include weaning off inappropriate medications. They identify the over-use of SSRIs, even in the face of compelling evidence revealing the latter's deleterious impact on the progress of paediatric bipolar disorder.

In relation to this lack of clarity regarding diagnosis, two consequences are of particular significance in the literature: The first consequence involves the evidence of a large space in time

between onset and diagnosis, which can have particularly negative impacts on the disorder. Primarily, delayed recognition of the illness leads to complex difficulties as far as the stabilisation of mood is concerned (Faedda *et al.*, 2004). Delayed recognition and intervention is also correlated with disruptions in personality development, which may manifest in disordered personality traits. The second consequence of the lack of diagnostic clarity for paediatric bipolar disorder relates to the mistreatment of the illness. The frequency with which AD/HD (instead of paediatric bipolar disorder) may be diagnosed may reflect clinicians' tendencies to emphasise attentional processes during the assessment. Frequently observed is the mistaken diagnosis of a bipolar child with AD/HD, and his/her consequent psychopharmacological treatment with a stimulant such as Ritalin (Faedda *et al.*, 1995). Ritalin can have a destabilising effect on the child's mood, with consequent debilitation in functioning at school and home.

PAEDIATRIC BIPOLAR DISORDER: ASSOCIATED RISK FACTORS

Children living with Bipolar Mood Disorder present with significant associated risk factors including suicide, self-harm, substance use, risk of sexual exploitation and functional impairment. The lack of systematic research into the course of paediatric bipolar disorder makes it difficult for clinicians to conduct satisfactory risk assessments (Strober, 2006). The risk of completed suicide in people with Bipolar Mood Disorder is among the highest of all psychiatric disorders (Goldstein *et al.*, 2005). The author provides statistics derived from a North American psychiatric population. Reportedly between 25 and 50% of adults with bipolar mood disorder will make at least one attempt, with 8 to 19% of bipolar patients dying from suicide. Such statistics may be poorly reflective of the associated risks of the disorder in developing countries. In this context, the prevalence of cumulative strain trauma, inadequate access to primary health facilities, and an often-reported difficulty with people in rural areas adhering to their medication may aggravate the course of the disorder and increase the risk of completed suicide.

Having said this, the literature makes three claims unequivocally: Firstly, the risk for completed suicide in adolescents with Bipolar Mood Disorder is high (Brent, Perper, & Moritz, 1993; Goldstein *et al.*, 2005). Secondly, the risk of suicide in adults presenting with childhood onset bipolar disorder is higher than in adults presenting with a later onset. Thirdly, suicidal behaviour in early-onset bipolar disorder occurs at a younger age than most psychiatric presentations, and is defined by more lethal and frequent attempts (Goldstein *et al.*, 2005). In general, there is a strong association between early onset illnesses and eventual suicidality.

Considering the significantly elevated risk of suicide, it is important to systematise an assessment procedure that could enable clinicians to assess risk. The following can be considered as red flags pointing to heightened risk: Firstly, people with Bipolar Mood Disorder who have a family history of suicidal behaviour are more likely to attempt suicide than those who do not. Secondly, a history of physical or sexual abuse is positively correlated with suicide attempts (Goldstein *et al.*, 2005). These two factors must be seen in combination with the specific clinical presentation of the bipolar child. The majority of people with Bipolar Mood Disorder who attempt suicide frequently present with mixed manic states, multiple depressive episodes, comorbid anxiety or panic disorders and/or substance abuse or dependence (Cox, Dierenfeld, Swinson, & Norton., 1994; Rudd, Dahm, & Rajab, 1993). Furthermore, children presenting with a history of mixed episodes as well as concurrent psychotic symptoms are more likely to evince suicidal ideation. An important observation in terms of the bipolar-AD/HD diagnostic blur is that no studies have managed to find a correlation that connects suicidal behaviour with AD/HD.

The correlation between bipolar and borderline personality is an important consideration when assessing suicidality. Specific traits are seen in adolescents with a suspected borderline/bipolar symptom structure. Among these are aggression, impulsivity, and fluctuations of idealisation and devaluation in relationships with primary attachment figures (Oquendo & Mann, 2001). Such interpersonal

fluctuations can have an impact on the individual's sense of safety, and could be continuous relational traumata precipitating suicidality. In addition to these features, the presence of non-suicidal self-harm is another possible indicator of risk (Faedda *et al.*, 2004). With this in mind, adolescents presenting bipolar mood symptoms in conjunction with the specific personality traits of the borderline spectrum are a particular risk. One final factor is the severity of the symptoms. With this in mind, a diagnosis of Bipolar Type 1, in which more extreme episodes of mania and depression may manifest, increases the risk of suicidal behaviour.

THE TREATMENT OF CHILDHOOD-ONSET BIPOLAR MOOD DISORDER

Pharmacotherapy and the child

The treatment of children with psychiatric medication is a sensitive process that requires nuanced judgements and considers each child in relation to his/her development. The use of psychotropic medication is an important consideration that has received insufficient scientific attention, with the bulk of research addressing adult responses to medication (McClellan, 2005). McShane *et al.* (2006) observed that the use of SSRIs is widespread, irrespective of diagnosis. Such medication is prescribed with insufficient proof of its effectiveness. In developing prescription hygiene, a history should be obtained to establish which medications have been helpful or unhelpful in the past. Patients should then be weaned off ineffective medications. In working towards effective medication strategies for bipolar children, Pavuluri and Bishop (2005) developed a Medication Algorithm in which they promote prescription hygiene, mood stabilisation and addressing breakthrough symptoms. SSRIs, unless they have been shown to be effective, should be discontinued as a matter of course. This is based on compelling evidence suggesting that SSRI administration in children with bipolar disorder either worsens existing mania or could switch the child from a depressive or neutral state to a manic state (Pavuluri & Bishop, 2005).

Another important aspect of prescription hygiene involves working with either the misdiagnosis of paediatric bipolar disorder as AD/HD, or a Bipolar-AD/HD comorbidity. It is well known that the stimulant Ritalin has a potentially aggravating effect on the mood presentation of bipolar children. It is therefore necessary to undo diagnostic errors and reshape the treatment regime by addressing the primary concern, mood stabilisation. The authors suggest that if AD/HD presents as an authentic comorbidity, the urgency of mood stabilisation should nonetheless be attended to prior to addressing attentional symptoms. The prescription of mood stabilisers such as Lithium and Sodium Valproate is widely recognised as effective. Should this prove ineffective, practitioners are recognising the effects of second generation anti-psychotic medications such as Clozapine, Risperidone, Quetiapine and Olanzapine (Kafantaris, Dicker, & Coletti, 2001; Ziervogel & McCallaghan, 2001). Following mood stabilisation, Pavuluri and Bishop's algorithm addresses breakthrough symptoms that fall outside of the bipolar diagnostic boundary. Among these are depressive features, psychosis, aggressiveness and sleeplessness. The presence of comorbid illnesses such as anxiety disorders and disruptive behavioural disorders should be addressed separately, and only after mood has been sufficiently stabilised.

Working therapeutically with bipolar children and their families

In this final section I shall discuss an integrative approach to psychotherapeutic interventions. This approach involves elements drawn from systems theory, interpersonal psychotherapy and cognitive behavioural therapy. Each of these elements has individually been seen to be highly effective in the symptom relief and management of childhood mood disorders as well as the impact of such disorders on the child's experience of self. I consider this approach as of potential value due to its emphasis on the system within which the child's psychic experience plays out. The system is engaged with therapeutically, as well as the child. Therapeutic responses to childhood mental illness that are framed in this manner are proposed as more completely addressing and working with the range of precipitating

and predisposing factors that are associated with paediatric bipolar disorder. West, Henry, and Pavuluri (2007) have conducted trials of this approach based on their observation that such an approach facilitates the containment of symptoms by working with the child and the system in which he/she exists. This is the primary justification for interest in and further exploration of this method.

The approach, called RAINBOW therapy, is intended for children living with bipolar disorder, their parents and siblings (Pavuluri *et al.*, 2004; Pavuluri & Bishop, 2005). Importantly, this technique can be moulded into a school-based intervention, addressing the child's difficulties in that environment. The RAINBOW therapy system is a step-by-step process, with each step carried out in order. A minimum of 12 sessions is required — one third of the sessions with the child alone, one third with the parents, and one third with siblings and school, if necessary. Although the process is designed to be flexible, certain aspects must be adhered to rigidly. These include the adoption of the medication algorithm, the involvement of parent(s) and child, and the successful completion of the process. The RAINBOW therapy process takes place as follows:

Routine: A strict routine needs to be established, included eating habits, sleeping patterns, and balance between work and play. This creates a containing and predictable environment. The benefit of routine in the child's development is indisputable and is promoted as a psychological necessity enabling a sense of safety. Routine in the sleep-wake cycle is an important aspect of this step.

Affect regulation/Anger control: This involves cognitive behavioural techniques that can be creatively moulded. Affect regulation involves psycho-education, in which the nature of the illness is described in an understandable manner. The child and parents are enlisted in charting the child's affective states through the day. Techniques from narrative therapy are used in this process, in which the child is asked to find a story in the pattern of moods and give each mood an externalisable character which the child can think of as a way of externalising the mood state. In the process of affect regulation, both child and parent can work out ways of narrating the unwanted mood state. Such narratives enable the child to develop insight into and control over his/her own mood states and the corresponding behaviours (Pavuluri *et al.*, 2004).

"I CAN DO IT!!!": This process aims to help the child develop positive self-esteem that is not dominated by the Bipolar Mood Disorder label. This step involves helping the child to construct a positive self-story (Pavuluri *et al.*, 2004) and involves sessions with the child alone. The child could be asked to tell the story of who he/she is, with the therapist providing different narratives to replace those that seem self-destructive and overly self-critical.

No negative thoughts: This aspect of the process derives from cognitive behavioural techniques in which the therapist works with the child towards restructuring those beliefs, thoughts and assumptions that are unhelpful or harmful, and replacing them with more facilitative cognitions. The therapist could help the child to articulate what he/she thinks it means to have bipolar disorder; what a person with bipolar disorder is like; what it means to be diagnosed with a mental illness. These issues could feature at the foreground of the child's awareness of the illness and his/her negative self-statements. Unkind comments from other children based on stigmatising attitudes may fuel such negative self-statements and need to be worked with. The child should be encouraged to find more helpful self-statements, which more adequately reflect his/her character, skills and proficiencies.

Be a good friend: In this component, parents assist their child by organising play dates with friends and facilitating the development of healthy peer relationships. This element focuses on enabling the parents to develop their own balanced lifestyle. It is suggested that parents will be unable to care for a child with bipolar disorder or meet the variety of fairly intense demands placed on them if they are not leading a balanced life themselves.

"Oh, how can we solve it?": This element of the process focuses on how family systems work. Families are worked with in an attempt to provide parents, siblings and the child concerned with solutions to the relational difficulties that emerge when the child is acting in an aggressive or irritable manner. Families are encouraged to engage in situational problem solving, in which children

and their parents dialogue around why such behaviour is undesirable, what the negative consequences are, and what positive consequences could arise out of changing the behaviour.

Ways to ask for and get support: Children are taught how to develop what is known as a support tree. The child is asked to name the people in his/her life who can be trusted. The aim of this is to sediment in the child's mind the fact that he/she does have a supportive network of relationships to rely on. The sense of safety that this is said to foster is proposed as having important therapeutic value for the child.

The RAINBOW therapy process is presented in accessible language and is proposed as being well suited to the treatment of bipolar children. This is so because the process addresses children in their lived world, taking into consideration their relational support network. RAINBOW therapy engages with the child's system of meaning and focuses on enabling this system to become helpful and facilitative, rather than damaging. The model was developed within the past decade, and so insufficient evidence exists to support its efficacy. Further research into its effectiveness in the treatment of paediatric bipolar disorder is greatly needed.

What I have attempted to show in this paper is the notion that the management of paediatric bipolar disorder is a multi-story engagement that should assess the child as an embodied self who lives in a relational world, struggling to come to terms with and to make meaning out of a thing called bipolar disorder. We have seen documentation in the literature of the uniqueness of paediatric bipolar disorder. In response to this, our treatment approach needs to be tailored to fit this unique shape. This paper has aimed to emphasise the need for further research into paediatric bipolar disorder, its associated risk factors in our context, and those interventions that could be most enabling of the child's development. Further research into the effectiveness of psychotherapeutic models is also needed. Added to this, the literature consulted reflects a gap in terms of responses to psychotropic medication, with attention paid more to the responses of adults and less to the responses of children. This article has attempted to highlight the gaps in the current literature, thereby opening up possibilities for future research.

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