

The Bipolar Child

by Demitri and Janice Papolos

Book Review by Siegfried Othmer, Ph.D.

A new diagnostic category is emerging: Childhood bipolar disorder. It was traditionally thought that as few as one in 200 cases of bipolar disorder had an onset which could be traced to childhood. Biederman's recent research shows that perhaps on the other of 20% of children identified as ADHD could be on the way to developing full-blown bipolar disorder. To make this identification, however, the markers of childhood bipolar disorder are destructive rage and irritation rather than the euphoria and elation that characterizes the adult form. The proof that the childhood form of the disorder metamorphoses into the adult form eventually must still be outstanding. The model is still too new.

The Bipolar Disorder model is the latest attempt to give diagnostic order and specificity to the most extreme end of the disruptive behavior spectrum. It is of course not the first. Years ago, George Murray of Harvard suggested that temporal lobe epilepsy was under-recognized by mental health professionals by a factor of 25. Clearly he was not referring to overt seizures here, which tend to attract clinical attention, but rather to the subclinical seizure activity that can manifest in erratic behavior, severe mood swings, rages and explosive behavior - but goes unrecognized as such. Partly based on Murray's model, we have emphasized as well the continuity between overt seizures and extreme behavioral dysregulation. Both are effectively treated with anti-convulsants, and both respond to the same Neurofeedback protocols. The developments in Neurofeedback therapy neatly parallel developments in psychopharmacology. But seizures have remained in the domain of neurology, and other mental health professionals have been reluctant to build on that model.

A second major attempt to bring order to this end of the behavioral continuum was by David Comings, who is most closely identified with the spectrum theory of Tourette Syndrome, which also includes rages, explosive behavior, the Jekyll-Hyde personality, and severe mood swings among its descriptors. In fact, Comings already pointed out the close correspondence of Tourette symptoms with those of Bipolar Disorder. This more inclusive view of Tourette Syndrome has remained controversial, however.

Papolos' model appears to be resonating with both the professional community and a public that is desperate for solutions to intractable behavior problems. In fact, one is tempted to propose that bipolar disorder in childhood may be a case of a solution looking for a problem. In recent years, pharmacologists have increasingly resorted to the stronger medications, antipsychotics and anti-convulsants, and to polypharmacy, to address childhood behavior disorders that would not yield either to the stimulants or to the anti-depressants. In this view, bipolar disorder is what these drugs treat. At one stroke, a kind of conceptual order is brought into this bewildering morass of disparate symptoms.

And the pharmacologists look just a little less like they are randomly experimenting on children with heavy medications. The Papolos treatment of bipolar disorder has a sense of urgency about it. The authors, husband and wife, have for a long time had to deal with desperate families. But the suspicion arises that a lot of this problem may be relatively recent in origin, and may even be medication-induced. Papolos points out that both stimulants and anti-depressants can stimulate these behaviors, and what may have started out as an apparently benign case of ADD can with casual (but typical) administration of a stimulant or antidepressant metamorphose into a raging pathology that can be tricky to manage.

The work of Emory and Suffin comes to mind, which by characterization of the EEG can segregate these populations into those that are appropriately addressed with stimulants, those that respond to anti-depressants, and those which yield to anti-convulsants and lithium.

We of course have been confounded by the same behavioral continuum, and have tried to make sense of this in the context of Neurofeedback protocols. Our classification parallels that of Emory and Suffin.

We consider primarily the arousal continuum, and have developed protocols that essentially normalize the arousal curve much as stimulants or anti-depressants do. For this strategy to work, the person has to be characterizable in terms of a particular pattern of arousal function. In other words, that pattern must be predictably stable. But then there is the entire realm of what we call instabilities, where the brain is susceptible, for one reason or another, to sudden changes in state. Whether such instabilities are thought of as seizure-like, or as more fundamentally mood instabilities, is probably beside the point. The distinction respects the niceties of the professional categories, neurology and psychiatry, but is otherwise benignly irrelevant.

We have reason to be pleased that the Papolos model of childhood bipolar disorder is coming to be accepted where the Murray and Comings models were not. It is then necessary to point out that bipolar disorder is simply a descriptor for brain instabilities, and that Neurofeedback is fundamentally a strategy for enhancing brain stability. It rewards the maintenance of continuity in brain state. This accounts for its efficacy for all those conditions for which anti-convulsants have been prescribed: seizures, migraines, mania, bipolar disorder, schizophrenia, Landau-Kleffner syndrome, and trigeminal neuralgia. And Neurofeedback compares favorably in terms of research history to the use of antipsychotics and anti-convulsants (in combination) with young children. It is now our turn to ask, where are the controlled studies on such polypharmacy? What are the long-term outcomes? We, on the other hand, can point to a thirty-year history of research on Neurofeedback with no negative findings for seizure-like phenomena. Contrast that with the state of research on anti-depressants in children, where only a single study has thus far even hinted at a positive outcome among children.

There is one other signal advantage to Neurofeedback. It is now becoming known that all these profound behavioral instabilities are characterized by hemispheric differences. Pharmacology can only address the brain as a whole. It cannot minister to one hemisphere preferentially. Neurofeedback, on the other hand, can be tailored to the demands of each hemisphere, and it can address specifically the issue of inter-hemispheric communication that appears to be a central issue in the entire instability category, or at least central to its clinical resolution.

– Siegfried Othmer

More information:

The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder

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(website: <http://www.bipolarchild.com/thirdedition/>)