Medication Primer for Bipolar Disorder in Kids

A Psychologist’s Perspective
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Is Every Irritable Kid Bipolar?

- Irritability may be a psychiatric disorder
  - Chemical imbalance or personality disorder
    - Depression, PTSD, ADHD
    - Bipolar Disorder: Mania
    - Borderline personality disorder
    - Antisocial personality disorder
- Irritability may be a neuropsychiatric disorder
  - Birth disorders, traumatic brain injury, seizures
    - Genetic disorder
    - Alcohol or drugs during pregnancy
    - Difficult delivery – anoxia at birth
  - Irritability may be due to substance abuse
Child-Onset Bipolar Disorder

Diagnostic controversy:

- Is Child-Onset (prepubertal) Bipolar Disorder just an early step in the evolution of classic adult Bipolar Disorder?
  - Biederman et al., 1999, 2004

- Or, should we consider severe mood and irritability problems in children a completely different condition?
  - Leibenluft et al., 2003
What about adolescent bipolar?

● Adolescent Bipolar - less controversial
  ● May meet DSM IV criteria for bipolar I or II
    ● Bipolar I – Manic (elated, irritable) for at least a week, with marked impairment in social or occupational activities or hospitalization, plus 3 symptoms (grandiose, euphoric, racing thoughts, pressured speech, no need for sleep, reckless)
    ● Bipolar II – Hypomanic (elated, irritable) for four days, no marked impairments or hospitalization, plus 3 symptoms from the above list.
Controversy Notwithstanding

Severe mood and irritability issues need to be treated no matter what the label.
- Call it Child-Onset Bipolar Disorder
- Call it Intermittent Explosive Disorder
- Call it Explosive Mood Disorder
- Call it Organic Aggression Syndrome

Treatments are similar: medication, psychosocial interventions, and school accommodations. (Let us call it Bipolar)
Bipolar - School Impairment

- Bipolar Children show high prevalence of academic dysfunction:
  - Reading/Writing
    - 42% (Wozniak, 1955)
    - 46% (Pavuluri, 2006)
  - Math
    - 30% (Wozniak, 1955)
    - 29% (Pavuluri, 2006)

- Also, Behavior Problems in school:
  - 79% (Geller, 2002)
Why Academic Problems?

- Not just a behavior or emotion problem
  - **Child Onset** Bipolar Disorder kids show:
    - Neuropsychological deficits (brain problems):
      - Memory problems are common
      - Lower verbal reasoning
      - Poor attention span
      - Slower processing speed
      - Decreased cognitive flexibility
  - Neurocognitive deficits persist even after “recovery” from mania and depression.
Mania-Specific Deficits

- Kids with mania may show:
  - ADHD Symptoms:
    - hyperactivity, distractibility, impulsivity
    - Intense energy; Talks too much
  - Irritability
    - Uncooperative, oppositional, aggressive
  - Elated mood, grandiosity
    - Giggly, reckless, feels superior to teachers
Depression-Specific Deficits

- Psychomotor retardation
  - Slowness, lack of energy, no motivation
- Negativity
  - I’m no good, never will be any good
- Poor concentration
  - Loss of interest, apathetic, flat emotions
- Moody
  - Sad: feels worthless, hopeless, helpless
General Bipolar Deficits

- **Social skill deficits**
  - Misinterpretation of jokes
  - Extreme shyness, irritability, or bullying
  - Peers may reject their bizarre behaviors
  - Perceive hostility in peer’s neutral faces

- **Medication side effects**
  - Fatigue, dry mouth, dizziness, poor bladder control, constipation, weight gain, tremor, diarrhea, drooling, itching, sweating, sedation, poor cognition, etc.

- **Absences (med changes, hospitalizations, etc.)**
Medication Subtypes

- Mood Stabilizers
  - Lithium and anticonvulsants
- Anti-psychotics
  - Second generation (atypical)
- Anti-depressants
  - Mostly SSRI’s
- Stimulants
- Others
Most Common Meds

- Mood Stabilizers
  - Lithium (approved by FDA - ages 12 & up)
    - Lithium carbonate – for mania and depression
  - Anticonvulsant Mood Stabilizers
    - Valproate (Depacote) for mania
    - Carbamazepine (Tegretol) for mania
    - Oxcarbazepine (Trileptal) for mania
    - Topiramate (Topamax) for mania
    - Lamotrigine (Lamictal) for mania
Antipsychotics

- FDA approved, short term, ages 12-17
  - Risperidone (Risperdal)
  - Aripiprazole (Abilify)
- Off Label
  - Olanzapine (Zyprexa)
  - Quetiapine (Seroquel)
  - Ziprasidone (Geodon)
  - Clozapine (Clozaril)
Antidepressants

- Mostly SSRI’s
  - (selective serotonin reuptake inhibitors)
- Floxetine (Prozac)
- Paroxetine (Paxil)
- Escilalopram (Lexapro)
- Citaloprom (Celexa)
- Sertraline (Zoloft)
- Fluvoxamine (Luvox)
Stimulants

- Methylphenidate (Ritalin Metadate, Concerta, Daytrana)
- Dextroamphetamine (Dexedrine, Dextrostat)
- Amphetamine/dextroamphetamine (Adderall)
- Dexmethylphenidate (Focalin)
- Methamphetamine (Desoxyn)
- Lisdexamfetamin (Vyvanse)
- Pemoline (Cylert) not recommended due to liver failure
- Atomoxetine HCL (Straterra)
Others

- Alpha Adrenergic Agonists
  - Clonidine (Catapres)
  - Guanfacine (Tenex)

- Antianxiety Medication
  - Lorazepam (Ativan)
  - Alprazalam (Xanax)
  - Diazepam (Valium)
  - Clonazepam (Klonopin)
School Accommodations Needed

- Medication Side Effects
  - Permanent bathroom pass
    - Thirst issues, gastrointestinal distress
  - Extra fluids/rest after gym
    - Dehydration and overheating common
  - Reduce written assignments
    - Fatigue, hand tremor, and drowsiness issues
  - Seat near door for access to nurse if needed
    - Dizziness, blurring, nausea, rash issues
Psychosocial Interventions

- Interpersonal Social Rhythm Therapy
  - Positive Discipline, don’t try to punish it away
  - Mood and Behavior Diary; sleep/light cycles
  - Adding Structure: routines, rigid schedules
  - Pick your battles; clear rules & Contracting
  - Rebuilding family/school relationships
  - Crisis Plan: suicidal/violent behaviors
  - Stabilizing sleep, light, and activity patterns
  - Building self-esteem and coping skills
- Integrated: Meds, therapy, school
School Accommodations Needed

Social difficulties
- Peer assistant or buddy system
- Social skills training, match face to emotion
- Use social stories, or act out social situations
- Peer education regarding diversity
- Preferential seating – good peer role models
- Regular mental health counseling
- Speech help with “social” communications
  - take turns, monitor peer’s interest in topic
School Accommodations Needed

- Agitation, episodic bad days
  - Schedule routine breaks
  - Extra time between classes
  - Preferential seating near natural light
  - Delay start, reduce demands, on bad days
  - Reduce homework, extend deadlines
  - Extra tutoring after absences
  - Email assignments to parents, if possible
School Accommodations Needed

- Cognitive Impairments
  - Emphasis on sight-words, not phonics
  - More time for exams, and for class-work
  - Visual aids for math, copies of assignments
  - Highlight important material, reduce load
  - Simplified instructions, condensed texts
  - Use of tape recorder, calculator in class
  - Get eye contact when giving directives
School Accommodations Needed

Irritability/Aggression/Meltdowns
- Access to safe place when “ready to blow”
- Seating that allows a “buffer space”
- Resource room near end of day
- Teach anger management
- Teach self-calming techniques
- Less competitive activities (e.g.: yoga)
- Staff supervision in hallways, café, bus
School Accommodations Needed

- Meltdowns in school – See it coming
  - Don’t get in their face, gently redirect
  - Suggest deep breathing, chill out time
  - Keep your cool as kid gets hot tempered

- Crisis management
  - Look for glassy-eyed stare, grit teeth, fists up
  - Rage lasts only 10 minutes if you back off
  - Clear room, allow emotional “seizure”
  - Don’t touch, avoid restraint if possible
Summary

- Bipolar kids may get strong medications
- Bipolar kids may have ADHD/LD
- Bipolar kids may have social deficits
- Multiple medications often used
- These may cause serious side effects
- On top of good days and bad days
- Classroom accommodations are needed
- Crisis management strategy is needed
References
