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# Bipolar Disorder in Children (Including Gifted and 2e Children)

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Ed Malin

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Mentor:
Dr. Sean O'Shea

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## Abstract

Bipolar Disorder in Children (Including Gifted and 2e Children)

Between the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952 and the DSM-IV in 1993, 277 new disorders were created and made available for life-altering diagnoses. Should it be surprising that, since the late 1990s, psychiatrists in the United States have invented the diagnosis of Childhood-onset Bipolar Disorder? Common practice before that time (and still, in Europe) was that 18 was the earliest age of onset for Bipolar Disorder, based on extensive observation and family history. While lithium and anticonvulsants had been in use to treat adults with Bipolar Disorder, by the late 1990s children as young as 2 years old were being diagnosed and treated with drugs which had not been tested on young people. Following several tragic fatalities and an FDA warning on anticonvulsant medications, more psychiatrists backed atypical antipsychotics for the treatment of Childhood-onset Bipolar Disorder. The number of children under 18 being medicated for this condition rose exponentially. The research is often funded by pharmaceutical companies. Although the DSM continues to expand the categories which might catch various symptoms of Bipolar Disorder in adults, the DSM-5 does not include Childhood-onset Bipolar Disorder.

Other scholars cite the work of Kazimierz Dąbrowski and his quest to understand overexcitability as a sign of altruism and evolution. Students who are gifted, or gifted plus one or more disabilities (Twice-Exceptional) might be misdiagnosed with Bipolar Disorder. Educators and psychologists would do well to explore the many situations that resemble Bipolar Disorder as well as non-pharmacological supports.

*Keywords:* bipolar disorder, childhood onset, dual diagnosis, misdiagnosis, medication, twice-exceptionality, Theory of Positive Disintegration

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## 1. Introduction and Rationale

Per the National Institute of Mental Health (2017), Bipolar Disorder (formerly called Manic-Depression) affects 2.8% of U.S. adults 18+ years. The data show even distribution between males (2.9%) and females (2.8%). An estimated 4.4% of U.S. adults experience Bipolar Disorder at some time in their lives. Bipolar Disorder is congenital, and if one parent has Bipolar Disorder, there's a 10% chance that their child will develop the illness. This disorder encompasses alternating mood swings, mania (high) to depression (low). According to the DSM-5 (American Psychiatric Association, 2013), there are three subtypes of this disorder. Bipolar I is a manic-depressive disorder which can exist both with and without psychotic episodes. Bipolar II consists of depressive and manic episodes which alternate, are typically less severe than Bipolar I, and do not inhibit function. Cyclothymia (literally, “circle of moods”) consists of depressive and manic episodes which alternate, are typically less severe than Bipolar I, and do not inhibit function.

Traditional understanding was that the earliest onset for Bipolar Disorder was age 18, and any discussion about Bipolar Disorder in children is relatively recent, stemming from research into ADHD. Indeed, some might argue that children are overdiagnosed or misdiagnosed, and medicated with a variety of substances for which the effects in children are not well studied. Some advocate avoiding medication and managing moods in non-pharmaceutical ways. To add to the complicated debate, some of the signs of Bipolar Disorder may instead be part of the reality of being “gifted and talented”. Or, if we look at children through the lens of Gardner’s (1983) theory of multiple intelligences, asynchronous development of skills could mean that a child is both gifted and has Bipolar Disorder. This type of “Twice-Exceptional” or “2e” child, like much in this introduction, will require thorough investigation later in this paper.

As I outline some of the growing body of research on Bipolar Disorder in children—including gifted and 2e children—I will find it necessary to start with the symptoms, the highs which are occasionally advantages or disadvantages, the lows, and the health risks as seen in adults.

For the expansion to thesis-length, I am delving further into Dąbrowski's Theory of Positive Disintegration (TPD). Dąbrowski, a Polish psychologist who was imprisoned first by the Nazis and then by the Communist regime, believed that symptoms of discomfort and questioning of the state of the world should not be treated as abnormal and taken as cause for punishment. Rather, he theorized that sensitive, somewhat neurotic individuals who questioned themselves and disliked reality might be poised to disintegrate and reintegrate their perspective on a higher level, in which they might be more connected to humanity as a whole. This theory opposes standard developmental theories (such as that of Erikson) which view all individuals as going through the same phases of development. The energized, "overexcitability" of some individuals with Bipolar Disorder may very well be a sign of potential and not of psychosis.

I will continue to review the works of several physicians who believe in the existence of Childhood-onset (pre-pubertal) Bipolar Disorder. Some of these physicians monitor the children of parents with Bipolar Disorder for various symptoms such as excitability, although not necessarily the episodic variety observed in adults. Some state the danger of not medicating these children is simply too great. One of the authors in this category, Mary McDonnell, founded S.T.E.P. Up 4 Kids, an advocacy group which is now defunct. A certain number of young people may indeed be at risk if they are not medicated for Bipolar Disorder, but that population must be evaluated with care. There are also certainly side effects of rushing into taking unnecessary and ineffective medication.

In contrast, I will present the ideas of a dozen or so additional authors who object to rapid diagnosis and medication of young people who present with some symptoms of Bipolar Disorder. It has been pointed out that childhood trauma and abuse leave an impact and may manifest as mania. It has also been noted that the editor of the DSM-IV disavowed the practice of the editor of the DSM-III of adding hundreds of new diagnoses without supporting research. The trend towards adding even more diagnoses, such as Childhood-onset Bipolar Disorder, should be viewed as suspect. Pharmaceutical companies may exert undue influence in many of these trends. Authors in this category include Mel Levine (advocate for differently-wired children) and Daniel Burston (biographer of Erich Fromm and R.D. Laing).

I have also obtained several books written for children about Bipolar Disorder. One was in fact written by someone diagnosed with the condition before sixth grade. Another was written by an adult psychologist with an agenda. I will consult a Bank Street thesis on practical methods to use with students who may have this condition.

Students' access to the arts may help all learners develop empathy and better cooperation as well as elevate the voices of students with Emotional and Behavioral Disorders (EBD), non-verbal students, and many others who wish to have control over their futures.

## 2. History of Bipolar Disorder

### Early observations, Emile Kraepelin

The condition referred to in the DSM since DSM-III (American Psychological Association, 1980) as Bipolar Disorder has been known to scientists for thousands of years, building on the medical theories of Hippocrates (c. 300 BCE) and Galen (c. 150 CE). While depressive/melancholic (i.e. believed to be driven by "*melaina kholé*" or black bile, of the spleen) and manic (passionate, insane) moods were observed as separate conditions, they were eventually observed as alternating in certain adults. As Mondimore (2005, p. 49) relates, the first European physician to write about bipolar symptoms was Soranus of Ephedrus (98-177 CE), who noted "many others consider melancholia a form of the disease of mania". Phillipe Pinel in 1801 observed the "periodic or intermittent" course of manic illnesses. In 1854, Jules Baillanger wrote of "*la folie à double forme*" and Jean-Pierre Falret several weeks later published observations about "*la folie circulaire*".

Emile Kraepelin, acknowledged as the father of many branches of modern psychiatry, wrote in the fourth edition of his *Psychiatry: A Textbook for Students and Physicians* (1893) of melancholia, mania, as well as "periodic mental disturbances," including circular forms of the illness. The sixth edition (1896) mentions "manic-depressive insanity." Important for Kraepelin was that the course of illness, rather than phenomenology alone, determines diagnostic validity. Kraepelin distinguished between Manic-Depressive illness (i.e. Bipolar Disorder) and Dementia Praecox (i.e. Schizophrenia), but postulated a related illness underlying both.

As Burston (2007, p. 111) notes, the average age of onset for Bipolar Disorder during the century after Kraepelin has been 15-45 years old. The illness affects males and females equally, and is present in 0.5-1.5% of the population. In general, this has been understood to be a genetic

condition. Janiri et al. (2014) used the Childhood Trauma Questionnaire (CTQ) to interview adult patients in order to detect traumatic childhood events which may have eventually led to the onset of Bipolar Disorder. Dr. Joseph Goldberg, psychiatrist at the Zucker Hillside Hospital in Glen Oaks, New York has also noted incidence of childhood abuse (Garno, Goldberg, Ramirez & Ritlzer, 2005), in patients with adult-onset Bipolar Disorder.

**Symptoms of Bipolar Disorder in Adults**

Per the National Institute of Mental Health (2017), Bipolar Disorder affects 2.8% of U.S. adults 18+ years. The data shows even distribution between males (2.9%) and females (2.8%). An estimated 4.4% of U.S. adults experience Bipolar Disorder at some time in their lives (Harvard Medical School, 2007). Bipolar Disorder is congenital, and if one parent has Bipolar Disorder, there's a 10% chance that their child will develop the illness. This disorder encompasses alternating mood swings, mania (high) to depression (low). According to the DSM-5 (American Psychological Association, 2013), there are three subtypes of this disorder. Bipolar I is a manic-depressive disorder which can exist both with and without psychotic episodes, or energy, with episodes lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary). Bipolar II consists of depressive and manic episodes which alternate, are typically less severe than Bipolar I, and do not inhibit function. Cyclothymia (literally, “circle of moods”, also known as a “mixed state”), consists of depressive and manic episodes which alternate, are typically less severe than Bipolar I, and do not inhibit function. From 1994’s DSM-IV criteria to those of the DSM-5, a wider scope has been applied, as criteria for the previous episode “are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general

medical condition (e.g., hyperthyroidism)" (Substance Abuse and Mental Health Services Administration, 2016).

From the times of Kraepelin and Theodore Ziehen (Baethge, Glovinsky and Baldessarini, 2004) the traditional understanding was that the earliest onset for Bipolar Disorder was the late teenage years, and any discussion about Bipolar Disorder in children is relatively recent, stemming from research into ADHD. Indeed, some researchers (Webb, Amend, Webb, Goerss, Beljan & Olenchak, 2016) argue that children are overdiagnosed or misdiagnosed, and medicated with a variety of substances for which the effects in children are not well studied.

During episodes of mania, those affected may find it difficult to sleep. They will typically have an excess of energy and focus for tasks of interest and exhibit grandiose thinking. This can be disconcerting for those around them. Due to their increased confidence, those affected may make unexpected business and financial decisions and behave in a comparatively reckless manner, including sexual activity or lewd speech.

Cycles of depression follow, and can be severe in contrast to the above manic states. The amygdala, which is responsible for the perception of emotions such as anger, fear, and sadness, as well as the controlling of aggression, has been observed to function at reduced capacity (Li, et al., 2018). Some people who do not have access to medication will be drawn to alcohol and other substance abuse. 60% are substance abusers (Jamison, 1993). To avoid this part of the cycle, some may attempt suicide.

**Connection to Creativity, Famous People Who Showed Symptoms of Bipolar Disorder**

And yet, if we are to believe extensive written accounts, diaries, paintings and the like, there may be a link between Bipolar Disorder and an artistic temperament. Just a cursory list of famous authors, composers, etc. who are believed to have lived with Bipolar Disorder includes: Emily Dickinson, Virginia Woolf, Ernest Hemingway, Vincent van Gogh, Edgar Allen Poe, Lord Byron, Nikolai Gogol, August Strindberg, Hector Berlioz, Johan Wolfgang von Goethe, Francisco José de Goya y Lucientes, Gaetano Donizetti, Georg Freidrich Händel, Robert Schumann, Gioachino Rossini, John Ruskin, Charles Baudelaire, Gustav Mahler, Delmore Schwartz, F. Scott Fitzgerald, etc. (Jamison, 1993; Janka, 2004). Sadly, many of these famous people perished from suicide or the effects of substance abuse.

Many left behind informative works about the human condition, often including themes and titles involving “melancholy”. Lord Byron famously wrote many poems about frustrated love, and, at the end of his life, volunteered to fight in the Greek War of Independence, where he was killed in 1824. He was 36 years old, and his story shows the great contrast between manic and depressive episodes. ADHD, often comorbid with Bipolar Disorder, has also been observed to have a connection to creative behavior (Cramond, 1994). Later on, I intend to address the positive, mood-regulating effects of artistry and visualization activities for young children. After all, for disorders commonly accepted to occur in children, such as ADHD, non-pharmacological in-school interventions have been proposed (Richardson, et al., 2015).

Missett (2013) examines multiple studies during the 21st Century about a possible link between gifted individuals and Bipolar Disorder. Studies by Santosa et al. (2007), by Andreasen (1987, 2005) and by MacCabe et al. (2010) seem to show a new direction in research that would

support the writing of this paper. In summary, not only creative individuals but also their siblings are likely to have Bipolar Disorder, and academic high achievers are at risk for developing signs of Bipolar Disorder later in life. Santosa found that healthy first-degree relatives of patients also tended to have high creativity scores on the Torrance Test of Creative Thinking, Barron-Welsh Art Scale, Adjective Checklist Creative Personality Scale, sometimes higher than the patients themselves (Santosa, p. 32).

MacCabe et al. (2010) found that participants who earned A grades had a significantly ($p < .05$) higher risk for developing Bipolar Disorder as adults than students with average abilities and academic performance. Karen Cross, in her doctoral thesis (2018) examines in detail the incidence of emotional behavioral disorders in high-ability students and notes that "intelligence is not a risk factor for the onset of EBDs; however, the results did not substantiate the hypothesis that intelligence was a protective factor" (p. 3).

**Medication**

Since 1948, lithium has been used to treat Bipolar Disorder. In the 1940s, Cade identified incidentally that lithium made guinea pigs lethargic, prompting him to administer it to 19 psychiatric patients (10 manic patients, 6 patients with dementia praecox, and 3 melancholics). He found lithium treated the "excitement" symptoms of mania, with no effect on hallucinations, delusions or depression. (Cade, 1949)

Anticonvulsants used to curtail epileptic seizures can help even moods, thus some doctors refer to these medications as "mood stabilizers". Examples are valproic acid (Depakote), carbamazepine (Tegretol) and lamotrigine (Lamictal). In the 20th Century, treatment included antidepressants: fluoxetine (Prozac), which can sometimes trigger a manic

episode, is usually prescribed along with a mood stabilizer or antipsychotic; for example, Symbyax (a combination of the antipsychotic olanzipine (Zyprexa) and the Selective Serotonin Reuptake Inhibitor (SSRI) antidepressant fluoxetine). Antipsychotics such as Zyprexa, Risperdal, Seroquel, Abilify, Geodon, Latuda or Saphris may help.

Olfman reports (2007, p. 6) that, unfortunately, in the decade from 1996-2006, there was a fourfold increase in the number of diagnoses of Childhood-onset Bipolar Disorder. [Other authors write of a fortyfold increase.] The side-effects of the "atypical" antipsychotic and anticonvulsant drugs often prescribed for such children have led to a doubled mortality rate, shortened lifespan, extreme weight gain, and occurrence of type 2 diabetes (Healy and LeNoury, 2007).

## 3. **Postulation of Childhood-onset Bipolar Disorder**

### Geller and Biederman

Childhood-onset Bipolar Disorder was first postulated in two sets of 1995 articles, published in the *Journal of the American Academy of Child and Adolescent Psychiatry* (Biederman et al., 1995, Wozniak et al., 1995) and the *Journal of Affective Disorders* (Geller et al., 1995). One study, funded by Harvard University, was headed by Joseph Biederman, M.D. and Janet Wozniak, M.D. of Massachusetts General Hospital. Another was headed by Barbara Geller at Washington University in St. Louis. These studies started with the common diagnosis of ADHD as well as Conduct Disorder in children and postulated that, instead, these children had some kind of early-onset Bipolar Disorder. Geller et al. (1995) observed symptoms of children 12 years of age and younger and determined that the mean age of onset for mania was $7.9 \pm 2.6$.

Citing disparate research studies from the 1980s (DeLong and Nieman, 1983; Carlson, 1984; Akiskal et al., 1985, Weller et al., 1986; McGlashan, 1988, all cited in Biederman et al., 2003), Wozniak, Biederman, and their colleagues (1995, p.868) reasoned as follows:

> While developmental variations have been accepted in DSM-III, DSM-III-R, and DSM-IV for major depression, no similar accommodations have been made for mania (Cantwell and Carlson, 1983). Unlike adult bipolar patients, manic children are seldom characterized by euphoric mood (Carlson, 1983). Rather, the most common mood disturbance in manic children may be better characterized as irritable, with "affective storms" or prolonged and aggressive temper outbursts (Davis, 1979). For example, one literature review (Carlson, 1983) found that bipolar children under the age of 9 years had more irritability, crying, and psychomotor agitation than older bipolar children, who were more likely to be "classically manic" with euphoria and grandiosity

Wozniak, et al. asserted that some children display short episodic or continuous mania as opposed to mania cycling with depression. They state that in the 1920s, Kraepelin (1921) documented that 4 (0.4%) of 903 manic-depressive patients had onset of symptoms before the age of 10 years. Later research by Levine (1978), Goodwin and Jamison (1990) and Anthony and Scott (1960) reached the same conclusion, according to the authors. Biederman (1995) used the Child Behavior Checklist (CBCL) clinical scale in interviews to identify symptoms of mania in children and asserted that these were distinct from ADHD.

I will reiterate that most other researchers relate that in the century since Kraepelin, the average age of onset of Bipolar Disorder was 15 years and above. Also, while Childhood-onset Bipolar Disorder is not [yet] in the DSM-5, diagnosis of all of the subtypes requires that the subject experience an episode of depression, for example, which lasts for a certain duration (such as one week), alternating with manic episode after a significant amount of time has passed. The idea that young people could be diagnosed with Bipolar Disorder based on observation of rapid cycling of moods during the same day or based on chronic irritability does not fit the current diagnostic criteria.

Biederman stated in an NBC Nightly News interview in May, 1996 that he couldn't understand why child psychiatry was lagging so far behind the adult world in its use of psychiatric drugs. (Diller, 2007, p.32) Biederman has also published a study in which the antipsychotic drugs risperidone (Risperidal) and olanzapine (Zyprexa) were used to treat symptoms of Bipolar Disorder in preschool children (Biederman, 2005). Whitaker (2010, p. 173) notes that Bierderman, "who, during the 1990s, led the way in popularizing juvenile bipolar disorder, received research grants from eight [pharmaceutical] firms, acted as a "consultant" to nine, and served as "speaker" for eight".

Barbara Geller, M.D. described cases of 'ultradian' (i.e. extremely rapid) cycling of mood in children where episodes could occur several times per day. She is co-editor with Melissa P. DelBello, M.D. of the massive volume *Treatment of Bipolar Disorder in Children and Adolescents* (2008). Several other contributors, such as David Miklowitz, Mani Pavuluri, and Janet Wozniak have authored copious works on this topic which are referred to later in this thesis.

**ADHD and Bipolar Disorder**

Some history from 1995 to the present: Joseph Biederman compared the diagnoses of ADHD and Bipolar Disorder and theorized that many people thought to have the former might, in fact, have the latter. Several years later, a feature story in *Time* magazine publicized the growing diagnosis of Bipolar Disorder in youth, alarming many with some consequences of going unmedicated: "Victims have an alcoholism and drug-abuse rate triple that of the rest of the population and a suicide rate that may approach 20%" (Kluger and Song, 2002). A 4000% increase in the diagnosis of Early-onset Bipolar Disorder followed (Gaviria, 2008, Whitaker, 2010, p. 232). *The Bipolar Child by* Papolos and Papolos (1999, 2007, 3rd ed.) is one book that

advocated for this diagnosis. The authors appeared on ABC News's 20/20, the Oprah Winfrey Show, and National Public Radio's "All Things Considered" and "The Infinite Mind," as well as CBS's "Early Show" and The Evening News With Dan Rather to spread their message to the nation, and Dr. Papolos developed online screening instruments for children deemed at risk of Bipolar Disorder.

**FDA Warning and the Rise of Antipsychotics and "Mood Stabilizers"**

Use of antidepressants with such individuals increased dramatically, until in October, 2003 the FDA held hearings and added a stern, black box warning for antidepressant use in children. Unfortunately, a smaller number of young people who actually needed the medication stopped taking it and committed suicide. Psychiatrists then prescribed use of antipsychotics ("atypicals"). While perhaps viewed as a matter of life and death, these medications had never been tested on children. Since then, much research has been done; however, research funded by pharmaceutical companies (which resulted in extended patents and profits) may be suspect. Among the proponents of use of atypicals in children with Bipolar Disorder, Dr. Kiki Chang of Stanford observed a decrease in the size of the amygdala (Gaviria, 2008).

Postulation of the existence of Childhood-onset Bipolar Disorder and growing diagnoses of such conditions followed recent FDA approval of atypical antipsychotic drugs, and the subsequent rebranding of anticonvulsants and antipsychotics as "mood stabilizers" (Olfman, 2007, p. 2). As Whitaker (2019, p. 297) relates, the trials of these drugs in adults in the early 1990s diverged from precedent by not including first-episode patients in placebo groups, as well as taking patients in treatment for psychosis off their medication and assigning them to the

placebo group, where they would likely exhibit symptoms of drug withdrawal and make the newer medication seem like an improvement. The development of olanzapine followed the lapse of patent protection of the older haloperidol (Haldol). While the trials were presented in a manner that suggested olanzapine was more effective than haloperidol, as an SSRI, it carried with it risks of long-term health issues such as weight loss or weight gain and abnormal heart rhythms. It is remarkable that medications for Schizophrenia which were not properly tested in adults were so eagerly prescribed for children. Miklowitz (2007, p. 140) also admits that the trials of Lamictal did not include a placebo group, so the effectiveness of the drug, especially in children, may be called into question. The Afterword to the Revised Edition of Whitaker's *Mad in America* (2019) cites more recent research into false claims from pharmaceutical companies, and shows that medical journals are increasingly questioning the use of antidepressants and antipsychotics. One example is a 2009 article in *The Lancet* entitled "The spurious advance of antipsychotic drug therapy".

From olanzipine (Zyprexa) in 2000 to asenapine (Saphris) in 2015, nine atypical antipsychotic medications have been approved by the FDA for use in treating bipolar disorder. Also, three anticonvulsants have been approved: valproate (Depakote) in 1995, lamotrigine (Lamictal) in 2003 and carbamazepine (marketed as Carbetrol, Epitol, Equetro, Tegretol, Teril) in 2004 (Butler, Urosevic, Desai, et al., 2018).

While the above drugs were tested on adults, use with children began without extensive knowledge of the long-term effects. Even for adults, the FDA trials were not without incident: "Of the 2,500 patients who received olanzapine, twenty died, five killed themselves, and two of the remaining eight deaths from 'aspiration pneumonia' were seen by the FDA reviewers as causally related to olanzapine. Twenty-two percent of the olanzapine patients suffered a 'serious'

adverse event. Two-thirds of the olanzapine patients didn't successfully complete the trials." (Whitaker, 2019, pp. 280-1) Concerning Risperidal, "Studies from McMaster University in Canada, the NIMH, and the University of Pittsburgh demonstrated that even a low dose of risperidone could cause Parkinsonism, akathisia, [muscle quivering and an inability to sit still], and extrapyramidal symptoms [i.e. involuntary muscle control issues]." (Whitaker, 2019, p. 277, 279). Nevertheless, a growing number of medical professionals believe the benefits of such medications outweigh the risk for children whom they believe to have Bipolar Disorder.

**4. Proponents of Childhood-onset Bipolar Disorder**
**Dr. Mani Pavuluri**

Mani Pavuluri, MD, PhD is a proponent of Child-and Family-Focused Cognitive Behavioral Therapy (CFF-CBT) to control "pediatric bipolar disorder" and has co-authored an article on this subject (West, et al., 2014). In his psychiatric practice, Dr. Pavuluri states he has seen many excitable children whom he recommends to be medicated for Bipolar Disorder. As he acknowledges that finding the right medication and dosage is "more an art than a science" (2008, p. 33) and involves "trial and error" (p. 81), he also urges parents not to waste time that could be spent getting children immediate help.

Dr. Pavuluri's innovation is called Rainbow Therapy, which is an acronym for **R**outine to encourage a stable schedule, **A**ffect (mood) regulation and Anger control, "**I** can do it" – positive self-talk to build self-esteem, **N**o Negative thoughts, **B**e a good friend (for your child) and lead a Balanced lifestyle (for you), **O**ptimal problem solving, **W**ays to get support-for the child and the rest of your family. This practice combines medication with lessons for the child and parents/guardians on how to behave towards each other. The conclusion is that CFF-CBT is more effective than psychotherapy as usual at preventing children who are medicated for Bipolar Disorder from dropping out of their treatment.

Dr. Pavuluri, in his book *What Works for Bipolar Kids* (2008), gives his up-to-date observations on various medications. He advises he has observed symptoms of "atypical Bipolar Disorder" (2008, p. 33), which potentially expands the number of patients to be treated. Atypical Bipolar Disorder is marked by mixed states, rapid cycling, and a lack of full recovery between episodes, but does not necessarily include psychotic symptoms such as seeing or hearing things. Because of his belief that young people are prone to rapid cycling of moods, Dr. Pavuluri has developed a Child Mania questionnaire (2008, Ch. 3).

To his credit, Dr. Pavuluri includes chapters which would be of use to any parent of a highly energetic child, such as teaching parents to collaborate with teachers and to share information about the child's special needs. For example, if a child is taking lithium for mania, teachers should be aware that this will make the child require more frequent bathroom breaks (2008, p. 202).

The book contains many references to the Child and Adolescent Bipolar Foundation (CABF) as well as a preface by its Executive Director, Susan Resko. Formed in 1999, this organization maintained the website www.bpkids.org, which is currently not in service.

In contrast, Dr. Pavuluri has continued to advocate for "bipolar disorder in children" and has more recently published *RAINBOW: A Child- and Family-Focused Cognitive-Behavioral Treatment for Pediatric Bipolar Disorder, Clinician Guide (Programs That Work)* (West, Weinsten and Pavuluri, 2017).

**Dr. Janet Wozniak**

After working with Dr. Biederman on the pioneering studies of Childhood-onset Bipolar Disorder, Janet Wozniak continued to author books which were more accessible to the public. In *Positive Parenting for Bipolar Kids: How to Identify, Treat, Manage, and Rise to the Challenge*

(Wozniak and McDowell, 2008), the first few chapters guide parents through the “confusion” they have surely encountered after dealing with the medical establishment. Wozniak and co-author McDowell, executive director of S.T.E.P. Up 4 Kids, are writing for children who have comorbid conditions, i.e. “bipolar plus…. Susie may have ADHD, anxiety disorder, and conduct disorder, which of course need to be addressed, but if Susie’s bipolar disorder isn’t treated first, treatment for the other problems won’t be effective.” (p. 21). This attitude is a shift from the 1996 conclusion that many young children diagnosed with ADHD in fact had Bipolar Disorder instead and nothing else. Citing stories which are composites of many families she has worked with, Wozniak talks about the importance of finding a good doctor, getting to know the realities of a child’s manic behavior including hypersexuality, the appropriate medication (including alternatives such as St. John’s Wort), and effective family routines, including therapy (Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Collaborative Problem Solving, Inter-Personal Therapy), negotiating the Individualized Education Program process (a quote from Susan Resko wishes families fortitude and encourages them to bring snacks to the IEP meeting) and therapeutic boarding schools such as F.L Chamberlain School (p. 198). Sometimes, a child must be reminded that getting his driver’s license is conditioned on taking medication (p. 214). This book further encourages parents to seek out friendly organizations which will steer them towards diagnosing their children with Bipolar Disorder such as CABF and STARFISH Advocacy Association as well as more neutral resources such as neurodiversity advocates All Kinds of Mind, Lindamood Bell Learning Centers, and Reuven Feuerstein’s International Center for the Enhancement of Learning Potential (pp. 287-88).

**David Miklowitz, PhD**

David J. Miklowitz, PhD, is Professor of Psychology and Psychiatry at the University of Colorado, Boulder, and a senior clinical Research Fellow in the Department of Psychiatry at Oxford University, Oxford, United Kingdom. Miklowitz and George, in their book on working with bipolar teens (2007, p. 6), note that the average age of onset of Bipolar Disorder is between 15 and 19, and estimate that 1 in 25 adults, or 4% of the population, has Bipolar Disorder. Chapter 5 cites Pavuluri, et al. (2006) to suggest that complications in pregnancy can increase the likelihood of Childhood-onset Bipolar Disorder. According to the authors' argument for medicating young people (p. 114), prolonged Bipolar illness damages the amygdala and the limbic system, and must be avoided. Because of their focus on medicating young people, Miklowitz and George devote a section—"I can't remember to take my medication" (p. 196)—to teaching patients organizational skills to overcome problems with attention and memory and the equally significant effects on their health that may result. In the aforementioned *Treatment of Bipolar Disorder in Children and Adolescents* edited by Geller and DelBello (2008), Miklowitz, Kimberly Mullen and Kiki Chang wrote about Family-Focused Treatment for Bipolar Disorder in Adolescence.

**Dr. Kiki Chang**

Now a psychiatrist in private practice, Dr, Kiki Chang was at Stanford University School of Medicine from 1996-2017. First through a Child and Adolescent Psychiatry Fellowship and T-32 Research Fellowship and subsequently as Professor of Psychiatry and Behavioral Science, as Director of the Pediatric Bipolar Disorders Program and as Co-Founder of the Stanford Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) Clinic (Chang, 2020), Dr. Chang has spent many years studying mood disorder in young people. In the Frontline episode on Bipolar

Disorder (Gaviria, 2008), Dr. Chang advocated for using medication to help children suspected of having Childhood-onset Bipolar Disorder. The argument presented in those years was that medication was the best way to reduce the size of the amygdala in young people who exhibited signs of extra energy and hyperactivity.

In the 2008 Frontline episode, Dr. Biederman was no longer speaking with the press and his associates recommended the interviewers to speak with Kiki Chang instead. Dr. Chang used MRIs to look at the amygdala and to advocate that medicating children prior to any Bipolar episodes is a possible way to prevent children from developing Bipolar Disorder. Dr. Chang acknowledges that, while pharmaceutical companies often finance drug studies, this also can give the appearance of bias. In 1997, President Clinton authorized 6-month extensions of exclusivity for prescription drugs (a potential $1 billion gain) for pharmaceutical companies which undertook further studies of their drugs on children.

From 2012 onwards, Dr. Chang's interest in PANS (a dramatic – sometimes overnight – onset of neuropsychiatric symptoms including obsessions/compulsions or food restriction; also presenting with symptoms of depression, irritability, and anxiety) came to include Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS). Like PANS patients, PANDAS patients also may suffer from uncontrollable emotions, irritability, anxiety and loss of academic ability and handwriting skills. Although PANDAS was identified as a medical syndrome more than a decade before PANS, it has been classified as a subset of PANS.

**Dr. G. Robert DeLong**

G. Robert DeLong was an advocate of using lithium to treat Bipolar symptoms in young children. His published work on this subject (1978, 1987), preceding much of the explosion of

Childhood-onset Bipolar diagnoses, was followed by articles suggesting that fluoxetine should be used to treat autism in children (1998, 2002). While eager to medicate young people for such conditions, DeLong asserted (1988) that Bipolar Disorder was a genetic condition, and seemed to be linked to autism and Asperger's syndrome.

**Child-Friendly Literature / Link to Pharmaceutical Companies**

While some of the above-mentioned advocates for medication present their findings in scientific journals, there is another form of outreach from the medical establishment to parents of excitable children. Several child-friendly picture books about bipolar disorder have been published by organizations such as the Child and Adolescent Bipolar Foundation (CABF). One of the most colorful such books I read is *Brandon and the Bipolar Bear: A Story for Children with Bipolar Disorder* (2009) by Tracy Anglada, illustrated by Jennifer Taylor and Toby Ferguson. Anglada is the founder and Executive Director of BPChildren. This book is the winner of the About.com 2011 Reader's Choice Award for Favorite Special-Needs Children's Book. Countless families have enjoyed the story of a stuffed bear which helps young Brandon control his moods until his psychiatrist can determine what medication he needs. Indeed, Brandon is highly energetic and cannot sleep. When he gets angry and harms his bear, he is willing to listen to what the adults have to say. After telling Brandon that he, like many famous artists, has Bipolar Disorder, his doctor advises him that after being medicated he will receive more help from his therapist, and will get additional evaluations and accommodations in school.

Anglada's book, *Intense Minds Through the Eyes of Young People with Bipolar Disorder*, (2011) has been used in the curriculum at the Harvard Graduate School of Education. She has also written *Turbo Max: A Story for Siblings and Friends of Children with Bipolar Disorder*,

(2008) illustrated by Deirdre Baxendale. Such colorful, accessible books easily guide parents concerned about their children into various therapeutic and pharmaceutical remedies.

However, on what medical research basis are these books based? How does an adult give unbiased, scientific accounts "through the eyes of young people with bipolar disorder"? In *Intense Minds*, Anglada advises readers that she, as a parent of a child with Bipolar Disorder, was motivated to collect stories from adults who were diagnosed with Bipolar Disorder during adolescence. Ironically, these accounts are consistent with the traditional view of the age of onset. The accounts include an exhortation to consult with a qualified doctor and to follow their advice. Most accounts use only a first-name alias, and the section on sexual behavior during manic episodes does not include any names whatsoever. On the BPChildren.com website (not dated, ¶ 1), it is noted:

> The BPChildren website is not a medical site but a resource/support site for families struggling to deal with bipolar disorder. We strive for accuracy when touching on medical matters and refer our readers to reliable sources. The field of bipolar disorder and mental health in children is one that has gone through many changes over the past decade, and will likely go through many more, as researchers continue to make advances in genetics and brain functioning. We endeavor to keep up with these changes including revising books and articles to reflect current knowledge. BPChildren collaborates with a variety of support organizations and medical professionals.

Healy & LeNoury (2007) note that the support the child characters receive comes after diagnosis. The schools do not provide testing or any support beforehand. He also notes that several of Anglada's books have glowing dust-jacket recommendations from Papolos and Papolos. One might see these books used as tools by psychiatrists who want to reassure young patients that their mood disorders are treatable.

Lionel Lowry IV has written a series of illustrated books for young people who may see controlling their feelings as their superpower. In 2016, he wrote and illustrated *Super Emotions!*

*A Book for Bipolar Children*. As in the companion volume for children with ADHD, a masked child learns to feel proud of taking deep breaths and listening to his doctor. The book has bright pictures and is geared towards grades K-2.

Another illustrated book of this type is *What it's like to be Bipolar* (2016), written by Andrew Publicover. This book is of note because Publicover wrote, illustrated and published it when he himself was an adolescent recently diagnosed with bipolar disorder. Frank illustrations show the kind of intense moods Publicover experienced. After explaining that he experienced a three-month episode of depression during his sixth grade year, Publicover makes a case for medication as a means to regulate his moods. Age 12 is closer to the originally-established age of onset of Bipolar Disorder.

This book is a personal account of Publicover's experiences. Somewhat out of place is a preface page written in another voice, though this is not credited to the author or to anyone else:

> Andrew…has since gone on to college…But this book is not about Andrew, his life, or anything to do with treatment of Bipolar Disorder. It is about YOU - or your child, your student or your patient – who may be struggling with the same condition….If you are an adult who knows a child with Bipolar Disorder, we hope you can gain insight from this book…

Given that educators, who can spend more time with students than their families, are a significant part of the process of observing and diagnosing mood disorders, I searched for a relevant Bank Street thesis and read Vicki Wolffe's *Childhood Mental Illness: Schizophrenia and Bipolar Disorder* (2009). Wolffe (pp. 18-22) cites recent research (Bardick and Bernes, 2005) which implied that symptoms such as decreased (or, paradoxically, increased) sleeping, bossy behavior in school and social withdrawal all point towards a diagnosis of Childhood-onset Bipolar Disorder instead of ADHD, Oppositional Defiant Disorder, etc. Without citing the source research, Wolffe notes (p. 20):

> ”Studies of adults with bipolar disorder reveal that those with onset prior to adulthood, particularly prior to adolescence, tend to present with a more pernicious disease, as has been learned of individuals with schizophrenia. Characteristics include longer illness duration, more chronic courses, as well as an increase of bipolar disorder along with other psychiatric disorders. Childhood-onset Bipolar Disorder is linked to lower recovery rates, increased mixed/rapid cycling episodes and more altered symptoms and polarity than those whose illness began during, or post puberty and adulthood. Some research suggests that childhood-onset bipolar disorder may reflect elevated rates for familial bipolar disorder and/or other disorders.”

While researching my thesis, I have not seen similar conclusions, and have repeatedly seen research that Bipolar Disorder is a familiar condition with onset in adolescence. I have not seen much scholarship that confirms Wolffe’s assertion (apparently according to Rende at al., 2007) that those with Bipolar Disorder “are likely to have lower socioeconomic status” (p. 20). I can agree with Wollfe’s conclusion (p. 21) that not enough research has been done on pharmacological treatment of children diagnosed with bipolar disorder.

## 5. **Opponents of Childhood-onset Bipolar Disorder**

### Background on Bipolar Disorder in the DSM

Several of the sources referenced in this thesis were written by MDs and PhDs who are critical of the sharp increase in medication prescribed for children believed to have Bipolar Disorder. In general, these professionals evidence an appreciation for, if not an advocacy of, the primacy of psychoanalysis. Was it not true that, when psychoanalysis held sway in the medical community, diagnoses of Bipolar Disorder were not very common and were limited to patients with a family history of the condition? Indeed, wasn’t there only one type of Bipolar Disorder in the first few editions of the DSM? What changed in the latter part of the 20th Century?

Alix Spiegel is a science reporter and frequent contributor to NPR. According to Spiegel's article *The Dictionary of Disorder* (2005), the turning point was the 1980 publication of the DSM-III. The editor of the DSM-III and the DSM-III-R (published in 1987), Robert Spitzer, was described by Allen Frances –editor of the subsequent DSM-IV (published in 1994)—as having invented hundreds of diagnoses; "Bob never met a new diagnosis he didn't at least get interested in" (Spiegel, 2005, p. 59). While the presence of the expanded DSM helped psychiatrists improve reliability of their diagnoses, get paid by insurance companies, and find uses for the many pharmaceuticals not yet living up to their potential (the antipsychotic Thorazine belonged to a class of compounds called phenothiazines developed in the late 1800s for use as synthetic dyes, which were then used as insecticides and for killing swine parasites, before in the 1940s they were considered for use as medication (Whitaker, 2010, p. 142), those who knew Spitzer speak of him making up new illnesses and bouncing these ideas off others for approval.

The DSM-II (published in 1968), at one hundred fifty wire-bound pages in length, covered about one hundred mental disorders. The DSM-IV described in Spiegel's article is nine hundred pages in length and covers approximately three hundred mental illnesses (p. 56). What of Spitzer, the man who, despite giving the green light to treatment of so many new conditions such as Autism, Attention Deficit Disorder and Post Traumatic Stress Disorder, also ensured that homosexuality was no longer viewed by the American Psychological Association as an illness and was removed from subsequent printings of the DSM?

Did this evolution of diagnoses make it easier to postulate Childhood onset Bipolar Disorder based on chronic irritability? Aides to Spitzer describe a short meeting in 1974 with experts on a new condition, which he decided should be divided into two new disorders,

factitious disorder and brief reactive psychosis. Spitzer asked for a typewriter and began to draft the language for the two new disorders, which appeared in the DSM-III (p. 59).

Because psychiatrists viewed the DSM III (1980) as having finally established reliable diagnoses based on some research, it changed the course of the profession.The shift to observing and attempting to treat symptoms as opposed to underlying causes of disease became that much more prevalent in the U.S.A.

In the DSM-III-R (1987), further improvement was made to the diagnosis of Bipolar depression as research about mood disorders and disorders of childhood and adolescence were added. Hence, this was the first time that Bipolar diagnoses were supplemented with subtyped classifications such as Bipolar Disorder-Mixed, Bipolar Disorder-Manic, Bipolar Disorder-Depressed, Bipolar Disorder-Not Otherwise Specified, and Cyclothymia.

DSM-III mentions Bipolar II, but the DSM-IV (1994) further expanded the subtypes of Bipolar Disorder. More adults were likely to meet the expanded, catch-all diagnostic criteria. By the 1990s, Whitaker (2010, Chapter 9) notes that 1 in 40 (or perhaps even 1 in 20) adults were estimated to have a form of Bipolar Disorder. Changing diagnostic criteria for Bipolar Disorder require only episodes of mania or depression but not both, indeed a change from the former designation “Manic-Depressive Disorder”. According to Renk, White, Lauer, McSwiggan, Puff & Lowell (2014, p. 3):

> In the DSM-5, symptoms of mixed episodes now are replaced with a mixed features specifier (a specifier that can be used with any of the mood episodes). This specifier is used when individuals experience full criteria for a manic episode and three symptoms of a depressive episode or when individuals experience full criteria for a depressive episode and three symptoms of a manic episode. This adaptation (i.e., the mixed features specifier) may allow for easier diagnosis in children.

**Sharna Olfman, David Healy, Daniel Burston, Robert Whitaker, Stringaris et al**

Sharna Olfman is currently Professor of Clinical Developmental Psychology at Point Park, was the Founding Director of the Childhood and Society Symposium from 2001-2008, and edited the *Childhood in America* series for Praeger. This series includes intriguing titles such as *No Child Left Different* (2006, Foreword by Mel Levine), *Bipolar Children: Cutting-Edge Controversy, Insights and Research* (2007), and *Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It* (2012). These anthology volumes and the work of their authors such as David Healy, Daniel Burston, and Robert Whitaker stand in opposition to the message of *Treatment of Bipolar Disorder in Children and Adolescents* (2008). Olfman (2007, p. 5) notes with alarm that the American Academy of Child and Adolescent Psychology (AACAP) issued guidelines that same year that childhood onset bipolar disorder could be captured under the category Bipolar Disorder Not Otherwise Specified found in the DSM-III-R and onward. The fact that two of the authors of those guidelines, including Robert McClellan and Robert Kowatch (also co-editor of *Pediatric Bipolar Disorder: A Handbook for Clinicians* in 2002) received grants from or consulted with 16 pharmaceutical corporations struck Olfman and David Healy as a conflict of interest.

David Healy is former Secretary of the British Association of Psychopharmacology. His advocacy, and his published work, such as *Let Them Eat Prozac* led to a ban on use of SSRIs in the United Kingdom. Healy's work also led to the 2003 US FDA black box warning on SSRI antidepressant use in children and adolescents. His focus on drug trials has highlighted the rebranding of powerful sedatives as "mood stabilizers" for use in the treatment of Schizophrenia and now Childhood-onset Bipolar Disorder. Use of these drugs may mute some of the symptoms, but does nothing to address any underlying causes (Healy and LeNoury, 2007).

Daniel Burston chairs the Department of Psychology at Duquesne University. He has published studies of Erik Erikson, R.D. Laing and Erich Fromm. Arguably the connecting factor in his previous scholarship is the learning of self-reliance. Erik Erikson theorized that all individuals pass through the same stages of development, building on learned competencies. R.D. Laing, amid the counterculture of the 1960s, advocated against psychiatry's equation of normalcy with mental health. Erich Fromm found an existential path to morality and self-actualization in contrast to the eugenics practices of contemporary authoritarian regimes. Burston's writings call into question the social stigma and health risks such as diabetes that come from labeling young children with psychological disorders and immediately medicating them. Indicting the increasing emphasis from the DSM-III onward of treating symptoms instead of giving credence to psychoanalysis (which would effectively identify those who truly have such disorders), Burston (2007), as well as Parry and Levin (2012), rail against the era of "Mindless Psychiatry" which, they feel, continues to diverge from the work of Kraepelin.

Robert Whitaker also goes back to the work of Kraepelin, who had assumed an underlying relationship between Schizophrenia and Bipolar Disorder. In his engrossing studies of the industry such as *Mad in America* (2019), and *Anatomy of an Epidemic* (2010), Whitaker questions whether the antipsychotics now being used to treat very young people suspected of having Bipolar Disorder were even properly tested before they were approved to treat Schizophrenia. By extension, Whitaker states that pharmaceutical corporations are claiming that all of these medications are effective in addressing a "chemical imbalance", such as an excess of dopamine or serotonin, which was claimed to cause Schizophrenia. Unfortunately, Whitaker states (2007, pp. 51-3), the individuals treated did not have any chemical imbalance until after they were treated with these medications, and that the use of these drugs is not a cure but a

pathway to making people psych patients for life. As proof, he cites Social Security Disability (SSDI) and Supplemental Security Income (SSI) payments to show that the number of disabled mentally ill has increased nearly sixfold between the introduction of Thorazine in the 1950s and 2000.

Whitaker (2007) challenges Geller and Biederman's conclusion that many children originally diagnosed with ADHD will benefit from being treated for Childhood-onset Bipolar Disorder instead. Why, he asks, would young people be observed to have ultra rapid mood cycling, especially when this phenomenon was not observed on such a large scale during the preceding century? Whitaker proposes that the use of Ritalin has caused formerly healthy brains to present with cycles of moods which may partially resemble Bipolar Disorder only because of the dangerous and unhelpful treatment they have already received. (Ironically similar to Whitaker's conclusion, DelBello et al. (2001) concluded that Bipolar adolescents with a history of stimulant exposure (including Ritalin) prior to the onset of Bipolar Disorder had an earlier age at onset of Bipolar Disorder than those without prior stimulant exposure.) Again, the transition from the DSM-III to the DSM-III-R not only included Bipolar Disorder subtypes but also broadened ADD to the more inclusive ADHD. The pharmaceutical companies may indeed profit from trying to medicate so many children, and may still reluctantly acknowledge the inefficacy of treatment, as they eventually acknowledged that SSRI use had exacerbated mania symptoms for many. Whitaker (2010, p. 240) cites more research that again singles out U.S. psychiatrists:

> In 2001, Dutch researchers reported that although 39 percent of U.S. adolescents with a bipolar parent develop bipolar disorder before age twenty, only 4 percent of Dutch children do. Thus, U.S. children in this at-risk group were *ten times* more likely to develop juvenile bipolar disorder than their Dutch counterparts, and the researchers concluded that this "huge difference" was likely due to "the much higher use of stimulants as well as antidepressants by U.S. children" (Reichart, Nolen, Wals, et al., 2002).

Some have pointed out that the increased diagnosis of Bipolar Disorder in children is a phenomenon limited to the United States of America (Harrington and Myattl, 2003; Carlson and Klein, 2014; Duffy, Dubicka, et. al, 2020). Parry, Allison, & Bastiampillai (2018) have reported that rates of pediatric Bipolar Disorder are lower than others would think, and re-examined the results of an often-cited meta-analyis (Van Meter, Moreira, & Youngstrom, 2011) of six U.S. studies and six non-U.S. studies of symptoms of Bipolar Disorder in children aged 7-21. They found that a Dutch study (reanalyzed as showing a 0% instance of symptoms of Bipolar Disorder in children) was one of several in the group showing a lower instance than the 1.7% in the U.S. and the stated global average of 1.8%.

Grimmer, Hohmann, & Poustka, researchers based in Germany and Austria, observed (2014, ¶ 4):

> Over the last 20 years, the prevalence of bipolar disorder in children has risen rapidly in the United States (from 0.42% [n = 25] in 1994 to 6.7% [n = 1003] in 2003), while the overall incidence of a bipolar diagnosis in children in Germany and other European countries has remained low.

The authors cite Duffy (2012): “childhood anxiety and depressive disorders are typical precursors of a later onset of bipolar disorder while, contrary to previous assumptions, easy annoyance, temper tantrums and ADHD symptoms are not.” The authors concluded: “So far, most findings suggest that the suspected symptoms, in particular chronic, non-episodic irritability (a mood symptom presenting with easy annoyance, temper tantrums and anger) do not constitute a developmental presentation of childhood bipolar disorder.”

Stringaris et al. (2010) inquired into whether children who displayed symptoms of non-episodic irritability—the authors use Leibenluft’s (2003) term “Severe Mood Dysregulation” (SMD)—went on to develop hypomania, as compared with the classic Bipolar Disorder. The

authors conducted a longitudinal follow-up study of a clinic sample of youth with SMD and narrowly defined BD to answer an important question related to the pediatric BD debate—namely, whether children commonly evolve from a phenotype characterized by severe, non episodic irritability to a more classic presentation of BD by developing distinct episodes of (hypo-)mania. They found that (hypo-)manic or mixed episodes were significantly less likely to occur in youth with SMD compared with BD. Only one of 84 SMD subjects manifested an episode of (hypo-)mania at follow-up. (As of 2020, Leibenluft's position is still clear from articles such as "Chronic irritability in children is not pediatric bipolar disorder: Implications for treatment".)

**Comorbidity**

According to proponents of Childhood-onset Bipolar Disorder cited in Section 4 above, children with Bipolar Disorder are known to suffer from several comorbidities, most frequently ADHD, anxiety disorders, Oppositional Defiant Disorder (ODD) or conduct disorder in adolescents. ADHD has been discussed above. According to Whitaker (2010, Chapter 11), while this condition appeared in the DSM for the first time in 1980 as ADD and was revised to the more inclusive ADHD in 1987, scientists had documented hyperactive tendencies in school children from the 1920s onward. In the 1930s, the first treatment proposed was the amphetamine benzedrine. In the 1950s, Ritalin was brought to market as a safer alternative, and prescription of this drug increased through the 1970s. The advocacy group Children and Adults with Attention Deficit Hyperactivity Disorder (CHADD) is partially funded by Ciba-Geigy Pharmaceuticals, makers of Ritalin. Because CHADD lobbied Congress to include ADHD as a covered disability under the Individuals with Disabilities Education Act (IDEA), many more students could be diagnosed with ADHD and would therefore need medication. Most of the

authors in Section 5 above, who are trained medical doctors and therapists, see the marketing of medications to young people based on research and legislation financed by drug companies as a conflict of interest. See also: Robbins, B.D., Higgins, M., Fisher, M., & Over, K. (2011).

**Hypoglycemia**

Webb et al. (2016), in their intriguing book about various types of misdiagnosis of mood disorders, advise that hypoglycemia should be investigated first as a cause of rapid mood swings in children (p. 237-40). Indeed, a child's need for a snack is a simple explanation for behavior which, the authors warn, might otherwise result in a diagnosis of Childhood-onset Bipolar Disorder. That unnecessary, perhaps too-eager diagnosis should be avoided and teachers, parents and other responsible adults should examine all the causes of the child's behavior.

**Gifted Children and Overexcitability**

Students who have been determined to be gifted (through standardized tests and other factors) have educational pros such as elevated energy levels and pattern recognition, as well as relative cons, such as perfectionism and sensitivity to all sorts of injustice in the world. Again, as Gardner (1983) observed, development can be uneven and gifted children's emotional and social development may be at a level below their cognitive development. For the benefit of students and teachers, it would be very helpful to determine if a student is gifted rather than living with Bipolar Disorder. Editors Susan Daniels and Michael Piechowski collect many accounts of identifying and working with gifted students in *Living with intensity: Understanding the excitability, sensitivity, and emotional development of gifted children, adolescents, and adults* (2008). For Piechowski, one focus of working with gifted students is Dąbrowski's overexcitabilities: psychomotor, sensual, emotional, intellectual, and

imaginational (Webb, et al., 2006; Daniels and Piechowski, 2008). Students who are so motivated they have a hard time sitting still may stand out, and may be confused with students who have ADHD. Students who feel they must thoroughly research an assignment may stay up all night reading books. A gifted child's extreme interest in a topic or project and inability to keep calm can confound teachers. Instead of throwing such students (and this includes children not yet identified as gifted) into a lifetime of medication, Webb et al. call for in-depth inquiries into alternative educational activities which match a student's learning preference.

**6. Dąbrowski's Theory of Positive Disintegration (TPD)**

**Individual Conscience in Opposition to Fascist and Communist Oppression**

In *The Bipolar Teen*, Miklowitz and George (2007, p. 103) observe a certain connection between gifted students and those with Bipolar Disorder, something which merits more research. Fortunately, much research has already been done, and as we have touched on issues related to moods in gifted children, it is important to review the work of Polish psychologist Kazimierz Dąbrowski (1902-1980). The individualistic philosophy of Dąbrowski may stem from his repeated imprisonment, first by the Nazis and later by the Communist Polish government. In contrast to theorists such as Erikson and Piaget, Dąbrowski observed that some exceptional youth go through stages of development at their own pace, and occasionally reach higher stages of moral consciousness.

In studying Polish youth, Dąbrowski observed that a person who is sensitive to injustice in this world may express their desire for change through one of five "overexcitabilities": psychomotor, sensual, emotional, intellectual, and imaginational. As is often true of gifted children, these individuals may have little patience for age-peers who are not interested in learning and who lack commitment to working on group tasks. However, should the state

(especially the oppressive regimes of Dąbrowski's day) demonize those who have too much energy and/or those who question the established order?

**Anxiety and Altruism**

Dąbrowski's Theory of Positive Disintegration is a five-stage process in which he examines how it may be reasonable, healthy and even progressive to go through phases of self-doubt, anxiety and non-linear development. (Dąbrowski, 1964). Dąbrowski describes a certain amount of neurosis as a sign that an individual is not comfortable with a status quo which does not match their ideals. This person may dismantle their own schemata ("disintegrate") and work to build a new, stronger personality. Thus, according to Dąbrowski, "mental illness" is not always something to be treated or kept out of the public view. Such views were not popular with regimes that espoused eugenics and conformity, nor would they fit in well with policies in the United States which led to the institutionalization and forced sterilization of certain categories of people.

Dąbrowski's first stage is Primary Integration, characterized by average, selfish behavior common to ordinary people and psychopaths alike. Unilevel Disintegration is a time of personal crisis of values, which will either lead upward to more positive developments or backwards to self-destruction. Spontaneous Multilevel Disintegration is a stage where a person sees the world differently, and experiences elevated ideals leading them to undertake a moral commitment to better society. Directed Multilevel Disintegration replaces the "spontaneous" nature of the previous stage with purposeful, authentic choices to work for justice. Secondary Integration is a self-actualized state of achievement, often in artistic fields.

**Dąbrowski on Mental Health**

As noted, a major advocate for the application of Dąbrowski's writings to the field of gifted education is Michael M. Piechowski, PhD. Originally from Poznan, Poland, Piechowski worked with Dąbrowski for 8 years.

Perhaps it is fitting that more of Dąbrowski's untranslated writings have been evaluated by Elizabeth Mika, who is also of Polish background. Mika (2008) notes that in the course of her studies she encountered one of the last works of Dąbrowski's published in Poland, *W Poszukiwaniu Zdrowia Psychiczniego* [*In Search of Mental Health*]. The overexcitabilities are an example of mental states which are not in themselves unhealthy, and which show that new and different diagnostic labels do not necessarily enrich our knowledge of the etiology, phenomenology, and teleology of conditions considered as mental disorders specifically, and of human psychological psychological suffering in general (Andreasen, 2007, p.141). Instead of viewing mental health as the absence of mental illness, Dąbrowski here focuses on several other metrics as he critiques societal expectations.

Mental Health as a State of Psychological Integration: "keeping it together" is often seen as the key to functioning in society. However, Dąbrowski posits that overexcitability, disintegration and developmental asynchrony may bring an individual to a greater level of maturity. Creative persons disparaged as naïve, sensitive and immature may indeed perceive themselves as maladjusted. Inner conflict, including moods which may indicate bipolar disorder or be mistaken for it, may be at odds with psychological integration.

Mental Health as Realism in Perceptions and Thoughts, Effectiveness and Productivity, and Ability to Adjust to Reality: in contrast to the views of Maslow, Dąbrowski theorized that lack of realism may sometimes be the key to extraordinary thoughts and creations. Further,

realism may be equated with conformity to the norms of an oppressive regime, in other words, not an effective mindset for creating authentic art.

Mental Health as Psychological Equilibrium: is a “golden mean” of physical wellbeing the same as mental health? This view does not support working through conflict, depression, anxiety and more as means to moral growth. Physical and mental progress cannot be measured the same way. The Who once sang, “Sickness will surely take the mind where minds can’t usually go.”

Mental Health as Physical, Mental, and Social Well-Being: Dąbrowski here suggests that pain, suffering, loss, grief and more, characterize authentic human experience and can be opportunities to learn and grow. Therefore, avoiding and demonizing such necessary parts of life cannot constitute a model of mental health.

In summary, mental health is dynamic, not a state but a process.…mental health is “the capacity for development toward multidimensional understanding, experiencing, discovering, and creating ever higher hierarchy of reality and values up to the concrete individual and social ideal” (2008, p. 150). Admittedly, only a small number of people would qualify as mentally healthy under this view.

As I will discuss in the next section, there are certainly students who are gifted and also have other exceptionalities. Probst, writing in the *2e Newsletter* (2007) believes that typical symptoms of behavioral disorders “that stem from unusual intensity, sensitivity or eccentricity…aren’t pathological at all.” Certainly, Webb, Amend, Webb, Goerss, Beljan & Olenchak. (2016, p. 77) caution educators and psychologists to distinguish between characteristics of gifted students and students who have a condition such as Bipolar Disorder or ADHD. In the case of ADHD, these authors include a concise comparison chart:

| Behaviors Associated with ADHD | Behaviors Associated with Giftedness |
|---|---|
| (Barkley, 2006; Hinshaw & Ellison, 2016) | (Webb, 1993) |
| Poorly sustained attention in almost all situations. | Poor attention, boredom, daydreaming in specific situations. |
| Diminished persistence on tasks not having immediate Consequences. | Low tolerance for persistence on tasks that seems irrelevant. |
| Impulsivity, poor ability to delay gratification. | Judgment lags behind intellect. |
| Impaired adherence to commands to regulate or inhibit behavior in social contexts. | Intensity may lead to power struggles with authorities. |
| More active, restless than normal children. | High activity level; may need less sleep; psychomotor OE |
| Difficulty adhering to rules and regulations. | Questions rules, customs and traditions. |

## 7. Twice-Exceptional Students

### Definitions and Academic Supports

In some cases, a gifted child also has a condition such as Autism Spectrum Disorder or ADHD which “cancels out” or “masks” the progress they are making in certain academic areas (Baum, 1989, Eide and Eide, 2006). Giftedness can coexist with any of the 14 disabilities identified by IDEA (with the exception of intellectual disability) (Reis, Baum and Burke, 2014). Students who are ultimately identified with two or more such characteristics are referred to as Twice-Exceptional (2e). Twice-Exceptional students can be assessed by various traditional and non-traditional means, and have been shown to regularly produce great achievements in the arts (Baum and Owen, 2004, West, 1991, Cramond, 1994). If we observe that Alfred Binet’s concept of Intelligence Scales was used by Lewis Terman to create the intentionally elitist (and also

racist) Stanford-Binet test, we must acknowledge that teachers may not always be able to detect signs of giftedness in students purely through use of traditional tests. While educators such as Leta Hollingworth (1923) may have defied Terman's views to acknowledge the coexistence of high ability in one or more subjects with disability, and Hans Asperger's research on the syndrome that bore his name certainly focused on "high functioning" individuals (Kaufman, 2018), for decades there was not much consensus on Twice-Exceptionality. Without a practical definition to aid in identifying such students, it proved hard for many to receive the services they needed. Brody and Mills (1997) noted: "When the Association for Children and Adults with Learning Disabilities (1985) proposed a definition that specifically included the phrase "average and superior intelligence" occurring concomitantly with the disability, the door was opened wider for recognition of children with disabilities who are gifted." The increased complexity of identifying and helping students comes through in the titles of articles such as "The Alphabet Children: GT, ADHD and More" (Baum and Olenchak, 2002), in which it is noted that giving a child ADHD and other additional diagnoses creates what the authors call an "alphabet child" whose needs are still not served by the school, since "mistaking attention disorders for giftedness and vice versa is entirely conceivable". Baum and Olenchak (2002, p. 83) provide a chart to illustrate how behaviors may be interpreted in different ways. For example, diminished ability to listen attentively can be interpreted in terms of ADHD (from the APA), Learning Disability (Baum, Nixon and Owen), Creativity (Cramond, Renzulli et al.), Giftedness (Piechowski, Renzulli, Silverman) and Contemporary Theories of Intelligence (Gardner, Sternberg).

To give effective accommodations to 2e students, the authors recommend that assessments be conducted by educators and psychiatric professionals familiar with the characteristics of both giftedness and LD, which may mean two separate assessors. Besnoy (2018, p. 178) notes that

the talents of 2e students may be displayed through analytic, creative and/or contextual ways, per Sternberg's (1985) triarchic theory of intelligence.

Olenchak (2009) studied successful interventions for students identified as 2e. These are found to be most effective when strength-based. Many 2e students are already lacking in self-esteem and do not want easy, low-challenge work. Talents Unlimited (Schlichter, 2009) is shown to be an effective intervention because, like Gardner's theory of multiple intelligences and Sternberg's triarchic theory of intelligence, it views the student's creative methods of expressing understanding of class content as valid. Therefore, despite any asynchronous development in skills heavily weighted in traditional, logic-based testing, the progress of 2e students can be assessed and the students can be taught thinking skills in 5 areas: productive thinking, decision making, planning, forecasting and communication. Indeed, the idea of Dual Differentiation (Baum, Cooper and Neu, 2001) implies that more intensive efforts are required in order to meet the needs of students who may benefit from various interventions appropriate to each of their exceptionalities. The following are some recommendations for differentiating classwork:

Table 1
*Fundamentals of the Dually-Differentiated Curriculum*

| Problems associated with special-needs students | Characteristics of gifted students | Curricular accommodations |
|---|---|---|
| Limited skills in reading and math | Propensity for advanced-level content to accommodate the gift or talent | Alternate means to access information |
| Difficulty with spelling and handwriting | Need to communicate creative ideas and knowledge | Alternate ways to express ideas and create products |
| Language deficits in verbal communication and conceptualization | Facility with and enjoyment of abstract concepts | Visual and kinesthetic experiences to convey abstract ideas concretely |
| Poor organization | Often demonstrate creative nonlinear styles of thinking and learning | Visual organization schemes, e.g., time lines, flow charts, webbing |
| Problems with sustaining attention and focus | Need for intellectual challenges based on individual talents and interests | Interest-based authentic curriculum |
| Inappropriate social interaction | Need to identify with others of similar talents and interests | Group identity based on talent or ability |
| Low self-efficacy and esteem | Heightened sensitivity to failure | Recognition for accomplishment |

Arguably the most pragmatic effort to help 2e students obtain services came in 2014 with Reis, Baum and Burke's article *An Operational Definition of Twice Exceptional Learners*. As many of the authors in this field note, since symptoms for various conditions may overlap, simply looking at symptoms a student exhibits may result in a misdiagnosis. Goerss, Amend, et al. (2006) suggest that, although some gifted students do also have ADHD and other disorders, the rate of misdiagnosis is high, up to 96% for Bipolar Disorder. Reis, Baum and Burke (2014) include a chart to help educators understand how for some students several comorbid conditions might apply:

**Table 1.** Sample Characteristics for Diverse Twice-Exceptional Students.

| | Attention deficit/hyperactivity disorder | Specific learning disabilities | Autism spectrum disorder (Asperger type |
|---|---|---|---|
| Academic difficulties | • Difficulty beginning, listening to, or completing tasks, as well as expressing ideas in writing<br>• Strengths in critical and creative thinking<br>• Preference for spatial tasks | • Verbal precocity but poor reading; confusion about similar letters and words<br>• Dysgraphic<br>• Dyslexic<br>• Dyscalculia<br>• Problems with short-term memory<br>• Strengths in critical and creative thinking<br>• Knowledgeable about specific areas<br>• Preference for spatial tasks | • Appropriate cognitive development with no delay in language<br>• Difficulty with abstract concepts or with tasks that involve critical and creative thinking<br>• Preference for spatial tasks<br>• Preoccupation with one or more stereotyped and restricted patterns of interests that is abnormal in either intensity or focus |
| Attention Issues | • Fidgets, squirms, is restless<br>• Difficulty remaining seated<br>• Easily distracted | • Short attention span, easily distracted<br>• Overactive, inactive, or listless | |
| Organizational issues | • Difficulty following directions and finishing tasks | • Difficulty understanding or following directions<br>• Difficulty in expressing or organizing thoughts verbally or in writing<br>• Difficulty functioning when there is no structure or predictability (nonverbal learning disability) | • Apparently inflexible adherence to specific nonfunctional routines or rituals<br>• Stereotypical or repetitive motor mannerisms<br>• Persistent preoccupation with parts of objects |
| Social issues | • Difficulty in understanding social contexts | • Problems reading the social context (nonverbal learning disability) | • Quantitative impairment in social interactions (manifests at least 2)<br>• Lack of nonverbal behaviors<br>• Failure to develop peer relationships<br>• Lack of spontaneous sharing of interests, joy, or achievement<br>• Lack of social or emotional reciprocity |
| Behavioral issues | • Often interrupts or intrudes on others | • Clumsy | • Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities |
| Impulsivity | • Often engages in physically dangerous activities without considering possible consequences—not for purpose of thrill seeking (e.g., runs into street without looking) | • Impulsivity and inability to foresee consequences | |
| Emotional volatility | • Blurts out answers to questions | • Oppositional and defiant as a coping skill | • Emotional fragility<br>• Clinical or significant impairment in social, occupational, or other important areas of functioning |

Significantly, 2e students may exhibit new traits not associated with any of their exceptionalities. Disruptiveness is an example: inability to control oneself and emotional volatility and impulsivity. While the authors note that giftedness can coexist with any of the 14 categories of disability under IDEA except for intellectual disability, the article does not mention any Bipolar Disorder diagnosis along with giftedness in students.

Jacqui Byrne helped found The Flex School, a progressive place for 2e children. The school was founded within a matter of a few months with $600,000 in investments and advance tuition, and expanded to include locations in Berkeley Heights, NJ, Bronxville, NY and online. Byrne explained in an interview (Reber, 2019) how two of her four children were having trouble functioning in the standard school environment, even the child who was selected for a gifted program. Three of these children are triplets, which prompts me to investigate the prevalence of mood disorders in twins, triplets and the like. Byrne talked about the specific accommodations that help many 2e students, such as allowing unlimited pacing in the back of the classroom, the lack of a hall pass (a confidence booster for students with anxiety disorder), and class games of Shark Tank which help students experiencing hypomania compete in healthy ways. If other schools acknowledged difference, and gave students some leeway to adapt to their sensory and learning needs, the learning environment would perhaps be less restrictive. In any case, artistic activities help so many students regulate their moods. It is unfortunate that arts education programs are not more widely funded. I will write more about arts integration in Section 8.

In the book *Twice Exceptional*, Deirdre Loveky suggests (2018, p. 93-94) that high IQ in the lower grades has been shown to be an indicator for Bipolar Disorder in adulthood. Lovecky notes that gifted students have a higher incidence of Bipolar Disorder as adults but, even if also diagnosed with ADHD, their test results do not reflect such deficits. Nowhere in the book are there any case studies to suggest that Bipolar Disorder in children would be a second exceptionality among 2e students.

I have very rarely seen Bipolar Disorder mentioned in connection with 2e children, notably in the online *2e Newsletter* article “Raising My Bipolar Gifted Son” by Marcia

McKinley (2008). McKinley, then an associate Professor of Psychology at Mount St. Mary's University in Emmitsburg, Maryland, advocates for labelling her child with all of the following: giftedness, ADHD and Bipolar Disorder. McKinley makes it clear that her son's earlier homeschooling did not lead to his condition, and advises "As one of his teachers has said, Nathan has changed "2,000% since he began treatment for bipolar disorder." In her list of references for parents of 2e students, McKinley includes *The Bipolar Child* (Papolos and Papolos, 2007), *Understanding the Mind of Your Bipolar Child: The Complete Guide to the Development, Treatment, and Parenting of Children with Bipolar Disorder* (Lombardo, 2008) and family-focused narratives such as *Matt The Moody Hermit Crab* (McGee and Woods, 2002) and *Mommy I'm Still In Here: One family's Journey with Bipolar Disease* (McLaughlin, 2008).

Quad Preparatory School hosts the annual Breakthroughs in Twice-Exceptional Education Conference. In 2021, Dr. Anthony Charuvastra gave a timely presentation entitled "17 Questions Every Parent Asks about Psychiatric Medicine, with Some Answers" (Quad Prep, 2021). Interviews with prominent educators in the field such as Susan Baum, Joseph Renzulli and Sally Reis, Audrey Ludemann, Andrea Lein, Heidi Molbak, Jacqui Byrne and Robin Schader are available online (Skolnick, 2018). These motivating videos explore alternative assessment, search engines which help find a student's interests, talent plans, and more.

While educators work out what disorder a student may have (or, perhaps that there is no disorder), students are most helped by strength-based lessons. Pavuluri (2008, 2014) has also urged parents and educators to focus on the student's strengths, not on their disorder. Cognitive Behavioral Therapy helps to reinforce this pattern at home.

A debate arose between Nelson, Hartnett, Rinn and Mika over the possible misdiagnosis of gifted children as having ADHD. (Mika, 2006; Nelson, Rinn & Hartnett, 2006). Following an article (Hartnett, Nelson, & Rinn, 2004) invoking Dąbrowski's Overexcitabilities, Mika repeatedly referred to the efforts of Nelson, Hartnett and Rinn to dismiss an ADHD diagnosis in favor of underlying giftedness as "subjective". While having an excess of energy certainly doesn't mean a child is gifted, I believe educators should observe students' achievement in all subject areas to detect any asynchronous development. ADHD and giftedness may be comorbid, and, since this is not an either/or situation, ideally, students should receive more evaluation rather than relegation to a class of underperforming students and an ADHD diagnosis.

Trail (2011, Chapter 2) claims Response to Intervention (RtI), increasingly used in schools following the 2004 reauthorization of IDEA, has helped constantly assess the performance of unidentified, underachieving gifted students including those from underserved communities and diverse backgrounds. Seeing that gifted learners might be performing at grade level in some areas while having a coexisting disability, Crepeau-Hobson and Bianco (2010) favor a mix of cognitive assessments and RtI to identify 2e learners.

**Issues of Identity**

In his dissertation *Gifted and bipolar: A phenomenological analysis of living with labels*, Michael Pietrus (2010) uses a hermeneutic phenomenological method to facilitate discussion of a dual diagnosis of gifted and bipolar. A selection of undergraduate and graduate students with these dual diagnoses tell of their experiences. The author examines the negative impact of labels, and explains how he settled on a research method that rejects scientific positivism. I believe that the testimony of the adult subjects (some of whom report they are managing Bipolar Disorder without medication) will help add perspective on the experience of

receiving this diagnosis at various different times of life. There is acknowledgment that some individuals strive to hold on to either, or both of the above labels out of fear of what it might feel like to have no label.

"Lisa", age 26, is a Caucasian female who was identified as gifted during elementary school and struggled with attention issues and a learning disability before she was later diagnosed with Bipolar Disorder. Lisa reported that her teenage years and experiences with mania resulted in uncontrollable shopping and multiple body piercings. She feels that medication has helped manage her moods. While displaying talent as a student of opera, Lisa states she had to overcome her earlier treatment in school as someone who could not read and had trouble planning for her future. As she came to terms with negative self-image expressed in a tendency towards obesity, Lisa came to identify with the label "fat" as well as with the overarching effect of being "Bipolar" and felt less uncertain about her life (ibid, pp. 85-105).

"Mark", age 27, is a Caucasian male who was identified as gifted at an early age. This status helped him feel special as he faced the death of his mother a few years later and, after that, attempted suicide. Though he states he still does not understand why he tried to take his own life, he was diagnosed with Bipolar Disorder after a misdiagnosis of dysthymia and found he could somehow consolidate his challenges and deal with them. Being labelled gifted set him apart, and yet he is more comfortable telling other people about these experiences than he is talking about being Bipolar. The latter often prompts others to make assumptions about him, he says (ibid, pp. 66-84).

"Stan", age 31, an African-American male, had trouble sleeping throughout his life. His son also has trouble sleeping, a sign of possible future episodes of mania. Stan says if it weren't for his wife, he might not have taken enough interest in his condition to get diagnosed. Stan mentioned that his energized belief in himself got him on track for college and away from a disadvantaged home. He started on medication only recently and is concerned about needing it for the rest of his life. One cause for concern is that he reports it only takes him down from intensity 10 to 9. Stan says he sometimes feels like the 1980s costumed TV character "The Greatest American Hero", who suddenly obtained supernatural powers from aliens but had no instruction manual and so felt out of control (ibid, pp. 106-136).

Pietrus (2010) recommends group therapy as a way for such individuals to compare their similarities and differences in terms of accomplishments and struggles. Living with multiple diagnoses can be an isolating experience. On the other hand—as we can see in the case of Asperger's, which was subsumed under Autism Spectrum Disorder and was no longer a separate diagnosis according to the DSM-5—a deeply-felt truth about oneself can become an identity. Those who find they do need medication can provide support to each other.

## 8. Non-Pharmacological Supports

### Natural Supplements

I am not a Medical Doctor or pharmacist, and it is not my place to discourage those who truly need medication from seeking assistance. At the same time, even the works I have cited which are written by proponents of medication occasionally note natural supplements and traditional remedies which may help to improve mood disorders.

Pavuluri (2008, Chapter 5) has good things to say about the potential benefits of omega-3 fatty acids, choline, inositol/Vitamin B8 and other natural substances. Such substances have been shown to elevate moods, thereby mitigating symptoms of depression. However, Pavuluri states that preliminary controlled studies have shown that S-AdenosylMethionine (SAM-e), if taken in excess, may not only alleviate depression but bring on episodes of mania. More research is needed into the proper use of such “biologic agents" compared with the effects of antipsychotics.

When working with young children and adolescents, Pavuluri as well as McDowell and Wozniak (2009) observe that regular sleep and reduced caffeine intake can help with controlling moods. A young person with a growing mind is often stretched to the limit already, and so should avoid additional stressors. Proponents of Childhood-onset Bipolar Disorder state that excessive consumption of alcohol and other depressants—as self-medication—should be curtailed so that the patient can find less toxic, sustainable ways of regulating moods. What other methods of mood regulation exist?

**Bibliotherapy**

Within Gifted Education and Talent Development, students whose everyday lives include overexcitability may use bibliotherapy – changing self-image through identification with biographical subjects and literary characters. Tomes such as *Some of My Best Friends Are Books* (Halsted, 2009) outline the benefits of bibliotherapy, and give hundreds of examples of books to read, divided by grade level and theme. Elizabeth Cook’s classic *The Ordinary and the Fabulous* (1969) is a gateway to narrating myths, legends and fairytales for children. Those who are willing to normalize a wide range of moods in children will find in these texts exemplars for

students who want to understand their own emotions and drives and wish to examine what it feels like to take control of the narrative.

Students can participate in an activity where they view the strengths of a famous historical personage and include disabilities in that evaluation. Among the successful people who lived with Bipolar Disorder, Beverly Trail, in her book *Gifted Twice Exceptional Students* (2011, Ch. 8, Fig. 24) counts President Abraham Lincoln, journalist Mike Wallace, and actress Patty Duke.

**Imagery**

Psychologist Arnold Lazarus has written much about the power of imagery. His work *In the Mind's Eye* (1977) contains many intriguing exercises for people of all ages who want to cultivate positive self-image. While writing of methods he uses with adults who struggle with lingering childhood phobias, Lazarus (Chapter 8) explains that human beings are inspired and dominated by their visions of the future. On the topic of stress and illness, Lazarus describes guiding a patient through visualization of going into his own body and healing his ulcer (Chapter 9). The focus is on developing tools which prepare people for solving anticipated problems, or "future shock" (Chapter 11). We all will experience the death of loved ones, and some of us will live with chronic illness. Lazarus provides methods of rehearsing for such likely events, which can take away the sense of helplessness which people with mood disorders may experience. These concepts are echoed 30 years later in works on meditation as management for depression.

**Mindfulness**

In *The Bipolar Teen*, Miklowitz and George (2007) suggest using mindfulness meditation as a coping strategy for Bipolar Disorder. They cite the Three Minute Breathing exercise, a

method of attuning to physical realities, and ideally minimizing self-deprecating, depressive thoughts caused by the "ruminating" mind. This is one of many mindfulness exercises found in *The Mindful Way Through Depression* (Williams, Teasdale, Segal & Kabat-Zinn, 2007), ultimately derived from Buddhist practices such as those advocated by the monk Thich Nhat Hanh, which greatly contrast with the driving philosophy of Miklowitz and George's book. For, while *The Bipolar Teen* posits that young people are prone to Bipolar Disorder and should be medicated as soon as possible and perhaps pursue therapy as an additional aid, the proponents of mindfulness urge anyone dealing with depression to develop a meditation regime between major depressive episodes as a way to avoid a lifetime of potentially ineffective pharmacological dependence.

Thich Nhat Hanh comes from a Buddhist tradition of meditation (Vietnamese: *thiền*, Chinese: *chan*, Japanese: *zen*, Sanskrit: *dhyāna*) which seeks to retrain the mind to recognize the reality of the present moment. The authors of *The Mindful Way Through Depression* believe that in our modern society, people are focused on constant listing and completion of tasks, which helps to accumulate rather than decrease the stress in their bodies. Through breathing and other meditation exercises such as the "body scan", practitioners are invited to attune to and learn to accept what the body can tell us about the state of our health. When limiting perception to bodily sensations, one may indeed experience unpleasant and painful sensations. The authors encourage practitioners to experience feelings and sensations within the body without mental categorization. "It's okay. Whatever it is, it's already here. Let me open to it." (p. 153). Through an eight-week program of mindful practice and recording of sensations, a practitioner may reduce the mental stress of an upcoming depressive episode. Like other types of therapy,

this method requires discipline and work. Perhaps the energy and task-commitment found in many gifted and talented students would help them to embrace these activities.

George Stone (2012) proposes that young people would benefit from strategic family therapy as an alternative to antipsychotics. This structured approach helps the entire family achieve balance when a child has a mood disorder including bipolar disorder. Through constant discussion of feelings, routines, actions and consequences, each person in the family can develop a plan for dealing with manic and depressive episodes. Though this method bears some similarities to Pavuluri's (2017) RAINBOW Therapy, it is explicitly designed to exclude medication.

Peter Fonagy is a proponent of Mentalization and its use as therapy for Borderline Personality Disorder and other conditions. Mentalizing is a form of imaginative mental activity that lets us perceive and interpret human behavior in terms of intentional mental states, and would be particularly useful to children who are learning to experience other people not as objects but as other individuals who employ thought processes. Some of the exercises included in the *Handbook of Mentalization-Based Treatments* (Allen & Fonagy, Eds., 2006) pertain to childhood disorders (Chapter 4). For a more lasting structure, the authors write about efforts to keep people with Bipolar Disorder out of restrictive environments in "Enhancing Mentalizing Through Psycho-Education" (Chapter 13). Whether or not a young person is medicated, episodes of mania may bring reckless conduct and disregard for the welfare of others. Mentalizing may help young people dealing with mania to consider their actions toward others. Another article which addresses this is *Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder* (Fristad, Goldberg-Arnold and Gavazzi, 2002).

**Arts Integration**

In March of 2021, I attended the University of Arkansas (2021) ARTful teaching conference. As an experienced playwright, I was excited to work with and learn from educators who wish to bring the benefits of the arts to all students, including those whose school districts may not fund such valuable programs. Arts integration teaches students empathy and other important skills such as planning, working collaboratively, and learning to listen to the stories of others with a view towards mutual respect. Caine and Caine (1994, p. 121-22) note that storytelling helps students learn to remember and organize information.

The Kennedy Center's (2020, § 5) definition of arts integration emphasizes how the arts can help students transfer skills across content areas and becoming interested in real-world application of knowledge:

> In Arts-Integrated Curriculum, the arts become the approach to teaching and the vehicle for learning. Students meet dual learning objectives when they engage in the creative process to explore connections between an art form and another subject area to gain greater understanding in both. For example, students meet objectives in theater (characterization, stage composition, action, expression) and in social studies. The experience is mutually reinforcing—creating a dramatization provides an authentic context for students to learn more about the social studies content and as students delve deeper into the social studies content their growing understandings impact their dramatizations. For Arts-Integrated Curriculum to result in deep student understanding in both the art form and the other curriculum area, it requires that teachers engage in professional development to learn about arts standards and how to connect the arts to the curriculum they teach.

Listening to song lyrics can be a tool for understanding figurative language. This teaches students an economical way to express concepts and provides help with self-regulation, all without relying on the written word. Students with EBD, with dyslexia, etc. can learn important coping skills through music. Musical tempo can teach self-regulation of emotions. Listening to

music has been shown to increase synaptic activity in the brain, making students and adults smarter and more effective at learning math while simultaneously empowering multiple intelligences (Loring, 2001)

Arts integration brings to underprivileged students the tools to tell resistance stories. Progressive educators often cite the Culturally Relevant Pedagogy of Gloria Ladson Billings (1995) and the Funds of Knowledge—specialized competencies from diverse communities--of Vélez-Ibáñez and Greenberg (1992). But why do the arts empower diverse students? First of all, as Paulo Freire wrote in *Pedagogy of the Oppressed* (2000), diverse, underprivileged students may not be aware that they have power in society because the dominant culture has taught them to privilege only the values of the rich and powerful. Freire's important work of teaching literacy to oppressed communities was followed by the work of fellow Brazilian Augusto Boal, who, in *Theater of the Oppressed* (1985), noted that Greek theater and other mass entertainments always reinforce the dominance of the ruling class. Theater as expression of the views of the oppressed masses requires consciousness-raising. Boal and Freire's Marxist and Brechtian doctrines show the power of the people can be harnessed through reflection and alienation as opposed to identification with the values of the dominant class which often permeate the media.

Are students with EBD an oppressed group in need of the tools to find their voices? Figurative language can be learned from songs/lyrics. This is an effective, economical way to learn, without reading, and may give students tools to work with their emotions. With the benefit of arts integration, the voice of a student from an underrepresented population can reach a wider audience. In the film *Deej* (Rooy and Savarese, 2007), D.J. Savarese, a non-verbal autistic person, uses computer technology to express himself. He writes and directs the school play, in which he has characters speak for the oppressed population of non-verbal people who are not

able to choose their educational and life path. Deej states that many of the people like him have been institutionalized and are in a highly restrictive environment. Through the arts, Deej also explores his feelings about his abusive birth-parents and his affection for his adoptive parents, who chose him knowing of his non-verbal status. It is inspiring to see the level of support in this family and the lack of residual anger towards toxic people in Deej's past. Eventually, Deej applies to Oberlin University and is accepted on the strength of his assertion that Oberlin, which by 1837 was the first predominantly White U.S. school of higher education to admit African-American males and females of all races, would understand Deej's desire to speak on behalf of and bring freedom to the oppressed. Deej was accepted to Oberlin and went on to teach classes in dis/ability advocacy

**Emotional Intelligence**

Daniel Goleman (2005) has built on Howard Gardner and Thomas Hatch's work on multiple intelligences (1989) to include the benefits of Emotional Intelligence. Through his work, Social and Emotional Learning (SEL) programs have become more prominent in many schools. At the core of Goleman's work is the idea that hasty and angry decision-making (often driven by uncontrolled, fight or flight impulses from the amygdala to the hypothalamus) can lead to violent outbursts, an unstable work situation and future outlook, and even a life of crime (Goleman, 2005,, pp. 13-25). Venting of anger has been understood to be of little use, compared with learning other ways of regulating emotion (Tice and Baumeister, 1993). The amygdala has been shown to be enlarged in people who have Bipolar Disorder (Altshuler, Bartzokis, Grieder, Curran and Mintz, 1998).

Goleman shows how various subjects with flat emotional affect (alexithymia) and those often not in control of their anger may be less successful in the corporate world and in committed relationships. Learning to calm oneself at the peak of rage, cultivating empathy and learning to show concern for others within one's work or school environment are shown to increase brain activity and growth and to promote immune health and reduce the risk of heart attacks. Emotional regulation has been shown to increase creative "flow" (Csikszentmihalyi, 1990) and similarly to help athletes stay "in the zone".

In the case of a woman who had PTSD following encounters with a stalker (Goleman, 2005, Chapter 13), talking about feelings and putting them into words placed them more under the control of the neocortex as opposed to the amygdala and the limbic system. Eventually, the PTSD symptoms were brought under control. Opportunities for discussing feelings (in therapy or with family) could help children with EBD. In school, starting class time to rate one's feelings on a scale of 1-10 can help students make friends and both give and receive empathy. Also used in the Child Development Project in Oakland, CA (ibid, p. 255) was reading of friendship-based texts such as the *Frog and Toad* series. As an afterword to the 10th anniversary of emotional intelligence, Goleman's colleague John Kabat-Zinn (co-author of *The Mindful Way Through Depression*) discusses studies of neuroplasticity. Over an 8-week period of mindfulness activities, subjects' brains were observed to learn routines leading to happiness and experienced increased immune health.

In an experiment by Chapela et al. (2020), twenty-six adult Bipolar type I patients were examined using the Mayer-Salovey-Caruso Emotional Intelligence Test or MSCEIT (the most validated test for emotional intelligence), BPRS, YMRS, HDRS, WAIS-IV, TMT and Rey Figure in order to determine the level of emotional intelligence and related factors. The authors

concluded that Bipolar patients show lack of emotional intelligence when compared with the general population. Cognitive impairment and age are the principal factors related.

Frajo-Apor et al. (2020) investigated a total of 54 outpatients suffering from Bipolar Disorder, 54 unaffected siblings, and 80 control subjects using the MSCEIT and the Brief Assessment of Cognition in Schizophrenia (BACS). Analyses of covariance (ANCOVAs) were performed with adjustment for the BACS composite score. The three groups were compared by one-way analysis of variance or chi-square test, depending on the variable type. As the three groups differed significantly in their level of education, additional ANCOVAs with adjustment for education were performed. Patients achieved significantly lower levels of overall Emotional Intelligence and overall nonsocial cognitive functioning compared to unaffected siblings and controls, whereas performance of the latter two groups was comparable in both domains.

**“How the Gifted CopeWith Their Emotions”**

Annemarie Roeper (1982) describes several different types of behavior which gifted children display which indicate levels of emotional intelligence and degrees of being well-adjusted to their life circumstances. The situation for gifted students may be complicated by the overlap of high academic achievement with comparative lack of emotional maturity seen in students who skip a grade. Roeper describes various more or less self-defeating personality types: the always competitive “Winner of the Competition”, the “Adult/Child” who poses as more emotionally mature, the “Exception” who believes that rules applying to the rest of the population are irrelevant thanks to perceived special ability, the “Perfectionist” who actively avoids negative data and the “Self Critic” who may avoid undertaking challenges he/she is not sure will be successful. Roper concludes that a child with a supportive family can integrate

negative feelings better. While giftedness is not a disability, Roeper makes it clear that gifted students face a variety of challenges which are certainly enough to lead to self-doubt and could endanger the student's welfare. A student with an Emotional and Behavioral Disorder could certainly benefit from as much stability at home as possible.

**9. Summary and Conclusions**

Bipolar Disorder (also called Manic-Depression) has been known to medical science for centuries and has been mentioned in every version of the DSM. So far, despite ever-broadening criteria for many conditions, no edition of the DSM has included a diagnosis of Childhood-onset Bipolar Disorder.

Since the work of Emil Kraepelin in the 1890s and of Theodore Ziehen several years later, prominent physicians and psychiatrists agreed that the earliest age of onset was 15. To this day, this is still the reported opinion of professionals outside of the United States. From the mid-1990s, researchers such as Biederman and Wozniak have stated that young people thought to have ADHD instead had some type of Bipolar Disorder. With much publicity often funded by pharmaceutical companies, some of the authors mentioned in this paper have urged parents to cautiously medicate their children, some as young as preschool age. In 2003, amid concerns about suicide of children who had been prescribed antidepressant medication, the FDA placed a black box warning on several current medications given to children for Bipolar Disorder treatment. Psychiatrists responded by recommending use of "atypical" antipsychotic medications which had not been tested on children. As Robert Whitaker reveals, such medications and those used to treat Schizophrenia in general have been shown to lead to a lifelong dependency with many negative side effects such as weight gain and susceptibility to diabetes. Whitaker also

challenges the “discovery” of Bipolar Disorder in children thought to have had ADHD, noting that use of Ritalin likely exacerbated the symptoms in the first place.

What are the risks and benefits of not starting young children on medication for a theoretical condition? If care professionals and educators took time to assess such students, they might find overlap with a condition which is not a disability: giftedness. Many young people, particularly those from diverse cultures and lower socio-economic status, may be unidentified, gifted underachievers who are bored at school or seemingly hyperactive due to what Polish psychologist Kazimierz Dąbrowski called overexcitabilities ("OE"). Dąbrowski noted that highly-developed individuals may exhibit signs of five OEs: psychomotor, sensual, intellectual, imaginational, emotional. These individuals are expressing their joy in learning, and their hyperfocus is not a sign of pathology. Additionally, a gifted student may simultaneously have a learning disability or other coexisting disability which may "mask" traits of giftedness. Such individuals display asynchronous development across content areas, and are called "Twice Exceptional" (2e). While there are gifted children who also have behavioral disorders, researchers such as Webb, et al. (2016) insist that Bipolar Disorder is not found in children and is therefore being misdiagnosed 96% of the time. High-ability children may have a higher risk of developing Bipolar Disorder later in life, as do people abused during childhood and, above all, those who have relatives diagnosed with Bipolar Disorder as adolescents or adults.

Researchers who are proponents of Childhood-onset Bipolar Disorder recommend Cognitive Behavioral Therapy in addition to medication. Those opposed to the Childhood-onset Bipolar Disorder diagnosis also recommend therapy and the family's help in creating less-stressful routines, without the use of medication unless absolutely required. Mindfulness practice may help individuals mitigate stress from upcoming cycles of mania and depression.

Research into emotional intelligence also supports the learning of less-heightened responses to stress as a path to success in school, and in the world beyond. From gifted pedagogy, bibliotherapy has been used to help students with overexcitabilities channel their energy.

For people of all ages, activities involving imagination--especially the arts--help teach many life-affirming and problem-solving skills. Broader funding of arts education would reach so many more students whose excess creative energy is sometimes misinterpreted as pathological. Arts integration gives students from diverse communities additional tools to transfer skills across content areas, to express themselves and their cultural identities, to engage in dis/ability advocacy, to use multiple intelligences, and more. Annemarie Roeper has written of the methods gifted children may use to effectively regulate their energy and moods; all types of students, especially those presumed to have Bipolar Disorder, may benefit from such ideas.

In addition, various natural supplements such as SAM-e, omega-3 and St John's Wort have been shown to help with depressive episodes, although some physicians warn that too much may aggravate mania.

Your author, Ed Malin, grew up in a gifted education program and has developed an appreciation for the neurodiversity movement. Therefore, I will end with some remarks written by neurodiversity advocate Mel Levine in the foreword to a volume of the Childhood in America series (2006). Levine notes that “today, most clinicians in the children’s mental health field spend the bulk of their time caring for children who present with the so-called “high-prevalence, low-severity” conditions, including problems with attention, learning difficulties, weak social skills, mood swings, or intermittent anxiety—and don’t we all suffer from the latter? When clinicians assess children who exhibit these common symptoms, they must scale the controversial gradient that separates normal variation from actual pathology and run the very real

risk of labeling too many children as abnormal." Indeed, symptoms are not equivalent to underlying conditions, and diagnostic labels can stigmatize and physically harm children. Instead, we would do better to create more inclusive classrooms and to know our students well enough to be able to provide them with stimulating educational content.

**Recommendations**

1) Talking about mental conditions and mood disorders can help reduce any stigma. As with cultural, gender, and other identities, diversity in the classroom should be welcomed.

2) Young students dealing with Bipolar Disorder may benefit from extensions for assignments and other accommodations re: depressive episodes.

3) Young students should be encouraged to express themselves. Excess energy can be channeled into independent projects. Artistic pursuits (graphic arts, music, dance, theater, etc.) can help students communicate what is going on inside. One of the prominent British bands of my youth, The Cure (formerly named The Easy Cure, known for albums such as *Wild Mood Swings* and *Disintegration*) acknowledge the healing power of music in their turbulent lives, which included several founding members being expelled from high school (Tolhurst, 2016). The band's wild hair and collaboration with Siouxsie and the Banshees endeared them to many waves of teenagers. Singer Robert Smith notes he would paste guidelines on the studio wall, such as "We must cry by 6pm tonight" (Lynskey, 2018, ¶ 17).

4) Encourage a balance between achievement and perfectionism. Help all students to develop social skills. Also, help students who may need behavioral support by providing Universal Design for Learning strategies in the classroom.

5) Closely observe students, including as relates to eating and hypoglycemia

6) In cases of 2e individuals, the Bipolar Disorder may "cancel out" signs of giftedness. Continue to assess skills. Differentiate instruction and seek to discover assets in children.

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**Appendix A: Permissions**

**Edward R. Amend, Psy.D. <dramend@theamendgroup.com>**

Sun, Jan 23, 8:29 PM

to molly @giftedunlimitedllc.com, me

Hello and thanks for reaching out. I will echo my colleague's congratulations on your accomplishment.

With proper citation, you have my permission use that table in your thesis. Thank you for taking an interest in giftedness and our work.

I have copied our publisher, Molly Isaacs-McLeod at Gifted Unlimited, who has acquired the rights to all books from Great Potential Press since Dr. Webb's passing, so that she is aware.

Best wishes,

_____

Edward R. Amend, Psy.D.

Licensed Psychologist

The Amend Group

3131 Custer Drive, Suite 5

Lexington, KY 40517

ph: 859.269.6465

fax: 859.269.6401

email: dramend@theamendgroup.com

web: www.theamendgroup.com

**Edmond Malin <emalin@bankstreet.edu>**

Mon, Jan 17, 3:10 PM

to dramend

Dear Dr. Amend,

I would like to request permission to use material from one of your publications in my graduate thesis, please. My name is Ed Malin and I am a graduate student at Bank Street College of Education. As I seek to publish my thesis entitled "Bipolar Disorder in Children (Including Gifted and 2e Children)", I would appreciate permission to use tables from the following:

Webb, J.T., Amend, E.R., Webb, N.E., Goerss, J, Beljan, P., & Olenchak, F.R. (2016) *Misdiagnosis and Dual Diagnosis of Gifted Children and Adults: ADHD, Bipolar, OCD Asperger's, Depression, And Other Disorders (Second Edition)*. Scottsdale, AZ: Great Potential Press Table on page 77

This is the very useful, concise summary I would like to use, please:

| Behaviors Associated with ADHD | Behaviors Associated with Giftedness |
|---|---|
| (Barkley, 2006; Hinshaw & Ellison, 2016) | (Webb, 1993) |
| Poorly sustained attention in almost all situations. | Poor attention, boredom, daydreaming in specific situations. |
| Diminished persistence on tasks not having immediate Consequences. | Low tolerance for persistence on tasks that seems irrelevant. |
| Impulsivity, poor ability to delay gratification. | Judgment lags behind intellect. |
| Impaired adherence to commands to regulate or inhibit behavior in social contexts. | Intensity may lead to power struggles with authorities. |
| More active, restless than normal children. | High activity level; may need less sleep; psychomotor OE |
| Difficulty adhering to rules and regulations. | Questions rules, customs and traditions. |

Thank you for any information on how to proceed.  Your work is a great inspiration to me.

Best regards,

Ed Malin


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