The Bipolar Child Newsletter **December, 2005 Vol. 21**--*Janice Papolos and Demitri F. Papolos, M.D.*

Obsessional Fears and Aggressive Behaviors in Children and Adolescents With Bipolar Disorder

In a previous newsletter, we discussed the great anxieties that children and adolescents with bipolar disorder suffer. We wrote in that July issue:

Indeed, there is a surprisingly robust scientific literature that documents the frequent co-morbidity or association between bipolar disorder and a number of anxiety disorders, but this association is frequently overlooked when a differential diagnosis is made. Instead, anxiety disorders are often seen as diagnoses existing all by themselves - divorced from the possibility of a co-existing mood disorder. Thus, a child frequently receives a diagnosis of separation anxiety, generalized anxiety disorder (GAD), or obsessive-compulsive disorder (OCD). An adolescent frequently gets the diagnosis of panic disorder, and the anxiety disorders are not viewed as a possible pre-cursor to a mood disorder...

We wrote about a study reported by Daniel Geller of 217 children with obsessive-compulsive disorder at the McLean Hospital/Massachusetts Pediatric OCD clinic. He and his colleagues found that a full 69 percent of the study sample also carried diagnoses of mood disorders.

The Epidemiological Catchment Area database supports the conclusion that the lifetime rate of comorbidity for obsessive-compulsive disorder is particularly high among bipolar subjects.

When people hear the term "obsessive-compulsive disorder," they think of someone constantly washing his or her hands, or avoiding cracks in the sidewalk, or even of the detective Adrian Monk whose fears of contamination are so aptly portrayed by actor Tony Shaloub. However, contamination fears are not the only kind of obsessive-compulsive fears. The well-accepted instrument that assesses the severity and type of obsessions - the Yale-Brown Obsessive-Compulsive Scale (the YBOCS) - lists nine categories or subscales, one of which is entitled "Aggressive Obsessions." These include:

- Fear might harm self
- Fear might harm others
- Fear harm will come to others (may be because of something child did or did not do)
- Violent or horrific images
- Fear of blurting out obscenities or insults
- Fear of doing something else embarrassing
- Fear will act on unwanted impulses (e.g. to stab a family member)
- Fear will steal things
- Fear will be responsible for something else terrible happening (e.g. fire, burglary, flood)

The fears that children have that harm will come to them or others is paralyzing and they may not always verbalize it. One boy did describe his fears for us, but only years after when they were less acute:

I would be sitting on the bus that my father is supposed to meet and I kept "seeing" him having a car wreck and being killed. I got so anxious that sometimes I would shake. These thoughts were strong and occupied my mind at all times. I still get them in my down time, but when I was younger I had them all the time.
I also thought I would get a disease, or if I went on a bike ride I would get really hurt, so I couldn't go.

Kim Nelson, in her soon-to-be published book, *Mommy I'm Still In Here*, recalls that her teenage daughter said:

I feel like I'm coming out of my skin, like my body can't contain my insides. My heart pounds and I shake all over. It's hard to catch my breath. Thoughts start going through my mind so quickly, I can hardly recognize them; and then they fly through again, round and round. Scary thoughts. Bad thoughts. Or maybe they're feelings, not thoughts. I don't know. I feel like I'm not safe, like I'm in danger. *Like an animal when it knows a predator is near* (authors' italics).

A sense of threat seems to pervade the waking and sleeping hours. Many of the children and teens experience nightmares where predators stalk them, chase them, and kill them or their families in particularly violent and horrific ways. One has to wonder whether the nightmares are informing their daytime thoughts, or the daytime thoughts are shaping the nightmares. Whichever, the children we spoke with described vivid dreams and nightmares where: "I was being chased by a masked shadowy man and I got to the stoop of my house, and he kept stabbing me in the back;" or, "I am being chased by headless men who are going to eat me."

As bipolar children talk about these dreams, they report the explicit appearance of blood (not just imagined or inferred, but actually visualized blood) and descriptions of mutilations of bodies, dismemberment, and the insides of body parts. Their dreams are considerably more affectively intense than regular nightmares.

It is not surprising that so many of the children mention their terror of "Chucky, the psycho-killer doll" from Hollywood's horror movie canon. This psycho killer transfers his "soul" into a doll in a toy store and tries to kill people with daggers and swords and axes in order to retrieve a human body. (Please note: the mothers do not take their kids to see Chucky movies; the kids are running into Chucky stand-alone placards or posters at Blockbuster stores, or inadvertently, the children see commercials on television and Chucky gets fixed in their mental landscape.) The children report being terrified as soon as it gets dark; many find it difficult to go upstairs alone, even in the daytime.

With such emotionally-charged imagery penetrating the child's waking hours, and attaching to the dream state throughout the night, is it any wonder that these children are so often in combative and irritable modes and that they are terrified of bedtime?

Indeed, the rate and frequency of night terrors and nightmares and their highly disturbing content seems referable to fight-or-flight mechanisms, and may be coupled with many of the behavioral problems these children have. Many of the behaviors are congruent with "fight" (oppositional, defiant, argumentative, and defensive behaviors), while other behaviors are more consonant with "fright" (anxious, fearful, withdrawn, and phobic behaviors). The disturbing content and imagery of their sleep may be contributing to the anxiety experienced during the day, or reinforcing them on a nightly basis.

The Amygdala

In the brain's architecture, the almond-shaped amygdala is poised like an emotional sentinel or alarm center that is involved in fear responses and in initiating the first stages of emotional memory. The amygdala receives signals that are of potential danger: signals from the eyes and ears travel first to the sensory thalamus, which transmits partial information about the stimulus to the amygdala, allowing a more rapid response well before centers in the visual cortex or the thinking brain have fully assessed the complete nature of the signal. A primitive emotion such as rage takes this route to the amygdala, causing a response that it totally raw

and unvarnished. Most of the signal, however, is delivered to the visual cortex, where it is analyzed and assessed for meaning and appropriate response. If this more measured response of the signal confirms that a threat indeed exists, the fight-or-flight response is triggered in the amygdala.

Incomplete or confusing stimuli from the sense organs signal the amygdala to scan the environment for danger. Bipolar children and those with learning and attentional deficits have significant problems with the integration of sensory information. Such disturbances may cause bipolar children and teens to misinterpret a casual touch or glance as something threatening or to overreact to normal social cues. These children can become hypervigilant and show paranoid tendencies as well as to express severe and prolonged defensive reactions. They can become oppositional, or aggressive, or withdraw.

Parents are often confused as they watch a child who, out of fear, appears unable to separate from them, yet, then flies into a rage with aggression singularly directed at the hands that protect them. And, then, just as rapidly the child turns to extreme remorse, begging for forgiveness.

One boy we interviewed told us that the thing that infuriates him more than anything is when he's raging at his mother and she turns away or does not look at him kindly (who can blame her?). He cannot see that his actions are the catalyst of the painful encounter. His mother should do something to lessen his overwhelming fear and to demonstrate her concern for his safety and protection. He feels abandoned to his terror. This Catch-22 situation is impossible for the parent to negotiate.

The Paradox

So we have a paradox here: a child who is terrified by fearful imagery and who is afraid to be hurt; a child who needs his or her parents for protection; yet a child who pushes the parent away for seemingly little reason (a glance, a gesture, or - the big one - the word "No"); and who is willing to hurt that same parent as retribution to a perceived slight.

Although aggression has been a hallmark of juvenile-onset bipolar disorder, nothing in the literature has examined the relationship between the fearful thoughts and aggressive behaviors of these children. A new study completed by researchers of the Juvenile Bipolar Research Foundation found that obsessive fear-of-harm, either fear of doing harm or fear of harm coming to self, may be closely linked with aggressive behaviors in children with bipolar disorder.

The Study

Parents of 1,600 children and adolescents with a clinician-assigned diagnosis of bipolar disorder were asked to complete both the Y-BOCS and a scale measuring aggression, the Overt Aggression Scale (OAS), on JBRF's secure online database. The Overt Aggression Scale is designed to assess observable aggressive or violent behavior. This instrument consists of four categories: verbal aggression, physical aggression, physical aggression toward self; and physical aggression toward other people.

When the data was analyzed, the parents who rated their children's fear of harm as "often" or "very often or almost constantly" on the Y-BOCS, also significantly endorsed items on the OAS that reported these same children expressing severe injury to self and others. This group, called the high fear-of-harm group had more than twice the rates of self-injury than

those children with low fear-of-harm. Moreover, the high fear-of-harm group was eight times as likely to hurt others. These very frightened youngsters were reported to make suicide threats much more frequently than the cohort who was not so afraid of harm to self or others.

To state it another way: excessive anxiety about aggressive acts done to the child or others very strongly correlate with the amount of aggression the child expresses toward him or herself and others. Among the younger children, parents reported that the target of aggressive behaviors was more likely to be other children rather than themselves. In contrast, among older children, the target of aggressive behaviors was more likely to be themselves rather than others.

What To Do With This Information?

Aggressive obsessions may serve to distinguish the boundary between a case of obsessive-compulsive disorder and bipolar disorder. In other words, if a child has the hallmark features of early-onset bipolar disorder (such as rapid shifts in mood, elation and grandiosity and poor modulation of aggressive impulses), as well as a family history of mood disorders, and scores "high" on the aggressive obsessions section of the Y-BOCS scale, then perhaps the primary diagnosis to be considered would be bipolar disorder rather than obsessive compulsive disorder. In such cases, antidepressants (commonly given to patients with OCD) would be avoided as they may trigger mania, rapid cycling, behaviors that are even more aggressive, and greater incidents of self-harm . Since it only takes parents a few minutes to complete the Y-BOCS scale as well as the OAS, these instruments could be extremely helpful in the diagnostic evaluation.

How Can the Clinician Help the Child or Adolescent?

The treating physician or therapist should be aware that an entire behavioral and intra-psychic repertoire can develop as a result of a poorly-regulated arousal system. This might include:

1. Difficulty regulating aggressive impulses
2. Disorders of sleep arousal (parasomnias) night terrors and nightmares with themes of pursuit and abandonment, and content of dismemberment and gore
3. Fear of abandonment (caretakers will be killed).
4. Emergence of daytime fears and separation anxiety, sensitivity to rejection, obsessional routines or rituals that develop around bedtime with a resistance to going to bed
5. Shame and helplessness about his or her actions and inability to control the fears and anger, and to act like all the other children

The treating physician or therapist would do well to ask the youngster specifically about the nature and extent of his or her fears, and help the child understand and talk openly about the aggressive outbursts. The children may be relieved that someone is aware of their struggles and that they are not bad or hurtful people. The children's misperception that people are hurting them can be explored so that they may not need to feel that they are defending themselves out of dire necessity.

Questions a therapist can ask: Do you usually feel fear when you are alone? What are the fears that you have at these times? What frustrates you most? What triggers the lash out? What is it like inside when you feel the anger? Do you believe you could control these impulses?

Providing a model that helps children understand their behavior based on biology, one that takes into account the difficulty that they have in regulating fear and aggression, can go a long way toward establishing a therapeutic alliance.

What Can Parents Do?

If parents become more aware of the child's internal experience - that he or she may be reacting to a perceived threat - the confusion and the pressure on the parents will ease a bit. Parents can gain some sympathy for the child's bewildering and hurtful behaviors, and respond less defensively as well, thus helping matters to de-escalate.

Only then can they help the child navigate this territory of fearfulness and defensive aggression. Perhaps the issue of sleeping alone and being alone in a room is one that can be dealt with at a later time, when the fears are not all so front-and-center (they do tend to become less acute as time goes by).

After proper medical management of her son's mood disorder, one mother was able to say to her son: "Josh, you are stable now, and you have a window of opportunity when these powerful aggressive impulses can be downgraded, and you can pause and reflect and find a way to control the feelings."

In Conclusion

If both clinicians and parents are aware of the correlation between obsessional anxieties (severe fear of harm) and aggressive behaviors, it can be discussed and worked through and the youngster may not struggle so deeply with these overwhelming feelings alone. Techniques can be developed that help the child reign in the fear and misperception that add to the likelihood of aggressive behaviors toward self or others.

Medications are key to stability, but the defensive and knee-jerk reactions that have developed as a result of a dysregulated arousal system - so early in life - must be addressed if the child is to move forward in life, less afraid and less ashamed.