Comments by Clinical Editor
The author educates readers about bipolar disorder in children and offers an argument for DIR/Floor Time to be part of a comprehensive treatment approach.

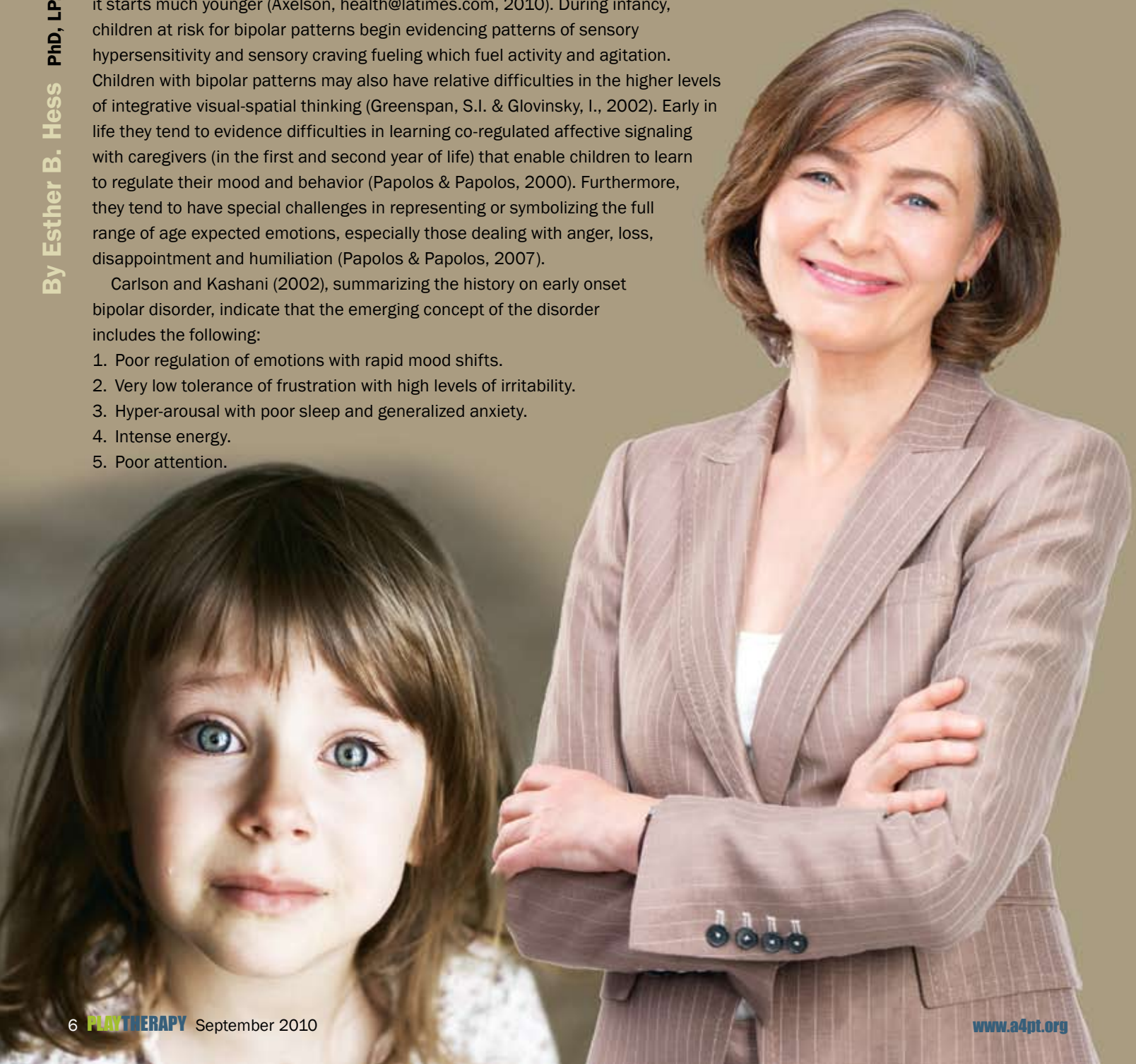
DIR/Floor Time
and Early Onset Bipolar Patterns in Children

By Esther B. Hess PhD, LP, ABPP, RPT-S

Bipolar disorder clearly exists in adults. If you look at adults who have bipolar disorder in the U.S., nearly 50% recall having significant mood symptoms in childhood and adolescence. This isn't an illness that starts at age 25 to 30; it starts much younger (Axelson, health@latimes.com, 2010). During infancy, children at risk for bipolar patterns begin evidencing patterns of sensory hypersensitivity and sensory craving fueling which fuel activity and agitation. Children with bipolar patterns may also have relative difficulties in the higher levels of integrative visual-spatial thinking (Greenspan, S.I. & Glovinsky, I., 2002). Early in life they tend to evidence difficulties in learning co-regulated affective signaling with caregivers (in the first and second year of life) that enable children to learn to regulate their mood and behavior (Papolos & Papolos, 2000). Furthermore, they tend to have special challenges in representing or symbolizing the full range of age expected emotions, especially those dealing with anger, loss, disappointment and humiliation (Papolos & Papolos, 2007).

Carlson and Kashani (2002), summarizing the history on early onset bipolar disorder, indicate that the emerging concept of the disorder includes the following:

1. Poor regulation of emotions with rapid mood shifts.
2. Very low tolerance of frustration with high levels of irritability.
3. Hyper-arousal with poor sleep and generalized anxiety.
4. Intense energy.
5. Poor attention.



6. A multiplicity of developmental difficulties (Carlson & Kashani, 2002, p. xvii).

Research in childhood bipolar disorder is now indicating that it exists comorbidly with subtypes including ADHD, anxiety, and conduct disorder (e.g., Wozniak et al., 1995; Faraone et al, 1998; Biederman, et al. 1999). Bipolar disorder starts far earlier than initially thought, is a chronic condition and requires multi-disciplinary intervention that includes psychotherapy, medication, special education programming and parent guidance.

DIR/Floor Time is a psychotherapeutic play intervention that focuses on a developmental/relational approach to the treatment of bipolar illness in children which takes into account a child's developmental age and bio-psychosocial framework that together as a whole may contribute to some of the more challenging symptomatic elements of this disorder. This model enables us to better understand bipolar pattern in children and help us to identify a unique intervening developmental organization (i.e., intervening between genetic-biological factors and the presenting symptoms and behaviors) that may characterize children with bipolar patterns.

Floor Time, the mental health component of this approach, is an opportunity to engage a child in all functional emotional developmental levels at the same time. Simultaneously the child is helped to broaden and regulate the full range of feelings and ideas appropriate for his/her developmental level. The key is to follow the child's natural interests and mobilize spontaneous use of communication. This means following a child's lead. It also means challenging the child to engage in longer and longer chains of co-regulated affective interactions (Greenspan & Weider, 1999).

The overall treatment goals are as follows:

1. To improve self-calming through soothing.
2. To deepen the pleasurable part of important relationships, especially where they have been polarized into power struggles and these struggles have begun to compromise trust. The child needs to feel again that he can trust and rely on the world.
3. To improve the regulation of affect and mood. This must be accomplished via the reciprocal affect regulatory gesturing system. (The opening and closing of circles of communication). The child must learn through gestural communication to be affectively regulated and reciprocal in relation to sensory stimuli, internal affects and interactions that tend to overload and agitate.

As the child develops the capacities for talking and thinking, additional goals are added such to include fostering:

4. The representation or symbolization of the full range of emotions, including anger, loss, and dysregulation.
5. The integration of emotions rather than their polarization.
6. Self-observation and reflection rather than action.

The needs of children with bipolar patterns will vary considerably in terms of the necessity for additional services beyond the play therapy model of Floor Time. Some have specific learning challenges in the area of motor planning and sequencing (executive functioning); others will have problems with high level visual spatial thinking; still others may have difficulties with language and/or aspects of cognitive functioning. It is critical then for a clinician well versed in both the model and this disorder to spearhead a comprehensive program that is tailored to a child's specific developmental profile.

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Often this kind of program includes a thorough medical evaluation and consideration of biological interventions. In considering bio-medical interventions for mood disorders, including bipolar patterns, it is important to view possible interventions within the context of the child's age and level of developmental capacities. Frequently, when antidepressants, including SSRI's, are used with older children with bipolar mood patterns, there has been observed an increase in reactivity, irritability and potential for aggression and the potential for more fragmented or polarized thinking (Greenspan & Glovinsky, 2002). While many children benefit from a consideration of bio-medical interventions, it is important to monitor very closely both the areas of improved functioning as well as compromised functioning because children change rapidly in terms of developmental capacities and what appears helpful at one stage of development may not be as helpful at another.

Case example: H. is a six-year old child diagnosed with bipolar disorder. Her early history included a diagnosis of Attention Deficit Hyperactive Disorder and Oppositional Defiant Disorder. But, when H. was five years old, her behavior escalated into extreme violence towards her parents, siblings and peers, periods of mania where she would sleep for no more than two hours a night for days on end, and have wide variations in her mood that swung between deep depression where she actively expressed a wish to die and euphoria where she felt that she was a super hero and able to fly. Therapeutic sessions with H. would often break down into potential destruction in the playroom as soon as the child was faced with a situation that caused her any frustration. It became clear that this child's inability to regulate and self-soothe, fundamental to her ability to access higher developmental/cognitive thought, was interfering with future overall progress. One advantage to this child's presentation, however, was that her emotional eruptions were typically accompanied by subtle signals, such as rapid breathing, that gave this clinician a clue for an intervention strategy.

DIR/Floor Time encourages a variety of techniques that can be used to help a child compose enough to move forward in the work of play. Often occupational therapy type tools such as giving proprioceptive input are used in session that provide the child's body with neuro-physiological messages that help reduce the anxiety that often is at the core of the severe dysregulation. As the clinician began to observe the pattern of this child's breakdown in communication, saw the rapid breathing that had accompanied her not being able to draw a picture exactly as she wanted, the interventionist offered a lollipop for the child to suck. The child accepted the lollipop and as she sucked the oral input created an opportunity to reregulate and once again become engaged. Once engaged this clinician reflected to the child a thought; "Wow, you just had a great idea! By sucking on

the lollipop, your whole body got calm. What do you call the funny feeling inside your body when your face looks so mad?" The child thought a moment and answered "fizzy, 'cause I don't like fizzy soda!" The child had become a complex thinker where she had begun to identify the fundamental experience of her meltdowns as well as a solution that she herself could activate as a way to regain control of her own actions.

By utilizing a developmentally based bio-psychosocial model-one which formulates the intervening developmental pathways that lie between genetic – biological etiological factors and presenting symptoms and behaviors in this context, these developmental organizations can provide the clues for earlier identification of challenges and more effective treatment approaches.

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