Juvenile Bipolar Research Foundation

Every Child Is Unique

It goes without saying that all children are different from the git-go. Additionally, the degree of FOH that a child inherits can range from profoundly debilitating to much less so. So, while generalizations can be made about the behaviors and symptoms of FOH, as you read the information below, it is important to remember that they all exist on a continuum. In fact, seeing the more subtle versions, the FOH-lite as we call it, is certainly harder than seeing the glaringly obvious one. That said, it is probably fair to say that all children affected by FOH face significant burdens and deserve the best understanding and support that we can provide to them.

What is Fear of Harm?

Like Bipolar Disorder, Fear Of Harm includes manic and depressive symptoms. However these are just two of the characteristics of a much broader syndrome.

Fear of Harm (FOH) is a syndrome, or collection of behaviors and symptoms, which occur along with a specific trait called fear-of-harm. The trait, which is heritable, is one of obsessive fear that harm will come to self and/or others.

Since FOH is a heritable condition, some children are much more affected by it than others.

Children with FOH have an unusually high perception of threat. The threat can be real, imagined or psychotic.

Children with FOH typically react negatively when they feel threatened. This can be expressed as confrontation, defiance, blame, bullying, retaliatory threats, attacks, and even rage. Sometimes the child turns the aggression inward on him or herself.

Children with FOH have extremely high levels of anxiety.

In addition to a Bipolar diagnosis, children with FOH typically have one or more co-morbid diagnoses. The most frequent are: mania, major depression, separation anxiety disorder, generalized anxiety disorder, obsessive-compulsive disorder, oppositional defiant disorder, conduct disorder and attention deficit disorder.

While this condition can be very severe and life altering, when the symptoms are quiet, children with FOH are typically loving, insightful, bright children. They often feel terrible remorse that they cannot better control their reactions, their thoughts and their lives.

Other Characteristics

Daily escalation of energy: In general, children with FOH have a low level of energy in the morning which escalates during the day. There is typically a difficult period around dinner time and they can reach a high level of energy prior to bedtime.

Rapid shifts of mood: Each child is unique in terms of where they fall on the behavioral spectrum between depression and mania. But within their individual range, the children can shift rapidly and unpredictably between moods many times within each day. Shifts into or out of difficult moods occur either spontaneously or can be rapidly triggered by events, interactions and/or expectations. Sometimes the shift is as sudden and dramatic as to be like a switch turned on or off.

Manic behavior: Along a continuum from mild to extreme, children can be giddy, goofy, and attention-demanding. They may be particularly enthusiastic for their usual activities, be expansive for new activities (often of a risky nature) and/or overestimate their own (or other's) value. They can speak rapidly, have racing thoughts and/or be more argumentative or bossy than typical. They also can have a reduced need for sleep.

Depressed behavior: Along a continuum from mild to extreme, children can be filled with feelings of sadness, anxiety, self-loathing, and hopelessness. This can be accompanied with increased negative perceptions of self/events/people.

They are likely to have low motivation, decreased ability to concentrate and/or a loss of interest in things previously enjoyed; all of which lead to a feeling of intense boredom. The child might isolate, sleep excessively, speak more slowly, and have a decreased appetite.

Irritable behavior: This is the chronic “on-guard” state of vigilance from which the child is quick to react negatively. Any parent of a child with FOH can tell you that they walk on eggshells careful to avoid the triggers. It is never far below the surface. In its most extreme form it escalates to rage.

Poor frustration tolerance: It is particularly difficult for the child with FOH to delay gratification. This is easily seen with limit setting. The child wants something and wants it now and denial of that “need” is interpreted (to a greater or lesser degree) as a threat to survival. The frustration caused by waiting in line, being asked to do something that they find difficult, and of course the all challenging “no”s by a parent, causes a high degree of anxiety and reaction.

Poor self-esteem regulation: The child’s sense of self can range from unrealistically positive to overly pessimistic; largely in relation to the current state of mania or depression. In a manic mind set, the child can be arrogant and overly-optimistic and believe him or herself to be all-knowing, superior to authority figures, and even possess super-powers. When the mood is depressed, they can be self-critical with intense feelings of shame, humiliation, worthlessness and insecurity.

Executive Function deficits: Many children with FOH have difficulty with executive functions. These are the brain functions involved in planning, working memory, attention, problem solving, verbal reasoning, inhibition, mental flexibility, task switching, and the initiation/ monitoring of actions. Problems with some of these functions are expressed as:

- Extreme resistance or anger to unexpected changes of plans
- Difficulty giving up an idea or desire, no matter how unrealistic it may be
- Difficulty starting or completing school assignments or tasks around the house
- Difficulty getting past small details in order to see the “big picture”
- Impulsivity and over-reactivity
- Restlessness or fidgetiness
- Poor handwriting

The extra challenges created by these deficits contribute significantly and inextricably to the overall levels of anxiety and obstacles that the child lives with.

Because of these Executive Function deficits, many children might mistakenly receive a diagnosis of ADHD. While indeed the observed symptoms might be ADHD, there are subtle variations which would distinguish between the two conditions.