Psychodynamics of Hypersexuality in Children and Adolescents with Bipolar Disorder

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Abstract: It has recently become evident that bipolar disorder exists in children and adolescents. The criteria for making the diagnosis of juvenile bipolar disorder (JBD) are in the process of being proposed for the fifth edition of the Diagnostic and Statistical Manual (DSM-V). In adults, a criterion for bipolar disorder is excessive involvement in pleasurable activities including hypersexuality. Recently, some clinicians and researchers have suggested that hypersexuality be included as a criterion for JBD as well. Although abnormal sexuality has been reported to be present in some youth thought to have JBD, the reason for this association is not yet clear. Hypersexuality may be primary and intrinsic to bipolar disorder in youth, secondary and associated with it as the result of psychosocial influences or psychodynamic factors, or due to general aggression and disruptive behavior. Not only have developmental psychosocial factors that may influence sexuality in children and adolescence not been fully investigated, but psychodynamic influences have been omitted from modern etiological constructs as well. This report discusses the importance of psychosocial and psychodynamic influences on the sexual experience and activity of bipolar children. It is proposed that a developmental, psychodynamically informed model is helpful in understanding sexuality in children and adolescents with bipolar disorder. It is also suggested that assessment of psychosocial and psychodynamic influences on the sexuality of bipolar children is necessary in order to adequately assess whether hypersexuality should be a criterion of bipolar disorder in youth.
INTRODUCTION: HYPERSEXUALITY AND BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS

The symptom of hypersexuality has recently emerged as an important issue in efforts to adapt the criteria of bipolar disorder to children and adolescents. Several psychiatric disorders that were once thought to affect only adults, such as major depression and schizophrenia, are now known to affect children and adolescents. However, their diagnostic criteria often require adaptation in order to be developmentally appropriate. Recently, a consensus has been achieved that, like other illnesses, bipolar disorder affects the pediatric population as well as adults (juvenile bipolar disorder, or JBD; National Institutes of Mental Health, 2001). There is evidence suggesting that hypersexuality, a symptom of bipolar disorder in adults, may also be a symptom of JBD. However, increased sexuality can be displayed in normal children or adolescents, and also by those with a variety of abnormal conditions or factors including sexual abuse, sexual overstimulation, and posttraumatic stress disorder. Psychodynamic factors are often significant influences of hypersexuality in these situations; they may be among youth with bipolar disorder as well.

While there is a need to adapt the criteria of bipolar disorder to children and adolescents, there are unique challenges in doing so. There is no universally accepted definition of hypersexuality for children and adolescents. Dimensions that are emphasized in the literature include increased erotic drive or sexual desire, impaired impulse control, diminished social judgment, or aggression in expressing sexual activity. Other challenges in adapting bipolar criteria to youth relate to the duration criteria for bipolar disorder. While there is evidence that the mood swings of bipolar disorder may be very rapid in the pediatric age range, sometimes lasting as little as four hours, there are special clinical difficulties in diagnosing mood swings of such short duration in children, whose symptoms are often reported by others, who may have immature coping mechanisms, and who may be reacting to stressors (American Academy of Child & Adolescent Psychiatry, 2007). In addition, there is significant overlap between the symptoms of bipolar disorder and those of other common psychiatric conditions in children and adolescents such as attention deficit hyperactivity disorder (ADHD). For example, both ADHD and JBD are characterized by inattentiveness, impulsive behavior, motoric over-activity, over-talkativeness, and disorganized thinking (Reich et al., 2005). There is evidence suggesting that an overly broad definition of JBD may have led to its over-diagnosis. There was a 40-fold increase in the diagnosis of bipolar disorder
HYPERSEXUALITY IN YOUTH WITH JBD

in youth between 1994/1995 and 2002/2003 (Moreno et al., 2007). In addition, when a broad definition of bipolar spectrum illness is used to define the disorder in children and adolescents, the incidence of JBD is out of proportion to the prevalence of the illness in the adult population (Leibenluft, Charney, Towbin, Bhangoo, & Pine, 2003). These facts underscore the need to precisely define the criteria of juvenile bipolar disorder in order to avoid over-diagnosis.

The literature on bipolar disorder in children and adolescents is much more recent and less extensive than that on bipolar disorder adults. That which does exist has not focused on psychodynamic factors influencing symptoms or treatment. Hypersexuality, if confirmed to characterize bipolar disorder in children and adolescents as well as adults, may be influenced by psychosocial events and psychodynamic factors.

IS INCREASED OR DISORDERED SEXUALITY PART OF JUVENILE BIPOLAR DISORDER?

Goodwin and Jamison (2007) review documentation of increased sexuality associated with bipolar disorder in adults. Both Kraepelin (1921) and Bleuler (1924) described increased sexuality associated with mania. One controlled study (Spalt, 1975) found increased “sexual drive” and a greater number of extramarital affairs in bipolar patients. Several case series have found similar evidence of increased sexuality in bipolar adults, including “hypersexuality” (Akiskal, 1983; Carlson & Strober, 1979; Himmelhoch, Mulla, Neil, Detre, & Kupfer, 1976; Leff, Fischer, & Bertelsen, 1976), increased sexual feelings and intensity (Jamison et al., 1980), frequent nudity and sexual exposure (Abrams & Taylor, 1976; Taylor & Abrams, 1977), or “episodic or unexplained promiscuity or extramarital affairs” (Akiskal, Djenderedjian, Rosenthal, & Khani, 1977).

Recent evidence suggests that hypersexuality may be a feature of bipolar disorder in prepubertal children and adolescents as well as in adults. Geller and colleagues (2002a) propose that the syndrome of JBD is characterized in youth 7 to 16 years old in part by hypersexuality, along with elation, grandiosity, flight of ideas, and decreased sleep. They propose that these core features help distinguish JBD from ADHD.

DSM-IV (American Psychiatric Association, 1994) incorporates increased or disordered sexuality as a criterion for manic and mixed bipolar episodes under the symptom rubric “excessive involvement in pleasurable activities that have a high potential for painful consequences,” examples of which include “sexual indiscretions.” Whether
this criterion should apply to children and adolescents as well as adults remains to be established. This depends on two factors: first, whether hypersexuality is confirmed to be present in youth with bipolar disorder and, second, whether their increased sexuality is relevant to the disorder in the same way that it is for adults.

In contrast with the increased sexuality included in the criteria for bipolar disorder, the “Sexual and Gender Identity Disorders” section of DSM-IV does not include any disorders related to excessive sexuality per se. It includes sexual dysfunctions (disorders of sexual desire, arousal, orgasm, pain, or dysfunction due to a medical condition), paraphilies (exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism and sadism, transvestic fetishism, and voyeurism), and gender identity disorder (GID), which is being reviewed in anticipation of the fifth edition of the DSM.

NORMAL AND EXCESSIVE OR DISORDERED SEXUALITY IN CHILDREN AND ADOLESCENTS

In order to adapt the symptom of hypersexuality to youth in a developmentally appropriate way as a possible criterion of juvenile bipolar disorder, it is important to consider the features of child and adolescent sexual development and some crucial differences between juvenile and adult sexuality. Descriptions of “hypersexuality” in children and adolescents need to be anchored in and referred to a framework of normal sexuality in youth.

Human sexual development begins in fetal life when brain structures that subserve sexual and gender-related function are organized partly under biological influences such as genes and sex hormones. It continues throughout infancy, childhood, and adolescence along characteristic pathways, although there is significant variability among individuals. These pathways are reviewed by Yates (2002) and by Delamater and Friedrich (2002); empirical knowledge about them is incomplete (O'Sullivan, 2003). Yates proposes a path of erotic development in which highly pleasurable sensations generated by an infant’s interaction with his or her parents leads to differentiation and appreciation of the genitals, incorporation of sexual parts in the concept of the body, then exhibitionism to test adult reactions, mastery of various self-elicited sensations, expansion of erotic interest to parents, siblings and peers, and finally to integration of genital function into the concept of self. As this happens, a variety of apparently pleasurable experiences
and a capacity for physiological arousal progresses from oral sensuality to anal and eventually genital stages. During this process, young children usually form concepts of their gender identity, and discover and play with their bodies. Their psychic representations of these are influenced by learning and social experiences. As children grow, they integrate sexual play into more complicated patterns of interpersonal play, with games such as “doctor,” and further elaborate their psychic representations of sexual and gender-related experience. They typically favor gender-typical patterns of play and, in later childhood, gender-segregated play, with some variability. As puberty approaches, a surge in sex hormones occurs under the influence of gonadotropic releasing hormone and luteinizing and follicle stimulating hormones in the hypothalamus. Under the influence of these hormones, testosterone levels rise (especially in boys, though to a lesser degree in girls) and activate the sexual functions of brain structures that were first organized in fetal life. Girls also experience cyclical fluctuations of estrogens and progesterone, which influence menstruation and aspects of erotic life. Youth then begin to have sexual experiences increasingly like adults. These come to be organized both intrapsychically and socially along patterns called “sexual scripts.” In adolescence, the developing ego identity usually includes a sense of the sexual self. It is experienced and manifested in accordance with the youth’s object relations, attachment patterns, and character style.

Clinicians must distinguish between normal sexual behavior in youth and excessive or disordered sexual behavior. Normal and excessive sexual behavior in youth at a variety of developmental stages has been identified both through empirical studies and clinical observation of the sexual behavior of normal, sexually abused, and psychiatrically ill children and adolescents (Friedrich 1993 Friedrich et al., 2001; Friedrich, Fisher, Broughton, Houston, & Shafran, 1998). In compiling available empirical data with clinical experience, Johnson (1993) describes a continuum of “natural and healthy behaviors . . . sexually reactive behaviors . . . extensive mutual sexual behaviors, and, on the far end of the continuum, sexually aggressive behaviors (p. 431),” and describes the following examples among others:

**Preschool Children:**

Normal Range: Touches the genitals, breasts of familiar adults and children.

Seek Professional Help: Sneakily touches adults. Makes others allow touching, demands touching of self. (p. 432)
Young School-Age Children:
Normal Range: Plays games with same-age children related to sex and sexuality.

Seek Professional Help: Forces others to play games related to sex and sexuality. (p. 435)

The excessive or disordered behaviors are characterized not only by their frequency, but also by features such as precocity, violation of social boundaries, compulsiveness, or aggression.

MULTIPLE FACTORS MAY INFLUENCE EXCESSIVE OR ABNORMAL SEXUALITY IN CHILDREN

Human sexuality and sexual development are determined by a complex set of factors that include biological, psychological, and sociocultural influences. A variety of social and interpersonal experiences with peers and adults may influence the level of young children’s sexual behavior. For example, a study of day care providers demonstrated that 4- to 6-year-olds imitate sexual behaviors they see or hear about (Phipps-Yonas, Yonas, Turner, & Kamper, 1993). In addition, children’s sexual behavior may be correlated with the sexual behavior of family members, including many types of family stressors and disordered behavior such as violence (Friedrich, et al., 1998).

Exposure to situations such as sexual abuse, other sexual trauma, or sexual overstimulation can lead to an increase in children’s sexual behavior. Children and adolescents who have been sexually abused have been found to display symptoms of posttraumatic stress disorder that include increased sexual behavior. Increased general levels of sexual behaviors have been described in children and adolescents with a variety of clinical conditions and in abnormal situations (Friedrich, 1993; Friedrich et al., 2001).

Yates (1991) describes four causes of “hypererotic” behavior in children. As an example of one mechanism, learning through overstimulating experiences in the family, she describes a 6-year-old son of a devoted single mother who, while not overtly abusing her child, stimulated him excessively in erotically charged activities like bathing, cuddling, and parading; the child later displayed an unusual interest in playing games with girls that included undressing, examining, and rubbing
genitals which led him to be suspected of being sexually abused, although evaluation determined he was not. As an example of a second mechanism, learning through abuse, she describes a boy who at age 4 lived in a chaotic family without supervision and was sexually abused by an adult male family friend, and who then went on by age 8 to engage in many, varied erotic activities (these are not described in detail). As an example of a third mechanism, development of sexual compulsions, she describes a 5-year-old girl whose strictly religious parents strongly scolded her for masturbation, but who, with the defiant negativism frequent in obsessive-compulsive behavior, persistently and increasingly did so, including publicly. As an example of a fourth mechanism, as a symptom of posttraumatic stress disorder, she describes a 7-year-old girl who was raped by a 23-year-old cousin, threatened with death, and expected to die; she later began making her younger brother pull down his pants and play “enema,” and jabbed sticks between the legs of her Barbie dolls.

IS EXCESSIVE OR DISORDERED SEXUALITY PART OF JUVENILE BIPOLAR DISORDER?

In their study of youth 7 to 16 years old with symptoms of bipolar disorder, Geller and colleagues (2002a) included a measure of “hypersexuality.” They elicited information about sexual behavior using an instrument called the Washington University Kiddie-Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS) based on a semi-structured clinical interview from an adult informant, interview with the child or adolescent, and observations of subjects’ sexual behavior during the interview. They assessed the degree to which hypersexuality was found in youth with bipolar symptoms, and compared that to the degree to which it was found in children and adolescents with symptoms of ADHD and normal controls. They found hypersexuality to be displayed by youth with symptoms of bipolar disorder, but not by those with ADHD or controls. Based on this finding, they concluded that hypersexuality may help distinguish juvenile bipolar disorder from ADHD. Hypersexuality was not explicitly defined in the text. However, in clinically describing juvenile bipolar disorder in a companion paper, Geller et al. (2002b) give the following clinical vignettes to illustrate hypersexuality in prepubertal children with symptoms suggestive of mania:
Normal Child
A 7-year-old child played doctor with a same-aged friend. A 12-year-old boy looked at his father’s pornographic magazines.

Child Mania
An 8-year-old boy imitated a rock star by gyrating his hips and rubbing his crotch during a research interview. A 9-year-old boy drew pictures of naked ladies in public, stating they were drawings of his future wife. A 14-year-old girl passed notes to boys in class asking them to f____ her. Another girl faxed a similar note to the local police station. A 7-year-old girl touched the teacher’s breasts and propositioned boys in class. A 10-year-old boy used explicit sexual language in restaurants and other public places. Another child called “1–900” sex lines, which his parents discovered when the phone bill arrived at the end of the month. (p. 7)

If the criteria for bipolar disorder that are used to diagnose mania is adapted to children and adolescents in a developmentally appropriate way, one would expect JBD in youth to be developmentally and biologically continuous with bipolar disorder in adulthood. That is, youth diagnosed as bipolar would be expected to continue to meet established criteria for the diagnosis of bipolar disorder as adults, and would tend to share genetic patterns and other biological markers with family members with adult bipolar disorder. In a prospective study of youth 7 to 16 years old in which the definition of JBD was limited to strict DSM-IV criteria for mixed or manic bipolar I episodes characterized by clearly clinically significant pathology, including cardinal symptoms of elation or grandiosity and clear evidence of dysfunction, Geller, Tillman, Bolhofner, and Zimerman (2008) found relapse rates of 73.3% eight years later for the group, and 44.4% for those over age 18. They concluded this provides evidence that JBD defined according to these strict criteria for mixed or manic bipolar I episodes is developmentally continuous with adult bipolar disorder. Data on rates of hypersexuality in these patients were not included in this study.

If it is definitively established that these criteria validly and reliably identify bipolar disorder in youth, and if it is also confirmed that increased or disordered sexuality characterizes bipolar disorder in youth as it does in adults, the relevance of hypersexuality to JBD would still need to be clarified before concluding that it should be a diagnostic criterion of juvenile bipolar disorder. The association of hypersexuality with juvenile bipolar disorder would not, in and of itself, prove that juvenile bipolar disorder causes hypersexuality in children and adolescents. To do so would require ruling out that the hypersexuality is due to another, confounding factor.
DEFINITION OF HYPERSEXUALITY

The mental health professions have not agreed on the definition of hypersexuality in children. For purposes of this discussion, hypersexuality refers to sexual behavior that is characterized by increased sexual drive, interest or preoccupation relative to developmental norms. It may be precocious, socially inappropriate, or associated with lack of impulse control. It may also be characterized by coercion or aggression.

POSSIBLE PSYCHODYNAMIC INFLUENCES ON HYPERSEXUALITY IN JBD

Even if researchers replicate the finding that bipolar children display increased sexuality, a psychodynamically informed, biopsychosocial developmental model is necessary to adequately understand the clinical significance of this observation. As noted above, the behavior of adult caretakers and other authority figures may influence the sexuality of children and adolescents. These factors undoubtedly influence children with bipolar disorder as they do other children.

Family, twin, and adoption studies show there to be genetic influences on the development of bipolar disorder (Smoller & Finn, 2003). Therefore, youth with bipolar disorder are more likely than the general population to have first-degree relatives with bipolar disorder, atypical and other bipolar spectrum disorders, including their parents and others with whom they live. As adults with bipolar disorder frequently display hypersexuality, it is reasonable to speculate that these youth may be exposed to and affected by adult hypersexual behavior more than the general population of youth (Etain, Henry, Bellivier, Mathieu, & Leboyer, 2008).

The sexual behavior of children and adolescents with bipolar disorder may thus be influenced by environmental factors including the traumatizing and other effects of adult sexual behavior to which they are exposed. If hypersexuality is truly associated with JBD, the reason may involve risk factors in the interpersonal environment that occur with increased frequency in cases of JBD such as sexual abuse, inappropriate family sexual boundaries or other family dysfunction, PTSD, or socioeconomic variables. Psychodynamic influences—that is, ones involving mental and emotional processes that are unconscious—may be a significant mediating factor in these environmental risks. In order
to understand them, it may be necessary to incorporate such psychodynamic factors into conceptual models of risk and causation.

Adults with bipolar disorder who commit sexual boundary violations, sexually overstimulate, or sexually abuse youth may cause them to experience overwhelming feelings. Youth may respond by marshaling defenses that remain entrenched for years, even when no longer adaptive. The relational and social experiences of such youth may thus have significant psychodynamic effects that adversely affect their sexual development. For example, a youth exposed to a hypersexual mother who violates sexual boundaries by behaving seductively with his peers or with the youth himself may be flooded with sexual overstimulation, anxiety over loss of control, and distress about developmentally inappropriate and incompetent parenting. Against the conflict and anxiety evoked by these traumas, the child may defend himself by rationalization of the mother’s behavior and identification with it. He might, for instance, develop a fantasy life in which his sexual self appears as an Oedipal victor. If these conflicts remain unresolved, their defensive maneuvers may be carried forward into adolescence and adulthood in a way that is crystallized in fantasy life and patterns of sexual behavior. Such a patient may try to reproduce sexual boundary violations with significant transference objects with maternal or childhood-self valences. For example, he might violate sexual boundaries with younger children or try to seduce teachers, therapists, or research interviewers in an effort to maintain a normalized image of the original maternal relationship and keep anxiety and conflict about it at bay. If such a child is seen in a research study, he may be scored as “hypersexual.” His behavior can only be fully understood if the psychodynamic influences on his behavior are reckoned.

Psychodynamic factors are distinct from other influences on sexuality such as genetic, hormonal, or sociocultural ones, although these are not mutually exclusive and may interact with one another. They may be particularly germane to youth who have experienced overstimulation or abuse. If hypersexuality is indeed present in children and adolescents with a valid syndrome of bipolar disorder, psychodynamic influences may be a significant factor. This fact highlights the importance of sophisticated psychodynamic thinking about human sexual development and mental health and, more broadly, to modern evidence-based psychiatry.

Psychodynamic factors may influence the sexuality of some bipolar children more than others. Psychodynamically informed treatment may be useful for bipolar children or adolescents with hypersexuality in conjunction with other treatments when psychodynamic factors are an influence on excessive or disordered sexuality, or when they influ-
ence a sexual expression of bipolar symptoms. In order to illustrate the usefulness of psychodynamic formulations regarding increased sexuality in children and adolescents with symptoms of bipolar disorder, the following case vignettes are presented. These are composites representing no individual patient. They are complex because in the clinical reality, there is always a great deal of complexity.

CASE VIGNETTES

Case 1

An 18-year-old male with JBD has an unusual number of sexual partners. He displays a persistent pattern of attachment difficulty and sexual anxiety that began in adolescence. He had experienced childhood trauma from parental conflict related to maternal bipolar disorder. He developed a sexual inhibition manifested as erectile difficulty. Inhibited by obsessive character traits, he engaged in shallow, unsuccessful efforts at establishing a relationship with a woman and engaging in partnered sex.

An 18-year-old male complained of concerns with school-related stress, anxiety, and dissatisfaction with girlfriends. He described an intense sexual drive, and had had 11 or 12 girlfriends as well as dozens of one-time “hook-ups,” although his first interpersonal sexual activity had begun only 3 years earlier. He had difficulty establishing closeness with each due to feelings of mistrust and erectile difficulty.

As a child, the patient was unusually energetic and strong-willed beginning in nursery school. At age 6 he was seen by a psychologist for being hyperactive, disruptive, and having a bad temper. Although he struggled to be good, he often fought with his siblings and clashed angrily with adults over matters of authority and rules. At home, his mother, who was diagnosed with bipolar disorder, but who was non-compliant with her treatment, had a chronically labile mood ranging from antic high-spiritedness to hair-trigger anger. She often angrily belittled the patient’s father, who in turn adopted a meek demeanor in an effort to mollify her. The patient’s mother often compared him favorably to his father, and would caress and stroke him while confiding her unhappiness with her marriage.

In grade school, the patient often felt moody, with ups and downs characterized by alternating excitement and disappointment. He often had difficulty focusing on schoolwork. He was very bright, but achieved grades below his potential. He was suspended two or three
times for physical fights with peers. In high school he was diagnosed with attention deficit hyperactivity disorder. Treatment with a stimulant was quickly terminated because it made him feel unpleasantly overstimulated.

The patient had clear mood fluctuations at least since puberty, with periods of elated mood, feelings of unusual confidence, inflated self-esteem, a feeling of being quick-thinking and decisive and having special insight into others, increased activity, and decreased need for sleep. In this state, he sometimes experienced racing thoughts, anxiety, difficulty with focus, and decreased performance at school or work, leading to negative feedback. This would lead in turn to feeling down with ruminative worry, low self-esteem, low energy, psychomotor retardation, and hypersomnia.

The patient first masturbated at age 12 after discovering a cousin’s pornographic magazines. He was intensely excited sexually and masturbated many times daily throughout adolescence to fantasies of multiple heterosexual conquests; having dominion over a submissive harem of female schoolmates who rejected rivals in his favor was a frequent fantasy. Although he had had friends of both sexes prepubertally, he avoided friendship with girls beginning in adolescence. He was attractive and athletic, and succeeded in getting dates with girls, but after a few he typically began to feel jealous and suspicious of girlfriends. He would at first feel intense sexual excitement in foreplay, then sexual performance anxiety that would lead him to lose his erection. He seemed to have difficulty acknowledging how embarrassed he was by this problem, and defensively devalued his girlfriends. He remembered the loss of virginity at age 15 with increasing nostalgia. He would find reasons to break up with girlfriends before establishing intimacy, and preferred habitually to go to bars and clubs to meet a “perfect” girlfriend.

_Psychodynamic Formulation._ As a result of his prolonged boyhood experiences both of being strong-willed and also of his mother’s unconsciously sexually stimulating behavior and encouragement to succeed his father, this individual developed a conflict over simultaneous wishes to compete with his father on the one hand, and on the other guilt about and fear of his aggressive, competitive impulses. As a boy, he learned to manage this anxiety with obsessional defenses such as reaction formation, forcing himself to try to be a dutiful child and immersing himself in structured outlets like athletics. As an adolescent with juvenile bipolar disorder, this young man experienced a driven sexual desire engaged in pursuit of one woman after another seeking sexual release. The intense gratification of sexual climax in intercourse
came to be overwhelmingly associated with unconscious fear of potential victory, which he defended against with unconscious compensatory inhibition. He developed erectile dysfunction. Feeling himself inadequate compared to fantasied rivals preferred by his partners as girlfriends because of the sexual dysfunction, he devalued these women and dropped them. He further compensated for the shame of sexual inadequacy through a counterphobic acting-out of competitive sexual wishes through numerous sexual contacts, which, in a self-defeating compromise, were never fully gratifying. The patient was subconsciously always safely "punished" with frustration for his competitive sexual urges.

Case 2

An adolescent girl with JBD displayed an unusually early onset of partnered sexual activity and sexually provocative behavior. These emerged in the setting of affective symptoms that included chronic antagonism and grandiosity. Her childhood was characterized by multiple losses and separations and sexual overstimulation. These led to the development of a sexual identity in adolescence that included a defensively grandiose and unempathic sense of an omnipotent sexual self.

A 15-year-old girl had a history of moodiness, defiant and disruptive behavior, and dressing in a sexually precocious and provocative way and arguing frequently with her mother about clothing she wore to school. She lived with her mother, a former prostitute with bipolar disorder and alcoholism living on public assistance, in a supportive housing program for dually diagnosed adults. She was the result of an unintended pregnancy with a client of her mother, and had never known her father.

The patient was perceived as physically attractive, and received much praise for this from a young age. Her mother enrolled her in local child "beauty pageants" starting at age 3 to support her feelings of self-worth. The patient and her family were overjoyed when she received second place in one, and a promise of a chance at child modeling.

The patient’s mother had received clients in their one-bedroom apartment until the patient was 8 years old. The patient and her mother would sleep in the same bed when no clients were present; when they were, the patient was banished to a fold-out couch in the living room. She was anxious when separated from her mother in this way, feeling that her mother was angry for some reason and had the impression she was keeping a powerful and important secret from her. On more than
one occasion, she entered the bedroom while her mother was with a client, and once saw her mother performing oral sex.

The patient had difficulty focusing and paying attention since the second grade, was easily distracted by peers, and was left back twice. From age 7 she displayed a chronically irritable mood and rude, disrespectful behavior toward adults. The patient’s favorite games as a girl involved playing with dolls including medieval knights striving to be reunited with beautiful princesses and living happily ever after. She discovered she could self-stimulate with her dolls around that time, and began to do so during her separations from her mother to self-soothe as well as derive pleasure.

When the patient was 8, she was truant from school for two weeks after developing school phobia while her mother was on an alcoholic binge. The school reported her mother to child protective services for educational neglect. The patient was taken into protective custody and placed in temporary foster care for ten months while the mother went through a dual-diagnosis treatment program, then reunited with her mother in the supportive housing program. On her return, she appeared unfazed about the separation, but became more oppositional in the classroom.

Her menarche at age 11 surprised and frightened her and made her think she had a tumor. Around then, she discovered that she could attain the attention of neighborhood boys through adult styles of dress and make-up that she had learned and seen her mother wear. She displayed a haughty, condescending attitude toward peers, and provoked much negative feeling among them by presenting herself as more attractive than they to their boyfriends. Because of her provocative clothing, her mother was extremely worried that she would earn a “bad reputation” with boys or be physically attacked by girls. However, the patient appeared unconcerned, expressing indifference because she was “better” than others. She first kissed a neighborhood boy at age 12, feeling that if she did he would become her boyfriend. She cried when he subsequently rejected her, but consoled herself during nightly masturbation with fantasies of powerfully attracting other neighborhood boys and rendering them helpless to resist her charms.

Mental status exam was notable for quick thoughts, somewhat pressured speech, and impatient mood.

Psychodynamic Formulation. This girl experienced an extreme level of multiple stressors, including paternal abandonment before birth, maternal alcoholism and mental illness, and foster care placement. These traumatic experiences led to a sense of shame that chronically threatened to evoke despair. They undermined her developmental need to
experience herself as effectively able to maintain significant relationships. In addition, her learning disability deprived her of a protective sense of academic success. However, she derived attention from her mother and others for her physical attractiveness as a way of getting positive attention. The patient never had a father, and wanted attention from men. She coped through defensive identifications with her mother, whom she began to see as able to get attention from men by being sexual. The patient began to display a pathologically grandiose sense of her sexual self, imbued with unlimited possibilities of love and seductive power. She was unconsciously driven to act out a scenario of being more attractive than other girls, triumphing over them and getting the attention of men. A shallow, exaggerated eroticism thus served defensively as an attempt to achieve mastery and control in reaction to experienced helplessness, traumatic sexualization, and abandonment. She displays precocious seductiveness without corresponding erotic behavior. While it is difficult in this patient to unravel features of her presentation that are intrinsic to bipolar disorder from those influenced by psychodynamic factors, psychodynamic factors were important in the choice of her symptom expression and genesis of her sexual behavior. She displays grandiosity, risk-taking, and poor judgment in the presentation of her sexual self.

The two foregoing cases illustrate how hypersexuality in youth with JBD may be influenced by psychodynamic factors. Case 1 illustrates a patient with a high number of sexual partners. In this case, a neurophysiologically robust level of sexual desire, driven partly by hypomania, was intensified by an overstimulating parent, generating anxiety that became associated with a sexual inhibition (the impotence and difficulty with intimacy), which in turn led to compensatory efforts to prove prowess. Case 2 illustrates a patient with sexually provocative and risk-taking behavior. Her life experiences led to a powerful, generalized unconscious belief that sexual attractiveness is key to preventing abandonment. These psychological influences shaped the expression of what appears to have been a robust level of sexual interest and preoccupation, also driven partly by hypomania.

In each case, a psychodynamic sexual script was constructed in childhood and adolescence that partly influenced the expression of hypersexual behavior. Pharmacological treatment of these individuals’ mood disorder might help normalize their sexual behavior, but psychodynamically oriented psychotherapy might be necessary to address aspects of hypersexuality that are due not only to bipolar disorder but also to underlying conflicts stemming from childhood experiences.
The challenge of determining whether children with JBD are hypersexual and, if so, the relevance of the hypersexuality to the disorder raises important questions about what we know about children and adolescents’ sexuality, including what is normal and what is not. Childhood sexuality has been of central importance to psychodynamic theory. However, empirically based knowledge about sexual development in childhood and adolescence is incomplete. Fundamental assumptions about sexual development, such as the role of erotic drives in causing psychopathology and the determinants of gender identity, have had to be updated in light of modern neuroscience. Modern psychodynamic thinking must be continually updated to incorporate these scientific advances.

Seen in this light, increased or disordered sexuality in children and adolescents is of interest for several reasons. It is clinically important in and of itself because of its association with clinical syndromes of sexual abuse, posttraumatic stress disorder, and juvenile bipolar disorder. In addition, it is of general significance in understanding children and adolescents’ sexual development, its influences and determinants, and the relevance of psychodynamic theories in explaining human sexual behavior. A particular challenge of ascertaining the relevance of hypersexuality in juvenile bipolar disorder is separating the influence of a chaotic, overstimulating family environment from the influence of the bipolar disorder itself.

CONCLUSION

Psychodynamic paradigms were the dominant models of human psychology and behavior reflected in the first and second editions of the DSM (American Psychiatric Association, 1952; American Psychiatric Association, 1968). Since the shift to empirical, descriptive nomenclatures in psychiatry, relatively less attention has been paid to social and psychological influences on normal and abnormal sexual development in children and adolescents. Attending to such influences on sexuality in future studies would enhance understanding of juvenile bipolar disorder in particular and child development in general, and would improve patient care. Future research on hypersexuality in youth with bipolar disorder should assess significant psychosocial factors in development, including sexual history. Further research is needed to
elucidate the role of psychosocial influences on the sexuality of bipolar children.

In conclusion, hypersexuality is observed in a proportion of bipolar youth. It is unclear at present to what extent the hypersexual behavior is due to the bipolar diathesis, and to what extent it is due to a chaotic, overstimulating environment that includes bipolar family members. Hypersexuality in bipolar children and adolescents may be influenced both by psychosocial and by psychodynamic factors. Thus, psychosocial events including both overt trauma such as abuse and subtler pathologies such as inappropriate family sexual boundaries and sexual overstimulation with unconscious psychodynamic meanings may have a significant influence on hypersexual behavior in youth with JBD.

REFERENCES


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