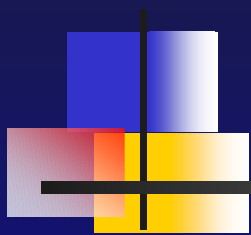


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Bipolar Disorder in Children and Adolescents



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BD in Children and Adolescents — Does It Really Exist?

- Does bipolar disorder exist in children and adolescents?
 - Conventional wisdom → bipolar disorder has onset in late adolescence or early adulthood
- Is it as common as brown eyes?
 - Conventional wisdom → affects 1-2 % of the population

BD in Children and Adolescents — Does It Exist?

- Recent, rapid changes in conceptualization of this disorder and increasing recognition of pediatric BD
 - Significant controversy and skepticism in the clinical and research child psychiatry community

BD in Children and Adolescents — Does It Exist?

- Few children diagnosed with BD have classic pattern of adult presentation with good premorbid functioning and discrete mood episodes
- Diagnostic boundaries have broadened so much that children previously called minimal brain disorder, early-onset schizophrenia, PDD, etc. are now labeled BD

BD in Children and Adolescents — Why Worry about It?

- Hundreds of thousands of families are concerned that their children have PBD
- Thousands of children are being exposed to a multitude of psychotropic medications for treatment of PBD, without the benefit of any randomized controlled studies establishing efficacy and without any FDA-indicated agents for PBD

BD in Children and Adolescents — How to Think about It

- How can a clinician go about contemplating PBD in patients?
 - BD never occurs in kids, so never diagnose it
 - If you fail a stimulant trial or get worse on a stimulant, you have PBD
 - “agnostic”—PBD is likely to be rare and the practitioner feels poorly trained to recognize and treat it

BD in Children and Adolescents

- Three lines of evidence support higher incidence of PBD than previously believed:
 - BD is one of the most heritable major mental disorders.

BD in Children and Adolescents

- Research in adult BD indicates earlier age of onset than previously known and more complicated pre-morbid functioning than known
- Classic adult presentation accounts for only 50% of adults with BD

BD in Children and Adolescents

- Controversies exist about:
 - Core symptoms
 - “broad,” “narrow,” and “intermediate” phenotypes
 - Cycling

Core Symptoms

- What is “enough” to diagnose mania?
 - Elation and grandiosity?
 - Irritability and aggression?
 - ✓ Most impairing symptoms but non-specific
 - Irritability only if accompanied by elation or grandiosity?
 - Affective storms?
 - ✓ Primary feature

Phenotypes

- Narrow
 - Recurrent episodes of major depression with mania or hypomania fitting the classic definitions of BD type I and II in the DSM-IV, including the duration criteria for mania (7 days) and hypomania (4 days)

Phenotypes

- Most have rapid cycling
- Core symptoms of elation and/or grandiosity
- Barbara Geller, et al.

Phenotypes

- Broad

- Severe irritability, “affective storms,” mood liability, severe temper outbursts, symptoms of depression, anxiety, hyperactivity, poor concentration and impulsivity

Phenotypes

- With or without clear episodicity
- No grandiosity or elation
- Corresponds to BD, NOS in DSM-IV
- Joe Biederman, et al.

Phenotypes

- Intermediate

- 2 subtypes

- ✓ Hallmark symptoms of classic BD, but do not meet duration criteria for mania and/or hypomania
 - ✓ Episodic irritable mania or hypomania without elation

Phenotypes

- Geller, et al. (1998, 2000)
 - Compared children with BD to children with ADHD and normal controls
 - Children with BD were differentiated from others by grandiosity, elated mood, hypersexuality, flight of ideas, decreased need for sleep
 - Irritability was common to both PBD and ADHD

Phenotypes

- Beiderman and Wozniak (1995, 1998, 2000) recommended diagnosing PBD if child meets DSM-IV criteria with irritability as a core symptom, even in the absence of grandiosity, elation or episodicity

Phenotypes

- Birhmaher, et al. 2004; Leibenluft, et al. 2003; Pavuluri, et al. 2004 consider irritability as a core symptom only if it occurs with elated mood or grandiosity
- Grandiosity without mood symptoms (elated or irritable) is not enough to diagnose BD

Phenotypes

- Do there need to be episodes?
- Definitions of cycling?
 - Complex cycling
 - Ultra-rapid cycling
 - Ultradian cycling
- Labile, unstable and changeable mood is common in typically developing, normal children under 10 years of age

Agreed Upon Features of PBD

- Chronicity with long episodes
- Predominantly mixed episodes and/or rapid cycling
- Prominent irritability
- High rate of co-morbid ADHD and anxiety disorders

What Does Mania Look Like in Children?

- Euphoria
- Grandiosity
- Decreased need for sleep
- Racing thoughts

Euphoria or Elated Mood

■ Normal

- Child is extremely elated on Christmas morning, when the family embarks on a trip to Disneyland, or when grandparents come to visit
- Mood is appropriate to context and is not disabling

■ Pathologic

- Elated and giggling in the classroom, when other youngsters are not; dancing around at home, exclaiming, “I’m high, over the mountain high.” after being expelled
- Mood is not appropriate and impairs functioning

Expansive Play vs. Grandiosity

■ Normal

- Playing at being a firefighter or teacher after school; directing other children who are expected to act like firefighters or pupils

■ Pathologic

- Child arises during class and instructs the teacher about educational policy; goes to the principal and demands the teacher be fired for incompetence
- Child informs the physician that he has consulted with God about exceptions to the 10 Commandments

Decreased Need for Sleep

■ Normal

- Children sleep 8-10 hours per day and are sleepy, tired or irritable the next day if they sleep fewer hours than usual for any reason

■ Pathologic

- An 8 yo boy chronically stays up until 2:00 a.m., rearranging the furniture and playing games; he arises at 6:00 a.m. for school; he is energetic and does not appear fatigued
- A 7 yo girl arrives at her neighborhood friend's house ready to play at 5:00 a.m.

Racing Thoughts

■ Normal

- Typical children do not respond affirmatively to inquiries about racing thoughts

■ Pathologic

- A girl points to her forehead and says, “I need a stoplight up there.”
- “Too much stuff is in my head.”
- “I don’t know what to think first.”

Challenges in Differential Diagnosis

- High rate of co-morbidity
- Overlap between symptoms of mania and more commonly occurring disorders
- Limitations of current diagnostic tools
- Bipolar disorder is cyclical and has a changing constellation of symptoms

Co-morbidities

- ADHD, ODD, CD and LD are most common co-morbid conditions; anxiety disorders and SUD are also common
- 2/3 to 3/4 of kids with BD also meet criteria for ADHD

Co-morbidities

- Co-occurrence with anxiety disorders is more common in adults with BD
- High rate of co-morbidity means textbook case of BD is rarely seen; more common and more familiar condition is recognized and treated, but BD is not

Symptom Overlap

- Bipolar depression looks the same as unipolar depression
- Mania and ADHD---the overlap is an artifact of redundancy, a sign of comorbidity or a distinct phenotype

Symptom Overlap

- ADHD and disruptive behavior disorders---irritable mood is a part of most child disorders---it is a formal diagnostic criteria in depression, mania, PTSD, adjustment d/o, intermittent explosive d/o, and a common associated feature in numerous d/o

Diagnostic Instruments

- Most research projects are using some version of the Kiddie Schedule for Affective Disorders and Schizophrenia (KSADs)---or the Wash U version

Diagnostic Instruments

- At present there is no practical, well-validated instrument available for clinicians
- Need to have collateral sources of information; self-reports underestimate incidence and severity of symptoms

Symptoms

- Primary features---affective storms
- Irritability and aggressive behavior are the most impairing symptoms---but non-specific

Symptoms

- Symptoms specific to mania---
elevated mood, grandiosity,
pressured speech, racing thoughts
and hypersexuality
- Geller's operationalized
definition=elevated mood plus three
other symptoms of mania

Evidence of Changes in Mood and Cycling

- Mood episodes reflect a change from the child's typical functioning
- Insidious onset, chronic course, overlapping comorbidities blur the boundaries of mood episodes
- Mood swings are unusual in frequency, intensity or duration

Extending the Window of Assessment

- Diagnostic clarity unlikely after the first couple of visits
- Current episode has to be combined with past episodes in order to make an accurate diagnosis
- Mood logs can establish the temporal criteria of the disorder

Recommendations for Diagnosing Pediatric Bipolar Disorder

1. Be open to the possible existence of PBD
2. Establish a reasonable base rate for prevalence—about 5% in non specialty outpatient clinic
3. Gather a detailed family history
4. Use screeners such as BASCs or CBCLs

Recommendations for Diagnosing Pediatric Bipolar Disorder

5. Gather info from multiple informants
6. Gather info about symptoms, especially those more specific to mania
7. Extend window of assessment
8. Monitor mood symptoms in an ongoing manner

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Thank You!



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