OPTUMHealth Education

UNVEILING BIPOLAR DISORDER IN CHILDHOOD AND ADOLESCENCE

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Disclosure

The educational presenter of this CME activity has no relevant financial relationships with commercial interests to disclose.

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OBJECTIVES

- Provide an overview of bipolar disorder in the pediatric population, including its prevalence, incidence, and symptoms.
- Review the childhood presentations of individuals who are diagnosed with bipolar disorder as adults.
- Identify the differential diagnoses for bipolar disorder in the pediatric population.
- Discuss the lessons by the presenter from her own experience in treating children with bipolar disorder and the applicability of these lessons to the participants' own practice.

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Subtypes of Bipolar Disorder

- Bipolar I disorder – diagnosis given for patients with 1 or more manic episode
- Bipolar II Disorder – diagnosis given for patients with a history of at least 1 hypomanic episode and at least 1 major depressive episode and no Manic episode.
- Cyclothymic Disorder – diagnosis given for patients with periods of hypomanic symptoms and periods of depressive symptoms which do not meet the criteria for a true hypomanic or depressive episode.
- Other specified Bipolar disorder – diagnosis given for patients who do not meet the Bipolar criteria.

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Epidemiology of Pediatric Bipolar disorder

- Lifetime prevalence of Bipolar Spectrum disorders for children is 2 percent.
- The stability in diagnosis of PBD in the United States has settled since the DSM-V.
- Child Psychiatrists in the United States for a while were diagnosing PBD 12.5 times more than other countries for a while; this trend has settled.
- There are several theories for this:
  - Loose interpretation of Bipolar symptoms
  - Co-morbidity complicating the diagnosing of children/adolescents
- Etiology for PBD continues to be a mystery

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Co-Morbidities

Disorder	%
Anxiety disorder	40-66%
ADHD	50%
ODD	40%
Conduct disorder	30%
SUD	20%
1 Medical condition	75%
Multiple Medical conditions	25-33%

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MDD : DSM V CRITERIA

- At least **2 weeks of pervasive change in mood** manifest by at least 5 of the following
  - **Depressed or irritable mood**
  - Loss of interest and pleasure.
  - Changes in appetite or weight
  - Change in sleep
  - Psychomotor agitation or retardation
  - Poor concentration or indecisiveness
  - Decrease in energy
  - Worthless, excessive guilt
  - Recurrent suicidal ideation or acts
- Symptoms represent change from prior functioning and produce impairment.
- Symptoms not attributable to substance abuse, medications, other psychiatric illness, bereavement, medical illness.

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MANIA : DSM-V CRITERIA

- **A distinct period of**
  - Abnormally and persistently elevated, expansive, or irritable mood
  - Abnormally and persistently increased goal-directed activity or energy
- At least **1 week of pervasive change in mood** manifest by at least 3 (4 if mood is irritable) of the following:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing.
  - Distractibility
  - Increase in goal-directed activity
  - Excessive involvement in activities that have a high potential for painful consequences

The mood disturbance is sufficiently severe to **cause marked impairment in social or occupational functioning or to necessitate hospitalization** to prevent harm to self or others, or there are psychotic features.

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HYPOMANIA : DSM-V CRITERIA

- **A distinct period of**
  - abnormally and persistently elevated, expansive, or irritable mood
  - abnormally and persistently increased goal-directed activity or energy
- At least 4 days **of pervasive change in mood** manifest by at least 3 (4 if mood is irritable) of the following:
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing.
  - Distractibility
  - Increase in goal-directed activity
  - Excessive involvement in activities that have a high potential for painful consequences

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DSM-V Criteria for Bipolar Disorder

Bipolar I Disorder – mania…

- The episode is **not attributable to the physiological effects of a substance** (e.g..,a drug of abuse, a medication, other treatment) **or to another medical condition.**
- The occurrence of the manic and major depressive episode(s) **is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder**, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

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PBD: DSM-V CRITERIA

For adult bipolar disorder, there are now five possible diagnoses:

- C 00 Bipolar I Disorder
- C 01 Bipolar II Disorder
- C 02 Cyclothymic Disorder
- C 03 Substance-Induced Bipolar Disorder
- C 04 Bipolar Disorder Associated with Another Medical Condition
- C 05 Bipolar Disorder Not Elsewhere Classified

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CHILDHOOD AND ADOLESCENCE AMONG ADULT BIPOLAR PATIENTS: A RETROSPECTIVE STUDY

Scott-Garnell K[1], Ezeobele I[2], Blake J[2], Gerondale T[3], Sanchez M[4], Averill PM[2], Soares JC[4] Psychopathological features during childhood and adolescence among adult bipolar patients: a retrospective study. Compr Psychiatry. 2014 Apr;55(3):422-5. doi: 10.1016/j.comppsych.2013.10.003.

Epub 2013 Oct 19.

Abstract

Objective: There are still several concerns regarding the inconsistency in the diagnosis of Bipolar Disorder (BD) in children and adolescents. This study reviews the symptoms of youth admitted to The University of Texas Harris County Psychiatric Center (UT-HCPC) prior to a confirmed diagnosis of BD to elucidate patterns and target symptoms which may facilitate early recognition of BD. **Methods:** A retrospective review of charts of adult patients with a discharge diagnosis of BD for three consecutive admissions who were also admitted to UT-HCPC as children or adolescents (N=26). The Kiddie SADS was conducted on each patient's first admission as a child and last admission as an adult**. Results:** Most of the symptoms found in adult BD were present in the child/adolescent subjects at equivalent rates, except for mood elevation, which was less common during childhood and adolescence. In spite of the psychopathological similarity, only 6 (23%) of the subjects were diagnosed with BD as youth. **Conclusion**: BD is poorly diagnosed among children and adolescents. Difficulties in the assessment of the youth, as well as particularities in the psychopathology of mood among children and adolescents may account for the low diagnostic rate.

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Methods

- Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (Wash-U-KSADS) was used to review the psychiatric symptoms
- The review focused on
  - ✓ Differing psychiatric symptoms exhibited by the patients during admissions
  - ✓ Differing admission diagnoses formulated by clinicians
  - ✓ Differing psychotropic prescription patterns upon discharge

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Methods

- The comparison of the results indicated good inter-rater reliability on the collection of the data.
- For the continuous variables, the statistical analysis was performed using paired t-tests.
- McNemar and Wilcoxon tests were utilized for the categorical and ordinal variables, respectively.

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McNemar Test

Comparison of the symptoms presented by patients with bipolar disorder during their psychiatric admissions as adults and as children.

Symptoms	Child value	Adult value	P value*
Mood elevation	17	25	0.04
Irritability	26	26	n.s.
Suicidal ideation	11	14	n.s.
Suicidal attempts	4	2	n.s.
Self-injurious behavior	5	2	n.s.
Grandiosity	10	17	n.s.
Alcohol use	15	16	n.s.
Drug use	13	16	n.s.
Decreased sleep	17	20	n.s.
Pressure of speech	10	18	n.s.
Flight of ideas	6	14	n.s.
Racing thoughts	12	18	n.s.
Distractiblity	18	21	n.s.
Increased goal directed activity	19	16	n.s.
Increased motor activity	22	19	n.s.
Poor judgment	25	25	n.s.
Increased energy	18	20	n.s.
Hallucinations	6	12	n.s.
Delusions	3	12	n.s.
Mood lability	26	25	n.s.
Loose associations	8	13	n.s.

* McNemar test.

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Similarities in symptoms in Adult and Pediatric BD

Children	Adults
Labile	Labile
Insomnia	Insomnia
Anxious	Anxious
Suicidal	Suicidal
Increased GD	Increased GD
Behaviors	Behaviors

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Differences in symptoms in Adult and Pediatric BD

Children	Adults
Hypomania	Mania/Hypomania
Irritability (severe)	Euphoria/Dysphoria
Anxious (severe)	Anxious mild
Grandiose (anger)	Grandiose (pleasant)

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Results

Adult patients had the following diagnosis during their childhood hospitalizations:

- ✓ 23% Bipolar Disorder
- ✓ 15.4% disruptive behavior disorder NOS
- ✓ 11.5% Major depressive disorder
- ✓ 7.7% Psychotic disorder NOS
- ✓ 7.7% substance-related disorder
- ✓ 3.9% adjustment disorder
- ✓ 3.9% Mental disorder due to a medical condition

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Limitations of the Study

- **Retrospective design**
  - ✓ While reviewing medical records possible inaccuracy in the inclusion of clinical information in the records may have been reflected in the result
- **Multidisciplinary setting**
  - ✓ The study was carried out in a multidisciplinary setting and the results may not be generalized to other settings.
- **Wash-U-KIDDIE-SADS**"
  - ✓ An instrument used and primarily designed for a live interview and not a retrospective chart review, as well as for children and not adult subjects.
  - ✓ The symptoms were considered positive if any licensed mental health provider included positive findings in their documentation.

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Case study: Session 1

- JP and parents arrive for the first time.
- Second opinion – Chief Complaint.
- JP is an 11-y.o. male who has been seeing psychiatrist and therapist since 8 years of age. His diagnosis ranged from ADHD, Schizophrenia, Disruptive disorder, Nos.
- JP has extreme irritability.
- Crying spells and aggression.
- Poor sleep but a good appetite.
- Numerous hospitalizations; numerous medication trials and numerous diagnosis.
- Medications: Adderall 40mg qam and 10mg qnoon, Clonidine .2mg TID; Haldol 1mg qhs.
- Father distant and disappointed in his son.
- Mother is the expert re: JP's mental health.

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Treatment plan adjustment

- Weekly visits a must
- Stop the Adderall on weekends and observe the difference in JP's demeanor
- Notes from teachers as to the time they felt the Adderall wore out and why
- JP being honest about how much he was sleeping

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Session 2

- JP walks into my office and has the demeanor of a "perfect gentleman."
- He opens the door for his mother and walks with his shoulders back as if strong and proud.
- His conversation that day was very goal oriented and demanding. That day he tore up his classroom; when asked why, his response:

  "I told that lady to turn up the air condition but she would not listen."

The mother asked to speak to me alone after the session. She raised her blouse to show me the bruises she had from one of JP's episodes.

I soon learned that the trigger that let the family know he was becoming grandiose or manic … was physical abuse, usually towards mother or objects. His rages would last for hours, and father would usually have to hold him down until he fell asleep.

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JP – Treatment Changes

- Subsequently put JP on a mood stabilizer in place of Haldol.
- Cross titrated the Adderall with Strattera.
- Family psychoeducation including empowering the voice of the father and engaging him more with JP's care. He was to bring him for appointments at least once a month.
- Mother encouraged to get her own therapy as she had stopped working to care for JP and was completely engulfed by his every need. She was encouraged to allow JP to began to do some things for himself, such as prepare his own afterschool snack and complete his homework without her assistance.
- JP did have individual therapy during childhood and again in adolescence which he requested after a male peer made a pass at him and he beat the peer up. He appeared to want to process his sexual identity.

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Whatever happened with JP?

Last time seen JP was 19 y.o. and attending a local university with the major of Electrical Engineering.

- Diagnosis – Bipolar Disorder and ADHD
- Not one hospitalization since our treatment started, age 11.

Final Medication regimen : Trileptal and Strattera from 11-16 yrs, then low dose Seroquel added at 16 when the mother came in and once again raised her blouse.

JP and his family really did do the work and as did many of my families, which taught me a lot about being a child psychiatrist.

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Lessons Learned from My Patients

1) Children with Bipolar disorder, although they may not always voice it, may think of suicide and choose life daily.
2) Neglect and mistreatment can lead to behaviors that mimic both ADHD and Bipolar disorder. Thus love, a stable home and support can be the cure.
3) Less medication is always better.
4) With bipolar children, especially adolescents, the more we can do to limit the need for questioning their behavior the better. E.G.… Hall passes around their necks….LAI rather than "have you taken your meds"….
5) Children with Bipolar disorder can not tolerate sarcasm.
6) The level of irritability is on an entirely different level. E.g., shoes touched… e.g., temper tantrums
7) Their grandiosity is seen in interactions with adults, not usually other children.
8) Most Bipolar patients can learn and identify a sign of their mood switching … examples: poor sleep, sarcasm, cleaning excessively, rearranging furniture. Again…
9) For Children/Adolescents the symptoms are there, but they are not good at describing them and we are not good at recognizing them. Discuss difference between goal-directed and hyperactive children.
10) Per the literature, adults report a 10-year delay in their first episodes and the final diagnosis of Bipolar disorder. Perhaps as Child Psychiatrists we should give ourselves some grace for requiring years to make the diagnosis in the pediatric population. Thus, the dx DMDD…oh, but that is for another grand rounds….

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Questions and Answers

Thank you!!!

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