Bipolar Disorder in Children and Adolescents: A Review of the Current Knowledge Base

DSM

- Manic Episode
  - Distinct period with abnormally and persistent elevated, expansive or irritable mood that lasts at least one week
  - Must be accompanied by at least 3 of the following:

(If irritability must have 4)

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Pressure of speech
- Flight of ideas/racing thoughts
- Distractibility
- Increased involvement in goal directed activities OR psychomotor agitation
- Excessive involvement in pleasurable activities with a high potential for negative consequences

DSM- Mania

- Associated Features
  - Do not recognize that they are ill (*anosognosia*)
  - Resist treatment
  - Poor judgment
  - Increase use of alcohol/drugs
  - Regret for behaviors while manic, when not manic

Mixed Episode

Criteria predominantly present for both a Major Depressive Episode and a Manic Episode every day for at least a week

Hypomanic – same symptoms but to a lesser degree

Depression

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed (anhedonia)
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeps
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thought of death or suicide

DSM-DIAGNOSES

- Bipolar I Disorder – occurrence of one or more manic or mixed episodes, also one or more depressive episodes

- Bipolar Disorder II Disorder – Occurrence of one or more major depressive episodes accompanied by at least one hypomanic episode

  - Rapid Cycling- Occurrence of four or more mood episodes during the previous 12 months (more frequently seen in females) Poorer prognosis

- Cyclothymic Disorder –chronic, fluctuating mood disturbance involving numerous period of hypomanic symptoms and numerous periods of depressive symptoms

Other diagnoses

- Depression – if actually Bipolar and treated with an anti-depressant may kick into mania

- ADHD
  - Many similar symptoms
  - ADHD may have sleep disturbance, but typically gets a full night sleep whereas mania in bipolar can go extended periods with no to little sleep
  - Stimulant use can provide agitation if bipolar
  - May be pre-morbid diagnosis or co-occurring

Trauma and other anxiety disorders – share many symptoms, not cyclical, although environmental factors may prompt anxiety symptoms

Conduct Disorder – may appear grandiose and goal-directed activities that are illegal

Substance Use – precipitant, differential diagnosis or self-medication

DSM

- Adolescents are more likely to include psychotic features and may be associated with school truancy, antisocial behavior, school failure or substance use
- Adolescents may have a history of long-standing behavioral problems that precedes the onset of a frank manic episode (co-occurring or prodromal?)
- Mean age of onset is 20 years
- Start suddenly, worsen over a few days

Current State

- Prior to DSM-IV Bipolar applied only to adults
- 40 fold increase in the diagnosis of Bipolar disorder in children from 1994-2003 (?)
- Due to neurobiological mechanisms in relation to development, it is possible that Childhood onset manic-depression could be more severe, have a chronic, non-episodic course and to be characterized by mixed, rapid-cycling features (This is similar to "treatment resistant" bipolar in adults)
- However could be only most severe get referred due to normal developmental fluctuations

NIMH Roundtable (2001),

There is agreement that pre-pubertal bipolar disorder is a chronic, mixed manic, continuously cycling disorder.

Diagnosing bipolar in Children and adolescents

- Familiar with typical development
  - Energy Level
  - Mood dysregulation
  - Magical thinking
  - Impulsivity
  - Sensation Seeking

Diagnosing bipolar in Children

- Mania and depression symptoms look different in youngsters than in adults.
  - Mania in adults – elated or euphoric mood
  - Mania in children and teens - irritability and prone to extreme temper tantrums and destructive
  - Depressed children may have physical complaints like headaches, muscle aches, stomachaches or tiredness
  - Children change frequently between mania and depression, sometimes several times in the same day.
  - Adults with bipolar can have periods in between the mania and depression of looking pretty normal

Key Characteristics

- Grandiosity
- Hypersexuality
- Days with no sleep but still feel energized

COMMON RED FLAGS FOR CHILDREN

- Frequent irritability
- Violent temper tantrums
- Constant complaining
- Unexplained crying
- Headaches, muscle aches, stomachaches, or fatigue
- Extreme sensitivity to rejection or criticism
- Talk of running away from home
- Alcohol or substance abuse (in teens)
- Preoccupation with death or suicide

Bipolar and attention deficit hyperactivity disorder

- ADHD can develop as early as age 4
- Bipolar usually doesn't develop until age 10 or later
- Medications used to treat ADD/ADHD are stimulants, which can worsen mania in children with bipolar disorder.
- Family history is often helpful in distinguishing between the two conditions, since a child has a greater risk of developing bipolar disorder if a close family member (parent, brother, sister, or grandparent) is bipolar.

Current knowledge base

- Children/adolescents more likely to first experience depressive cycle, more likely to have rapid cycling, and may not meet full criteria for persistence of manic symptoms

- Clinical Characteristics for Children/Youth

•Elated affect, appear happy •Grandiose** – failure to follow the laws of logic and a firm belief that often leads to action •Sleep – not a brooding, laying awake, but an active engagement in other activities	•Pressured Speech –speech difficult to interrupt, racing thoughts •Increased distractibility •High rate of goal-directed behaviors •Hypersexuality**

Current knowledge

- Child and Adolescent Onset higher prevalence in males
- Typically of normal intelligence but can co-occur with MR or Autism Spectrum Disorders
- Genetic/familial link
- Severe and long tantrums, rages
- High co-occurrence between early-onset bipolar disorder and attention-deficit/hyperactivity disorder, disruptive behavior disorders, anxiety disorders, and substance use disorders

Proposed new addition for DSM-V

- Bipolar disorder can be diagnosed in children and teens but must meet same adult criteria
- Researchers have found that there is no gender distinction in adults with bipolar disorder,
- In children, bipolar diagnosis is much more common in boys
- New diagnostic category under the Mood Disorders Section of temper dysregulation with dysphoria (TDD).

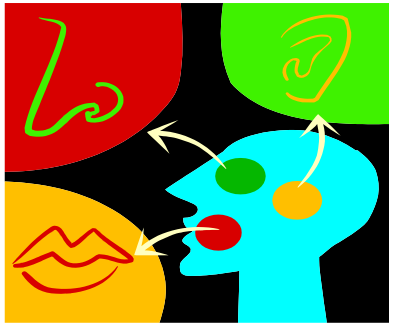
Disruptive Mood Dysregulation

- Severe temper outbursts that occur three or more times per week
- Persistent anger, irritability, or sadness between temper outbursts
- Onset of symptoms between ages 6 and 10
- Symptoms present for at least 12 consecutive months
- No signs of mania
- Temper outbursts or anger, irritability, or sadness are observed in at least two different environments (for example, at home and at school)
- Symptoms occur absent any drug abuse or physical ailment

Treatment

- Psychopharmocology
  - **Lithium – been tested and viewed as safe with children and adolescents (mood stabilizer)
  - Valproate acid (anti-seizure) can cause obesity and ovarian cancer
  - Carbamazepine (anti-seizure)
  - Chlorpromazine (anti-psychotic)
  - Methylphenidate (stimulant) – may make it worse

Therapies/Interventions



- Cognitive Behavior Therapy
  - Educates patients and loved ones about symptoms and managing the disorder.
  - Helps to create an early warning system to detect symptoms before they escalate.
  - Teaches strategies for controlling negative emotions and thinking and destructive behavior patterns.
  - Helps individuals stick with treatment and take medication consistently.
  - Focuses on managing stress and solving life problems.

THERAPIES/INTERVENTIONS

- Family
  - Families with high expressed emotion increase the propensity for poor outcomes. Family-focused treatment in addition to pharmacotherapy has been shown to decrease depressive relapse rates when compared with controls receiving treatment as usual
  - Psychoeducation, enhancement of problem-solving, and communication style

Supports that can help

- Lack of a consistent routine and disrupted sleep can trigger a mood episode
  - Help the youth maintain a consistent schedule
  - Identify when this can't be done and provide support
  - Work with family to encourage normal sleep and activity pattern
- Therapy/counseling and supports to deal with day to day issues of having Bipolar Disorder
  - Stigma
  - Schedule
  - Illness Management

Supports that can help

- Remaining calm during episodes of anger/mania to help de-escalate
- Supports to avoid alcohol/drug usage and maintain a healthy life style
- Creating a support system
- Helping adjustment to medications and support compliance with medications
- School liaison

School Issues

- At risk for school failure
- May be sleepy from medications
- Have difficulty concentrating
- Difficulty making transitions
- Often have other learning disabilities.

- Flexibility and open communication are key in supporting the child with a bipolar disorder

IDEA and 504

- Individuals with Disabilities Education Act (IDEA) requires schools to identify students with special needs and provide needed educational service from K–12 until age 22.

- Section 504 of the Rehabilitation Act of 1973, schools must make necessary academic adjustments for students with learning impairments.

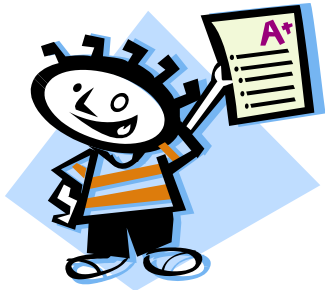
COMMON ACCOMMODATIONS

- Extending time to take tests
- Reducing homework and allowing flexible due dates
- Providing the student with a place to go to regain composure or take a break
- Allowing unlimited access to water (important for children taking certain medications) and unrestricted bathroom breaks
- Alerting the child and parents if there will be unexpected changes in a school day's routine (for example, a substitute teacher, fire drill, field trip, or upcoming test)

IDEA and Section 504 and discipline

- Important to look not just at the behavior but at the circumstances behind the behavior, the environment in which the problem occurred, and the events leading up to the undesirable behavior
- Often, problematic behavior occurs when a child does not have the appropriate tools to cope with a situation
- The more that the school staff can work to address behavioral problems by looking at the root cause, the better the chance the child will replace these behaviors with more appropriate responses.

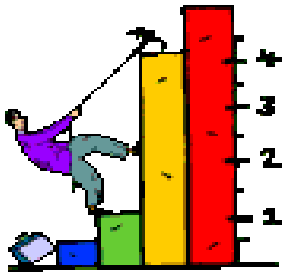
Other issues in schools



- If the child is socially isolated or shy, teachers should take steps to prevent any bullying or teasing from the other students.
- Foster a more positive environment by being patient and ignoring minor negative behaviors while encouraging positive ones.
- Teachers should also stay calm during difficult situations and be a model of desired behavior.

- A child with bipolar disorder will function within the environment based on what skills they have. A child with Bipolar does not intend to cause trouble, but rather to cope with a situation that causes him stress or anxiety.

- By understanding the challenges presented by bipolar disorder, and accommodating the child's needs as necessary, both parents and teachers can give the child a road map to success at school



A DIFFERENT PERSPECTIVE

- All parents hope that their adult children will find a way to use their special talents, and for people with bipolar disorders, these talents can help make up for the down side of their illness.

- Reframing Strengths
  - High energy level
  - Often strong verbal skills,
  - Sometimes a creative way of looking at solving problems

Resources

- Geller, B. and Luby, J. (1997)Child and Adolescent Bipolar Disorder: A Review of the Past 10 years, Journal of the American Academy of Child and Adolescent Psychiatry, 36- 1168-1176. www.bpso.org/bpreview.htm

- Child and Adolescent Bipolar Foundation www.bpkids.org

- http://www.everydayhealth.com/bipolar-disorder