14 Juvenile Onset Bipolar Disorder

Essential Concepts
Screening Questions

- Have you had periods of time when you feel so happy and energetic that you feel "on top of the world" or as if you could do anything?
- Have you had periods of time when your friends said you are talking too much or too fast?
- Has there been a period when you were so hyper and irritable that you got into lots of arguments with people?

Mnemonic: DIGFAST

Initially thought to be only a disorder of adolescence or adulthood, bipolar disorder (BD) is now increasingly being recognized and diagnosed in prepubertal children. Considerable ambiguity remains about the actual prevalence of BD in children. Lifetime prevalence of BD is estimated at 1%. A point prevalence of mania in 14- to 16-year-olds of 0.6% was identified by Carlson and Kashani. The comorbidity with ADHD has also not been established, although data suggest it may be common (around 30%). Some symptoms (high levels of activity, talkativeness, appears as if powered by a motor) may be similar, and it is important to differentiate a mood component in the differential diagnosis. Other frequent comorbidities are conduct disorder, substance abuse disorders, anxiety disorders, trauma-induced disorders, and borderline personality disorder traits. Schizophrenia may be confused with bipolar disorder. Although BD in adults tends to be gender neutral, it is estimated that prepubertal BD is almost four times more frequently diagnosed in boys. Compared with adults, children and adolescents with BD may have a more prolonged early course and be less responsive to treatment.

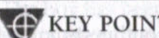
CLINICAL DESCRIPTION

Bipolar I disorder requires the existence of a manic or mixed episode. A manic episode is defined in the DSM-IV-TR as a distinct period of "abnormally and persistently elevated, expansive,

or irritable mood." A mixed episode is characterized by "rapidly alternating mood with symptoms of a manic episode and a major depressive episode." Children with manic episodes may not present with the same discrete periods seen in adults. Early onset bipolar disorder has been described as highly variable, often with a rapid-cycling, chronic, nonepisodic presentation. Additionally, irritability and unpredictable, labile mood and psychotic features may be more common in young people presenting with the disease.

Bipolar II disorder includes major depressive episodes alternating with hypomanic episodes. Hypomania may present as elevated, expansive, or irritable mood, which is less severe and less functionally impairing than a manic episode.

Cyclothymic disorder is a chronic and fluctuating mood disorder, with hypomanic and depressive symptoms that are less functionally impairing that BD and that have been persistent for a year.

 KEY POINT

Early onset BD often begins with an episode of depression, not mania. It is estimated that 20 to 40% of youth will "switch" to BD within 5 years of depression. Features associated with "switching" include early onset depression, psychomotor retardation, psychosis, mood lability, seasonal pattern, family history of BD or mood disorders, and antidepressant-induced hypomania.

Diagnosis of Manic Episode

A mnemonic that is helpful in recalling the essential features of mania is **DIGFAST.** The term may refer to the speed with which a manic patient would dig a hole if put to the task, as they may appear as if "driven by a motor." At least three symptoms are required (four if mood is only irritable):

Distractibility
Indiscretion (excessive involvement in pleasurable activities that are likely to have adverse consequences)
Grandiosity or inflated self-esteem
Flight of ideas or racing thoughts
Activity increase (increase in goal-directed activity or psychomotor agitation)
Sleep deficit
Talkativeness or pressured speech

A manic episode must last at least a week or be severe enough to require hospitalization.

KEY POINT

The usual adult psychiatric interview to discuss manic and depressive episodes generally does not work with children. The onset of the disorder may be more insidious; the presentation may be "atypical" with psychotic symptoms, suicidal attempts, and serious acting-out behavior that may mask the mood disorder. It is essential to get information from a variety of sources to clarify timelines, specific mood symptoms, sleep patterns, energy level, and course of illness to more clearly clarify the diagnosis.

TIP

Mood lability (rapid mood swings) and rage outbursts in children and adolescents may have many etiologies, including bipolar disorder. The marked increase in the number of prepubertal children being diagnosed with BD is suspect, as it is higher than that expected by epidemiological studies in adults. I have the "Five Stars in Alignment" theory of the increase in diagnosis. Here are the five stars which I feel have "aligned" to substantially increase the number of prepubertal children being diagnosed with bipolar disorder:

1. Children have BD which has gone unrecognized, and we are now beginning to appropriately diagnose these patients;
2. There is a great deal written about the labile child being the bipolar child. Parents find this reassuring, in that there is an actual diagnosis and treatment for the disorder that they have been struggling with;
3. Children like the disorder because it helps deflect punishment of "bad" behavior to that of "ill" behavior ("it's just another manic episode");
4. Psychiatrists like it because it gives a sense of efficacy in treatment. Also, the same medications may be used to treat mood lability and aggression as those for BD;
5. There is insurance parity for bipolar disorder, and payment may be secured for this diagnosis and not for a more nebulous diagnosis associated with aggressive outbursts and labile mood (such as conduct disorder or many others).

CLINICAL VIGNETTE

A 12-year-old boy presented due to a new onset of increased irritability over the past 2 months. He has been talking back to his parents, and when they say, "No" to a request, he flies into a rage. They bring him to your office for an evaluation after he punched and kicked holes in the wall during one of his rages. His family noted an increase in stress in the family—his grandmother, with whom he had been close, died 2 months ago. Additionally, he had an argument with his best friend, and they have not been speaking. He has seemed moody and "on edge" and has not been sleeping well. He was suspended from school last week for disrespectful behavior. You learn that there is a strong family history for mood disorder (his mother is depressed, her brother is bipolar, and his paternal grandfather is an alcoholic and possibly bipolar; his father drinks a great deal). The boy has been taking methylphenidate since age 8 for ADHD with generally good results, although he has always been oppositional and impulsive. You are considering a diagnosis of bipolar disorder. What else do you want to explore? Rule out any medical conditions (e.g., thyroid) or beginning experimentation with substances. His father drinks, his mother is depressed, and his grandmother recently died—is this an atypical grief reaction/major depression, or an adjustment disorder related to domestic violence or other noted stresses? He has ADHD and oppositionality—is this a secondary conduct disorder? School issues—social and academic—need to be explored.

Etiology

Etiology is multifactorial. There is genetic loading for all mood disorders in family members of BD children, some specificity-increased loading of BD, and family loading that is higher for childhood onset than for adolescent onset BD. Earlier onset of BD in adults increases the risk of BD in offspring during childhood or adolescence. Earlier onset disease often has a more chronic and debilitating course (Table 14.1).

A link has been reported between bipolar adults and the serotonin transporter gene. The long (l) allele has been associated with the prophylactic antidepressant response to lithium. The short (s) allele has been identified as a risk factor for suicidal behavior (common in BD) and for pharmacologically

TABLE 14.1. Essentials of Assessment for Early Onset Bipolar Disorder

- Physical examination, review of systems, and laboratory testing to rule out suspected medical etiologies, including neurological, systemic, and substance-induced disorders.
- Interview of parents regarding child's symptoms—timeline, character, and severity. Ask about child risk-taking behaviors (substance use, legal issues, sexual acting out, suicidal/homicidal threats or behavior). Get family genetic history.
- Interview of child/youth—questions, observation, and description of their inner state. Assess thought process, psychotic symptoms, depressive symptoms, anxiety symptoms. Always ask about suicidality/homicidality and risk-taking behavior (substance use, legal issues, sexual acting out). Always ask about a history of trauma.
- School performance and interpersonal relationships should be assessed to determine the youth's functional impairment and educational needs.
- Rating scales may be helpful (e.g., General Behavior Inventory [GBI] and the parent version [GBI-P]; or the Young Mania Rating Scale [Y-MRS] and the parent version [YMRS-P]).

induced mania. There are mixed findings in MRI scans of children and adults with regard to brain structure changes.

The environment potentiates a genetic vulnerability. Environmental and psychological factors, particularly acute and chronic stress, have been implicated in the precipitation of the episodes as well as in prognosis.

KEY POINT

Much is said about the risk of suicide for depressed individuals. However, bipolar disorder is an even higher risk factor. An individual in the throes of grandiosity and feeling good may seem to be at low risk, but high levels of irritability and impulsivity, and poor ability to consider consequences increase risk of completed suicide. Ensuring safety is always the first consideration.

Treatment

Treatment of bipolar disorder includes stabilization of acute symptoms, as well as longer-term stabilization and maintenance.

TABLE 14.2. Essentials of Treatment of Bipolar Disorder

1. Level of care considerations—safety issues are primary.
   Hospitalization for acute safety issues. Partial hospitalization, intensive outpatient treatment, intensive in-home services as needed for stabilization and safety.
2. Medication treatment
   Mood stabilizer—consider family history of response. Lithium and divalproex are the fist-line treatment for episodes of euphoric mania. (Divalproex may be more effective for mixed or rapid cycling. For females, possible risk of polycystic ovary and not to be used if pregnant.)
   Antipsychotic medication can be used during acute mania with or without psychotic symptoms to stabilize mood, ensure safety, and provide sleep. Chronic use may be needed. (Monitor for "hypermetabolic syndrome" with weight gain, increased lipids, and possible risk of diabetes.)
3. Psychosocial treatment
   Psychoeducation about BD, its risks, treatment, prognosis, and complications associated with medication noncompliance.
   Family therapy to stabilize environment and improve prognosis.
   Individual therapy for support. CBT, anger management, or insight-oriented work may be helpful. Ongoing safety assessment.
   Educational—collaboration with school regarding behavioral management, special educational needs, and appropriate individualized educational plan.

Table 14.2 presents essential issues to consider in treatment of early onset bipolar disorder.

Treating comorbid psychiatric disorders must be done carefully. Stimulants may be used to treat comorbid ADHD once the patient has been stabilized on a mood stabilizer. In general, antidepressants should be avoided; but if the youth becomes depressed and is not responsive to other pharmacotherapy, cautious use of antidepressants may be necessary. Carefully monitor for manic "activation" or "switch," as well as suicidality.

Prognosis

Early onset bipolar disorders have a greater chronicity than do adult onset bipolar disorders and are less responsive to treatment. Up to one-third of children with major depression may later be diagnosed with bipolar disorder. Risk factors for poor outcome have been reported to be long episode duration and high prevalence of mixed mania, psychosis, and rapid cycling.