Diagnosis and Treatment of Bipolar Disorder in Children and Adolescents

May 01, 1996 | Bipolar Disorder [1], ADHD [2], Schizophrenia [3], Antisocial Personality Disorder [4], Sleep Deprivation [5], Gambling [6], Bipolar II Disorder [7], Circadian Rhythm Sleep Disorders [8], Mania [9], Major Depressive Disorder [10], Addiction [11] By Mary Beth Cogan [12]

Since 1980, criteria for diagnosing bipolar disorder in adults have also been used to diagnose mania in children, with some modifications to adjust for age. Similarly, to diagnose a child or adolescent with bipolar disorder, there need be at least one period of mania that is manifested by a distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least one week or any duration if hospitalization is required. In addition, during the period of mood disturbance the children or adolescents may experience to a significant degree at least three of the following symptoms (or four if their mood is irritable): inflated self-esteem or grandiosity, decreased need for sleep, pressured speech, flight of ideas or racing thoughts, distractibility, increased goal-directed activity, or excessive involvement in activities with the potential for painful consequences. For a diagnosis of bipolar disorder these symptoms must also produce marked impairment in functioning and be unaccounted for by other psychiatric disorders due to physiologic effects of substances or medical conditions (American Psychiatric Association 1994).

Obstacles in identifying and diagnosing this disorder in children and adolescents include the low base rate of the disorder, the diversity in clinical presentation within and across episodes, the symptomatic overlap of mania with other disorders commonly found in childhood, such as attention-deficit hyperactivity disorder (ADHD), and the constraints placed upon symptom expression due to the developmental stage of the child (Bowring and Kovacs 1992). Developmental factors may confound the presentation of symptoms; for example, normal behavior in children may sometimes resemble hypomaniac activity. Therefore, if not viewed within the context of normal behavior, psychopathology may not be recognized.

In young children it is difficult to identify discrete episodes of mania or depression. The clinical presentation of childhood bipolar disorder is variable but includes a waxing and waning course, worsening disruptive behavior, moodiness, irritability, difficulty sleeping, impulsivity, hyperactivity and decreased concentration. Episodically they experience short attention span, low frustration tolerance, explosive anger followed by periods of guilt, depression and declining academic performance (Weller and colleagues).

In adults the lifetime prevalence for bipolar disorder, according to the Epidemiologic Catchment Area (ECA) survey, ranges from 0.6 percent to 1.1 percent (Robins and colleagues). An epidemiologic study of adolescents in the United States reported consistent prevalence rates. However, a significant number also reported experiencing a distinct period of abnormal, persistent, elevated, expansive or irritable mood, although they did not fulfill criteria for bipolar I, bipolar II or cyclothymia (Lewinsohn and colleagues). This corresponds with survey results of the membership of the National Depressive and Manic-Depressive Association (DMDA), which reported the onset of illness during childhood or adolescence in 59 percent of adult respondents (Lish and coworkers). At present, large-scale epidemiologic studies on prepubertal children are not available. However, studies have revealed descriptions of children and adolescents likely to develop the disorder.

Akiskal described the profile of a child at risk to develop bipolar illness as one who experienced emotions, whether they be positive or negative, passionately and intensely and whose mood and behavior was dysregulated and disinhibited. Predictors of bipolar outcome in adolescents with major depression have been identified as a family history of bipolar disorder, sudden onset of symptoms, delusions, psychomotor retardation and hypersomnia, pharmacologically induced hypomania/mania (Akiskal and coworkers; Strober and Carlson).
Medical and psychiatric conditions may mimic symptoms of bipolar disorder. Differential diagnoses to be considered include: thyroid disorders, neurologic disorders, substance abuse, ADHD, conduct disorder, schizophrenia, as well as Axis II diagnoses. Childhood-onset bipolar disorder is commonly comorbid with other psychiatric disorders, especially disruptive disorders. The major symptomatic difference between ADHD or conduct disorder and bipolar disorder is that disruptive disorders are chronic and may present insidiously, whereas mania is episodic and reflects a change in functioning. Disruptive disorders reflect aberrant attention and/or behavior while mania is primarily characterized by abnormal mood and activity. In addition, earlier age of onset is more commonly seen in ADHD. It is important to recognize that children with ADHD may also experience irritability or dysphoria due to demoralization and decreased self-esteem, making the differential diagnosis with bipolar disorder difficult. Furthermore, bipolar disorder may be superimposed on ADHD. In these cases one would expect to see an increase in the intensity or severity of symptoms.

Like bipolar disorder, conduct disorder frequently emerges during adolescence. These children usually engage in high-risk behaviors with the potential for painful consequences seen in mania. However, unlike the manic child, the conduct disorder child's motives are more hurtful, vindictive, antisocial. (Bowring and Kovacs; Weller and colleagues). Psychotic symptoms are also significant in determining diagnosis. These are not present in disruptive disorders, but may be present during an acute bipolar episode or with thought disorders.

Manic symptoms are recognized as a barometer of psychopathology severity in children and adolescents and have been correlated with greater psychosocial impairment. In addition to the daily interference in functioning and increased risk of suicide, long-term consequences of symptoms include interference with the mastery of developmental tasks such as regulating emotions, acquiring competencies, and establishing and maintaining social relationships (Nottelmann and Jensen). Respondents to the DMDA survey acknowledged the negative impact on their lives, reporting problems with crime, substance abuse, self-injurious behavior or aggression toward others, unstable relationships, gambling and financial difficulties and interruption in their education.

Thorough evaluation and treatment are essential. A biopsychosocial approach to intervention that incorporates psychoeducation and school intervention is warranted. Psychoeducation should incorporate child, adolescent and parent. They should be informed of symptoms of manic and depressive episodes and supported in the exploration and identification of symptoms of the index episode and of future symptoms indicative of a recurrence. The physician should discuss treatment options that include medication and psychotherapy.

While adolescents are treated with the same pharmacologic agents as adults, it appears that adolescents with bipolar disorder tend to have more mixed or rapid cycling presentations; these have been associated with poor response to lithium. Furthermore, questions remain regarding the efficacy of pharmacologic treatment and how long treatment should be maintained in the child and adolescent population. Advocates of long-term treatment acknowledge the serious consequences and course of illness; others favor discontinuing medication after the patient is stable, since the long-term effects of pharmacologic intervention remain unknown and noncompliant adolescents may contribute to their own refractoriness (Nottelmann and Jensen).

Double-blind, placebo-controlled studies are needed with lithium and other mood-stabilizing agents, carbamazepine (Tegretol) and valproate in order to assess their role in the treatment of children and adolescents with bipolar disorder. A multisite study funded by the NIMH is underway to investigate the effectiveness of prophylactic medication therapy in adolescents with bipolar disorder. Psychotherapy has also been conceptualized as a prophylactic intervention with strategies seeking to improve interpersonal relationships and stress management. Stressful life events are viewed as potential precipitants for recurrent episodes. Therefore, the attempt of therapy is to reduce the number and severity of events. Attention is also given to routines, activities or substances that may disrupt one's normal schedule in attempts to enhance circadian integrity. These are important interventions, because it has been found that sleep deprivation (which can be self-induced in adolescents) may trigger a manic episode.

Collaboration with educators is invaluable, as teachers are able to provide objective observations comparing the child to their age peers. Working with educators can help promote strategies for intervening with depressed or manic children, and thereby help facilitate an environment that enhances learning.

The DMDA survey supports the stance that treatment of bipolar disorder can be enhanced by public health efforts that promote early diagnosis and treatment, ensuring adequate medication trials of mood-stabilizing agents for patients with frequent recurrent episodes, improving access to mental
health services and expanding research efforts.

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