

# PEDIATRIC BIPOLAR DISORDER: DIAGNOSTIC UNCERTAINTIES

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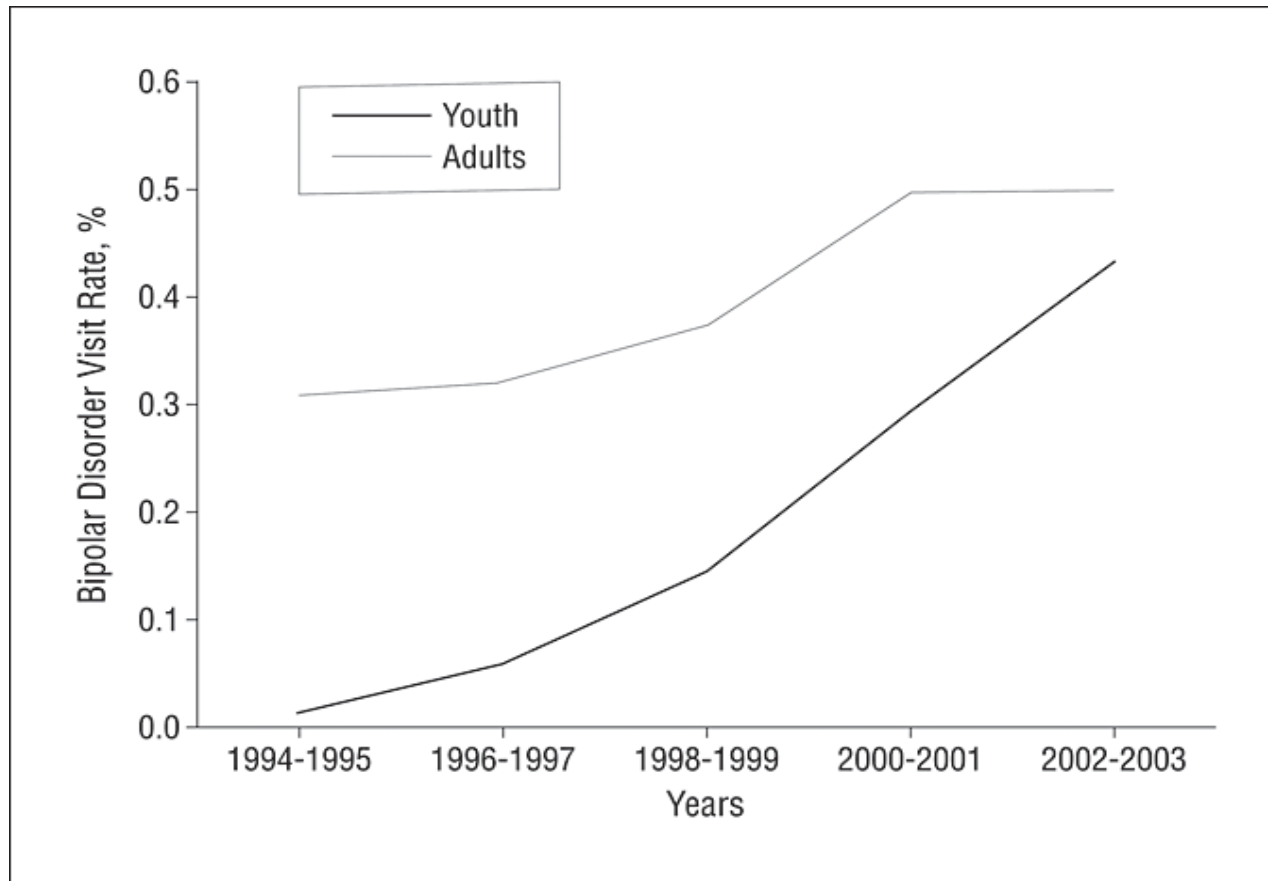


# Outline



- I. Bipolar Disorder Diagnostic Controversy
- II. Debate: What is Pediatric Bipolar Disorder?

# Bipolar Disorder Diagnoses



Moreno C, Laje G, Blanco C, Jiang H, Schmidt AB, Olfson M: National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Arch Gen Psychiatry* 2007, 64:1032-1039.

# Epidemiology

- England: 1.7 cases PBD /100,000
- Ireland: 2.2 cases PBD/100,000
- US & Brazil: 1000 cases PBD/100,000



HOW DID THIS HAPPEN?

# ADHD: 1950s-70s

- **Hyperkinetic Impulse Disorder:** ADHD symptoms + *unpredictable and explosive behavior, low frustration tolerance*
- **Minimal Brain Dysfunction:** ADHD + *emotional lability*

# ADHD: DSM II-IV



- 1980s: Emotional symptoms entirely excluded
- Why? Difficult to measure

# Emergence of a new PBP Phenotype



- Case reports began emerging late 1980s: Drs. Akiskal, Biederman, Wozniak, Geller
- Adults with bipolar disorder presenting to adult psychiatrists, complaining about their kids



# Redefining Mania

- Rapid cycles from mania or hypomania to euthymia or depression, including those who switched moods in the course of a day (Geller, 1994)
- Attention problems, irritability, anxious depression and aggression (Biederman, 1995)
- DSM-IV: “A distinct period of abnormally and persistently elevated, expansive, or irritable mood” lasting for at least 1 week.

# Case Report

Janie is a 3-year, 5-month-old child referred because she “Is very aggressive.” She started to have sleep problems before the age of 6 months. Her grandmother, who is raising her due to impairment of her mother by bipolar illness, described her as having depressive and manic symptoms in the same 24-h period. Depressive symptoms included depressed affect, a propensity to cry easily, anhedonia (“she seems unable to enjoy anything”), psychomotor restlessness, low energy, insomnia, and decreased appetite. She exhibited both irritable and euphoric affect. Her grandmother regarded her to be grandiose as she claimed to be able to do things that simply were not possible for her to accomplish. She also exhibited pressured speech, flight of ideas, and incessant motor activity. Janie met the criteria for ADHD.

S.C. Dilsaver, H.S. Akiskal *Journal of Affective Disorders* 82S (2004) S35–S43

# How do C&A psychiatrists diagnose PBD?

- Lability, grandiosity, family history, aggression, and expansive/euphoric mood
- Only 39.6% C&A reported sufficient knowledge of DSM-IV symptoms
- Understanding of DSM criteria associated with participants' region, less experience (< or =10 years practicing), and lower levels of self-reported confidence in their ability to diagnose BPD (Galanter et al., 2009)


# BIPOLAR DISORDER IN CHILDREN IS RARE

Leslie Hulvershorn, MD MSc

# Do these children really have PBD?


- PBD exists, although rare in children
- Concern about medication use
- Same medications can be helpful in aggression, BPD and PDDs

How do we classify the children with chronic irritability and temper outbursts that enter our office?



“There is a group of children with severe irritability or affective aggression or rages whose explosive behavior is significantly impairing, that we have been chasing with different diagnoses over the years, that populate child psychiatry clinics, and that we haven’ t had a great deal of success in treating.” -**Gabrielle Carlson, MD**

Parens and Johnston, *Child and Adolescent Psychiatry and Mental Health* 2010, 4:9



“This may ultimately prove to be a heterogeneous group. Some may eventually meet the strict criteria for (hypo) mania; the course of others’ illness may be consistent with dysthymia, major depressive disorder, or some form of disruptive behavior disorder; and still others may prove to have a syndrome that is not well captured by the current diagnostic system.”

**-Ellen Leibenluft, MD**

# Severe Mood Dysregulation (SMD)

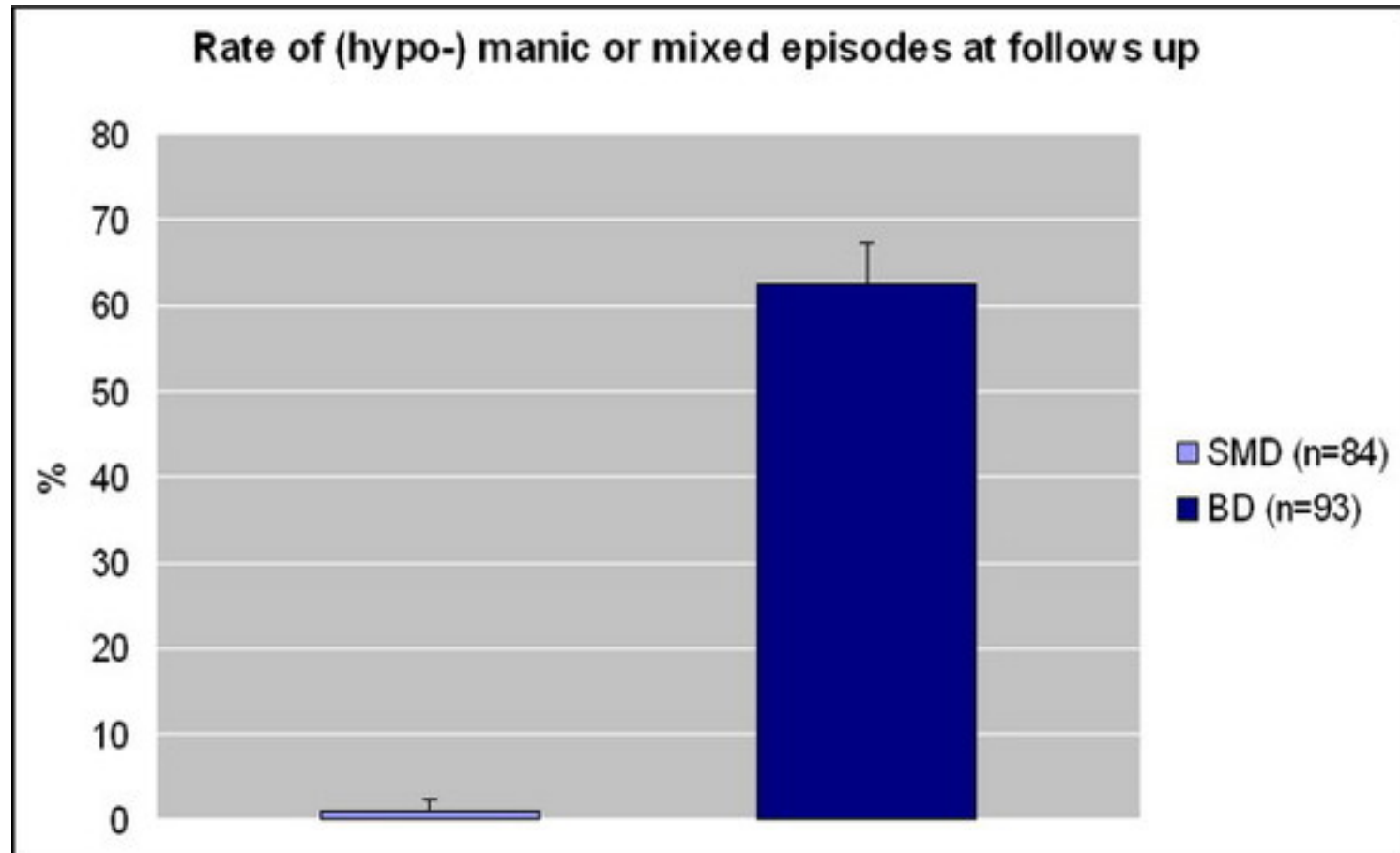
- ❑ Severe chronic irritability and hyperarousal symptoms
- ❑ Do NOT share the hallmark episodic elevated mood or grandiosity required by the DSM for BP I
- ❑ Developmentally inappropriate reactivity to negative emotional stimuli, such as “outbursts characterized by yelling and/or aggression” three times per week in 2 or more settings, onset before age 12
- ❑ 3.3% prevalence (retrospectively determined)



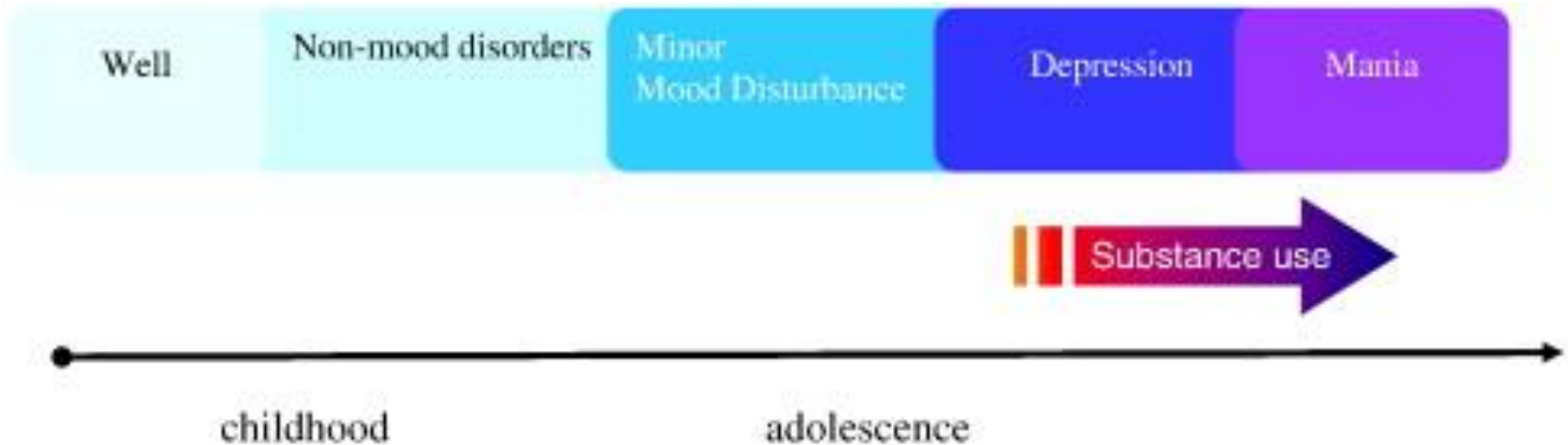
# Characterization of SMD

- At significant risk for later MDD and GAD but not BPD in community samples (Brotman et al 2006; Stringaris et al 2009 )
- Less likely to have parents with BPD than youth with BPD (Brotman et al, 2007)
- Significantly different from youth with BPD on biological measures: ERPs (Rich et al 2005), face labeling (Rich et al 2007), fMRI

# SMD vs. PBD: Rate of Mania/Mixed States



# Model for Progression to BD



# Disruptive Mood Disregulation

- **Severe recurrent *temper outbursts*** in response to common stressors three or more times per week for at least 12 months
- Nearly every day, the **mood between temper outbursts is persistently negative** (irritable, angry, and/or sad)
- Chronological age is at least 6 years (or equivalent developmental level), onset is before age 10 years

# Treatment for BPD



## -Medications:

Lithium

Depakote

Atypical Antipsychotics

Lamotrigine

ECT

## -Therapy:

Social Rhythms

CBT

# Conclusions

- Changes in diagnostic criteria for PBD proposed in the late 1980s appear to have dramatically changed diagnostic practices for the subsequent 2 decades
- SMD and DMDD are novel conceptualizations of impaired and “diagnostically homeless” youth
- Children with chronic irritability and severe temper outbursts have high rates of mood, anxiety and disruptive behavior disorders, difficulty with emotion regulation and parents with significant psychopathology