Bipolar Disorder in Children

What is it?
What else could it be?
What in the world to do?

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Disclosures

I am very conservative with the use of mood stabilizers and antipsychotics in children and adolescents due to side effect profile and limited evidence.

I am part of a nationwide initiative of child psychiatrists developing de-prescribing guidelines due to our opinion that these types of medications have been overprescribed in the last decade.

In most situations, I will try many other treatment strategies before recommending a mood stabilizer or antipsychotic medication.

NO FINANCIAL DISCLOSURES
Objectives

- Define Bipolar Disorder based on DSM criteria & review recent expansion and contraction of proposed criteria for pediatric presentation
- Examine epidemiology of bipolar disorder in children & adults
- Contrast clear presentation of mania with multi-symptom presentation in children
- Discuss next best steps when a child presents in crisis
Why are we so confused?

- Definitions are inconsistent.
- Research methods are inconsistent.
- We REALLY want to help kids in crisis.
What we know for sure:

- It’s debilitating.
- Some symptoms can start “early” – well before first manic episode.
- Family history is important.
What we think we may know:

- The younger bipolar disorder is diagnosed:
  - Poorer response to Lithium
  - Higher co-morbidity
  - Decreased frank Manic symptoms
  - Increase irritability

- Most consistent clinical predictors of Bipolar Spectrum Disorder:
  - Anxiety Symptoms
  - Depressive Symptoms
  - Affective Lability
  - Parent with history of mood disorder diagnosis <18yo
Do the best we can.
THE DSM (criteria)

- Bipolar I
- Bipolar II
- Other Specified Bipolar and Related Disorder
- Unspecified Bipolar & Related Disorder
- The birth of DMDD
- The death of “Mood Disorder NOS”
Manic Episode

- Most of the day/Nearly EVERY DAY for AT LEAST ONE WEEK
- Elevated or Irritable* MOOD (a CHANGE from BASELINE)
- Increased ENERGY or Goal-Directed ACTIVITY
- 3-4* of the following SIGNIFICANT & ABNORMAL for patient
  - Distractibility
  - Inflated self-esteem, grandiosity
  - Decreased need for sleep
  - Pressure to keep talking
  - Flight of Ideas or Subjective Racing Thoughts
  - Excessive involvement in activities with painful consequences

Legend:
- D - distractibility
- I - increased activity
- G - grandiosity
- F - flight of ideas
- A - activities with pain
- S - sleep decreased
- T - talking pressured
Hypomanic Episode

- Most of the day/Nearly EVERY DAY for FOUR CONSECUTIVE DAYS
- Elevated or Irritable* MOOD (a CHANGE from BASELINE)
- Increased ENERGY or Goal-Directed ACTIVITY
- 3-4* of the following SIGNIFICANT & ABNORMAL for patient
  - Inflated self-esteem, grandiosity
  - Decreased need for sleep
  - Pressure to keep talking
  - Flight of Ideas or Subjective Racing Thoughts
  - Distractibility
  - Excessive involvement in activities with painful consequences
Major Depressive Episode

- Symptoms are present for a **TWO WEEK PERIOD**
- Depressed mood or Loss of interest (a **CHANGE from BASELINE**)
- 5 of the following **SIGNIFICANT & ABNORMAL for patient**
  - Sad/empty/hopeless OR Appears tearful OR Iritability in children
  - Markedly diminished interest or pleasure in almost all activities
  - Significant weight loss (>5%), change in appetite, **failure in children to make expected weight gain**
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Worthlessness or excessive guilt
  - Difficulty concentrating, thinking or making decisions
  - Recurrent thoughts of death, suicide attempt or specific plan
Diagnosing Bipolar Disorder

- **Bipolar I** – at least ONE MANIC EPISODE

- **Bipolar II** – at least
  - ONE HYPOMANIC EPISODE
  - ONE MAJOR DEPRESSIVE EPISODE
What else we know (epidemiology)

- Typical age of onset (can occur at any age)
  - Bipolar I: 18 years
  - Bipolar II: Mid 20s

- 3 general ages of onset for bipolar spectrum disorders
  - Middle to Late adolescence
  - Young adult
  - Adult
What else we know (epidemiology)

- Family history of bipolar or schizophrenia strongest risk factor
- Suicide risk 15x general population
- 30% of those with Bipolar I will have significant social/employment dysfunction
- Depressive episodes are the most destabilizing episodes of Bipolar II
What else we know (epidemiology)

- The earlier in life the diagnosis is made,
  - Poorer prognosis
  - Higher rates of:
    - Lifetime anxiety
    - Alcohol and substance abuse disorders
    - Suicide attempts
    - Worse mood outcomes
    - Rapid Cycling
What else we know (epidemiology)

**IN ADULTS**
- 12-month US prevalence: 0.6% Bipolar I 0.8% Bipolar II
- 12-month International prevalence: 0-0.6% Bipolar I 0.3% Bipolar II

**IN CHILDREN**
- Prevalence in US & non-US community samples of 12 years & older of combined Bipolar I, Bipolar II, & Bipolar NOS (based on DSM-IV): 1.8%
- 1/5 of people with Bipolar Disorder diagnosed in adulthood reported evidence of the disorder before age 12.
0.3%
So what else could it be?
DMDD?
What is the differential here?

- Panic Disorder
- Other anxiety disorders
- ADHD
- Major Depressive Disorder
- PTSD
- Obsessive Compulsive Disorder
- Parent/Child Relational Disorder
- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Premenstrual Dysphoric Disorder
- Substance Use Disorders
- Personality Disorders
- Autism Spectrum Disorder
- Schizophrenia Spectrum
Let’s explore.
11yo male dx of ADHD, ODD, irritable, fighting with sister, moody, chronic suicide thoughts, mother treated for bipolar d/o

Dx: ADHD, MDD, GAD
Rx: Stimulant + SSRI
Limit setting, individual & family therapist, close follow up
12yo female h/o perinatal substance exposure, extreme hyperactivity on antipsychotic & stimulant, NSSIB, impulsivity, biological mother dx with bipolar.

Dx: ADHD-CT, FAS
Rx: Stop antipsychotic, increase stimulant & dose multiple times daily, + alpha 2 adrenergic agonist BID
Continue therapy
Now 15, doing well & transitioning to high school
17yo female s/p OD. CC “I feel like I’m not in control of my life.” Reports mood cyclicity, excessive worry, NSSIB worsening since 14yo & before menstruation.

Dx: Bipolar 1 Disorder, most recent episode depressed, without psychosis
Rx: Lithium
Severity of cycles lessened then resolved. Felt “gray,” developed acne. Attempted Lamictal which worsened depressive symptoms. Graduated early from high school & moved.
16yo male dx with Bipolar & ADHD, h/o abuse, irritability, aggression, distractibility, recurrent HI, SI, suicide attempts & hospitalizations despite 3 psychotropics including an antipsychotic.

Dx: ADHD-CT, PTSD, MDD
Rx: Stimulant, continue antipsychotic, alpha 2 adrenergic agonist & SSRI. Continue therapy.
Resolution of symptoms prompting taper of antipsychotic. Did well until aged out of child clinic.
What in the world to do?
Stay calm.

Examine the child alone.
- Screen for safety – Safety concerns require immediate action
  - Delusions/Psychosis
  - Current acute Suicidal Ideation/Intent/Plan
  - Homicidal Ideation/Intent/Plan
  - Imminent Risk of Trauma/Abuse

Go back to the basics of investigating symptoms
- When did it start? How long has it lasted? Is it intermittent?
- Where did it start? How did it progress?
- How bad is it? What makes it worse? What makes it better?
Questions about your child's anger

1. HOW EASY IS IT FOR HIM/HER TO GET ANGRY? (Please circle the letter of the ONE BEST response)
   a. She is rarely irritable or angry
   b. She is mostly reasonable but has days at a time where she is very touchy and gets very angry very easily.
   c. She rarely gets angry but when she does, the explosion is huge compared to the incident that provoked it.
   d. She has always been cranky and easily angered.

2. WHAT CAUSES HIM/HER TO GET ANGRY? (Please circle ALL THAT APPLY)
   a. She feels she is being criticized
   b. She misunderstands what others are saying
   c. Her/his demands must be met immediately
   d. She can't handle change in routine
   e. She is frustrated because she can't do something (task or activity)
   f. She is hungry, tired, or pre-menstrual

3. WHICH OF THE FOLLOWING DOES YOUR CHILD USUALLY DO? (Please circle ALL THAT APPLY)
   a. Expresses anger in an appropriate way (e.g., explains her/his perspective; goes to her/his room to cool down)
   b. Argues, whines or sulks
   c. Becomes verbally insulting, swears, shouts
   d. Threatens
   e. Slams doors, punches walls, makes a mess, destroys property
   f. Self-mutilates, bangs head, or otherwise takes it out on self
   g. Throws things
   h. Hits, kicks, bites, spits
   i. Needs physical restraint

   (please circle THE BEST RESPONSE to EACH QUESTION BELOW)

4. HOW OFTEN DOES A SERIOUS TANTRUM OR OUTBURST OCCUR?
   a. Never
   b. Rarely
   c. Several times a month
   d. Weekly
   e. At least 3 times/week
   f. Daily

5. HOW LONG DOES A TANTRUM OR OUTBURST LAST?
   a. A few minutes
   b. Up to 15 minutes
   c. Up to half an hour
   d. Up to an hour
   e. Up to half a day

6. IS YOUR CHILD ANGRY OR IRRITABLE BETWEEN OUTBURSTS?
   a. Not at all
   b. Sometimes
   c. Often
   d. Very often

7. HOW DOES YOUR CHILD UNDERSTAND THE OUTBURST?
   a. Remorseful
   b. Forgets or denies it
   c. Blames others
   d. Spiteful

WHAT HELPS YOUR CHILD CALM DOWN?

G.A. Carlson, MD  Stony Brook University, 2015
**RE-EVALUATE** kids who present to you with bipolar diagnoses.

- TRUST NO ONE.
- If you think it’s something else, and you are comfortable treating, document and treat.
- ALWAYS CONSENT APPROPRIATELY.

If you think it is bipolar disorder, especially in the midst of an episode:

- **GET SPECIALTY HELP.**
  - Urgent referral to child psychiatrist.
  - Hospital if necessary.
- Encourage
  - **GOOD SLEEP**
  - **Avoidance of illicit drugs**
  - **Avoidance of SSRIs**
Medications we use:
- Atypical antipsychotics
- Lithium
- Valproate

Medication monitoring is so very important:
- Weight, BMI, Waist Circumference
- Abnormal Involuntary Movement Scale (AIMS)
- Metabolic labs
- TSH

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Antipsychotics are easy to start. They can be frightfully difficult to stop, especially outside the safety of inpatient sanctuaries. These same caveats are not too different for mood stabilizers.

Through subtraction [of medications] we may at times be able to best see the patient before us.

-Kratochvil, Varley, Cummins, and Martin, 2006
In conclusion:
Questions and discussion:
References


Resources

- www.bpkids.org For Bipolar Kids and Adults Who Need to Lose Weight
- http://www.dbsalliance.org/site/PageServer?pagename=home Depression and Bipolar Support Alliance
- Unquiet Mind by Kay Redfield Jamison