

Bipolar and Reactive Attachment Disorders: Dual Diagnosis and Intervention

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AGENDA

- Definitions of BPD & RAD
- Differential Diagnosis and Co-morbid Disorders
- Assessment of BPD & RAD
- Multimodal Interventions for BPD & RAD
- Resilience Model
- Conclusions and Discussion

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Brief History of BPD

- Kraepelin (1913) established Manic-Depression as separate from Psychosis
- In 1920-30's, Freudian theory stipulated that mood disorders could not occur before psychosexual maturity
- U.S. not accept BDP until 1970's & labeled 2 types BPD I & II
- In 1975, the National Institute of Mental Health recognized mood disorders in childhood
- Skepticism continues for BPD in youth despite higher interest, societies for BPD, & the new journal (Bipolar Disorders)

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Brief History of BPD-Continued

- DSM III published in 1980 included child onset disorders and DSM III-R in 1987 expanded application of adult disorders to youth. Continued in current DSM-IV-TR
- Carlson(1990) found 20% BPD onset before age 19
- Dx of BPD in youth is complex due to overlap with other disorders

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Provisos for Understanding BPD in Youth

- Child in Process of Developing Disorder
- Youth Differ from Adults in Sxs (More Rapid Mood Changes & Irritable with Aggressive Outbursts) & Duration of Sxs
- Complex Dx & Differential Moods Criteria (e.g., subtle differences in manic & hypomanic)

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Provisos-Continued

- Comorbidity & Differential Dx. With Many Disorders
- Need to Consider Many Disorders Simultaneously
- Need Knowledge of Medical Conditions, Medications, & Substance Use
- Interdisciplinary Approach Needed
- Lack Valid Assessments of Diagnostic Criteria

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Provisos-continued

- Problems in Dx & Treatment frequently occur
- Need for longitudinal studies to clarify early precursors and diagnostic criteria for youth with mood disorders

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Most Common Sxs of BPD in Youth

(DSM-IV-TR and Papolos & Papolos, 2001)

- Grandiosity & Giddiness
- Risk-Taking Behavior (Hyper-sexuality)
- Racing Thoughts & Speech
- Long & Explosive Rages
- Irritable & Aggressive
- Depressed & Lethargic Mood
- Separation & Social Anxiety
- Carbohydrate Craving
- Low Self-Esteem
- Hyperactive & Impulsive
- Obsessive/Compulsive

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Reactive Attachment Disorder (RAD)

- Relatively new diagnosis
- Applied to children who spent early formative years in abusive or out of home settings
- Precursor and/or comorbid with other disorders including BP
- Part of the research showing over 50% of BP youth have comorbid anxiety (e.g., Wozniak et al.(2002)

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Brief History of RAD

- Freud & Erikson introduced Attachment Theory (i.e., normal psychosocial development based on establishing trust in an “attachment figure”)
- Harlow, Bowlby & Ainsworth indicated secure vs. insecure attachment etc.
- General lack of evidence that early attachment predicts later psychopathology

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DSM-IV-TR Criteria for RAD

- “Markedly” disturbed & developmentally inappropriate social relatedness
- Consistent in most settings
- Onset before 5 yrs. of age
- One few DSM Dx for child under age 3
- Result of “grossly” pathological care/neglect
- 2 types (Inhibited & Disinhibited)

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Inhibited vs. Disinhibited RAD

- Inhibited: Fail to initiate or respond to social interaction (frozen watchfulness, resist comforting, & approach-avoidance)
- Disinhibited: Social problems due to indiscriminately seeking attachment & comfort from unfamiliar adults.

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Criticism of DSM RAD Criteria

(Boris et al., 1998)

- Focus on social problems rather than developmental research on attachment
- Including “pathological” care & maltreatment that are not defined rather than attachment problems
- Requiring consistent Sxs in all settings
- Weak reliability found for DSM criteria in Dx of children (Boris et al., 1998)

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Differential Dx. of RAD

- Not due to MR
- Autistic Spectrum & PDD typically have overlapped Sx.s but not “grossly pathological” care
- Social Phobia has attachment & only in some settings
- CD & ODD beyond RAD

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RAD Issues

- Very Uncommon
- Lack definition of Dx. Criteria
- Abuse & neglect difficult to assess
- Often based on retrospective reports
- Response to stress and long-term outcome not clear

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CRITICAL INDICATORS

- What Needs To be Ruled Out
- Most Common Sxs in Youth
- Comorbid Disorders
- Age of Onset & Prevalence
- Course of BPD
- Family History

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What Needs to Ruled Out when Identifying Bipolar Disorders

- General Medical Conditions that cause bipolar (e.g., Vitamin B12 deficiency, hepatitis, mono., & neurological conditions)
- Substance-Induced Mood Disorders for certain medications and drugs (e.g., antidepressant, steroids, crystalline meth, etc.). Withdrawal also can cause moods
- Consider onset of Sxs and proximity to onset of Med. Condition or Substance use
- Need evidence from history, physical exam, or lab report

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Disorders most comorbid with BPD

- BPD can overlap with such disorders as ADHD, CD, ODD, OCD, GAD, Panic, Substance Abuse, & Psychotic Disorders
- Some disorders subsumed by BPD
- Key issue is to typically prioritize BPD for Tx
- Differential Diagnosis Critical

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Onset & Prevalence of Bipolar Disorders in Youth

- Mean Age of Onset is 21 years
- Peak Years of Onset is 20-24 & 15-19
- Low Rate below 15 & esp. below 12
- Estimate of 1% for full-blown BD with 4-6% having bipolar spectrum

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Course of BPD

- Manic episode onset is usually sudden with escalation over few days
- Episodes last few weeks to several mos.
- Rapid cycling is 4 or more episodes of Manic, MDD, Mixed, Or Hypomanic over 12 mos. (Rapid mood shifts more common in youth)
- Seasonal Pattern

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Family History

- 1st degree biological relatives of one with Bipolar I have elevated risk of PBD I (4-24%), BPD II (1-5%), & MDD (4-24%) as update in DSM-IV-TR
- If 1 parent has mood disorder, 15-30% of children at risk
- If both parents have mood disorder, 50-75% of children at risk
- Risk increases with no. of relatives with mood Dx
- Family Hx of substance abuse also risk factor

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Family History (Continued)

- About 1 in 3 adopted with BPD have parents with Mood Dx while only 1 in 50 adopted without BPD
- Risk for identical twin is about 70%
- Risk for fraternal twin and sibling is about 15-25%
- Epidemiology of higher incidence & earlier onset with unknown cause

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Types of Bipolar Disorders

- **Bipolar I:** Manic, Mixed, and Major Depression Episodes with 6 subtypes
- **Bipolar II:** Major Depression followed by at least 1 Hypomanic Episode
- **Cyclothymic:** Hypomanic & Dysthymic with 1 year duration
- **Bipolar Disorder, NOS:** Bipolar Features (with less severity and frequency)

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Types of Bipolar I Disorders (BPD I)

1. With only Single Manic Episode & no past MDD Episodes
2. Most Recent Episode Hypomanic with Hx of at least 1 Manic or Mixed Episode
3. Most Recent Episode Manic with Hx of at least 1 MDD, Manic or Mixed Episode
4. Most Recent Episode Mixed with Hx of at least 1 MDD, Manic or Mixed Episode
5. Most Recent Episode Depressed with Hx of at least 1 Manic or Mixed Episode
6. Most Recent Episode Unspecified with a Hx of at least 1 Manic or Mixed Episode

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Types of Bipolar II Disorders

1. Most Recent Episode Hypomanic
2. Most Recent Episode MDD

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Differences in Bipolar Disorders

- Bipolar I: Marked Change in Behavior with often Inability to Perform Daily Living & Hospitalization
- Bipolar II: Change in Behavior Observable by Others but Can Perform Daily Living
- MDD in both Bipolar I & II but not Cyclothymic Disorder
- Mixed Episodes only in Bipolar I

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Differences in BPDs (continued)

- Psychotic Sxs. In Mania but not Hypomania
- Duration of Sxs at least 1 week for Bipolar I, 4 days for Bipolar II, & 1 year for Cyclothymia
- Bipolar II often Precursor to Bipolar I

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Diagnostic Key: Must Know Criteria for Moods

- Manic vs Hypomanic
- MDD vs Dysthymia
- Mixed vs Manic & MDD
- Severity of Impairment with marked levels for Mania and MDD
- Severity for Hypomania & Dysthymia
- Psychotic Sxs only in Manic & MDD

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DSM-IV-TR CRITERIA FOR MANIA

At least 1 week of 3 of the following symptoms:

- ☉ Inflated self-esteem or grandiosity
- ☉ Decreased need for sleep (e.g., 3 hours)
- ☉ More talkative than usual or pressure to keep talking
- ☉ Flight of ideas or “thoughts are racing”
- ☉ Distractibility
- ☉ Increase in goal-directed activity or psychomotor agitation with poor judgement
- ☉ Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., sex, aggression, etc.)
- ☉ Marked Impairment or Hospitalization
- ☉ Not due to antidepressants, medical, or drug use cause

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DSM-IV TR Criteria for Hypomania

- Same Sxs as Mania but not severe enough to cause “marked” impairment in social or school functioning or hospitalization
- Psychotic Sxs not present in Hypomania Episode but may be in Major Depression Episode for Bipolar II
- Psychotic Sxs may be in present in Mania

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DSM-IV TR Criteria for MDD

- 5 or more of 9 Sxs for 2 weeks and at least 1 Sx is either (1.) Depressed Mood or (2.) Loss of Interest
- 1. Depressed (Irritable) mood most of day & every day*
- 2. Loss of interest in activities most of day & every day
- 3. Change of weight by more than 5% in a month*
- 4. Insomnia or Hypersomnia most days
- 5. Psychomotor Agitation or Retardation
- 6. Fatigue or Loss of Energy most days
- 7. Feeling Worthless or Guilt
- 8. Less Ability to Think, Concentrate, or Make Decisions
- 9. Death & Suicidal Ideation

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DSM-IV TR Criteria for a Mixed Episode

- Criteria of both Manic and MDD Episodes (except duration) most days for at least 1 week (Criteria A)
- Rapid Changes in Moods (Sadness, Irritability, Euphoria) with Manic & MDD Episodes with severe Sxs (e.g., agitation, psychotic Sxs, & suicide risk) & marked Impairment (Criteria B)
- Sxs not due to medical condition or substance use (Criteria C)
- Medical Tx for depression especially need to be R/O for youth with mixed Episode

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DSM-IV TR Criteria for Dysthymia

- Depressed mood for most of day & more days than not for at least 1 year and has not been without Sxs for more than 2 months
- 2 or more of following Sxs
 1. Poor appetite or overeating
 2. Insomnia or hypersomnia
 3. Low energy or fatigue
 4. Low self-esteem
 5. Poor concentration & decision-making ability
 6. Feelings of hopelessness

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Differences in MDD & Dysthymia

- **Severity:** MDD has at least 5 major & more severe Sxs of list for 9 Sxs (e.g., loss of interest most days & feeling worthless). Dysthymia has at least 2 less severe Sxs (e.g., low self esteem)
- **Duration:** MDD has Sxs present most of day & nearly everyday for at least 2 weeks with a later variable course. Dysthymia must be present for 1 year and not most of the day & most days (e.g., up to 2 mos. No Sx)
- **Onset:** Dysthymia often has an insidious onset in childhood and adolescence while MDD has an obvious, sudden onset & can begin at any age with average onset in the mid-20s.
- **Psychotic Features:** Can only occur with MDD
- Dysthymia as precursor to MDD (75%)
- Cyclothymia is hypomania with dysthymia (no MDD)

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Differentiating BPD from Other Disorders

- Complex Task Requiring Detailed Knowledge of Many Disorders and Child's Background
- Sxs often Overlapped as "Comorbid" with following:
 1. Disruptive Behavior Disorders
 2. (ADHD, CD, ODD, Tic,&TS)
 3. Anxiety Disorders (e.g., GAD, PTSD, OCD, Panic, & Sep. Anxiety)
 4. Eating Disorders
 5. Substance Use
 6. Learning Disorders
 7. Psychotic Disorders

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Differential Diagnosis

Physical
 Iatrogenic (i.e. steroid use)
 Endocrine Disorders (i.e. hyperthyroidism)
 Neurological conditions
 Head trauma

Psychiatric
 ADHD Sexual Abuse
 Conduct disorder Substance Abuse
 Schizophrenia

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Similarities of ADHD & BPD

- Hyperactivity
- Decreased concentration
- Distractibility; Inattentiveness
- Impulsive behavior
- Sleep problems
- Poor judgment
- Weak social skills
- Temper problems
- Poor frustration tolerance

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DIFFERENCES in ADHD & BPD

- ⦿ Chronic Sx in ADHD & variable in BPD
- ⦿ Absence of mood swings & MDD in ADHD
- ⦿ Absence of psychotic features In ADHD
- ⦿ Behavior patterns are stable in ADHD
- ⦿ Early Onset before age 7 in ADHD & BPD usually later in teen years

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Research Studies: BPD & ADHD

(90% overlap between ADHD & Bipolar Features)

- 50% of mania characteristics can be applied to ADHD behavior
- 94% of sample of N=43 children with mania met DSM-III-R criteria for ADD with hyperactivity
- Recent research suggests both ADHD and Bipolar can be co-morbid or co-occurring
- In some cases childhood ADHD may be an early stage culminating in a full blown bipolar disorder

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Similarities

ODD & CD vs BPD

- negative mood
- bullying behavior
- hostility (internal & external)
- risk seeking behaviors
- poor impulse control
- rule breaking behavior
- substance abuse
- disrespectful
- destroy property
- test classroom and school rules to extreme limits
- temper outbursts
- recklessness

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DIFFERENCES in BPD & CD

- ☉ Absence of grandiosity in CD
- ☉ Absence of flight of ideas in CD
- ☉ Sleep pattern Unstable In BPD
- ☉ Behavior patterns are stable IN CD
- ☉ Progressive Course in CD
- ☉ Deliberate Violations in CD & "Thrill of Insubordination" in BPD

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Behavior Disorders & BPD Research

Research Studies

- N=96 adolescent inpatients (1989)
 - 77% with other primary psychiatric conditions
 - 23% diagnosed as bipolar
 - 42% of bipolar group had a secondary diagnosis of conduct disorder
 - N=26 bipolar adolescents (1995)
 - 18 had history of conduct disorder at sometime in their life
 - study concluded original sample had 69% lifetime comorbidity rate
 - 54% of the bipolar group had overlapping mania or hypomanic episodes with conduct disorder

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Bulimia vs BPD

Similarities

- Agitation & Irritability
- Self-Medicating with Illicit Drugs
- Depression but no Mania in Bulimia

Differences

- Bulimia more F & BPD equal M&F
- Bulimia more binge/purge & BPD not
- Bulimia onset late adol. or Early Adult & BPD varies from childhood on

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Borderline Personality Dis.vs BPD

Similarities

- History of unstable social relationships
- Impulsive behaviors & temper outbursts
- Mood shifts & intense anger
- Substance abuse & psychotic-like symptoms

Differences

- Borderline onset over age 18 & BPD varies
- Borderline mostly F & BPD equal in M & F
- Borderline has stable Sxs & BPD Episodic
- Borderline has fear of abandonment

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Assessment Guidelines

–*Need for thorough assessment of diagnostic criteria and comorbid disorders (see Mood and Behavior Rating Scale for Youth handout)

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Assessment Approaches

- Bipolar Specific Methods
- Bipolar Sxs need to be monitored across time due to variable course
- Comprehensive Assessment of Multiple Personal-Social Domains for Differential Dx & to Rule Out Comorbid Disorders
- Family Hx, Medical Hx & Substance Use Hx need to be reviewed

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Assessment (Continued)

- Comprehensive Interview of Child, Parent, & Teacher Needed
- Semi-structured Interview of all Sxs, Background, & Safety Issues (See attached Child Background Info. Form)
- Structured Interview & other methods to Specifically Dx BPD Sxs & related Disorders reviewed later

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Assessment Issues

- No specific laboratory tests to confirm Bipolar condition in children
- Difficult to discriminate normal and pathological behaviors in very young children
- Developmental factors
- Short duration (due to young age)
- Lack of normal impulsive control

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Assessment Issues Continued

- Many overlapping symptoms, especially in children's disorders
- Bipolar symptoms in children can reflect differing degrees of manifestation over time depending on temperament and environment
- Chronic Stressors & Reactions can mimic Bipolar Sxs

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Variety of Presenting Problems

— Misdiagnosis or dual Dx when a variety of symptoms are reported with BPD such as:

- separation anxiety
- night terrors
- distractibility
- poor attention span
- restlessness
- hyperactivity
- obsessive behaviors
- defiant behaviors
- irritability
- mixed mood states

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Common Diagnostic Problems

Parent Report of Symptoms

- exaggeration
- malingering
- denial
- under-reporting

Observation Bias

- situation specific
- varies with environmental structure
- in partial remission with medications

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Source of Errors in Dx

■ Family History

- reliability of data
- incorrect past diagnoses
- undiagnosed family history

■ Clinical Course of the Disorder

- reaction to medications
- age of onset
- duration
- mixed symptomatology
- reliability of reports

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Medical Conditions that can Cause Mood Sxs

Hormonal & Metabolic Disorders

- diabetes
- hyperthyroidism
- hypoglycemia
- hypothyroidism
- Cushing's Disease
- Wilson's Disease

Infectious Diseases

- Hepatitis
- Mononucleosis
- AIDS
- Viral Pneumonia

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Medical Conditions (contd.)

Neurological Disorders

- Temporal Lobe Epilepsy
- Kleine-Levin Syndrome

Metal Intoxications

- Mercury
- Manganese

Nutritional Disorders

- Pernicious Anemia
- Pellagra

Other

- chronic fatigue syndrome
- fibromyalgia
- lyme disease

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Assessment Model

Mood Disorder Specific Measures

- Depressive Mood Status
- Manic Mood Status
- Fluctuating Mood Status

Assessment of General Maladjustment

- Standardized Assessments
- Observation & Interview

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Sample BPD-Specific Measures

- Bipolar Child Questionnaire
- Parent Version of the Young Mania Rating
- Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS) Mania and Rapid Cycling Sections

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Parent Version of the Young Mania Rating P-YMRS

Gracious et al.,(2002)

- Experimental Research Instrument (Subjective parent questionnaire)
- 11 items
- Raw score 14+ is Positive for potential childhood & adolescent mood disorder

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The Bipolar Child Questionnaire (BCQ) Papolos (2003)

- Developed as a screening inventory of symptoms and common behavioral features of childhood – onset bipolar disorder
- First version contained 85 items
- Second version is under study and includes 65 of the highest rated symptoms included in the original BCQ
- Research is currently funded by the Juvenile Bipolar Research Foundation

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Standardized Assessments Applied to Dx of BPD

- Beck Youth Inventories
- Child Behavior Checklist
- Child Interview for Psychiatric Syndromes
- Child Symptom Inventory
- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
- Reynolds Adolescent and Child Depression Scales

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What is not measured by BPD-Specific Scales

- Diagnostic criteria of all BPD spectrum disorders (duration of moods)
- Impairments & levels of distress needed to discriminate types of BPD
- Needed rule-outs such as medical conditions and substance use induced BPD Sxs
- Diagnostic criteria of frequent comorbid disorders such as ADHD

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Limitations of using standardized measures

- Items of related scales such as Hypomania of MMPI-A do not have actual BPD diagnostic criteria
- Most scales do not have adequate scales to measure Mania & Hypomania critical for adequate identification of BPD Sxs
- Don't measure specific domains of BPD such as onset and duration of Sxs
- All assessments currently lack adequate research evidence for valid BPD assessment

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Mood & Behavior Rating Scale for Youth (MBRSY)

Perry & Bard (2005)

- Currently as experimental edition for research to validate a comprehensive assessment of the complex BPD criteria for children and adolescents
- Based on DSM-IV criteria and recent research of characteristics of youth with BPD
- (See MBRSY handouts)

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Description of MBRSY

Parent Form (MBRSY-PF) has 6 domains:

1. Behavior & Emotions (44 items)
2. Speech & Thinking (25 items)
3. Physical & Medical Background (22 items)
4. Impairments & Distress (21 items)
5. Mood Changes (7 items)
6. Developmental & Family Background (17 items)

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Description of MBRSY continued

Teacher/Therapist Form (MBRSY-TF) has 4 domains:

1. Behavior & Emotions (45 items)
2. Speech & Thinking (27 items)
3. Impairments & Distress (21 items)
4. Mood Changes (7 items)

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Description of MBRSY Items and Content

- Actual unique BPD Sxs such as “needs no more than 3 hours of sleep to feel rested”.
- Instead of a Lickert measure of frequency, the degree that items are sometimes or mostly true of the child used to measure episodic Sx of BPD vs consistent Sx in ADHD
- Dx criteria of other overlapped disorders included in scale
- A profile of scoring based on face validity provided until evidenced-based factors available

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Major Goals of the MBRSY

1. Provide a valid and reliable standardized measure of BPD for youth
2. Apply the MBRSY in research to improve the accuracy of BPD Dx for youth
3. Include not only the DSM-IV-TR Dx criteria but also previous research about the unique Sxs experienced by youth with BPD
4. Include the criteria for comorbid disorders & differential Dx

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