

BIPOLAR DISORDERS IN CHILDREN AND YOUTH

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TOPICS

- **DSM-IV-TR Criteria for Bipolar Disorders (BPDs) & Frequent Comorbid Disorders**
- **Limitations of DSM-IV-TR Criteria**
- **Comprehensive Assessment Model**
- **Intervention Planning**

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Foundations for Understanding BPD in Children and Youth

**Complex diagnosis & Differential Moods Criteria
(e.g. subtle differences)**

1997-1 in 20K ; current estimates 1 in 200 (Harvard Mental Health letter, May 2007) ---**NIMH says 1% of adults (18+)**

2/3 of children with mood disorders are undiagnosed

Others say it's over diagnosed—drugs dispensed too freely—cite the role of abuse, trauma, & inadequate parenting

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Foundations—Con't.

- **Co morbidity With Other Disorders**
- **Need to Consider Many Disorders Simultaneously**
- **Familiarity with Medical Conditions, Medications, & Substance Use**
- **Interdisciplinary Approach Needed**
- **Lack Valid Assessments of Diagnostic Criteria**

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Foundations—Con't.

- **Confusion in Diagnosis & Treatment is frequent**
- **Many other conditions mask bipolar because of overlap of symptoms**
- **Youth with BPD are a heterogeneous group with differences due to different types of BPDs, severity levels, & co-morbid disorders**

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Most Common Symptoms 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**
- **Suicidal ideation is a concern early on**

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Relevance to Schools

- **High Stakes Disorder with High Risk for Violence and Disruptive Behavior during a Manic Episode**
- **High Morbidity & Mortality with Risk for Suicide during Depressed Episode**
- **Youth with BPD & Related Serious Emotional Disorders are 4 TIMES more likely to drop out of school than peers(i.e., 85% vs. 21% according to US Dept. of Ed., 1999)**
- **Early Diagnosis, Prevention, & Crisis Intervention Critically Needed**

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Onset & Prevalence of BPD

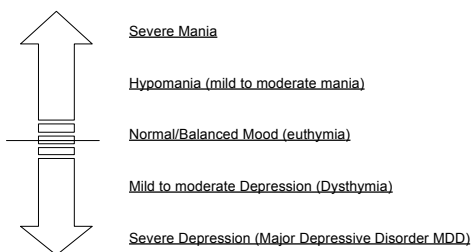
- **Mean Age of Onset is 21 years**
- **Peak Years of Onset is 20-24 & 15-19**
- **About 1% of age 13-18 have BPD with 4-6% having bipolar spectrum and about 1/2 that have BPD below age 12 (Fristad, 2005)**
- **Higher prevalence of BPD in US vs. Europe may be linked to higher use of psychotropic meds. & substance abuse in US (i.e., may trigger Mania in those at risk for BPD)**

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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) Used often with children because of the variability in symptoms

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Course of BPD

- **Depression usually precedes mania for development of BPD1**
- **Manic episode onset is usually sudden with escalation over few days**
- **Episodes last few weeks to several mos.**
- **Rapid cycling (mood shifts) more common in children and youth & do not cycle with distinct mood swings-in fact may cycle rapidly even hour to hour** (Harvard Mental Health letter, May 2007)

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Causes of Bipolar Disorders

- **Biological with chemicals that transmit messages in brain different in BPD than typical child**
- **Brain chemistry is inherited with genetics indicated**
- **Psychosocial stress in home if parent(s) have BPD or depression**
- **The severity of problems & course of BPD influenced by psychosocial stress**

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Causes of Bipolar Disorder (cont'd)

(Birmaher et al, 1996)

- **About 1/4- 1/2 of Youth with depression disorders will have BPDs within 2-5 yrs**
- **Risk factors include:**
 - **Psychomotor retardation or psychosis**
 - **A family history of BPD**
 - **A family history of any mood disorder**
 - **Mania or hypomania caused by medications**

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DSM-IV-TR CRITERIA FOR MANIA

At least 1 week with 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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Mania "Symptom Thresholds" for

Youth (Kowatch, et al.(2005), Harvard Mental Health Letter, (May, 2007)

- **Euphoric/Expansive Mood: Being happy, silly, & inappropriate giddiness**
- **Inflated Self-Esteem/Grandiosity: Beliefs by child that have risk of harm (e.g., belief that he can fly like superman).**
- **Less Need for Sleep: At least 2 hours less than usual with no fatigue & not due to insomnia, substances, etc.**
- **Extreme Bossiness and Defiance of Authority (a 12 year old tells a coach how to play soccer)**
- **Irritability is common to both mania & depression**

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Mania "Symptom Thresholds" (cont'd)

- **Flight of Ideas:** Child actually reports "racing thoughts" that impair concentration.
- **Distractibility:** Not as ongoing as in ADHD, but as change with Mania from usual euthymic (normal mood) times.
- **Increased Goal-Directed Acts:** When Manic, can be very productive. Note: higher correlation of BPD with high IQ & creativity.
- **Pleasurable Acts:** Erotic sexual behavior rather than anxious sex behavior of the sexually abused

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BPD is Often Comorbid

BPD can overlap with many disorders such as ADHD, CD, ODD, OCD, GAD, Panic, Substance Abuse, Psychotic Disorders, & Eating Disorders

Some disorders subsumed by BPD

Co morbidity & Differential Diagnosis Critical for Effective Treatment

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Differential Diagnosis

- Complex Task Requiring Detailed Knowledge of Many Disorders and Child's Background
- Symptoms often Overlapped as "Comorbid" with following:
 - Disruptive Behavior Disorders
 - ADHD, CD, ODD, Tics, & Tourette's Syndrome
 - Anxiety Disorders (e.g., GAD, PTSD, OCD, Panic, Separation Anxiety)
 - Eating Disorders
 - Substance Use
 - Learning Disorders
 - Psychotic Disorders

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Similarities of ADHD & BPD

- 70-90% of children & 30-40% of adol. with BPD have co morbid ADHD (Kowatch et al. ,2005) Others say 50%+. (Harvard Mental Health Letter, May, 2007)
- A child diagnosed ADHD has a 30% chance of later being diagnosed 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 symptoms in ADHD & Variable symptoms in BPD
- Absence of mood swings & Major Depressive Disorder 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 of ODD & CD with 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: BPD & CD/ODD

- 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
- Absence of grandiosity in CD & ODD

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BPD Assessment Guidelines

- **Need for thorough assessment of diagnostic criteria and co morbid disorders**

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Assessment Issues

- No specific laboratory tests can confirm Bipolar
- Difficult to discriminate between normal and pathological behaviors in very young children
- Developmental factors
- Behaviors tend to be of short duration due to young age
- lack control of impulsive behaviors is normal in younger children

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Assessment Issues Continued

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

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Standardized Assessments Applied to Dx of BPD

- Beck Youth Inventories
- Child Behavior Checklist
- Suicide Probability Scale
- Child Symptom Inventory
- Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
- Reynolds Adolescent and Child Depression Scales

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Standardized Assessments (cont'd)

- Personality Inventory for Youth
- Personality Inventory for Children-2
- Revised Connor,s Rating Scales
- Differential Test of Conduct & Emotional Problems
- Child Interview for Psychiatric Syndromes

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Critical Indicators For Diagnosis of BPD in Youth (Sterling, 2005)

- Extended & Severe Tantrums
- Unpredictable Behavior
- Extreme Reactions (when changes occur or limits placed)
- Sexualized Behavior
- Oblivious to Environment
- Self-Centered & Rigid Attitude
- Irritability seen in both 'up' and 'down' moods

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Critical Indicators (cont'd)

- Episodes of Extreme Over-activity
- Physiologic Description (e.g. sleep)
- Obsessive and Demanding
- Developmental Symptoms (e.g. late onset of toileting problems)
- Classic Signs of Mood Fluctuations
- Reactions to Stressors far Beyond the Typical Reaction of Children
- Psychosis & Unusual Fantasies

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BPD Specific Treatments (Papoulos & Papolos, (2001))

- Mood Stabilizing Meds: Lithium & Anticonvulsants such as Tegretol & Depakote-newest is Abilify
- Meds for co morbid disorders used after mood is stabilized
- Careful use of stimulants if marked BPD Symptoms present
- Anger Management (e.g., Aggression Replacement Training)
- Relaxation Training & Behavior Mod.

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Medication Cautions

- Antidepressants and Stimulants without a mood stabilizer can trigger Manic Episode
- can increase frequency on cycling & mania
- not used early in treatment
- may cause earlier onset
- initial reaction can be positive, although deterioration can follow
- may be risky and potentially harmful with family history of bipolar
- First-control the BPD-then treat other conditions (e.g. ADHD)

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SCHOOL-BASED INTERVENTIONS FOR BPD & RELATED MOOD DISORDERS

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Persistent Under-Identification and Service Problems of Students With EBD

- Less than 1 % of children nationwide receive services through this service classification (but should be 3 to 6 %)
- Compared to students with LD, those with ED tend to be identified at later ages...most are in the 12-17 year age range
- Students with ED have the highest rates of school dropout (60 to 70 %)

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What Can Schools Do?

- Universal screening with earlier identification and intervention
- Refocus classification criteria away from general ED definition and toward an externalizing/internalizing system
- Respond effectively to bullying
- Have a continuum of services available-get away from "BD class or nothing" mentality
- Adopt prevention programs
- Develop "mentoring" programs

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What Can Schools Do? (cont.)

- Educate faculty to recognize symptoms
- Establish policy and resources for helping kids with mood disorders.
- Include unit on mental health
- Develop parent education centers/programs
- Encourage students to assist depressed and anxious peers
- Evaluate stress factor in school environment
- Build in flexibility-give kids “wobble room”

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