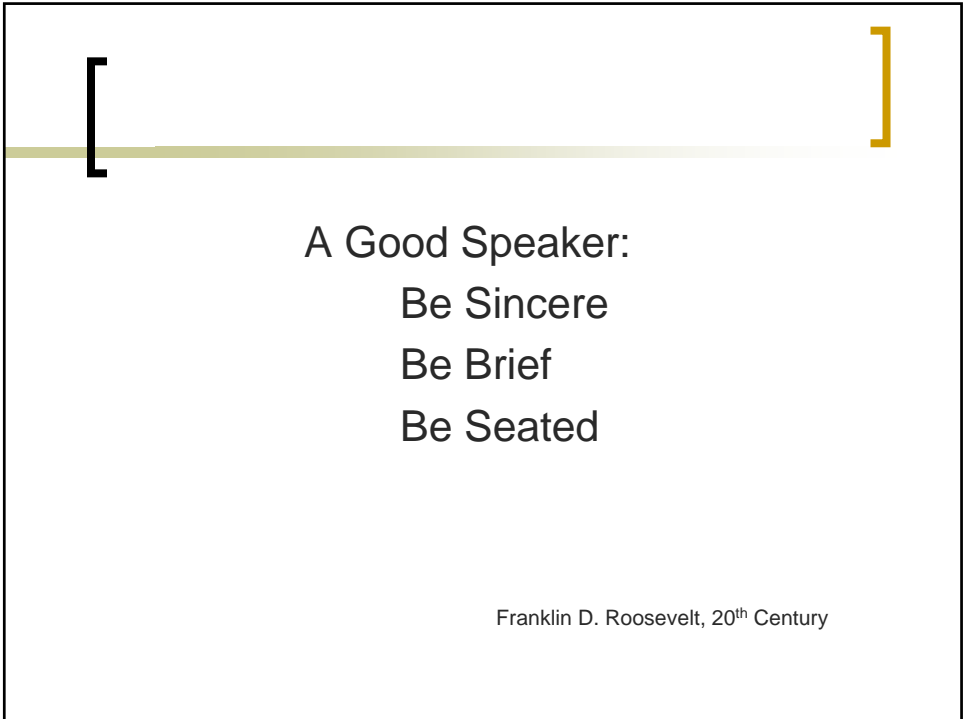




**Bipolar Disorders in Children  
and Adolescents**



**A Good Speaker:  
Be Sincere  
Be Brief  
Be Seated**

Franklin D. Roosevelt, 20<sup>th</sup> Century



DSM IV  
& DSM V



FACTS:

1. ALL Adolescents are Psychotic until proven otherwise
2. Not ALL Adolescents are bipolar

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Clinicians:

Above all

Do No Harm!

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## Genetic Vulnerability

- Adults (Bipolar) = 50% (+) family history
- Childhood onset = greater than 50%
- Identical twins = 40-70% concordant
- Cohort effect – increased rate and earlier onset since WWI

## Common Comorbid Disorders

	Pre-Puberty %	Adolescent %
ADHD	70-90	30-60
Anxiety Disorders	20-30	30-40
Conduct Disorders	30-40	30-60
Oppositional Disorders	60-90	20-30
Substance Abuse	10	40-50
Learning Disabilities	30-40	30-40
EEG Abnormalities	?	

## Features for which a higher level of suspicion about possible bipolar disorder should be considered

- Family history or mood disorders
- Episodes of aggressive behavior in the context of other manic symptoms
- Early age at onset for depression
- Mood disorder with psychotic features
- Recurrent depressive episodes resistant to treatment
- Mood destabilization secondary to stimulants or antidepressants

## Evidence that bipolar illness may be a progressive disorder

- Episode severity increases over time.
- An illness progresses, patient spend more time symptomatic than euthymic.
- Although episodes may be initially brought on by psychological stress, over time episodes may begin without being precipitated by stressors.
- Tolerance to effective treatments can occur over time.
- Patients being discontinued from an effective treatment may not experience the same effectiveness if the medication is reinitiated.
- Rapid fluctuations in mood appear to develop in the later stages of mood disorders.

## Adolescent Bipolar Disorder

- 58% has mixed episodes
- 69% were rapid cycling
- 35% had psychosis
- 75% ADHD
- 30% suicidal – study
- 20-30% of Bipolar II convert to Bipolar I

## Behaviors with Mood Disorders

- Find = Frequency  
= Intensity  
= Number of occurrences  
= Duration

\*school, home, peers, neighborhood

## Poor Outcomes?

- 1. Medication compliance
- 2. Accurate diagnosis?
- 3. Substance abuse
- 4. Abuse
- 5. EEG Abnormal
- 6. Inadequate Dosing

<u>Symptoms</u>	<u>Attention Deficit Disorder, with or without Hyperactivity</u>	<u>Bipolar I Disorder, Mixed Type (Rapid Cycling)</u>
Age of Onset	Infancy – toddler, 6, 13	2-3, 6, 13-25
Family History	ADHD, academic difficulties, (based on task completion) alcohol and substance abuse.	Any mood disorder (depression or bipolar), academic difficulties, based on motivation problems or opposition or defiance, alcohol and substance abuse, adoption, ADHD
Lifetime Prevalence	Approximately 3-6% of general population	1-3% of general population
Etiology	Genetic, neurochemical, fetal, development, brain traumas, nutritional deficiencies, exacerbated by stress.	Genetic, exacerbated by stress and hormones.

<u>Symptoms</u>	<u>Attention Deficit Disorder, with or without Hyperactivity</u>	<u>Bipolar I Disorder, Mixed Type (Rapid Cycling)</u>
Duration	Chronic and unremittingly continuous, tending toward improvement	May or may not show clear emotional and behavioral episodes and cyclicity; worsens over years with increased severity of symptoms.
Attention Span	Short, leading to lack of productivity and task performance and completion.	Entirely dependent on interest and motivation, distractibility common.
Impulsivity	Secondary to inattention or obliviousness, regret and remorse.	"Driven." "Irritable", grandiosity, thrill-seeking, counter phobia, little regret or remorse. Pressured speech.
Hyperactivity	50% are hyperactive. Disorganized, fidgety, jittery.	Wide ranges, with hyperactivity common in children.

<u>Symptoms</u>	<u>Attention Deficit Disorder, with or without Hyperactivity</u>	<u>Bipolar I Disorder, Mixed Type (Rapid Cycling)</u>
Self-esteem	Low, rooted in on ongoing performance difficulties.	Low because of inherent unpredictability of mood. Grandiose or expansive mood could mask low esteem.
Mood	Usually friendly in a genuine manner. Some irritability.	Unpredictable, oversensitive, expansive, grandiose, irritable, hard to please or satisfy.
Control Issues	Desire to seek approval – get into trouble by inability to complete tasks.	Intermittently desire to please but tend to push limits and relish power struggles. Expert hasslers, persuasive.
Opposition/Defiance	Demonstrate argumentativeness but will relent with show of authority, redirectable. Short attention span allows them to “let go” easily.	Usually overtly and prominently defiant, at times passive aggressive, often not relenting to authority. Tend to insist on getting own way.

<u>Symptoms</u>	<u>Attention Deficit Disorder, with or without Hyperactivity</u>	<u>Bipolar I Disorder, Mixed Type (Rapid Cycling)</u>
Blaming	Self-protective mechanism to avoid immediate adverse consequences.	Grandiosity contributes to disbelief/denial they caused something to go wrong.
Lying	Avoid immediate adverse consequences.	Enjoys “getting away with it”.
Fire Setting	Play with matches out of curiosity, nonmalicious.	Intrigued with matches/fire setting and can have malicious intent.
Anger, Irritability, Temper and Rage	Situational, in response to over-stimulation, poor frustration tolerance and need for immediate gratification. Rage reaction is usually short-lived	Secondary to limit-setting or attempts to control their excessive behavior, rage can last for extended periods of time, at other times may be explosive and over quickly. Overt, aggressive and assaultive.

<u>Symptoms</u>	<u>Attention Deficit Disorder, with or without Hyperactivity</u>	<u>Bipolar I Disorder, Mixed Type (Rapid Cycling)</u>
Anxiety	Uncommon, unless performance-related	Emotional wired. High potentials for anxiety, fears and phobias. Somatic symptoms common, needle phobic. Dissociation
Sexuality	Emotionally immature and sexually naive	Sexual hyperawareness, pseudo-maturity, high interest and activity level
Alcohol and Substance Abuse	Strong tendencies, out of coping mechanisms for low self-esteem	Very strong tendencies in attempt to enhance or reduce hypomanic/dysphoric moods.
Parenting Techniques	Support, encouragement, redirection	Nothing works long term until correctly diagnosed and medically treated.
Optimal Environment	Low stimulation and stress, support and structure. Identify learning disability components or psychological factors.	Clear and assertive, balance of limits, encouragement, negotiation. Helpful if all members of treatment work together.

## 2009 Issues

- Drug/Etoh issues
- Affluence/poverty
- Divorce
- Mobility
- Lack of Grandparents
- Lack of school involvement
- Extended Adolescence
- Childbearing has been delayed
- Menses onset is much earlier
- STD issues
- Hormones
- Violence/Gangs
- Sexual/Physical abuse
- Spiritual
- "INTERNET"
- Overwhelmed families



“It is not attention that the child is seeking  
but love”

Sigmund Freud