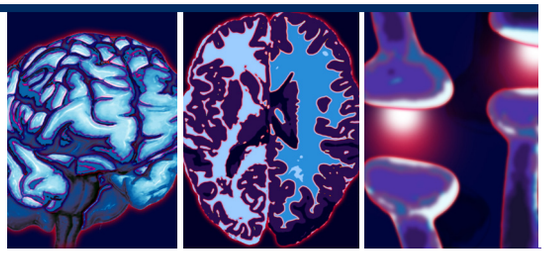

Challenges remain in the diagnosis and treatment of childhood-onset bipolar disorder

Janet Wozniak†

"Even the most emotionally stable parent meets his match when raising a bipolar child ... A phenomenon I commonly see is that of traumatized parents, traumatized by their own children and traumatized by the mental health professionals they turn to for help..."

Parents will often come into my consultation office bringing videotapes of their children; not the happy home movies of childhood, but videos of their child's worst moments. Often the youngster is screaming, thrashing and crying. Often a mother or father is attempting to wrestle the child to the floor, trying to place them in the 'basket hold' learned from a therapy session that may have also included their umpteenth lesson on controlling their child's behavior with star charts and time-outs. Such parents need a professional to bear witness to what they already know: their child has a severe mental problem.

A recent editorial in the *New England Journal of Medicine* [1] regarding childhood bipolar disorder notes that "children who have outbursts frequent and severe enough to warrant this diagnosis may live in stressful households", implying that stress leads to the child's outbursts. While true, the stress in the household is more often than not coming from the child's frantic agitation, traumatizing parents and siblings. In cases where parental mental illness or familial substance abuse complicates the situation, a child can be said to have two problems: the inherited tendencies toward psychiatric illness and environmental deprivation. The same can be true of the poor child's parents: not only are they grappling with their own symptoms, but they are stressed to the maximum by an out of control child. Even the most emotionally stable parent meets his match when raising a bipolar child [2]. A phenomenon I commonly see is that of traumatized parents, traumatized by their own children and traumatized by the mental health professionals they turn to for help, who rigidly adhere to the 'child as victim' model, sometimes owing to a reluctance to provide a major diagnosis for a small child.

A major diagnosis, after all, generally triggers the possibility of a psychopharmacologic intervention. Antipharmacology pundits, such as the authors of the *New England Journal of Medicine* editorial, argue that using medication may risk "overlooking problems that require nonpharmacologic

"Even if they were widely available ... non-medication interventions for children with severe emotional dysregulation are largely unproven and those that are helpful ... are generally impossible to implement in the midst of constant crisis..."

†Pediatric Bipolar Disorder Clinical & Research Program, Massachusetts General Hospital, MA, USA
and
Harvard Medical School, Boston, MA, USA; Tel.: +1 617 503 1038; Fax: +1 617 503 1092; jwozniak@partners.org

part of future medicine fsg

solutions" [1]. Even if they were widely available (which they are not), non-medication interventions for children with severe emotional dysregulation are largely unproven and those that are helpful (cognitive behavioral therapy, dialectical behavioral therapy and collaborative problem solving) are generally impossible to implement in the midst of constant crisis [3].

Whenever I tell someone what my job is (prescribing medication to children with severe mood problems), I prepare for the inevitable appalled reaction. The side effects of medications are easy to see and fear. However, the ill effect of not medicating often goes unconsidered. Delaying pharmacological interventions prolongs dangerous and highly impairing psychopathologic states. Children with bipolar disorder have, on average, been ill for 4 years by the time of psychiatric referral [4]. To be ill for 4 years in the life of a 40 year old is a tragedy, but 4 years of illness in a child or adolescent wields a major impact on identity and sense of self, which could take years or decades to undo. Furthermore, leaving any medical condition subject to no, or ineffective, treatment generally leads to a worsening condition, which may become more difficult to treat. By this reasoning, psychopharmacologic interventions that can quickly remove symptoms of emotional dysregulation are even more critically indicated in the young, but remain more vilified the younger the patient. Since the outcome of bipolar disorder in youth includes delinquency, substance abuse and suicide, when carrying out the risk–benefit analysis, parents, clinicians and society need to be aware that the decision to avoid pharmacologic interventions carries risks that are as great as (and perhaps greater than) exposing children to psychiatric medications.

"In my clinical practice I use the bipolar diagnosis because it best captures the nature of the dramatic mood shifts, reckless impulsivity and bizarre behavior characteristic of so many unfortunate children."

Virtually all psychiatric disorders are disorders of childhood, and the high rates of disorder seen in adults reflects many cases that begin in childhood. In an analysis of over 10,000 adolescents, Merikangas *et al.* reported on data from the National Comorbidity Survey and found extremely high rates of psychiatric disorders in adolescents, including bipolar disorder, which was present in 2.9% of those surveyed [5]. Data from nearly 1000 adults with bipolar disorder found that 65% report a childhood or adolescent onset to their disorder [6]. In studies from around the USA, the average age of ascertainment or referral for children is often 8 or 9 years old, but the age of onset of pediatric bipolar disorder is often prior to the age of 5 years old. Pediatric bipolar disorder is a preschool age disorder, and yet some psychiatric clinics will not even consider a preschooler for psychopharmacologic intervention. Few studies address the phenomenonology or treatment of preschool-aged children with bipolar disorder or even the more acceptable 'emotional dysregulation'. Physicians are committed to early intervention; in psychiatry, if we take this responsibility seriously, we must begin to understand bipolar disorder in the youngest among us.

There is resistance against considering that psychiatric illness can start very early, and the cultural zeitgeist is very much against the concept, with the press and media popularizing stories that place blame on bad parents or drug-happy psychiatrists. However, the brain is complex and fragile and it stands to reason that it could be in a state of poor functioning from the earliest years of life. Emotional equilibrium, especially in the face of boredom, discomfort or disappointment, under normal conditions develops with age. Owing to this development, we often make the common error of calling moodiness in children 'normal development' or typical reactions to stress [7]. Yet, among youths, there is a wide range of emotional reactivity, with some children standing out as particularly mood reactive. While most children are moody, some children make huge emotional scenes, standard deviations away from the norm in intensity and frequency. Tantrumming is part of childhood, but it tails off dramatically after the preschool years. Even in the preschool years, tantrums are generally short lived and involve easily contained crying or falling to the floor. Prolonged and recurring hitting, kicking, biting, spitting or destructive behaviors are not part of typical childhood development and should signal the need for psychiatric intervention, with bipolar disorder firmly in the differential diagnosis.

Some researchers and clinicians rely on euphoria and grandiosity as cardinal symptoms of mania because, unlike irritability, neither of these symptoms appear in any other Axis I diagnostic category [8]. The problem with these symptoms is that, unlike destructive rage, they really do overlap with typical development of childhood. Euphoria manifests with goofy, silly, giddy, exuberant and excited states, and grandiosity is part of normal childhood development. Euphoria and grandiosity can be characteristic of many children who have no other problems; to my knowledge, the documentation of euphoria in youth with normal development has not been studied. When it is present, even in *bona fide*

bipolar youth, it is often not such a big problem that it drives a psychiatry referral. While these symptoms may stand out in an adult, they may be difficult to differentiate from typical development in youths. Extreme irritability, however, is disabling, disruptive and dangerous, and often triggers the question of bipolar disorder.

In part, owing to concerns that clinicians are 'over-using' the bipolar disorder diagnosis in youth, and in part owing to concerns that highly irritable states are not 'enough' to qualify an individual for bipolar disorder, temper dysregulation disorder has been proposed as a new diagnosis for the upcoming *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-V). Temper dysregulation disorder seeks to codify angry states into a diagnostic category, much as the National Institute of Mental Health (NIMH) proposed severe mood dysregulation to differentiate irritable youth with few other symptoms of mania from those with 'classic' bipolar disorder [9]. This represents a late breaking attempt to acknowledge that anger/irritability/rage are abnormal emotional states that need to be addressed by clinicians as serious Axis I disorders. Currently, criteria for childhood depression recognizes anger as a presenting mood symptom. Irritability or temper problems are also symptoms of anxiety and oppositional defiant disorder. The only diagnosis with a place for extreme irritability, however, is mania. The diagnosis of mania is based on the fulfillment of a set of criteria, not just one symptom, but often bipolar disorder can begin with subthreshold symptoms, and follow a gradually developing and harmful and worsening course. The Course and Outcome of Bipolar Youth (COBY) study found that 25% of youth presenting with even a small number of brief episodes of 'manic-like' symptoms (categorized as bipolar disorder, 'not otherwise specified') switched to bipolar I or II by the 4-year follow-up [4].

In my clinical practice I use the bipolar diagnosis because it best captures the nature of the dramatic mood shifts, reckless impulsivity and bizarre behavior characteristic of so many unfortunate children. The terms 'severe mood dysregulation' or 'temper dysregulation disorder' are certainly apt and descriptive terms, and could be used throughout the life cycle to capture some subset of mood disordered individuals (these, however, are only proposed as childhood diagnoses). However, we have to wonder why we need any more categories, what purpose do they really serve? Do these diagnoses serve the mentally ill or do they serve a society already rapt with fear and denial? Any attempt to divert severely ill individuals of any age from psychopharmacological treatment, which can be lifesaving, due to prejudice, denial or fear, does a terrible disservice to the mentally ill and their families.

"Any attempt to divert severely ill individuals of any age from psychopharmacological treatment, which can be lifesaving, due to prejudice, denial or fear, does a terrible disservice to the mentally ill and their families."

Financial & competing interests disclosure

J Wozniak is the author of Is Your Child Bipolar? *and* Positive Parenting for Bipolar Kids. *She is a speaker for Primedia/MGH Psychiatry Academy and receives research support from McNeil, Shire, Janssen, and Johnson and Johnson. The author has no other relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript apart from those disclosed.*

No writing assistance was utilized in the production of this manuscript.

Bibliography

1 Parens E, Johnston EJ, Carlson G: Pediatric mental health care dysfunction disorder? *N. Eng. J. Med.* 362, 1853–1855 (2010).

2 McDonnell MA, Wozniak J: *Positive Parenting for Bipolar Kids*. Bantam, NY, USA (2009).

3 West AE, Pavuluri MN: Psychosocial treatments for childhood and adolescent bipolar disorder. *Child Adolesc. Psychiatr. Clin. N. Am.* 18(2), 471–482, x–xi (2009).

4 Birmaher B, Axelson D, Goldstein B *et al.*: Four-year longitudinal course of children and adolescents with bipolar spectrum disorders: the Course and Outcome of Bipolar Youth (COBY) study. *Am. J. Psychiatry* 166(7), 795–804 (2009).

5 Merikangas KR, He JP, Burstein M *et al.*: Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication – Adolescent Supplement (NCS-A). *J. Am. Acad. Child Adolesc. Psychiatry* 49(10), 980–989 (2009).

6 Perlis RH, Miyahara S, Marangell LB *et al.*: Long-term implications of early onset in bipolar disorder: data from the first 1000 participants in the systematic treatment enhancement program for bipolar disorder (STEP-BD). *Biol. Psychiatry* 55(9), 875–881 (2004).

7 Groopman J: What is Normal? *The New Yorker,* 9 April 2007.

8 Geller B, Zimerman B, Williams M, Delbello MP, Frazier J, Beringer L: Phenomenology of prepubertal and early adolescent bipolar disorder: examples of elated mood, grandiose behaviors, decreased need for sleep, racing thoughts and hypersexuality. *J. Child Adolesc. Psychopharmacol.* 12(1), 3–9 (2002).

9 Leibenluft E: Severe mood dysregulation, irritability, and the diagnostic boundaries of bipolar disorder in youths. *Am. J. Psychiatry* 168(2), 129–142 (2011).