Bipolar Disorder
Assessment and Diagnosis

Carmel Foley, MD
Director, Peds C/L Service at CCMC
Speaker:

Carmel Foley, MD

Director, Peds C/L Service at CCMC
Disclosures

Neither I nor my spouse/partner have a relevant financial relationship with a commercial interest to disclose.
• “I have mood swings, I think I’m bipolar”

• Most so called mood swings are shifts from normal euthymia “I’m fine” to “I’m down, I’m sad, I’m annoyed” but are not shifts from very high to very low

• “Normal” mood fluctuates like the water of a calm sea
DSM-5

• Bipolar I – classic manic-depression – a manic episode defines the condition
• Bipolar II – episodes of depression and hypomania
• Cyclothymia – depressive and hypomanic periods that never meet criteria for full blown mania, hypomania or depression over a one year duration for children, 2 years for adults
• Other – for the left overs
Mania Rules!

If no mania then it’s not Bipolar I!
So what is mania?
Mania Is a,

• Distinct period of ELEVATED IRRITABLE or EXPANSIVE mood AND persistently increased activity or energy, lasting at least 1 week
• Present most of the day, nearly every day- any length if hospitalized
During the mood and energy disturbance 3 of the following, 4 if mood only irritable

1. inflated self esteem- grandiosity
2. decreased need for sleep
3. more talkative
4. flight of ideas or subjective racing thoughts
5. distractibility
6. increase in goal directed activity
7. excessive involvement in activities with a high potential for negative comments, buying, spending, sexual indiscretion

Symptoms **must** occur at the same time and produce marked impairment in functioning
Some Individuals Will Have Psychotic Features

• The symptom picture must not be due to a drug of abuse like cocaine or stimulants or methamphetamine
• The symptom picture must not be due to prescription drugs-such as steroids, L-Dopa, antidepressants, or a medical condition like hyperthyroidism
Hypomania

• All the same criteria as in mania, lasts for 4 days, and is less severe and impairing
The Pnemonic GRAPES

• G – Grandiosity
• R – Racing thoughts
• A – Activity- goal directed ↑
• P – Pressured speed
• E – Elation
• S – Sleep disturbance
How Common?

• Life time prevalence
• Adults: Bipolar I 1%
  Bipolar II 1%
  Subthreshold – 2.4%
• (Merikangas 2007)
• Adolescents 1.0 – 1.4% (Kessler 2011)
• Children – unknown
• 60% adults have onset before age 20
The Problem with IRRITABILITY!

Pathological but totally non-specific
Getting a History

• 2/3 of Bipolar begins with depression
• Information from parents, siblings, school personnel

Family History
• General population risk for Bipolarity is 1%
• Increases five fold if a parent is bipolar
• 1\textsuperscript{st} degree relatives highly relevant
• 2\textsuperscript{nd} degree relatives not so much
• Estimated heritability 80%
• Negative family history does not rule it out
Psychological Factors

- Low SES
- Exposure to negative events (abuse)
- High expressed emotion
- Poor sleep hygiene
- Irregular routines

ALL can make the condition worse
They Young Mania Rating Scale

Scoring the Parent Version of the Young Mania Rating Scale (pdf version)

January 11, 2010

The P-YMRS consists of eleven questions that parents are asked about their child’s present state. The original rating scale (Young Mania Rating Scale), was developed to assess severity of symptoms in adults hospitalized for mania. It has been refined in an effort to help clinicians such as pediatricians determine when children should be referred for further evaluation by a mental health professional (such as a child psychiatrist), and in help decide whether a child’s symptoms are responding to treatment. The scale is not intended to diagnose bipolar disorder in children (which requires a thorough evaluation by an experienced mental health professional, preferably a board-certified child psychiatrist). This version has been tested in a pediatric research clinic with a high number of children with bipolar disorder. The YMRS total score is determined by adding up the highest number circled on each question. Scores range from 0-40. Extremely high scores on the P-YMRS increase the risk of having bipolar disorder by a factor of 9, roughly the same increase as having a biological parent with bipolar disorder. Low scores decrease the odds by a factor of ten. Scores in the middle don’t change the odds much.

The average score in children studied was approximately 25 for mania (a syndrome found in patients with Bipolar-I), and 20 for hypomania (a syndrome found in patients with Bipolar-II or Cyclothymia). Anything above 31 indicated a potential case of mania or hypomania for the group that was studied, while anything above 25 was a probable case. In situations where this cutoff of bipolar diagnosis is high to begin with (such as with mood symptoms lasting under 2 years in children having bipolar disorder), the P-YMRS can be extremely helpful. But for most groups of people, the broad range of bipolar diagnosis is unclear but low. Therefore, the more that a high score can do is raise a red flag (similar to having a family history of bipolar disorder).

Even a high score is unlikely to indicate a bipolar diagnosis. The P-YMRS performs similarly to the screening test for premenstrual syndrome, where it will identify most cases of bipolar, but with an extremely high false positive rate. The P-YMRS is currently being studied in a community pediatrics practice to determine its validity in that setting. The P-YMRS is provided here for educational purposes only, and should not be used as a substitute for evaluation by mental health professionals.

• Life mood charts
  [www.dbsalliance.org](http://www.dbsalliance.org)

 Do better ruling out than ruling in
Co-morbidity

- ADHD – 55%
- ODD – 42%
- Conduct Disorder – 27%
- Anxiety Disorder – 23%
- Substance abuse – 9% (increases with age)
- Borderline Personality Disorder
Bipolar vs ADHD

- Late onset (10+)
- ADHD appearing abruptly in an otherwise healthy child
- Non response to stimulants
- ADHD symptoms come and go
- ADHD kid with periods of elation, grandiosity, depression, no need for sleep, sexualized behaviors
- ADHD child has hallucinations or delusions
• Bipolar versus Disruptive Behavior Disorder – ODD/Conduct Disorder

• If the behavior problem ONLY occurs with mania or depression, then its **NOT** ODD or Conduct Disorder

• Borderline Personality Disorder – pattern of instability in interpersonal relationships, self image, affects, and marked impulsivity. While mood instability is common the overall pattern is long standing rather than episodic
Disruptive Mood Dysregulation Disorder - DMDD

• Impairing chronic severe, **persistent irritability**, frequent temper tantrums, onset between 6 and 10 years of age.
• Endures for 12 months, not occurring exclusively during an episode of depression
• Not better explained by ASD, PTSD, Separation Anxiety, Persistent Depressive Disorder (Dysthymia)
• Cannot co-exist with ODD or Bipolar
What Do We Know About DMDD Kids

• They grow up to have unipolar depression and/or anxiety disorders but **NOT** bipolar disorder
• Rates of Bipolar- low prior to adolescence
• DMDD more common prior to adolescence
If psychotic symptoms are present, then the differential must include the schizophrenia spectrum conditions, delusional disorder, or psychosis due to a medical condition. Prescription Drug Induced or Illegal Drug Induced – will be evident from the history. Other medical conditions – will be evident from history, physical and relevant labs.
To Summarize

• Bipolar I – mania is a must
• Remember your GRAPES!
• Bipolar II – Depression and hypomania
Biggest Differential Conundrum

- DMDD – earlier onset, CHRONIC not episodic
- ADHD – chronic, not episodic, earlier onset, no decreased need for sleep, no grandiosity, no increase in goal directed activity, not hypersexual, not psychotic
AND NOW TREATMENT