Childhood Onset Bipolar Disorder: Issues in Assessment

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Bipolar disorder can be difficult to diagnose in children. Accurate diagnosis, however, is of vital importance to avoid inappropriate treatment. In childhood, the symptoms of Bipolar Disorder can initially look like Attention-Deficit/Hyperactivity Disorder (ADHD) and/or unipolar depression. It is well known among clinicians that if a child is treated with stimulant or antidepressant medication and there is an underlying undiagnosed bipolar disorder, the medications can induce a manic state with very serious consequences (Papolos and Papolos, 2002).

Bipolar disorder has only been recognized in children since the 1990's. Even then there was intense debate about whether it could occur prior to age 12. Diagnostic criteria in DSM-IV were developed for adults. and children with bipolar disorder do not always meet these criteria. Their mood swings tend to be frequent, comparatively short and intense with irritability rather than the euphoric periods that are more characteristic of adult mania. In addition, children often have mixed mood states, in which they experience symptoms of both depression and irritable mania simultaneously, rather than discrete episodes of depression and mania that last for several days.

In 2000 NIMH hosted a roundtable on prepubertal bipolar disorder. This group of experts reached agreement that diagnosis of bipolar disorder in prepubertal children is possible. They also agreed that there can be a form of bipolar disorder in childhood that does not meet strict DSM-IV diagnostic criteria and they recommended the use of the category Bipolar Disorder not otherwise specified (NOS) for this group. The symptoms suggested by this group consist primarily of irritability and aggressiveness.

Over the last decade, there has been a great deal of research about diagnosis and treatment of childhood onset bipolar disorder. The publication of books such as *The Bipolar Child* by Janice Papolos and Demitri Papolos, MD (1999), currently in its third edition, has spurred some of this research. Several websites and organizations now exist to assist parents of these children as well as practitioners. On the bipolar child website (www.bipolarchild.com) there should be a 65-item questionnaire parents can take online which they can print our and take to their doctors. The website for the Child and Adolescent Bipolar Disorder Foundation provides another great source of information for parents and professionals as well (www.bpkids.org).

Initially, issues in assessment focused on differential diagnosis between ADHD and bipolar disorder. More recently research has focused on broader issues involved in diagnosis and treatment, including controlled medication trials. Some of the current research has examined neuropsychological variables in childhood onset bipolar disorder. Pavuluri found that children diagnosed with bipolar disorder demonstrated impaired ability on tests of attention, executive functioning, working memory, and verbal learning. Children with bipolar disorder and co-morbid ADHD did worse on tests of attention and executive functioning than those with bipolar disorder alone (Pavuluri et aI., 2006). McClure reported that children with bipolar disorder did less well than a comparison group of children on tests of pragmatic use of language and facial expression recognition as well as on a test that required response flexibility (McClure et at., 2005). Dickstein also found that children with bipolar disorder were more impaired than a group of controls on tests of attentional set-shifting and visuospatial memory (Dickstein et aI., 2004).

There have also been attempts to develop rating scales that will assist with diagnosis. They are easily accessible for clinicians in contrast to the lengthy structured diagnostic interviews that are used in research. Prior to 1995 when I first wrote on this topic *(ADHD Report* v.3 #3), the only rating scale in the literature was the Young

Childhood Onset continued on next page

Childhood Onset continued from previous page

Mania Rating Scale, an eleven item scale based on the DSM-IV diagnostic criteria for mania. This scale was developed for observers such as nurses on psychiatric units to complete about a patient. Currently there is a form for parents to complete about a child that looks promising (Gracious, Youngstrom, Findling, & Calabriese, 2002). In addition, in 1995, Joseph Biederman, MD, one of the leading researchers in this area, published an article in which he and others found that specific scales of the Achenbach Child Behavior Checklist (CBCL) were found to discriminate prepubertal mania from ADHD. The CBCL is an 112-item questionnaire completed by parents that results in 8 scales. The scales that were elevated in Biederman's study were the Delinquent Behavior, Aggressive Behavior, Somatic Complaints, Anxious/Depressed, and Thought Problems scales (Biederman et aI., 1995). Other groups have reported similar findings with the CBCL (Pliska, 2006).

What we are looking for in making an accurate diagnosis is whether the child's symptoms represent those that would be expected of any child the same age, those of a child with ADHD or some other disorder, or those of a child with a bipolar disorder. Looking at each of the DSM-IV symptoms of mania can be helpful.

- Euphoric mood: Children can be very happy and silly when they are excited about something or when they are manic. A detailed mood chart can reveal whether the silliness was due to some real life event, how often it occurs, how long it lasts, and whether or not it interferes with the child's functioning.
- Irritable mood: The same can be said for irritability, which is common to many childhood disorders. Hungry and tired children can be irritable. Children with ADHD can be irritable when their medication wears off or when they are over-stimulated by their environment. Children with mania are irritable frequently and more intensely than other children and often in response to parental limit setting. In addition they often behave in aggressive and self-injurious ways while irritable and their rages last much longer than those of other children. Children with bipolar disorder often have extreme periods of anger due to seemingly minor events, such as being asked to wash their hands.
- Grandiosity: Children with bipolar disorder often have difficulty distinguishing fantasy from reality. Grandiosity in the bipolar child far exceeds the normal imaginary play of childhood. Children often play pretend games in which they are a teacher. However the bipolar child tells others what to learn while refusing to do schoolwork because they know everything. The nine year old who looks at her mother and says in response to a request, "You're not the boss of me" may be exhibiting grandiosity.
- Pressured speech: Children with ADHD often talk a lot. However the bipolar child when manic may be loud, intrusive and hard to interrupt.

Racing thoughts: In the same way, children with ADHD often change from one activity to another. However the bipolar child will often say that their mind is going a million miles an hour and they can't keep track of their daily activities because of it.

- Distractibility: This symptom is one of the hallmark features of ADHD. However children with bipolar disorder can often be more distractible than usual during a manic episode. The change in behavior is what is important.
- Increase in goal directed activity: The bipolar child also can show an increase in goal directed activity during a manic episode. While children with ADHD have a high level of activity, those with bipolar disorder have a pressured quality to their behavior, as if the child absolutely must do something immediately and there is no stopping them. When given a reward coupon for ice cream at 8 am, the child demands to go right now to get the free ice cream, and will not listen to the fact that the store isn't open yet, then rages about it.
- Excessive involvement in pleasurable or risky behaviors: Children with bipolar disorder are often hypersexual in a way that is not common among other children.
- Psychosis: Children with bipolar disorder also often have hallucinations and delusions and it is important to ascertain whether such symptoms are due to another psychiatric disorder such as schizophrenia.

There are four distinct sources of information that are important to collect to assist with diagnosis of childhood onset bipolar disorder: interviews, psychological tests, rating scales, and mood charts.

1. Interviews:

a. Parents and child interviews are essential to include a thorough assessment of diagnostic criteria. Family history is vital since bipolar disorder has a strong genetic component.

b. Teacher reports or interviews can also be very helpful since bipolar children often have school difficulties and many have symptoms of ADHD.

2. Use of well validated rating scales is also very helpful to evaluate for the possibility of bipolar disorder and to track changes over time. The two that are currently most well validated at this time are the Achenbach Child Behavior Checklist and the Young Mania Rating Scale.

3. Psychological test data can be useful as well to look for associated learning disabilities and ADHD, and to rule out other explanations for a child's behavior.

Childhood Onset continued on next page

Childhood Onset continued from prel'ious page

4. Mood charting is a very helpful component of both diagnosis and treatment with bipolar children and their families. Samples of mood charts are available in the Papolos' book and both websites listed above. To do this, parents must keep track of the child's mood variations as well as other factors that might influence their mood, especially medication changes.

In addition, consultation with the child's pediatrician is essential to make certain that there are no specific physical problems that would explain the symptoms. Physical disorders that can mimic mania include temporal lobe epilepsy, hyperthyroidism, head injury, multiple sclerosis, among others (Kowatch et a!', 2005).

In conclusion, research into childhood onset bipolar disorder is still in its infancy. Diagnosis remains complicated by the fact that children with bipolar disorder often have co-occurring conditions such as ADHD, ODD and anxiety disorders. There is no one instrument that can diagnose this or any other disorder in children's mental health. However, information obtained from multiple sources as outlined above can help to prevent both misdiagnosis as well as overdiagnosis of one of the most serious childhood disorders.

Dr. Judith Glasser is a clinical psychologist now in private practice in Rockville, MD. She has been in practice in the Northern Virginia area since 1983. *Dr. Glasser has had a long term interest in the diagnosis and treatment of ADHD, with special interest in the area ofdiffirential diagnosis and co-morbidity with psychitltric disorders, learning disabilities and giftedness.* ψ