Dr Kerryn Armstrong
Specialist Psychiatrist,
Western Cape
drkarmstrongreception@gmail.com

PRESENTATION OF BIPOLAR DISORDER IN YOUTH

Bipolar disorder is a recurrent, familial mood disorder defined by the presence of recurrent manic or hypomanic episodes, with or without episodes of depression. While once controversial, the occurrence of bipolar disorder in children and adolescents is now well-recognised. Studies have shown rates of bipolar disorder of between 1-3% in youth, with the majority of adults with bipolar disorder reporting onset of mood symptoms before age 20 years. However, bipolar disorder in youth remains difficult to diagnose for various reasons. Insight into the presentation of this disorder in youth is essential to enable early recognition and appropriate management of the condition, which results in significantly improved outcomes.

MANIA/HYPOMANIA

Youth can be diagnosed with mania/hypomania using DSM criteria as for adults. However, these criteria should be used cautiously, with careful consideration that symptoms:

- Must be out of keeping with the developmental stage of the child/adolescent, particularly with regard to mood elevation, grandiosity and increased interest in sexual experimentation, which may occur at different ages in children and teenagers as part of normal development.
- Should cluster in episodes that occur in combination with abnormal mood changes.
- Should represent a change from what is normal for the individual child/adolescent.
- May be difficult to elicit as a result of a child's cognitive and emotional immaturity.
- Cannot be accounted for by other disorders such as ADHD or ODD.
- Cannot be explained by environmental/cultural context or the presence of medical illness, drugs or medications.
- Should affect the function of the youth in several areas such as school, family and friends.

It's important to note that irritability is a very common mood presentation in mania/hypomania in youth. However, studies have shown that irritability rarely occurs in manic/hypomanic youth without elation – both are typically present. In addition, irritability must be accompanied by other symptoms of mania/hypomania and needs to be episodic when considering bipolar disorder.

MAJOR DEPRESSION

Similarly to symptoms of mania/hypomania, the symptoms of major depression in youth should be in excess of what is normal for the child/adolescent's stage of development; must cluster in episodes that represent a change from normal for the individual and shouldn't be mainly accounted for by co-morbid disorders.

As is the case when assessing manic/hypomanic symptoms, cognitive and emotional immaturity may make it difficult to identify some symptoms of major depression in youth. Children/adolescents may not report feeling depressed, but may appear bored, irritable, oppositional or behaviourally disturbed. Suicidal intent may be masked because children may choose methods that are not lethal in reality, such as holding their breath.

Children with major depression typically show fewer neuro-vegetative or melancholic symptoms and

depressed adolescents seem to present more frequently with atypical symptoms such as hypersomnia, increased appetite and weight gain, when compared to adults. Symptoms of depression may fluctuate more frequently and depressed youth may be more reactive than adults. They may be depressed at school or at home, but appear happier when with friends or playing games. However, the proportion of time they're depressed remains substantial (at least over 50% of the time).

Bipolar disorder can present with either polarity in youth, including manic/hypomanic, depressive or mixed episodes. However, it seems to present most frequently with depression. Treatment with antidepressants may precipitate an episode of mania in these cases. Studies suggest that depressed youth with a family history of bipolar disorder, pharmacologically induced mania/hypomania and the presence of depression with psychotic symptoms are at high risk of developing bipolar disorder. These youth require careful monitoring when prescribed antidepressants. It seems youth with bipolar disorder often have subtle symptoms of mania/hypomania that may go unrecognised. Patients with bipolar disorder who present with depressive episodes have been shown to have younger age onset, more depressive episodes with less response to antidepressant agents, more frequent suicide attempts, comorbid anxiety, impulse control issues, substance abuse, family members with bipolar disorder and worse outcome. Therefore it's of utmost importance to consider these factors when managing depression in youth.

CO-MORBIDITY

Bipolar disorder in youth is frequently accompanied by other psychiatric disorders, including disruptive behaviour disorders, ADHD, anxiety disorders and substance use disorders in adolescents. The presence of these disorders creates a challenge for differential diagnoses, as symptoms, particularly those of ADHD and ODD, which may overlap with symptoms of bipolar disorder. Co-morbid disorders also impact on treatment response and prognosis, making accurate diagnosis and appropriate management important.

Certain tips may be helpful to consider with regard to differential diagnoses.

One may suspect the presence of bipolar disorder in a child/adolescent with ADHD if:

- The 'ADHD' symptoms only present later in life e.g. age 10 years or older
- 'ADHD' symptoms appear suddenly in an otherwise healthy child
- 'ADHD' symptoms were responding to treatment with stimulants but are no longer
- A child/adolescent with ADHD begins to display periods of abnormally elevated or irritable mood, grandiosity, depression, sleep disturbance or inappropriate sexual behaviours
- A child/adolescent with ADHD has a family history of bipolar disorder

The following points should be noted when considering the diagnosis of bipolar disorder versus behavioural disorder:

- If behavioural problems only occur while the child is experiencing episodes of mania/depression and resolve when mood symptoms improve, diagnoses of behavioural disorders should not be made.
- If behavioural problems only occur while the child is experiencing episodes of abnormally elevated or depressed mood, mood disorder should be considered.
- If the behavioural disorder precedes the onset of the bipolar disorder, both diagnoses may be given.
- If a child/adolescent with a behavioural problem has a family history of bipolar disorder, the possibility of bipolar disorder should be considered.

CONCLUSION

Bipolar disorder may carry severe consequences for the normal development of a child/adolescent if unrecognised and untreated. The recurrent nature and negative psychosocial impact associated with this illness during crucial developmental stages makes careful, comprehensive longitudinal evaluation, prompt recognition and appropriate management imperative, as delays in treatment are associated with poor outcomes. MHM

References available upon request