

Does pediatric bipolar disorder exist?

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Unfortunately, there are no blood tests or brain scans available to diagnose bipolar disorder. Only a careful assessment can reach such a conclusion. In child psychiatry, such an assessment is particularly complex as it relies on information from many different sources, including the experiences of parents or other primary caregivers, developmental history, environmental circumstances, family and genetic history, school observation, and, last but not least, an interview with the child themselves. In the busy world of managed care and unforgiving time constraints, we often miss many vital aspects in such a process. It is perhaps long forgotten that the word “assessment” comes from the Greek *assidere*, which means, “to sit beside.” The opportunity “to sit beside” someone and get to know them in the clinical setting can at times be a challenging task, and in the case of a child or teenager can be downright resisted!

Imagine a child who is chronically irritable, angry, unhappy, explosive and has increasingly frequent temper tantrums, especially when adults tell him “No.” As per Kaplan, a distinguished psychiatric author, “anger and irritability are among the most common reasons parents consult mental health professionals, and intractable anger and disruptive behavior are the most common reasons for psychiatric hospitalization.” A child with this profile, unruly and adding undue stress onto their environment, may quickly be labeled as “Bipolar.” The term is typically reserved for those who experience near-psychotic mania and often require inpatient stabilization in the psychiatric realm, however it has been ingrained in the public consciousness differently, rippling with multiple meanings and connotations, a sort of

shorthand for “emotionally unpredictable.”

When it comes to the mood stability of children and adolescents, the line between “normal” and “abnormal” can get even murkier, particularly when trauma or developmental pathology are present. Even though irritability is considered a non-specific symptom in most cases, found in nearly 80% of psychiatric disorders, it is often appreciated as specific to bipolar disorder in children who, ironically, are the most “emotionally unpredictable” at baseline. As you may have observed yourself in the community at large, over diagnosis of pediatric bipolar disorder is a growing trend and can also be used as a justification to prescribe medications that carry significant risk. Psychiatrists, therapists, and primary care physicians on the front-lines of behavioral control can also be overwhelmed by a family’s statements of helplessness in the face of a child’s temper, and gravitate towards the solace that there is a “biological condition” that can be turned off.

Thankfully, there have been important attempts to limit the number of kids mistakenly diagnosed and then inappropriately treated, most recently the DSM-5 (the updated diagnostic manual for psychiatric disorders) that allows for more nuanced behavioral diagnoses such as

DMDD (Disruptive Mood Dysregulation

Disorder). This diagnosis, for example,

requires chronically irritable mood beyond what is expected for developmental age and a minimum of three behavioral outbursts per week, behavior that may be best treated first through more focused behavioral strategies and IEP planning in school. There are also multiple longitudinal studies being performed to better understand the trajectory of bipolar symptoms

in youth and the benefits of early, aggressive treatment. There is an interesting study by Stringaris and colleagues (2009), where they followed



children who struggled with significant irritability over the span of roughly 20 years. The expectation was that in time a large number of them would develop more concrete symptoms of adult bipolar disorder if untreated; however, surprisingly the highest percentage of children developed depressive episodes or improvement of behaviors. Such studies highlight the relative discordance between child-onset symptoms and adult diagnostic features, as well as provide evidence that excessive irritability in children may be much harder to classify than imagined.

Consider little Joe who starts having explosive outbursts in preschool. His teacher says that his face changes and he looks like he is “in a trance” when angry, a stark contrast to other students in the room who become frightened by his behavior. After careful assessment, it turns out that he was adopted a few months back and that right before his pick-up time from school he typically worries that his “new mom” won’t be there for him. His mom agrees to call him 30 minutes before the end of the day and slow changes are observed. Joe calms down. Offering some insight into this dynamic for family and teachers would likely be more therapeutic than a medication trial at this juncture but was only possible once a clinical relationship had time to develop.

How about 15-year-old Kate who complains of intense bursts of insomnia and perpetual restlessness during her day? Her mother reports that her mood “swings” rapidly from high to low in the span of hours and is only worsening. After a few sessions, she confesses that she has been cyber-bullied by classmates and ruminates at length each night about how to respond to embarrassing situations. Her parents are supportive but she doesn’t want to disappoint them. She also claims to hear her name being

called at night in the distance and a “strange voice” in her head, telling her she is worthless.

Then finally there is Frank, a 13-year-old boy who speaks at length about building a computer that is going to be “better than the Apple one.” During the evaluation his speech is quite pressured and he clearly has a hard time catching up with his own thoughts. Yesterday he took his mother’s credit card and spent a lot of money on computer games within 30 minutes, which he associates with “the path to being a leader.” His dad says that he hasn’t slept for four nights in a row and still seems to have boundless energy. There is a strong family history of bipolar disorder on both maternal and paternal sides and an uncle was hospitalized for acute depression.

You may wonder about the presence of “true” bipolar disorder in such cases, though this entity remains elusive even to mental health professionals. These children presented with different shades of “irritability,” all filtered through unique developmental challenges that were shared at only the right time and place for them. Each patient may require substantially more sessions than is typically requested (by both the medical establishment and the anxious parent) to actualize change or learn why a child’s mood has been so “unpredictable.” Indeed, data has shown repeatedly that children and adolescents require more time and resources to accurately diagnose bipolar disorder than what is typically allocated for adults, and allowing this time to a trained mental health provider to wade through these waters carefully may be the most effective way to limit unnecessary and invasive solutions.

* Stringaris et al Adult outcomes of youth irritability: a 20-year prospective community based study. *Amer J Psychiatry*. 2009.166:1048-1054.

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