Paediatric Bipolar Disorder
&
Transitions to adult services

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on behalf of ABS
Talk

• Paediatric Bipolar Disorder [PBD]: Why bother
• DMDD
• Comorbidity and/or Differential Diagnoses: EUPD, ADHD & ASD
• Challenging cases and risk
• Transitions
Paediatric Bipolar Disorder

What is all the fuss about???
Mania:
A young person’s perspective
There was a young girl and inside her head she was living in a sad and lonely world. She constantly had deep and angry thoughts. She was mad at herself because she couldn’t hide them anymore. Losing self confidence, constantly crying she honestly couldn’t see the point in trying. She said to the doctor she could see no future and that wasn’t her lying.

The doctor got worried and off he hurried to call a specialist to decide what’s going to be best for this girl. The specialist decided to admit her to hospital where they could give her what she needed.

So away the ambulance drove up round, down past a school like Byker Grove. She was so scared because all she wanted was to be with her mam.

Now she lies in bed at the ward knowing that right now she wants to die. But the staff are here to eventually make that a lie.
Trends Over Time

National trends in visits with a diagnosis of bipolar disorder as a percentage of total office-based visits by youth (aged 0-19 years) and adults (aged ≥ 20 years).

(Moreno et al., 2007)
Patterns of Illness Among 258 SFBN Patients Treated and Followed Prospectively for 1 year

Group 1: > 9 year III 36%
  Plus Ultradian

Depression
  prodromal

Mania
  prodromal

Chronic depression

Group II: Episodically III 48%
  Depression +
    full-blown mania

Depression +
  hypomania

Depression +
  mania

Mania
  prodromal

Group III: Minimally Impaired 35%
  Ill first 1/3 year,
    well second 2/3

Hypomania only

Mild depressions only

Virtually well
Controversies

• How frequent are the manifestations of mania in preadolescents (Merikangas et al. 2010; Leibenluft 2011)

• Differences in clinical manifestations of BD by age (Youngstrom et al. 2008; Papolos et al. 2009)

• Should there be a modification in criteria eg: number of symptoms
Controversies

- PBD have less discrete episodes and greater irritability and volatility (Mick et al. 2005; Wozniak et al. 2005)

- More mixed episodes (Findling et al. 2001; Axelson et al. 2006)

- Developmental modifications for symptoms of mania (Geller et al. 2002)

- What is grandiosity in PBD (Youngstrom et al. 2009)
Where have the Bipolar kids gone?

Disruptive Mood Dysregulation Disorder (part of depressive disorders)
1. **Severe recurrent temper outbursts** manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.

2. The temper outbursts are **inconsistent with developmental level** (e.g., the child is older than you would expect to be having a temper tantrum).

3. The temper outbursts occur, on average, **three or more times per week**.

4. The mood between temper outbursts is **persistently irritable or angry** most of the day, nearly every day, and is observable by others (e.g., parents, teachers, friends).
Disruptive Mood Dysregulation Disorder

5. The above criteria have been present for 1 year or more, without a relief period of longer than 3 months. The above criteria must also be present in two or more settings (e.g., at home and school), and are severe in at least one of these settings.

6. The diagnosis should not be made for the first time before age 6 years or after age 18. Age of onset of these symptoms must be before 10 years old.

7. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

8. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder.
Disruptive Mood Dysregulation Disorder

- Longer term follow up shows high rates of depression and anxiety disorders and not Bipolar Disorder

- DMDD is part of depressive disorders section
Narrow Phenotype in Paediatric Bipolar Disorder

• Manic/hypomanic episodes only diagnosed in the context of elevated mood

• Irritability on its own (particularly in prepubertal children) not enough
Why Bother?

- Recent exponential rise in rates of BD in children and adolescents (mostly in the USA)
- BD is 4th leading cause of disability among adolescents aged 15-19 years
Why Bother?

- Limited evidence of pharmacological efficacy
- Dramatic increase in the use of medication for early onset Bipolar Disorder
- Early age at onset predicts a longer time to first pharmacological treatment
"Diagnosis of bipolar disorder in children or young people should be made only after a period of intensive, prospective longitudinal monitoring by a healthcare professional or multidisciplinary team trained and experienced in the assessment, diagnosis and management of bipolar disorder in children and young people, and in collaboration with the child or young person's parents or carers."
NICE Bipolar Guidelines 2014

- Longitudinal prospective assessment
- Drug treatment
- Caution with diagnosis of Bipolar II
- Focus on assessment of carer needs
Comorbidity or Differential Diagnoses?
Comorbidity

• The norm and not the exception
• Neurodevelopmental disorders (ADHD, ASD)
• Mental health disorders: Anxiety
• Substance use
• Emerging Personality Disorder i.e. EUPD
• Assess for these and also treat
• Do not ‘double count’ symptoms
ADHD

Data from USA suggests:

- PBD cases: >80% have ADHD
- ADHD cases: >20% have PBD
- Not consistent with UK and Europe
ADHD vs Bipolar Disorder

- Pervasive vs episodic mood fluctuations
- Present since birth vs peak age at diagnosis (16-19 years)
ADHD Medication

All ADHD medication contra-indicated in severe and hard to manage Bipolar Disorder
Autism Spectrum Disorder
Why know?:

Association

• Studies assessing comorbidity in subjects with ASD have often not assessed for paediatric BD (Green et al., 2000)

• Screening tools for PBD not validated with ASD

The Association in under 18s

- Significant ASD traits reported in >50% of youth with PBD with no pre-established diagnosis of ASD (Towbin et al., 2005)

- In a recent systematic review, the weighted mean prevalence rate in subjects with PBD arising from pervasive developmental disorders was 19% (Frias et al. 2015)

- ASD probands have elevated rates of PBD (DeLong and Dwyer, 1988; DeLong et al., 2002)


Why know?: Diagnosis

- ASD is associated with social interaction and communication deficits including communicating ones mood

- BD is a disorder of mood

- Clinicians quite frequently rely on youth to report change in mood

- This is hard for subjects with ASD
Why know?: Diagnosis

- In subjects with ASD, if irritability is misattributed as associated features of ASD, BD could be missed.

- On the other hand, EPSE could be mistaken for ASD.

Why know? Management
Monitoring

- Monitoring response to medication treatment
- Focus on asking about biological symptoms i.e. sleep/appetite
- Reports of changes in mood
Use of Anti-psychotics

- If ASD limited abstract thinking and restricted expression of emotions are misattributed to BD it may result in higher than required use of psychotropics (Joshi et al., 2013)

- Watch for higher rates of EPSE
Comorbidity: Epilepsy

- Epilepsy occurs in ~30% of ASD

- Consider anticonvulsants when ASD associated with epilepsy
Comorbidity: Anxiety

- Heightened rates in both ASD and BD
- Needs assessment and appropriate management
- Role of medication: Antidepressants/Antipsychotics
Psychotherapeutic Approaches

• Engagement with psychotherapies requires adaptations i.e. modified CBT

• Therapies such as the FFTA-UK need modifications to psychoeducation and communication enhancement

Emotionally Unstable Personality Disorder

- Frequent co-morbidity in BD
- In under 18s, EUPD cannot be diagnosed
- EUPD is not the only PD
- Emerging EUPD can occur
- Late diagnosis of BD can contribute to development of personality disorder
Emotionally Unstable Personality Disorder

- Disorder of ‘self’
- Emotion dysregulation common
- Late diagnosis of PBD can contribute
- Transference vs counter-transference
Complexity and Risk
Videos
Transition
Transition

• Young people aged 16 and 17 are making the transition to adulthood and

• Transitioning from CAMHS and AMHS and

• Transitioning from living with parents to individuating and

• Transitioning from school to university
IT CAN BE Frustrating WHEN THINGS DON'T Go ACCORDING TO PLAN.
Transition

- Allow time to heal
- Time to catch up: loss of teen years and siblings when ill
Transition

- Consider comorbidities: ASD
- Systemic approach (lack of parental involvement)
Transition

• Liaison with schools to university and others

• Driving
To Conclude

- Bipolar Disorder diagnosis in children & adolescents is infrequent.
- More than 1 in 5 adults with BD reported onset of symptoms before age 19 years.
- Age of onset between 13 and 16 years.
- Research suggests an unacceptable (~8 year) delay between onset of symptoms and start of treatment.
- Consider the diagnosis and assess in a robust manner.
- Seek a second opinion if felt necessary.
Thank You!

Adolescent Bipolar Service (ABS)

The Adolescent Bipolar Service is a specialist tertiary provision for children and adolescents with mood disorders, accepting referrals from across the United Kingdom.