Bipolar Disorder Assessment and Diagnosis

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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
- 1st degree relatives highly relevant
- 2nd 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

Child Name: _____
Date: _____

YMRS - PARENT VERSION

Directions: Please read each question below and circle the answer number which most closely describes your child for the past 24 hours (from pickup time on this date until the next morning).

1. **Mood** - *Is your child's mood higher (better) than usual?*

   0. No
   1. Mildly or possibly increased
   2. Definite elevation- more optimistic, self-confident; cheerful; appropriate to their conversation
   3. Elevated but inappropriate to content; joking, mildly silly
   4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. **Motor Activity/Energy** - *Does your child's energy level or motor activity appear to be greater than usual?*

   0. No
   1. Mildly or possibly increased
   2. More animated; increased gesturing
   3. Energy is excessive; hyperactive at times; restless but can be calmed
   4. Very excited; continuous hyperactivity; cannot be calmed

3. **Sexual Interest** - *Is your child showing more than usual interest in sexual matters?*

   0. No
   1. Mildly or possibly increased
   2. Definite increase when the topic arises
   3. Talks spontaneously about sexual matters; gives more detail than usual; more interested in girls/boys than usual
   4. Has shown open sexual behavior- touching others or self inappropriately

4. **Sleep** - *Has your child's sleep decreased lately?*

   0. No
   1. Sleeping less than normal amount by up to one hour
   2. Sleeping less than normal amount by more than one hour
   3. Need for sleep appears decreased; less than four hours
   4. Denies need for sleep; has stayed up one night or more

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

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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 revised 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 also to help assess whether a child's symptoms are responding to treatment. The scale is NOT intended to diagnose bipolar disorder in children (that 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 child's total score is determined by adding up the highest number circled on each question. Scores range from 0-60. 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 scores in children studied were approximately 25 for mania (a syndrome found in patients with Bipolar-I), and 20 for hypomania (a syndrome found in patients with BP-2, BP-NOS, and Cyclothymia). Anything above 13 indicated a potential case of mania or hypomania for the group that was studied, while anything above 21 was a probable case. In situations where the odds of bipolar diagnosis are high to begin with (a child with mood symptoms with 2 parents having bipolar disorder), the P-YMRS can be extremely helpful. But for most groups of people, the base rate of bipolar disorder is unknown but low. Then, the most 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 prostate cancer, where it will identify most cases of bipolar, but with an extremely high false positive rate. The P-YMRS is presently 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.

The P-YMRS was revised from the Y-MRS originally developed by Young et al and was presented at the First Annual International Conference on Bipolar Disorders, Pittsburgh, June, 1996 (Gracious Barbara L et al). Exploration of its statistical properties are outlined in: Discriminative Validity of a Parent Version of the Young Mania Rating Scale. (Gracious, Barbara L, Youngstrom Eric A, Findling, Robert L, and Calabrese Joseph R et al). Journal of the American Academy of Child and Adolescent Psychiatry (2002) 41(11): 1350-1359.

- Life mood charts

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