Bipolar Disorders in Adolescents

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Abstract

In the 1980s, with the transition from the DSM II to the DSM III, the possibility for an adolescent to present a bipolar disorder became close to non-existent. Adolescent psychodynamic psychiatrists did not agree with this change and stayed with the old classification. Nevertheless, DSM III led to a decrease of bipolar diagnosis in adolescents especially in Anglo-Saxon countries, even becoming a rarity in the 2000s. Now, the evolution of current criteria for adolescents tends to bring these two approaches closer together. Despite the differences, there is a consensus regarding the poor prognosis of type I bipolar disorder, particularly when psychotic traits are observed. Early diagnosis and treatment are therefore important, yet they both remain a challenge, with each having limitations inherent to their respective approaches. In "classical psychiatry", if the criteria are met for bipolar disorder, treatment is started right away amid the risks of over-diagnosis and the stigmatization of false positives. For psychodynamic psychiatrists, even if the criteria for bipolar disorder are met, it is still necessary that the psychopathological analysis of the disorder in the developmental framework of adolescence confirms that the disorder is stable, at the risk of delayed treatment and increased or insufficiently treated false negatives.

Key words: mood disorder, bipolar disorder, adolescence, nosology.

Introduction

A number of adolescent psychiatrists have always had difficulty with the DSM classification system since the publication of its third version. This is true in general, and particularly for mood disorders, including bipolar disorder. These psychiatrists continued to rely on the DSM II system because of its psychodynamic-like dimension. According to their most salient criticism, in the revision of DSM-II, under the influence of R. L. Spitzer (1968), toward a Kraepelinian nosology, the notion of "adolescent crisis" had disappeared. The Kraepelinian system of DSM III differs from the more normothetic psychodynamically influenced system of DSM II, by putting more emphasis on objective rather than subjective symptoms. Therefore, the highly subjective concept of "crisis" could not subsist in the revised nosology. Although "adolescent crisis" does not appear as such in DSM II, it is always present in the coding system that requires the clinician to determine the reactive nature of the observed disorders. If the definition of DSM II provides the clinician with the flexibility to include clinical pictures that can be found in the adult age range, this is excluded from the DSM III nosology, which only allows for specific disorders to be coded. If the symptoms correspond to an adult disorder, they must be coded in the adult nosology. This change in the diagnostic system led to the relative disappearance of some disorders. Indeed, the new requirement to meet the entire diagnostic criteria of the adult nosology reduced the incidence of certain disorders such as bipolar disorders. Conversely, in the Francophone countries where there were more psychodynamic psychiatrists (PP), the diagnostic criteria have not changed and bipolar disorder has maintained, as in adults, an approximate prevalence of 1%. Realizing the impact of this underestimation, the Anglo-Saxon psychiatrists are

currently re-addressing the diagnostic criteria for children and adolescents. In this respect, Professor E. Weller has contributed to reconciling these trends while arguing in 1986 against the undervaluation of these disorders in adolescents in the US.

In this article, we propose the following.
(a) To familiarize the readers with the nosological concepts of mood disorders, particularly bipolar disorder in the psychiatry of adolescents.
(b) To highlight the major issues in the field of adolescent bipolar disorders.

Mood disorders among adolescents

For PP the diagnosis of a mood disorder in adolescence requires two prerequisites. On the one hand, the adolescent person is conceived as a subject who is wholly psychically unstable, and on the other hand, adolescence is perceived as a depressive developmental stage (Zdanowicz et al., 1996). Because of the psychic reorganization related to adolescence, PP believe that teens can display a number of different clinical pictures, including those of adult disorders. In most cases, clinicians consider that these disorders are not stable and hence they are neither as serious nor require the same treatment or suggest similar prognosis as those of adults. What determines the stability of the disorder (therefore, its seriousness) are psychodynamic criteria, i.e. data on the adolescent's subjectivity. In this conception, normality and pathology are not defined by a ratio of exclusion but by a ratio of continuity. Being considered the essence of being a human, "Pathos" is one of the possible modes of the human psyche's functioning. The criteria of normality in this case are "stuck" on the one hand in the subject's inner world (subjectivity) comprising instinctual life and coping mechanisms, and on the other hand, in the external reality, i.e. the objective symptoms (Bergeret, 1974). For PP, the presence of objective symptoms is not enough to establish that a teenager displays a psychiatric disorder in the full sense of its definition for adults; internal criteria are still required. These internal criteria for adolescents mainly include the existence of psychological distress and stereotyped coping mechanisms, but also a blockade in the subjective process of the acquisition of autonomy (Diatkine 1972). Furthermore adolescence is also conceived as a depressive episode, not only because it includes a process of separation from childhood, but also because this forsaking is necessary for the child to redefine him/herself as a future adult. Unlike depression and grief in adults that result in loss, grief-depression in adolescents has a good prognosis, mainly because it opens the way to the adult world, richer in potential than that of childhood. Hence, depression in adolescence would be frequent and even necessary. For PP one must distinguish normal adolescent "depressive mood" from major depressive disorder. In this perspective, depressive symptoms among adolescents are common and mundane. The diagnosis of major depressive episode is made even more complex as the number of depressive symptoms increases between 12 and 17 years, and in the range 17-18 years they are so frequent that the boundary between "depressive mood "and major depression becomes tenuous. This conception of depression in adolescence has led some authors to hypothesise a normal dysthymia of adolescence (Marcelli and Braconnier, 2008).

Since DSM III, bipolar disorders belong to the category of mood disorders. The former classification insisted much more on the psychotic dimension of these disorders, therefore, in DSM II, they were classified as "affective psychoses". Today, this above psychotic dimension is only present in schizoaffective disorder. PP, have remained much attached to the old conception of manic-depressive psychosis that covers two distinct phenomena: those that occur in the context of a normal personality, and those occurring in the context of psychotic traits. Faced with a teenager who displays bipolar symptoms, PP must answer several questions pertaining to their diagnostic process, assessment of severity of the disorder, and treatment options:

1 / Is the disorder stable or is it just a temporary state (see above)?
2 / if the disorder is stable are there reasons to believe that the adolescent patient is psychotic? If yes (as is more frequently the case with type 1 bipolar patients), the diagnosis is of manic-depressive disorder. This diagnosis requires a more intense treatment in terms of neuroleptics.
3 / Is the adolescent patient displaying traits of psychotic functioning? If not (as often in hypomania BPD II), then the diagnosis is rather conceived in terms of a counter-depressive reaction, and

antidepressant treatment is more important than antipsychotic treatment.
4 / Is the delusional aspect of the symptoms the most salient of the clinical picture? If so, the diagnosis is that of a schizoaffective disorder.

Current Issues in bipolar disorder

Notwithstanding these differences between psychiatrists, the issues that arise in relation to bipolar disorder are almost identical in the two trends of adolescent psychiatry. They include:
3.1 Prevalence
3.2 Diagnostic criteria
3.3 Co morbidities, particularly in relation to ADHD
3.4 Therapeutic strategies

3.1 Prevalence

Professor Weller has shown in 1986, that many U.S. adolescents suffering from a bipolar disorder were wrongly diagnosed with schizoaffective disorder (Weller and Weller, 1986). Although bipolar disorder was under-diagnosed at that time, between the years 1994 and 2003, we observed an "epidemic" of bipolar disorder diagnoses in the same cohort. In 10 years, in the U.S., the estimated annual number of youth below 20 with a diagnosis of bipolar disorder increased from 25 (1994-1995) to 1003 (2002-2003) office-based visits per 100,000 population (Moreno et al, 2007).

3.2 Diagnostic criteria

Beyond the under-diagnosis in previous years, one reason for this "epidemic" undoubtedly lies in the great variability of diagnostic criteria used by researchers. They indeed had to leave the strict confines of DSM as "officially" this condition does not require a description different from that of adults (the only specific remark regarding age found in the DSM is that mixed disorders seem more common among adolescents and young adults). In 2001 the National Institute of Mental Health Research Roundtable on prepubertal bipolar disorder "is considering a new classification for youth offering a subdivision of the disease in terms of "narrow", "broad" and "mixed" phenotypes.

- The "narrow" entity refers to the DSM-IV-TR bipolar disorders I and II.
- The "broad" entity includes bipolar disorder not otherwise specified (NOS) with two phenotypes: the intermediate and broad.
    - Intermediate: the symptoms that are necessary to the diagnosis are present but either do not meet duration criteria, or conversely, duration criteria are met, but all the necessary symptoms for the diagnosis could not be observed.
    - Broad: the disorders identified with the broad entity show a phenotype of severe irritability, without episodic nature of the condition, ideas of grandeur, or high mood.
- The mixed states fall into a continuum between manic symptoms and concomitant depression, forming either a homogeneous episode, or a more heterogeneous pattern whereby mania and depression are present simultaneously, with at each moment, the predominance of one over the other.

This classification and the creation of a scale of prodromes (Bechdolf et al. 2010) obviously represent a significant advance for early diagnosis. However, PP are left wanting in two areas: 1/ they still have not recovered the old concept of crisis (formerly the old Transient Situational Disturbances of the DSM II) even if the concept of the bipolar spectrum of Akiskal (Akiskal, 2007) is closest to it, and 2/ Van Os's hypothesis (Van Os, 2009) of bridges between bipolar disorder, schizophrenia and schizoaffective disorder, does not appear in this classification.

3.3 Comorbidities, particularly in relation to ADHD

The co morbidities are many, and include:

- Anxiety disorders, and ADHD among younger adolescents;
- Drug Use and Antisocial Behaviours among older adolescents.

Comorbidity with ADHD presented a particular interest among Francophone psychiatrists, since 85% of young people with ADHD also meet the criteria for bipolar disorder. This is strange because the dual diagnosis is more common than the diagnosis of the single entity. Various explanations have been proposed to account for that peculiarity (Zdanowicz and Myslinski, 2010) in the international literature.

1. A partial overlap of symptoms between ADHD and bipolar disorders causes diagnostic errors
2. Treating ADHD with psychostimulants can induce a bipolar disorder.
3. ADHD may be a prodrome of bipolar disorder.
4. Various arguments advocate for the existence of a new "ADHD-BPD " diagnosis.

3.4 Therapeutic strategies

What are the secure and effective therapeutic strategies? Regardless of these differences, there is unanimity on the poor prognosis of bipolar disorder I in adolescence, and especially, according to PP, if the disorder is accompanied by psychotic features. Indeed, the return to euthymia is slower, the rate of remission is lower, and relapse is more frequent than in the adult form of the disorder. The disorder seems even more deleterious in that it hampers a crucial stage of the adolescent's development toward becoming an adult. Dawn (Dawn et al. 2004) argues that the evolution of bipolar disorder in early life is characterized by a greater number of mixed episodes or rapid cycling, and greater symptomatic periods. The first episode is often manic, with a time of remission of five weeks to six months, and a relapse twenty-three months later. Regarding treatment, one must obviously take into account the fact that studies of safety and effectiveness are rarer than in adults.
The current consensus among psychiatrists in relation to bipolar disorders in adolescents is as follows:

Acute manic or mixed phase

• Without psychotic symptoms, the first choice is monotherapy. Several treatments are more or less well documented: lithium, valproate, carbamazepine, olanzapine, risperidone, quetiapine. Only in the case of successive failures of three monotherapies will a combination of a mood-regulator with an atypical neuroleptic be attempted.
• In the case of psychotic symptoms, the first choice is the combination of a mood-regulator with an atypical antipsychotic. If no therapeutic effect can be observed, another association of two treatments of the same family must be attempted. The lack of response causes the transition to another association where the mood-regulator is maintained, but the antipsychotic is changed.

Depressive phase

The treatment of this phase does not benefit from clear guidelines. It often involves lithium in combination with an SSRI. Lamotrigine gives encouraging results during adolescence, especially when combined with an antidepressant, especially venlafaxine.

Maintenance treatment

It is believed that the medication that helped control the manic phase should be continued for 12 to 24 months. The relapse rate decreases if, in addition to lithium, atypical antipsychotics are associated. In the absence of clear consensus and safety studies, the risk/benefit ratio should be investigated each time before deciding on the maintenance of long-term medication. If interruption is decided, it must occur at a time when the risk of an unfavourable change seems small, in a stable environment, and under close supervision.

Bipolar disorder NOS

There is no consensus on Bipolar disorders NOS, mainly because of their many forms. The intervention focuses on the predominant symptoms in the clinical picture, comorbidities, and issues of concern for the social environment.

Psychotherapeutic intervention

Apart from the interest in psychoeducation, the authors point out that bipolar disorder in adolescence affects a highly strategic period in the development of the individual, and of the development of both the patients' functioning and his social network. The consequences are therefore very harmful to patients by hampering the process of their personal evolutionary process, as well as by disconnecting them from the outside world. Individual psychotherapy can help patients develop individual abilities, provide support, and accompany their development. Psychosocial intervention is often recommended to maintain or restore the patients' relationship with the outside world.

Discussion

The evolution of the diagnostic criteria in the DSM system seems to allow some level of reconciliation between different conceptions of psychopathology in adolescence. It is certain that a prompt diagnosis and early treatment are an asset in the treatment of young bipolar I patients. Even though the two psychiatric paradigms agree on this point, their respective attitudes toward young people with bipolar disorder are different. It is at this level that the above two systems of thought reach their limits. For the "classical psychiatrist", if the criteria for bipolar disorder are met, the treatment is decided upon at the risk of over-diagnosis and of stigmatization of false positives. For PP, even if the criteria are met, it is still necessary that psychotic features should be present and that the psychopathological analysis of the disorder in the developmental framework of adolescence confirms that the disorder is stable at the risk of beginning treatment later and an increase in insufficiently-treated false negatives. If these two psychiatric trends could be brought together, we could increase the sensitivity and specificity of diagnostic criteria.

GP Comment

What have I learned from this paper?

Although the busy GP is to unlikely consider the complexities of the underlying psychodynamic theory, it is important to understand the psychiatric assessment of teenagers against the background of what is often a time of great change and instability in their lives.

Teenagers with bipolar I disorder are likely to require prompt and expert treatment.

Dr.Juan Mendive, Family Physician, Barcelona.

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