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Psychopathological features during childhood and adolescence among adult bipolar patients: A retrospective study

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Abstract

Objective: There are still several concerns regarding the inconsistency in the diagnosis of Bipolar Disorder (BD) in children and adolescents. This study reviews the symptoms of youth admitted to The University of Texas Harris County Psychiatric Center (UT-HCPC) prior to a confirmed diagnosis of BD to elucidate patterns and target symptoms which may facilitate early recognition of BD.
Methods: This is a retrospective review of charts of adult patients with a discharge diagnosis of BD for three consecutive admissions who were also admitted to UT-HCPC as children or adolescents (N = 26). The Kiddie SADS was completed based on each patient's first admission as a child and last admission as an adult.
Results: Most of the symptoms found in adult BD were present in the child/adolescent subjects at equivalent rates, except for mood elevation, which was less common during childhood and adolescence. In spite of the psychopathological similarity, only 6 (23%) of the subjects were diagnosed with BD as youth.
Conclusion: BD is poorly diagnosed among children and adolescents. Difficulties in the assessment of the youth, as well as particularities in the psychopathology of mood among children and adolescents may account for the low diagnostic rate.

1. Introduction

Although approximately sixty percent of adults with Bipolar Disorder (BD) report the onset of their mood symptoms during adolescence [1], the illness remains a challenge to accurately diagnose at younger ages [2–4]. Diagnosing Pediatric Bipolar Disorder (PBD) has proven difficult in the area of Child and Adolescent Psychiatry. The varied range of interpreting criteria and symptoms for PBD is one reason for the inconsistent identification of this diagnosis [5]. Additionally, the overlap between clinical features and symptoms of PBD compared to other psychiatric disorders commonly found in children and adolescents (such as Attention Deficit Hyperactivity Disorder (ADHD) and atypical depression) makes the identification of PBD challenging [6].

Some authors suggest that characterizing particular psychopathological domains may be useful in conceptualizing BD in children and adolescents, as well as aiding in its differential diagnosis with other disorders. For instance, the combination of impulse control deficits and affective instability in children and adolescents is considered highly suggestive of PBD [3]. In addition, persistent and severe irritability and violent 'affective storms' (prolonged and intense aggressive tantrums) seem crucial in diagnosing BD in children and adolescents [7]. Other studies, however, concluded that elated mood, grandiosity, flight of ideas/racing

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thoughts and decreased need for sleep were imperative when differentiating BD from ADHD in children and adolescents [6,8], whereas some believe that irritability, hyperactivity and distractibility, are not characteristic of mania (National Alliance on Mental Health (NAMI), 2013) [9].

Despite evidence suggesting a specific psychopathological domain among children and adolescents with BD, it is not clear if these profiles remain stable over time [3]. In other words, evidence is scant in regard to possible changes or manifestations of BD symptoms presented from youth into adulthood. Furthermore, little is known on the diagnostic and prognostic implications of those changes as well.

The present study compares the clinical features exhibited by properly diagnosed adult patients with BD to their previous psychiatric presentations during childhood and adolescence. The main hypothesis of this study is that similar symptomatology exists for early onset BD patients between their adult and childhood hospitalizations. Confirmation of this hypothesis would support the continued development of criteria to properly identify symptoms and promote early diagnosis of BD in youth.

2. Methods

The study was conducted at The University of Texas – Harris County Psychiatric Center (UT-HCPC), a 250-bed inpatient psychiatric center, located in Houston, Texas. The hospital's electronic database was utilized to search for adult patients who met the inclusion criteria for the present study, which were: (a) three consecutive admissions to UT-HCPC as adults with a discharge diagnosis of BD; (b) previous admission to UT-HCPC during childhood (17 or younger); (c) availability of both (adult and child) medical records for review. Patients with developmental or cognitive conditions were excluded, as well as those whose medical records did not provide enough information to complete the instruments of interest (see below). The study was approved by the internal review committee for the hospital and the UT-Health IRB (IRB # HSC-MS-05-0365).

Seven hundred and ninety nine adult patients met criterion "a", while only 26 (10 males, 16 females; age ± SD = 23.19 ± 2.61) met all inclusion criteria and subsequently were selected for the present study. The first admissions for the youth occurred between 1988 and 2002 and for the adults between 1995 and 2006. The medical records of the 26 subjects were reviewed by trained evaluators (child psychiatrists and registered nurses with experience in child and adolescence psychiatry). A multisystematic review of the chart included the use of notes from all disciplines (MD, PhD, RN, and LMSW) to identify symptom patterns. Information pertaining to the subjects' medical records included electronic charts regarding adult hospitalizations and hard copies of hospital records regarding childhood hospitalizations.

The aforementioned chart review focused on differing psychiatric symptoms exhibited by the patients during admissions, differing admission diagnoses formulated by clinicians, and the differing psychotropic prescription patterns upon discharge. In order to systematically review the exhibited psychiatric symptoms, the Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (Wash-U-KSADS) was utilized [10,11]. A research psychologist with experience in the use of that instrument coordinated the training of the different professionals involved in the administration of the Wash-U-KSADS. In addition, the first 10 charts were reviewed independently by two evaluators, and the comparison of the results indicated good inter-rater reliability on the collection of the data.

The data on the child admissions were compared with the information regarding the adult admissions. For the continuous variables, the statistical analysis was performed using paired t-tests, whereas the McNemar and Wilcoxon tests were utilized for the categorical and ordinal variables, respectively.

3. Results

At the time of their admissions as children, the patients' mean age was 15.58 years (SD = 1.50), with 9 ± 1.44 years of schooling. Ten patients required special education. Most patients lived with one or both parents, while one was in CPS custody and two were under the guardianship of the correctional system. Nine subjects reported parental unemployment at the time of their childhood admission, and both parents were unemployed in six cases. As adults, the patients had 10.17 ± 1.75 years of schooling and the vast majority of them (25 out of 26) were unemployed.

Table 1 displays the comparison between adult and childhood admissions in regard to the profile of psychiatric symptoms obtained through chart review and summarized through the Wash-U-KSADS. No statistically significant differences were found regarding most of the symptoms. However, mood elevation was significantly more common during adulthood than during the childhood admissions ($p = 0.04$).

Despite the similar symptom profiles between the childhood and adult admissions and the fact that, based on the KSADS, the diagnosis of BD could be established already during childhood, only 23% of the adult patients had a previous diagnosis of BD during their childhood hospitalizations. The remaining subjects had, at that time, received the diagnosis of major depressive disorder (11.5%), substance-related disorder (7.7%), adjustment disorder (3.9%), disruptive behavior disorder NOS (15.4%), psychotic disorder NOS (7.7 %) and mental disorder due to a medical condition (3.9%).

In addition, the duration of childhood admissions was significantly longer than the adult admissions (mean = 26.38 days vs. 10.65 days, respectively; $p = 0.002$). Further, there was a trend to higher values in the Global Assessment of Functioning (GAF) admission scores at the childhood admissions ($p = 0.05$).