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Research report

Bipolar disorder subtypes in children and adolescents: Demographic and clinical characteristics from an Australian sample

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ABSTRACT

Background: Bipolar disorder (BD) phenomenology in children and adolescents remains contentious. The study investigated Australian children and adolescents with bipolar I disorder (BD-I), bipolar II disorder (BD-II), or BD not otherwise specified (BD-NOS).**Methods:** Index episode demographics, symptomatology, functioning and diagnostic data were compared for 88 participants (63 female) aged 8–18 years ($M=14.8$, $SD=2.5$) meeting DSM-IV-TR criteria for BD-I ($n=24$), BD-II ($n=13$) or BD-NOS ($n=51$).**Results:** BD-I had higher rates of previous episodes, psychotropic medication (compared to BD-II but not BD-NOS), rates of inpatient admissions (compared to BD-NOS), and number of inpatient admissions (compared to BD-II). BD-II had lower rates of lifetime depression and anxiety disorders, higher frequency of hypomania, shorter duration of illness, and fewer previous episodes. BD-NOS had younger age of onset, chronic course, irritability and mixed presentation. All BD subtypes had high rates of self-harm (69.3%), suicidal ideation (73.9%), suicide attempts (36.4%), psychiatric admission (55.7%), and psychosis (36.4%).**Limitations:** There were relatively small numbers of BD-I and BD-II. Diagnoses were based on retrospective recall.**Conclusions:** All BD subtypes had high levels of acuity and clinical risk. In accord with previous results, BD-I and BD-II participants' phenomenology was consistent with classical descriptions of these subtypes. BD-NOS participants were younger, with less euphoric mania but otherwise phenomenologically on a continuum with BD-I, suggesting that child and adolescent BD-NOS may be an early and less differentiated phase of illness of BD-I or BD-II and hence a target for early intervention.

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1. Introduction

The phenomenology of bipolar disorder (BD) in children and adolescents remains a contentious topic in psychiatry practice and research. There is general acceptance that BD symptomatology often has an onset in the mid to late teenage years (American Psychiatric Association, 2002; Mitchell et al., 2003) and that BD can present in children and younger adolescents, but with a much less certain prognosis (Carlson and Meyer, 2006; Kowatch et al., 2005; Kyte et al., 2006). Researchers remain divided as to whether instances of

BD in children and adolescents represent a more potent presentation of the classic adult illness, a separate subtype of BD, a variant of other conditions such as attention deficit-hyperactivity disorder (ADHD), or a newly recognized illness unrelated to adult-onset BD (Kyte et al., 2006).

Researchers attempting to define the core features of child and adolescent BD have generally focused on bipolar I disorder (BD-I) (Biederman et al., 1999; DelBello et al., 2007; Findling et al., 2001; Geller et al., 2002b; Jairam et al., 2004; Srinath et al., 1998). Such studies have been reviewed comprehensively elsewhere (Birmaher and Axelson, 2006; Jairam et al., 2006; Kowatch et al., 2005). In summary, current research suggests that children and adolescents with BD-I tend to be predominantly male, present with an episodic course, history of functional impairment, high rates of prior hospitalization, medication treatment, mixed mood episodes longitudinally,

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suicidal ideation, psychotic symptoms and suicide attempts (Axelson et al., 2006; Birmaher et al., 2009; Geller et al., 2002b; Hazell et al., 1999; Masi et al., 2007).

In contrast to the many BD-I samples described in the literature, far fewer studies have described other variants of child and adolescent BD such as bipolar II disorder (BD-II) and bipolar disorder not otherwise specified (BD-NOS). Only two large-scale studies have described in detail the phenomenological features of BD-I, BD-II and BD-NOS subtypes in children and adolescents: First, the Course and Outcomes of Bipolar Youth (COBY) study (Axelson et al., 2006) is a US multi-site prospective naturalistic study that examined 438 children and adolescents ($M=12.7$ years) with BD-I ($n=255$), BD-II ($n=30$), and BD-NOS ($n=153$) recruited from 3 US academic medical centres, with primarily an outpatient focus. Second, Masi et al. (2007) recruited 217 patients ($M=13.6$ years; $n=78$ BD-I, 97 BD-II and 42 BD-NOS) from a unit for inpatient and outpatient children and adolescents with mood and anxiety disorders based in Pisa, Italy. Between them, the studies found BD-I participants had higher scores on overall symptom severity, and comparatively high rates of psychosis, psychiatric hospitalization, suicide attempts, and use of psychotropic medication; BD-II participants had more anxiety disorders and lifetime depressive episodes; and participants with BD-NOS exhibited an earlier age of onset, and more frequent irritability and comorbid ADHD and oppositional-defiant disorder (ODD) (Axelson et al., 2006; Masi et al., 2007). Other studies have included children and adolescents with bipolar spectrum diagnoses, but without examining subtype differences (Faedda et al., 2004; Findling et al., 2010; Lewinsohn et al., 1995; Scott et al., 2013; Soutullo et al., 2009; Starling et al., 2013).

One major challenge in researching BD subtypes in children and adolescents is the lack of clear and consistent diagnostic instruments and criteria for defining BD-NOS. For example, Axelson et al. (2006), Masi et al. (2007) both used the Schedule for Affective Disorders and Schizophrenia for School-Age Children–Present and Lifetime Version (KSADS-PL) (Kaufman et al., 1997) to determine diagnoses, however, the COBY study modified the present episode version to include severity ratings for mania and depression (e.g., KMRS, Axelson et al., 2003). A modified version of the KSADS – the Washington University in St Louis KSADS (WASH-U-KSADS) – has been purpose-built for examining bipolar spectrum disorders in children and adolescents to account for such methodological limitations (Geller et al., 1998, 1996). No studies to date however, have reported on the characteristics of BD subtypes using purpose-built instruments such as the WASH-U-KSADS. We have provided a comparison of the methodological differences between WASH-U-KSADS and KSADS-PL, and how the instruments have been applied across studies of child and adolescent BD subtypes (see Table 1). Although an extensive discussion of the differences is outside the scope of this study, the reader is referred to Galanter et al. (2012) for a thorough discussion.

Given the limited existing research, there is a need for further studies of child and adolescent BD subtypes in other cultural contexts and using instruments that are designed specifically for this population. The present study reports on the index episode characteristics of an Australian child and adolescent BD sample, analysing BD subtypes and comparing findings with existing US and non-US studies to add to the phenomenological description of child and adolescent BD subtypes internationally. To our knowledge, the study is the first examining the phenomenology of bipolar spectrum disorders in an Australian child and adolescent sample.

1.1. Hypotheses

1.1.1. Clinical presentation

BD-I participants will score higher on measures of overall clinical acuity (higher rates of psychosis, psychiatric hospitalization, suicide attempts, and psychotropic medication). BD-NOS participants will have higher levels of irritability (Axelson et al., 2006; Masi et al.,

2007). BD-I participants will have lowest scores, and BD-II participants highest scores, on measures of psychosocial functioning (Axelson et al., 2006; Masi et al., 2007).

1.1.2. Course of illness

BD-I participants will have higher rates of multiple mood episodes, BD-II participants will have higher rates of lifetime depressive episodes, and BD-NOS participants will have an earlier age of onset (Axelson et al., 2006; Birmaher et al., 2009; Masi et al., 2007).

1.1.3. Patterns of comorbidity

BD-II participants will have more internalizing (anxiety) disorders, and BD-NOS participants will have more externalizing disorders (ADHD, ODD and conduct disorder [CD]) (Axelson et al., 2006; Birmaher et al., 2009; Masi et al., 2007).

2. Methods

2.1. Participant selection and assessment

Participants were recruited between 2005 and 2010 from The Bipolar Program (TBP), a specialist public community mental health clinic for the assessment and management of possible bipolar disorder in young people aged 5–18 years, embedded within a local child and adolescent mental health service (CAMHS) located in Newcastle, Australia. Newcastle is a metropolitan area of New South Wales with a population of about 308,000; approximately the population of the US city of Pittsburgh, PA. Sample characteristics are described in detail in the following section. The study was approved by the relevant ethics committees (Hunter New England Local Health District and University of Sydney).

Index episode data were collected at service admission, based on current symptoms and function using the standard assessment procedures of the clinic, which included initial assessment (clinical interview and history taking), subsequent structured diagnostic interview and final review by psychiatrist. Psychosocial functioning was assessed using the Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983). Socioeconomic status (SES) was assessed based on parental occupation using the Australian Socioeconomic Index 2006 (AUSEI06) (McMillan et al., 2009), a numerical occupational status score (0–100) based on the Australian and New Zealand Standard Classification of Occupations (ANZSCO).

Diagnoses were established using the Washington University in St Louis Kiddie Schedule for Affective disorders and Schizophrenia (WASH-U-KSADS) (Geller et al., 1996, 1998, 2001) conducted with both parents and clients. The WASH-U-KSADS was chosen as it is designed specifically for assessing child and adolescent mood disorders, with the methodology being quite similar to the modified protocol of Axelson et al. (2006). Assessments were conducted by clinical psychologists (SH and TH, one of whom [TH] has received formal training in WASH-U-KSADS administration with Dr Geller's research team in St Louis, achieved acceptable inter-rater reliability with Dr Geller's research team and subsequently provided comprehensive training for the other clinician, including direct observation and feedback). All diagnoses were verified by a child and adolescent psychiatrist. Clients with schizophrenia, autism, intellectual disability, or a primary medical or substance-related mood disorder were excluded.

Inclusion criteria were current or past diagnosis of BD-I, BD-II or BD-NOS. Diagnoses of BD-I and BD-II were made based on standard DSM-IV-TR criteria (American Psychiatric Association, 2000) using the WASH-U-KSADS scoring procedures as described by Geller et al. (1996, 2002b, 2002c) and with reference to considerations described by Leibenluft et al. (2003): Mania and hypomania were defined as

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