Judicious Use of Bipolar Diagnosis Is Advised

BY MARY ELLEN SCHNEIDER

NEW YORK — Juvenile bipolar disorder is a controversial diagnosis, and broad disagreement exists among both clinicians and researchers about how the diagnosis should be made, according to Dr. Jennifer Harris, of the department of psychiatry at Harvard Medical School, Boston.

Making the diagnosis is further complicated by the fact that the research literature includes three different major approaches to the diagnosis of the condition, Dr. Harris reported at the annual meeting of the American Society for Adolescent Psychiatry.

There appears to be agreement on how to interpret the presence of category B symptoms as described in the DSM-IV criteria for mania, but there is little agreement on the category A symptoms, which are defined as a "distinct period of abnormally and persistently elevated, expansive, or irritable mood," lasting at least 7 days for mania or 4 days for hypomania.

The first diagnostic approach that is detailed in the literature is a narrow phenotype in which clinicians apply strict adult criteria for bipolar disorder, looking for distinct manic episodes of long duration.

This definition doesn't require the presence of euphoria or grandiosity, just irritability alone. However, the mood symptoms must occur only during a distinct time frame and they cannot be chronic.

The second approach is marked by the expression of cardinal symptoms and brief frequent cycles. These patients demonstrate very rapid mood changes and complicated cycling patterns with about three cycles per day. This definition uses strict criteria for the quality of mood symptoms, requiring not only irritability, but grandiosity or euphoria.

The third approach focuses on patients with persistent, impairing irritability. This diagnostic approach does not require the cardinal symptoms of grandiosity or euphoria and does not focus on distinct episodes. Severe, persistent, impairing irritability is considered sufficient to meet criteria for mania, even if it is not a change from the patient's baseline.

The best way to categorize patients with persistent irritability remains an open question, but some think severe mood dysregulation is the proper diagnosis in those cases.

A consensus is starting to develop that the narrow phenotype group should be called bipolar disorder I or II, because it reflects the classic bipolar disorder, Dr. Harris said.

She noted that there are some children whose symptoms meet this strict set of criteria.

More controversy exists about whether or not patients who present with the cardinal symptoms and rapid cycling should be categorized as bipolar not otherwise specified (NOS), but included in the spectrum, she said.

Finally, the best way in which to categorize patients who fall into the persistent irritability group remains an open question, Dr. Harris said, although she added that there is some support for diagnosing these patients with severe mood dysregulation.

In practice, Dr. Harris recommends that clinicians diagnose juvenile bipolar disorder "judiciously," using narrow phenotype criteria and looking for distinct episodes.

If a case doesn't meet the narrow phenotype criteria, Dr. Harris said she wouldn't be convinced that the patient should be treated the same way as an adult with classic bipolar disorder.

However, she cautioned that it's important not to be completely skeptical about the diagnosis of juvenile bipolar disorder.

"These are challenging kids to treat and kids who have really significant problems," Dr. Harris said. "You can make mistakes either way." ■