Editorial

Irritability as a Criterion in Diagnosis of Child and Adolescent Bipolar Disorder: Thorny Road Ahead

Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5)[1] diagnosis of bipolar disorder (BD) makes it necessary to meet the following criteria for a manic episode:

"A distinct period of abnormally and persistently elevated, expansive, OR IRRITABLE MOOD… lasting at least one week and present most of the day, nearly everyday…."

It is elation or irritation, along with three or four other symptoms.

DSM 5 criteria for BD are applicable to all age groups with the same weightage.

"Irritable mood" occupies a prominent place in the diagnostic criteria of many other disorders, especially childhood and adolescent disorders like oppositional defiant disorder; intermittent explosive disorder; conduct disorder; disruptive mood dysregulation disorder (DMDD); other and unspecified disruptive, impulse control, and conduct disorders; and attention deficit/hyperactivity disorder (ADHD) in the classificatory systems.

With "irritable mood" sharing space in the diagnostic criteria of BD and several childhood and adolescent diagnostic disorders, there looms a possibility of "over diagnosis" of childhood adolescent bipolar disorder. The misdiagnosis, whenever it occurs, hopefully less often, leads to a major therapeutic mismatch resulting in polypharmacy and treatment failures.

National Institute of Mental Health research roundtable on prepubertal bipolar disorder, 2001 recommends that patients with grandiosity/elation be classified as bipolar I and irritability/rage be classified as bipolar NOS (DSM IV TR).

Access this article online	
Website: www.ijpm.info	Quick Response Code
DOI: 10.4103/0253-7176.130954	

There was always a doubt about reliability of irritability as a symptom criterion in the diagnosis of mania as shown in this USA–UK study:

USA–UK project (2005)

Elation/grandiose – mania diagnosis – 96.4% USA and 88.9% UK

Irritability/rage – mania diagnosis – 86.2% USA and 31.1% UK

There is rather unacceptable poor concordance, with irritability as the criterion.

A few valid arguments that merit attention are the following:

1. That delusions/hallucinations occur only in BD (true, but a significant majority of patients with BD do not have delusions/hallucinations).
2. Family H/O of BD favors diagnosis of bipolar illness (yes, very valuable supporting point in those who have a family history).
3. BD is an episodic disorder, whereas other childhood disorders outlined above are all continuous in course. Is it true?

Let us look at the existing data.

EVIDENCE

Age of onset

"The greatest frequency of first attacks falls, however, in the period of development with its increased emotional excitability between the fifteenth and twentieth year…. In rare cases, the first beginnings can be traced back even to before the tenth year…." – Kraepelin, 1921

In 28% of the BD patients recruited into the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) study, age at onset was younger than 13, and in the Bipolar Collaborative Network study, 15% of patients had illness onset before the age of 13 years. The younger age of onset in BD seems to be a well-documented fact.

Diagnosis

Some studies have defined mania by the presence of highly labile moods with intense irritability, rage, explosiveness and destructiveness; extreme agitation, and behavioral dysregulation.[2-5] The picture that emerges from several independent research groups is that prepubertal children with BD typically have multiple daily mood swings and that irritability is much more common than euphoria.[6,7]

Course

Studies indicate a highly pernicious course with substantial chronicity.

In 81% of a well-defined group of patients, Geller *et al*.[6] reported continuous daily cycling from mania or hypomania to euthymia or depression. In this study, 1-year mania recovery rate stood at 37%. Findling *et al*.[8] reported that BD I is characterized by high rates of rapid cycling (50%) with almost no interepisodic recovery.

Course and Outcome of Bipolar Illness in Youth (COBY) study was conducted by Birmaher *et al*.[9] in a group of 263 pediatric BD patients followed up for 2 years. In summary, the entire cohort spent approximately two-thirds of the study follow-up in symptomatic condition. In comparison with adults,[10] COBY patients spent more time being symptomatic, indicating more severe illness course.

Experience

Observations are based on focused attention in this specific area during the later half of the last decade, a spin off of running the bipolar clinic at Asha Hospital, India, Asha Bipolar Clinic (ABC). The last few years have seen a perceptible increase in the number of adolescent patients (15–20 years) with disturbing symptom of irritability as the presenting complaint, brought by parents, but with great reluctance from the patient. Also reported are symptoms of sadness, crying withdrawal, refusal to eat, keeping awake late into the night, etc. General description is that there are "mood swings" lasting for varying durations with varying frequencies and no delusions/hallucinations/bizarre behavior. The clinical picture is as follows:

As given by parents: In the last few months, irritability, argumentativeness, rash behavior, stubbornness, demanding, frequent quarrels at home, breaking mobile phones, unsatisfactory educational performance, spending too much time with friends, keeping awake late into the nights and preoccupation with video games, computer and TV, sadness, crying, withdrawal, refusal to eat, threats of self-harm, etc.

As per patient: No issues, my parents always on my back, NO is the only answer they know, "Why can't I buy a smart phone," try to control every minute, restless and agitated, not cooperative, refuses to answer questions, poor concentration, irritable mood, etc.

Good possibility of diagnostic work-up leading in the direction of Adolescent Bipolar Disorder, Mixed (DSM IV TR).

In-depth evaluation reveals, in a significant majority of adolescents, presence of personality traits – meticulous, organized, possessive, punctual, particular about cleanliness and neatness, stubbornness, sensitive (specifically inability to forget insults and repetitive rumination over it), extreme dislike toward repetitive reminders, short-tempered sometimes amounting to rage, not having satisfactory interpersonal relationships – somewhat suggestive of Obsessive Compulsive Personality Disorder (OCPD). Parents describe the child as "very good but very difficult child to handle."

On many occasions, Escitalopram at a dosage of 10–20 mg significantly reduced the symptoms, which was of course accompanied by counseling and family discussions always.

Do SSRIs help patients with OCPD?[11]

Do these adolescents fit into the diagnosis of DMDD?

Is major depressive disorder (MDD) more common in patients with premorbid OCPD?

YES, my clinical experience hints at this possibility.

Being aware that it stands at the bottom level of evidence, I await evidence from my esteemed colleagues' controlled studies.

Irritability, thereby, shows up as a common, yet relatively understudied, symptom in pediatric psychopathology, crossing over boundaries of many a diagnostic entity leading to wrong diagnosis, with the suspicion currently hanging on overdiagnosis of childhood and adolescent BD, resulting in misdirected, and supposedly lifelong, therapeutic regimens.

BD is a serious disorder in children and adolescents, and we owe it to our patients and their families to accurately diagnose and effectively treat this disorder.[12]

M. S. Reddy

Asha Hospital, Hyderabad, Andhra Pradesh, India.
E-mail: drmsreddy@gmail.com

REFERENCES

1. Diagnostic and Statistical Manual of Mental Disorders. DSM 5. 1000 Wilson Boulevard, Arlington, VA: 22209-3901. American Psychiatric Association.
2. Biederman J, Mick E, Faraone SV, Spencer T, Wilens TE, Wozniak J. Pediatric mania: A developmental subtype of bipolar disorder? Biol Psychiatry 2000;48:458-66.
3. Faraone SV, Biederman J, Mennin D, Wozniak J, Spencer T. Attention-deficit hyperactivity disorder with bipolar disorder: A familial subtype? J Am Acad Child Adolesc Psychiatry 1997;36:1378-90.
4. Carlson GA, Kelly KL. Manic symptoms in psychiatrically hospitalised children--what do they mean? J Affect Disord 1998;51:123-35.
5. Geller B, Zimerman B, Williams M, Delbello MP, Frazier J, Beringer L. Phenomenology of prepubertal and early adolescent bipolar disorder: Examples of elated mood, grandiose behaviors, decreased need for sleep, racing thoughts and hypersexuality. J Child Adolesc Psychopharmacol 2002;12:3-9.
6. Geller B, Zimerman B, Williams M, Bolhofner K, Craney JL, Delbello MP, *et al*. Diagnostic characteristics of 93 cases of a prepubertal and early adolescent bipolar disorder phenotype by gender, puberty, and comorbid attention deficit hyperactivity disorder. J Child Adolesc Psychopharmacol 2000;10:157-64.
7. Wozniak J, Biederman J. Childhood mani: Insights into diagnostic and treatment issues. J Assoc Acad Minor Phys 1997;8:78-84.
8. Findling RL, Gracious BL, McNamara NK, Youngstrom EA, Demeter CA, Branicky LA, *et al*. Rapid, continuous cycling and psychiatric co-morbidity in pediatric bipolar I disorder. Bipolar Disord 2001;3:202-10.
9. Birmaher B, Axelson D, Stober M, Gill MK, Valeri S, Chiappetta L, *et al*. Clinical course of children and adolescents with bipolar spectrum disorders. Arch Gen Psychiatry 2006;63:175-83.
10. Judd LL, Akiskal HS, Schetter PJ, Endicott J, Maser J, Solomon DA, *et al*. The long-term natural history of the weekly symptomatic status of bipolar I disorder. Arch Gen Psychiatry 2002;59:530-7.
11. Kramer PD. Listening to Prozac. 1993.
12. Kowatch RA, Fristad MA, Findling RL, Post RM. Clinical Manuel for Management of Bipolar disorder in Children and Adolescents. Washington DC: APA Publishing; 2010.

How to cite this article: Reddy MS. Irritability as a criterion in diagnosis of child and adolescent bipolar disorder: Thorny road ahead. Indian J Psychol Med 2014;36:109-11.