Treating Children For Bipolar Disorder

Wall Street Journal 25/05/2005 LEILA ABBOUD

Child psychiatry, roiled last year by revelations that antidepressants could increase children's risk of suicidal behavior, now is embroiled in another controversy: How to treat troubled children who have explosive rages and dramatic mood swings that defy conventional diagnosis.

Doctors increasingly agree that some of these children have bipolar disorder. Once thought to be exceedingly rare among children, the problem is being diagnosed more frequently and at younger ages than ever before. A small but growing group of psychiatrists say they are treating children as young as four for bipolar disorder, prescribing mood-stabilizing drugs and antipsychotics that have rarely if ever been used on patients so young.

The number of children diagnosed as bipolar rose 26% from 2002 to 2004, to 19,776 cases in a database of 113 million anonymous patient records kept by health-care information company NDCHealth Corp. Increased use of antipsychotic medicines, such as Seroquel and Risperdal, was a big driver of pediatric drug costs last year, according to pharmacy-benefit manager Medco Health Solutions Inc.

A debate is brewing over how to diagnose and treat these children. In its classic form, bipolar disorder causes people to cycle between manic, euphoric highs and crushing, depressive lows that last a week or more. The picture in children often is muddier. A bipolar child can flip between a high and low several times a day. There also is disagreement over what constitutes the highs, with some doctors saying the manic phase in children often reveals itself as extreme rages, violence and emotional outbursts, rather than the traditional euphoria.

Making diagnosis even harder is the great overlap between the symptoms of bipolar and attention deficit hyperactivity disorder. Research has shown that 50% to 80% of children with bipolar also have ADHD.

"We all agree that kids with classic symptoms definitely have bipolar," says Boris Birmaher, professor of psychiatry and director of a pediatric bipolar clinic at the University of Pittsburgh. "The controversy is over the kids with vaguer symptoms."

The debate is a key topic at the annual meeting of the American Psychiatric Association this week in Atlanta, where two camps are airing theories about which children are actually bipolar and how to treat them. One group, led by Joseph Biederman and Janet Wozniak of Massachusetts General Hospital in Boston, argues that a child displaying violent outbursts and rages is likely bipolar even without classic weeklong manic symptoms that help define the disorder in adults. The opposing group is led by Barbara Geller, at Washington University in St. Louis, who believes children should display the textbook grandiose feelings or elated moods. In their practices, many pediatric doctors who treat bipolar disorder fall somewhere in between and follow the treatment guidelines for adults.

The difference between the two positions isn't just academic. Children incorrectly diagnosed with bipolar would be given powerful mood-stabilizing medications they may not need, such as lithium or Depakote, or a so-called atypical antipsychotic such as Zyprexa or Risperdal -- few of which have been tested in children and all of which carry serious side effects. Lithium can cause thyroid problems and increased thirst, while the atypical antipsychotics can cause serious weight gain.

If a bipolar diagnosis is missed, children are likely to be put on antidepressants such as Zoloft, or ADHD drugs such as Adderall, both of which can actually push bipolar children into a manic mode. Indeed, some psychiatrists believe the whole flap linking antidepressants with a heightened risk of suicide in children may be explained by the fact that these children really were bipolar and not depressed.

A number of studies are exploring the diagnosis and treatment of bipolar children. Among the research is a large, six-year study at the Washington University School of Medicine and five other sites, funded by the National Institutes of Health, that is trying to determine which medications work best in bipolar patients who are six to 15 years old. The NIH is conducting another trial that will follow 700 children ages 6 to 17 to try to map what bipolar looks like in children.

Dr. Biederman's group at Massachusetts General recently presented a small study of 39 children

ages 4 to 6, which showed that those with bipolar benefited from treatment with antipsychotic drugs, though with significant side effects including increased appetite and sedation. The study was funded by the nonprofit Stanley Medical Research Institute, the NIH and the hospital itself. Dr. Biederman's group has received research funds from makers of atypical antipsychotics. He and Dr. Wozniak also consult for some drug makers.

Ann Elliott's daughter, Chloe, was given Prozac for depression when she was six years old, after a two-year history of rages, giddy spells and self-destructive behavior, including bashing her head against a bathroom sink. Within a month of starting on the drug, she became mean and manic, says Ms. Elliott, a computer programmer from Northern California. Prozac was stopped. Chloe later was diagnosed as bipolar. Now eight, she is doing well on Trileptal, a mood stabilizer, and Abilify, an antipsychotic.

Such extreme behavioral problems fall under an umbrella of symptoms called "irritability" that Dr. Biederman and Dr. Wozniak think is central to bipolar in kids. These children can have three-hour rages touched off by something as routine as being told to brush their teeth. The rest of their families walk on eggshells, never knowing what could set the children off. Dr. Wozniak says these children are bipolar, even though their symptoms differ from those seen in adults.

Dr. Geller and other psychiatrists, however, point out that "irritability" can be found in many illnesses, like depression, autism and retardation. The scientific data aren't yet convincing, she says, to show that children who have rages, but not the conventional manic symptoms, ac tually have bipolar disorder.

In a study funded by the NIH, Dr. Geller for four years followed 86 children whom she identified as bipolar. She identified grandiosity and elated mood as two key symptoms. Since the two symptoms aren't present in ADHD, Dr. Geller says, grandiosity and elation can distinguish the children with bipolar from those with ADHD. She concedes that current science can't give clear answers. "We need biological tests or markers," she says. However, genetic tests or brain scans are probably decades away.

Doctors say parents with such troubled children should consult with a child psychiatrist who specializes in bipolar disorder at a large academic medical center, where much of the research on bipolar children is done. The Child and Adolescent Bipolar Foundation Web site at www.bpkids.org also may be a helpful source.

Making a diagnosis can take months. It can involve interviews with the child, parents, teachers and siblings, and even observation of the child at school or at home.

It took more than eight years for doctors to diagnose Sue Cahalan's daughter with bipolar disorder. The girl had tantrums and violent fits going back to age 4. At age 8, she stole from family and neighbors. At 10, she tried to choke her mother in an argument over the telephone. At 12, Ms. Cahalan came home to find her daughter holding a butcher knife outside the upstairs bathroom in which she had locked her two younger siblings. "The psychiatrist said he was finally ready to call it bipolar," says Ms. Cahalan, a lawyer from the Chicago area.

Her daughter was put on lithium and her condition improved. For the next few years, doctors had to tinker with her medication, but Ms. Cahalan says her daughter slowly stabilized and was able to attend high school at a residential facility and will head to college next year. "I do wonder whether things would have been different had she been diagnosed earlier," she says.