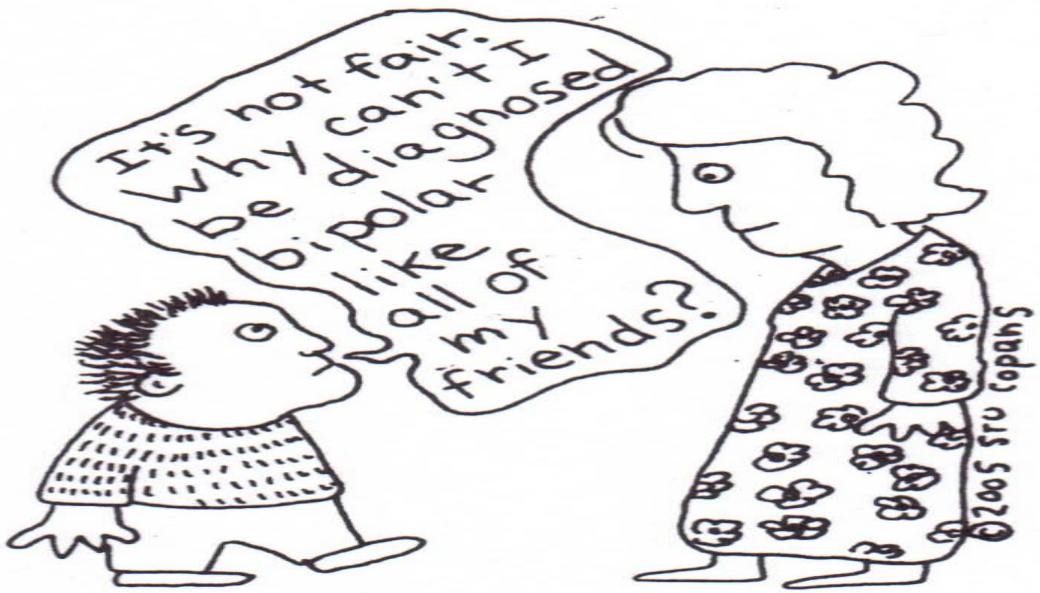
The Myth of the "Bipolar" Syndrome

Allan M. Josephson, M.D.
University of Louisville
Division of Child and Adolescent Psychiatry
CEO Bingham Clinic
September 19, 2014

Introduction

Some Personal Observations

- **Bipolar Disorder is NOT a myth**
- **The Lego Story**
- **The “aha” experience**


It's not fair. Why can't I be diagnosed bipolar like all of my friends?
©2005 sru copans

Today's Agenda

- How the "bipolar phenomenon" developed
- The role of families in self regulation

Two Key Statements Which Led to the Diagnostic shift

- Most cases have a preschool onset and irritability, not elevated mood, is bipolar disorder hallmark. (Wozniak, et. Al. 1995)
- Several cycles of mania and depression could occur in one day. (Geller and Luby, 1995)
- A narrow phenotype became a broad phenotype ("a broad net").

The "Case Example" of Child and Adolescent Bipolar Disorder

- An outpatient study indicates an increase in the frequency diagnosis of bipolar disorder in youth by 40 X in a recent 10 year period (Moreno et al, 2007)
- There is no credible scientific evidence indicating why this shift should have occurred
- We must look to diagnostic practices in child psychiatry to understand how we got into this situation.

Points of Convergence:

- Bipolar Disorder as described by Kraepelin exists in children and adolescents and may have been underdiagnosed
- Diagnostic criteria are confusing in younger patients, the older the adolescent the more the diagnosis approximates the adult form
- The further one gets from requiring discrete episodes of illness, with a return to baseline functioning, as part of the bipolar definition (i.e. non-episodic/broad), the more vague the diagnosis becomes.

Points of Convergence (cont'd)

- Impulsivity, irritability, and anger are increasingly used in clinical practice in diagnosing the condition
- These symptoms are not sensitive or specific for bipolar disorder
- Comorbidity seems very high, particularly with the Disruptive Behavior Disorder diagnoses

Points of Convergence (cont'd)

- There is growing consensus that narrowly defined Bipolar Disorder and more broadly defined disorder, Disruptive Mood Dysregulation Disorder (DMDD), are two different entities.
- In the latter condition, emotional dysregulation is usually not episodic but pervasive. (Leibenluft, 2003, 2008, 2011).
- Pervasive does include behaviorally meaningful "incidents." (e.g. "anger when he does not get his way")

Points of Convergence (cont'd)

- When followed into adulthood, the DMDD kids do not become bipolar.
- Dysregulation of mood, affect and behavior is the key clinical observation, however it is defined, it is labeled or its putative etiology.
- The family plays a key role in affective and behavioral regulation.

Diagnosis

- "The beginning of wisdom is calling things by their right name". (Leahy, 2004)
  - dia: "through"
  - gnosis: "to know"

Thoughts on Diagnosis

- DSM IV and DSM V are not homogeneous documents (McHugh, 2001; 2005).
- These documents include diseases (what the patient has); dimensions (who the patient is); behavior (what the patient does)
- Could these kids have evolving personality disorders?

The Answer

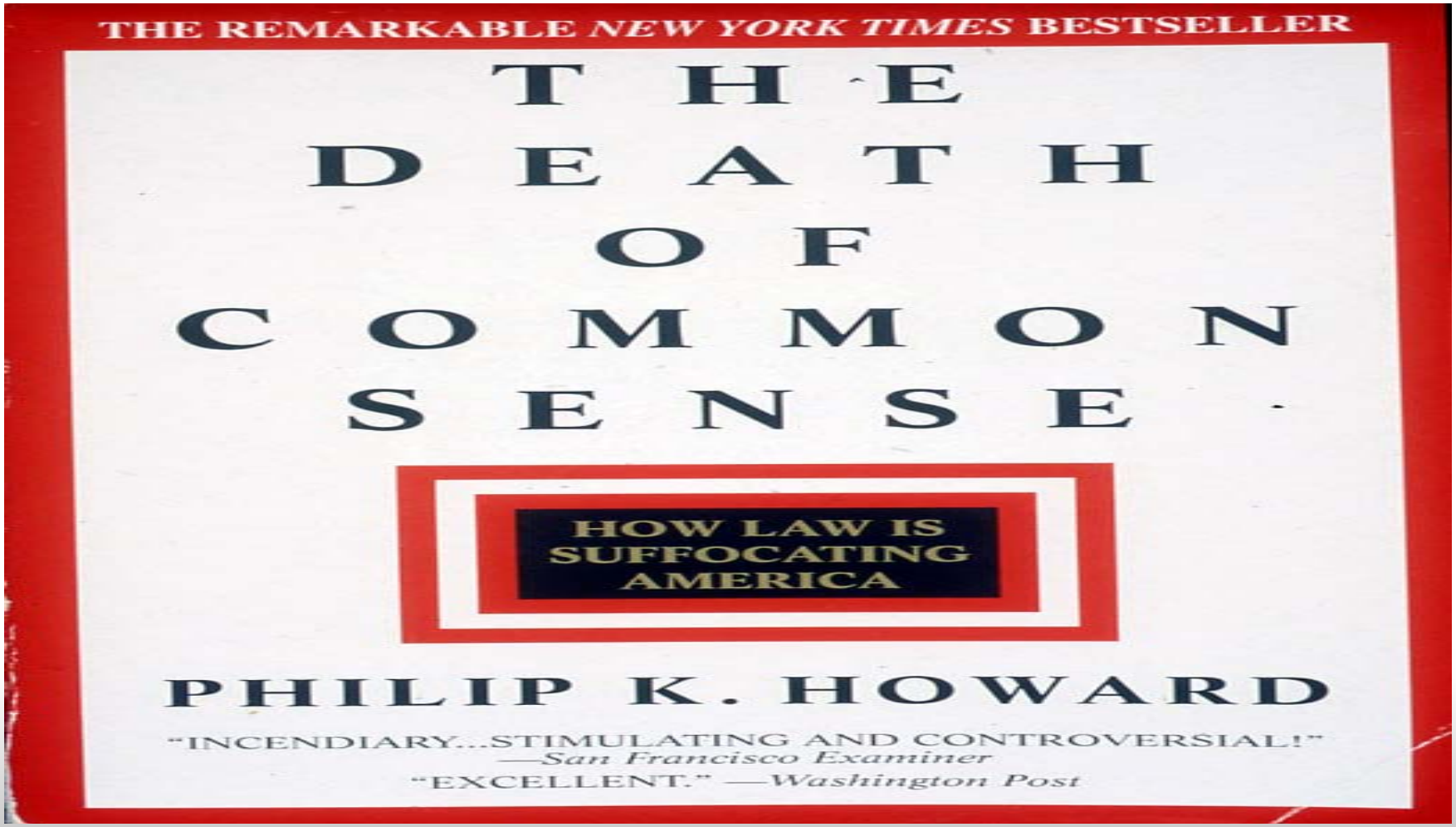
- The “bipolar controversy” arose when conditions became identified as “diseases” rather than characterized by “dimensions” and “behaviors”.
- We must distinguish between what the patient “has” (episodic) and who the patient “is” and what the patient “does” (non-episodic)

How Did This Happen?

- To some extent this is an historical problem, new diagnoses get overused.
- But there are contemporary shifts:
  - Psychiatrists spend less time with patients
  - Longitudinal care more difficult in training
  - Economics/insurance revolution
  - Pharmaceutical industry – “marketing based medicine”

How? (Cont'd)

- The unintended consequence of an "atheoretical" DSM
- Advances in the field emphasize neuroscience


THE REMARKABLE NEW YORK TIMES BESTSELLER
THE DEATH OF COMMON SENSE
HOW LAW IS SUFFOCATING AMERICA
PHILIP K. HOWARD
"INCENDIARY...STIMULATING AND CONTROVERSIAL!"
—San Francisco Examiner
"EXCELLENT." —Washington Post

The Psychoeducation Approach

- “You have a disease”
- Learn to spot the warning signs
- Encourage medication compliance
- Develop healthy family relationships as protective
- Minimize triggering effects of environmental stress
- Learn stress reduction and communication techniques

Family Intervention Approach

- Here the clinician attempts to help families change relationships and interactions associated with dysregulated affect and behavior of their children
- Families are not epiphenomena, but central to the etiology of dysregulation and its resolution
- The clinician formulates the family's role in regulation of affect (anger;irritability) and behavior (impulsivity)

Families and Child Development

- Child development literature indicates families regulate all aspects of child development, especially affect and behavior.
- Parents contribute in multiple ways to the children's developing executive functions and inhibitory competencies
- Regulation occurs within a relationship.

A Clinical Guide to Family Regulation

- **Patterns of regulation:**
  - **appropriate**
  - **overregulation**
  - **underregulation**
  - **inappropriate**
  - **irregular**
  - **chaotic (Anders,1989):**

The Family's Regulatory Influence: A guide to Intervention

- Anger, impulsivity and irritability – "The big three".
- Given family life experience, there is meaning to this dysregulated behavior
- Dysregulated behavior and affect are somewhat predictable.
- Symptoms generated and maintained by family interaction.

ANGER

- **“He gets rageful, destructive, angry when he doesn’t get his way”.**
- **Anger is precipitated by frustration of the immediate gratification of a felt need.**

Grandiosity and entitlement is who they are, it means something.

IMPULSIVITY

- Impulsivity exists on a biologic spectrum.
- Behavioral action before full appraisal of the situation.
- Parents need to be available to empathically teach what is acceptable and what is not.

IRRITABILITY

- All children have poorly regulated, irritable behavior at some point in development.
- This type of moodiness is often difficult for parents to accept – mismatch.
- Parental understanding of temperament and developmental norms is often lacking.

The Pre-eminence of Attachment

- Attachment relationships affect all three prominent symptoms: anger,impulsivity, and irritability.
- Deficits in attachment are associated with:
  - entitlement born of parents too available or unavailable.
  - minimal behavior repetition of modulation of impulsivity
  - few opportunities for learning to self soothe and monitor one's own irritability

Key Perspectives

- When do mood/affect and behavior shift?
- They often shift in response to events which have meaning for the child (eg. Lego Boy)
- Mood and affect also shift related regulatory functions which have not been internalized due to deficient learning
- Meaning is enhanced by contextual data

- Beck AT (1991) Cognitive therapy: A 30-year retrospective. *Am Psychol* 46, 368-375.
- Carlson GA, Glovinsky I (2009) The concept of bipolar disorder in children: A history of the bipolar controversy. *Child Adolesc Psychiatric Clin N Am* 18, 257-271.
- Fonagy P, Target M. (1997) Attachment and reflective function: Their role in self-organization. *Development and Psychopathology,* 9, 679-700.
- Jensen PS, Hoagwood K (1997) The book of names: DSM-IV in context. *Development and Psychopathology* 9, 231-249.

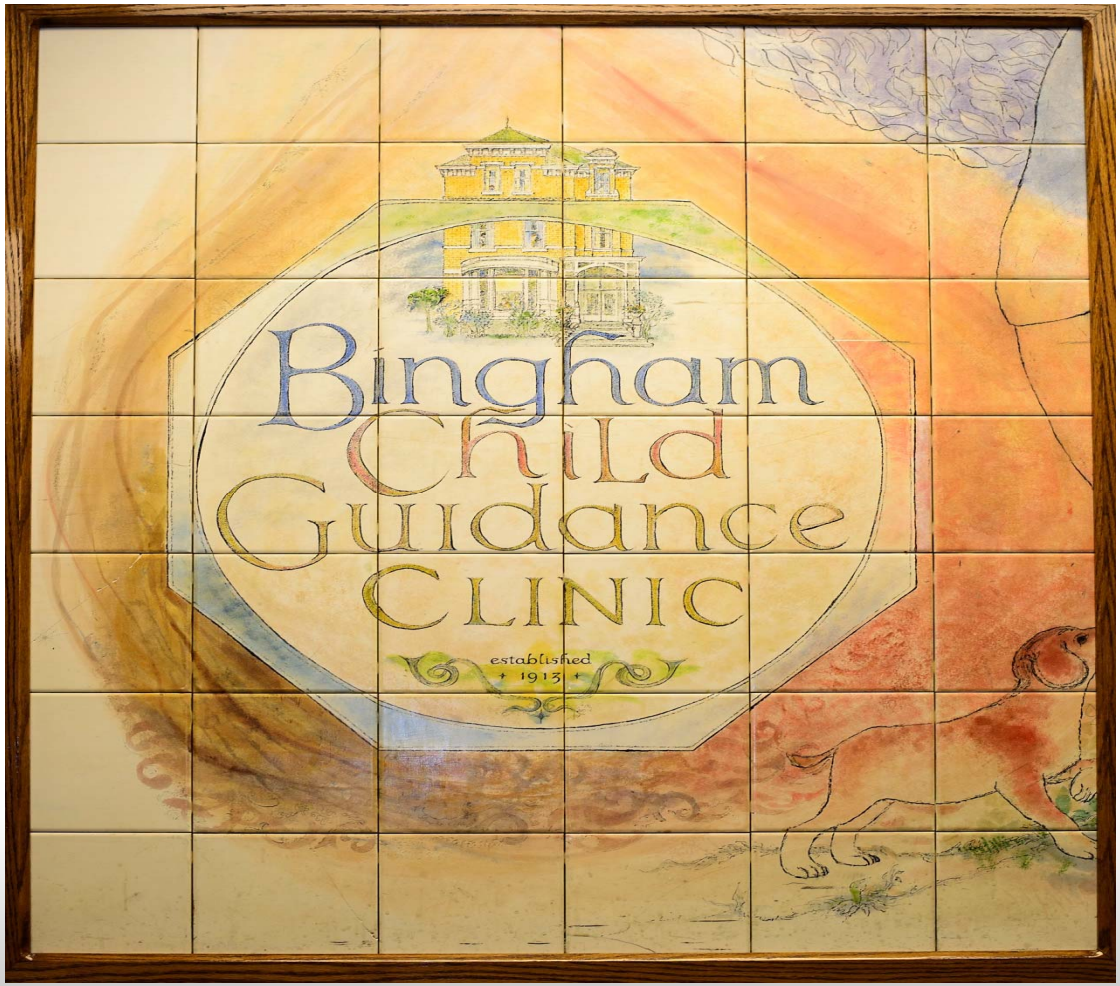
- Josephson AM (2008) Reinventing family therapy: Teaching family intervention as a new treatment modality. *Academic Psychiatry* 32:5, 405-413.
- Josephson AM, Serrano A (2001) The integration of individual therapy and family therapy in the treatment of child and adolescent psychiatric disorders. *Child Adolesc Psychiatric Clin N Am* 10:3, 431-450.
- Klinnert MD. et al (1983) Emotions as behavior regulators: Social referencing in infancy. In R. Plultchik and H. Kellerman (Eds.), *Emotion: Theory, research and experience, Vol. 2*. Academic Press, New York.
- Leahy CW (2004) *The Birdwatcher's Companion to North American Birdlife*. Princeton University Press, Princeton, 786.

- Leibenluft E et al (2003b) Defining clinical phenotypes of juvenile mania. *Am J Psychiatry* 160:3, 430-437.
- McHugh PR (2005) Striving for coherence: Psychiatry's efforts over classification. *JAMA* 293:20, 2526-2528.
- Meyer SE, Carlson GA (2008) Early-onset bipolar disorder. *FOCUS: The Journal of Lifelong Learning in Psychiatry* 6:3, 271-283.
- Parry PI, Levin EC (2012) Pediatric Bipolar Disorder in an Era of "Mindless Psychiatry". *Journal of Trauma & Dissociation* 13:51-68.

- Rice F et al (2006) Family conflict interacts with genetic liability in predicting childhood and adolescent depression. *J Am Acad Child Adolesc Psychiatry* 45:7, 841-848.
- Rich, BA et al (2007) Different psychophysiological and behavioral responses elicited by frustration in pediatric bipolar disorder and severe mood dysregulation. *Am J Psychiatry* 164:2, 309-317.
- Siegel DJ. (1999) *The Developing Mind:Toward a Neurobiology of Interpersonal Experience.* The Guilford Press, New York.

- Rice F et al (2006) Family conflict interacts with genetic liability in predicting childhood and adolescent depression. *J Am Acad Child Adolesc Psychiatry* 45:7, 841-848.
- Rich, BA et al (2007) Different psychophysiological and behavioral responses elicited by frustration in pediatric bipolar disorder and severe mood dysregulation. *Am J Psychiatry* 164:2, 309-317.
- Siegel DJ. (1999) *The Developing Mind:Toward a Neurobiology of Interpersonal Experience.* The Guilford Press, New York.

- Stern, D. (1985) *The Interpersonal World of the Infant.* Basic Books, Inc., New York.
- Weissman MM et al (2006) Remissions in maternal depression and child psychopathology: A STAR D-child report. *JAMA* 295:12, 1389-1398.


Bingham
Child
Guidance
Clinic
established
1913

ADHD vs. Bipolar Cases

Allan M. Josephson, M.D.

September 19, 2014

Use the Course of Disorder, Not Symptom Collection

"ADHD and Bipolar share multiple symptoms:

- Insomnia
- Distractibility
- Flight of ideas
- Pressured speech
- Intrusiveness
- Irritability/anger"

Case of TM

- Anger and disruptive behavior are pervasive.
- Daily irritable moods are “who she is”, not an illness.
- What do we do when parents say “She never sleeps.”
- Her poor attitude/disruptive behavior, and lying suggest an evolving (eventual?) personality disorder.

Case of TM (cont'd)

- Entitlement engenders paranoia; no friends.
- There are obvious systemic problems: father's perceived incompetence, "four against one."
- DMDD is it, with caveat: It is not a disease.

Treatment Issues

- Individual therapy will not be effective.
- The marital unit is foundational – father is needed to control the child but parents do not work together.
- An individual therapist at school while father is not involved will not get it done.
- Medications are an adjunct to blunt impulsivity – 15 % of the variance?

Case of L

- What does euphoria mean in a seven year old?
- This child is also entitled – threatening the MD!
- The family has three symptomatic children, with the brother likely misdiagnosed. Bipolar patients do not require long term placement with comorbid personality pathology.
- Cursing and work refusal: are not symptoms of disease. Common sense is not common.

Case of L (cont'd)

- What mother walks out on her children? This is profound and suggests a lifetime of parental inadequacy which has engendered abandonment fears now projected on to stepmother.
- The child who threatens suicide with limits – what do we do?
- The iatrogenic drug problem.
- DMDD is it, with a caveat: The patient does not have a disease.

Treatment

- Work with stepmother – she knows what limits need to be set.
- Engage father to take care of second marriage!
- This is not rocket science - the child knows “he goes nuts when he does not get his way.”
- Instruct the family in what medications and cannot do. “The family was frustrated with the limited effect on mood.”
- Provide instruction in Parent Management Training. Why didn’t it work the first time?