Inflated Self-Esteem or Grandiosity:

- Believing, talking or acting as if he is considerably better at something or has considerably better at something.
- Irritability: Energized, angry, raging, or irritable mood, "out of the blue" or as an inappropriate reaction to external events for an extended period of time.
- Inflated Self-Esteem or Grandiosity: Believing, talking or acting as if he is considerably better at something or has special powers or abilities despite clear evidence to the contrary.

Diagnosis: Manic Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphoria</td>
<td>A child laughs hysterically for 30 minutes after a mildly funny comment by a peer and despite other students staring at him.</td>
</tr>
<tr>
<td>Irritability</td>
<td>In reaction to meeting a substitute teacher, a child flies into a violent 20-minute rage.</td>
</tr>
<tr>
<td>Inflated Self-Esteem or Grandiosity</td>
<td>A child believes and tells others she is able to fly from the top of the school building.</td>
</tr>
</tbody>
</table>

Diagnosis: Manic Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased Need for Sleep:</td>
<td>Despite only sleeping 3 hours the night before, a child is still energized throughout the day.</td>
</tr>
<tr>
<td>Increased Speech:</td>
<td>A child suddenly begins to talk extremely loudly, more rapidly, and cannot be interrupted by the teacher.</td>
</tr>
<tr>
<td>Flight of Ideas or Racing Thoughts:</td>
<td>A teacher cannot follow a child's rambling speech that is out of character for the child (i.e., not related to any cognitive or language impairment the child might have).</td>
</tr>
</tbody>
</table>

Diagnosis: Manic Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distractibility:</td>
<td>A child is distracted by sounds in the hallway, which would typically not bother her.</td>
</tr>
<tr>
<td>Increase in Goal-Directed Activity</td>
<td>A child starts to rearrange the school library or clean everyone's desks, or plan to build an elaborate fort in the playground, but never finishes any of these projects.</td>
</tr>
<tr>
<td>Excessive Involvement in</td>
<td>A previously mild-mannered child may write dirty notes to the children in class or attempt to jump out of a moving school bus.</td>
</tr>
</tbody>
</table>

Hypomanic Episode

- Similarities with Manic Episode =
  - Same symptoms
  - Rule Outs (i.e., due to substance or general medical condition)
- Differences =
  - Length of time
  - Impairment not as severe
  - Tend to be not as recognizable; may be seen as signs of well-being
  - Believed to play huge part in under & missed diagnosis.
  - Red flags = decreased need for sleep & lack of daytime fatigue.
Developmental Aspects

- Bipolar Disorder in childhood and adolescence appear to be the same clinical entity.
- However, there are significant developmental variations in illness expression.

### Most frequently reported symptoms

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed Mood: Feels or looks sad or irritable (low energy) for an extended period of time.</td>
<td>A child appears down or flat or is cranky or grumpy in class and on the playground.</td>
</tr>
<tr>
<td>Markedly Diminished Interest or Pleasure in All Activities: Complains of feeling bored or finding nothing fun anymore.</td>
<td>A child reports feeling empty or bored and shows no interest in previously enjoyable school or peer activities.</td>
</tr>
<tr>
<td>Significant Weight Loss/Gain or Significant Weight Lost/Gain or significant change in appetite.</td>
<td>A child looks much thinner and draws or has a great deal heavier, or has no appetite or an excessive appetite at lunch time.</td>
</tr>
</tbody>
</table>

From Lofthouse & Fristad (2006, p. 216)

### Diagnosis: Major Depressive Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia or Hypersomnia: Difficulty falling asleep, staying asleep, waking up too early or sleeping longer and still feeling tired.</td>
<td>A child looks worn out, is often grumpy or fussy, or reports sleeping through alarm despite getting 12 hours of sleep.</td>
</tr>
<tr>
<td>Psychomotor Agitation/Retardation: Looks restless or slowed down.</td>
<td>A child is extremely fidgety or can’t stay seated. His speech or movement is sluggish or he avoids physical activities.</td>
</tr>
<tr>
<td>Fatigue or Loss of Energy: Complains of feeling tired all the time.</td>
<td>Child looks or complains of constantly feeling tired even with adequate sleep.</td>
</tr>
</tbody>
</table>

From Lofthouse & Fristad (2006, p. 216)

### Diagnosis: Major Depressive Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Self-Esteem, Feelings of Worthlessness or Excessive Guilt: Thinking and saying more negative than positive things about self or feeling extremely bad about things one has done or not done.</td>
<td>A child frequently tells herself or others “I’m no good, I hate myself, no one likes me, I can’t do anything.” She feels bad about and dwells on accidentally bumping into someone in the corridor or having not said hello to a friend.</td>
</tr>
<tr>
<td>Diminished Ability to Think or Concentrate, or Indecisiveness: Increased indecisiveness beyond child’s baseline attentional capacity, difficulty stringing thoughts together or making choices.</td>
<td>A child can’t seem to focus in class, complete work, or choose unstructured class activities.</td>
</tr>
</tbody>
</table>

From Lofthouse & Fristad (2006, p. 216)

### Diagnosis: Major Depressive Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hopelessness: Negative thoughts or statements about the future.</td>
<td>A child frequently thinks or says “nothing will change or will ever be good for me.”</td>
</tr>
<tr>
<td>Recurrent Thoughts of Death or Suicidality: Obsession with morbid thoughts or events, or suicidal ideation, planning, or attempts to kill self.</td>
<td>A child talks or draws pictures about death, war casualties, natural disasters, or famine. He reports wanting to be dead, not wanting to live anymore, wishing he’d never been born; he draws pictures of someone shooting or stabbing him, writes a suicide note, gives possessions away or tries to kill self.</td>
</tr>
</tbody>
</table>

From Lofthouse & Fristad (2006, p. 216)

### Most frequently reported symptoms

(Outpatient sample, aged 7-20)

- Depression
- Anger
- Anxiety
- Insomnia
- Fatigue
- Difficulty concentrating
- Difficulty falling asleep
- Suicidal ideation
- Family problems
- School problems
- Physical symptoms
- Sleep disturbances
- Appetite changes
- Weight loss/gain

From Jerrell & Shugart (2004)

### Developmental Aspects

- Bipolar Disorder Onset
  - Childhood: 67.5%
  - Adolescent: 48.2%
- Chronic Course: 57.5%
- Episodic Course: 42.5%
- Attention-deficit/Hyperactivity Disorder: 38.7%
- Oppositional Defiant Disorder: 35.9%

Mazi et al. (2006)
"Until we know more about the underlying causes of child psychiatric disorders, no diagnosis should be discounted because another disorder is present…"

---Dr. Demitri Papolos (The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder (3rd ed.). p.47.

### Comorbidity (in children)*

<table>
<thead>
<tr>
<th>DISORDER</th>
<th>Weighted Rate</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>62%</td>
<td>(29-87)</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder (ODD)</td>
<td>53%</td>
<td>(25-79)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>42%</td>
<td>(24-62)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>27%</td>
<td>(15-43)</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>19%</td>
<td>(11-30)</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>12%</td>
<td>(5-29)</td>
</tr>
</tbody>
</table>

*Adapted from Kowatch et al. (2005)

### Additional Differentiation Factors

- Family history
- Intense affective rages
- **Parent-Young Mania Rating Scale (P-YMRS)** is an effective tool to differentiate (cut scores of 11-efficient & 26-sufficient; Gracious, Youngstrom, Findling, & Calabrese, 2002).

### ADHD + Bipolar Disorder

- 10-30% of individuals with ADHD will develop bipolar disorder
- This comorbidity is associated with poorer prognosis
- Comorbidity more frequent with ADHD combined-type (over 25%), but is also elevated among hyperactive-impulsive type (14%) and inattentive type (8%).

### ADHD Criteria Comparison

#### Bipolar Disorder (mania):

1. More talkative than usual, or pressure to keep talking
2. Distractibility
3. Increase in goal directed activity or psychomotor agitation

#### ADHD:

1. Often talks excessively
2. Is often easily distracted by extraneous stimuli
3. Is often “on the go” or often acts as if “driven by a motor”

Even subtracting these criteria, individuals typically continue to meet criteria for both disorders.
ADHD... Assistance

- Age of onset
- Dysphoric mood
- Family history
- Destructiveness, misbehavior, & harmful behaviors
- Manic symptoms after stimulants introduced
- Psychotic features

Conduct Disorder

- Aggression & provoking-types of behaviors are frequently seen in children with bipolar disorder.
- Many of the medications used to treat bipolar disorder have an impact on aggressive behaviors.
- Differences may include:
  - Family history
  - Nature of aggression seen
  - Control & remorse
  - Social impairments
  - Psychotic features

Unipolar Depression

- Approximately 50% of individuals diagnosed with MDD will switch to bipolar disorder.
- Depression typically index episode
- Look for:
  - Signs of hypomania (decreased need for sleep, lack of daytime fatigue)
  - Atypical triad of depressive symptoms (overeating, oversleeping, & excessive physical fatigue)
  - Unexpected response to medications

Schizophrenia

- Psychosis is not synonymous with schizophrenia.
- Genetic connections between the two disorders.
- Key differences:
  - Delusions & hallucinations
  - Family history

Concluding Comments

- DSM-V may help us in this area...
- At present it may be more useful to think in terms of comorbidity rather than differentiation.
- Much more research in this area is needed to make definitive statements.

References


References (cont.)


