Introduction to Youth Bipolar Disorder

Dr. Benjamin Goldstein, Centre for Youth Bipolar Disorder, CAMH

October 11, 2023
6 – 7 PM (EST)

camh

Land acknowledgement

CAMH is situated on lands that have been occupied by First Nations for millennia; lands rich in civilizations with knowledge of medicine, architecture, technology and extensive trade routes throughout the Americas. In 1860, the site of CAMH appeared in the Colonial Records Office of the British Crown as the council grounds of the Mississaugas of the New Credit, as they were known at the time. Today, Toronto is covered by the Toronto Purchase, Treaty No. 13 of 1805 with the Mississaugas of the Credit. Toronto is now home to a vast diversity of First Nations, Inuit and Métis who enrich this city.

CAMH is committed to reconciliation. We will honour the land through programs and places that reflect and respect its heritage. We will embrace the healing traditions of the Ancestors, and weave them into our caring practices. We will create new relationships and partnerships with First Nations, Inuit and Métis – share the land and protect it for future generations.

Reference: https://www.camh.ca/en/driving-change/building-the-mental-health-facility-of-the-future

AGENDA

1. About the webinar hosts
2. About today's speakers
3. Presentation: Introduction to Youth Bipolar Disorder
4. Q&A session

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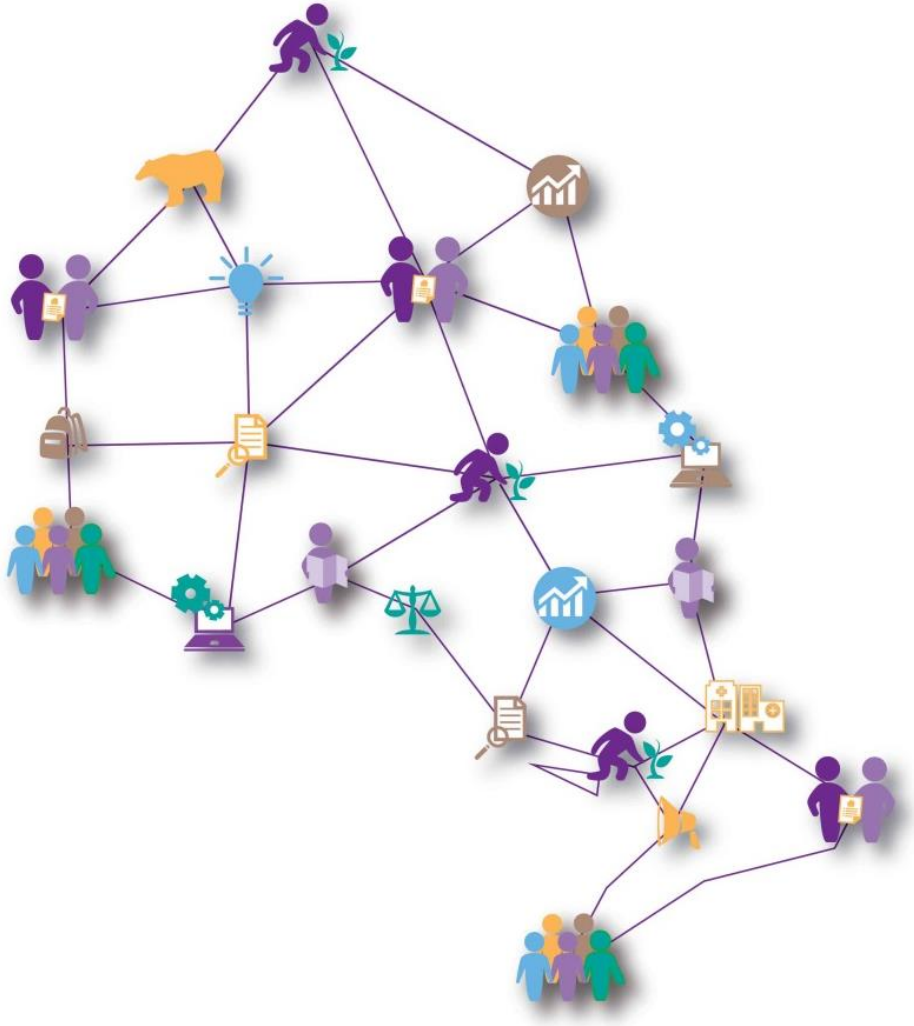
About the webinar hosts

CAMH's Provincial System Support Program (PSSP)

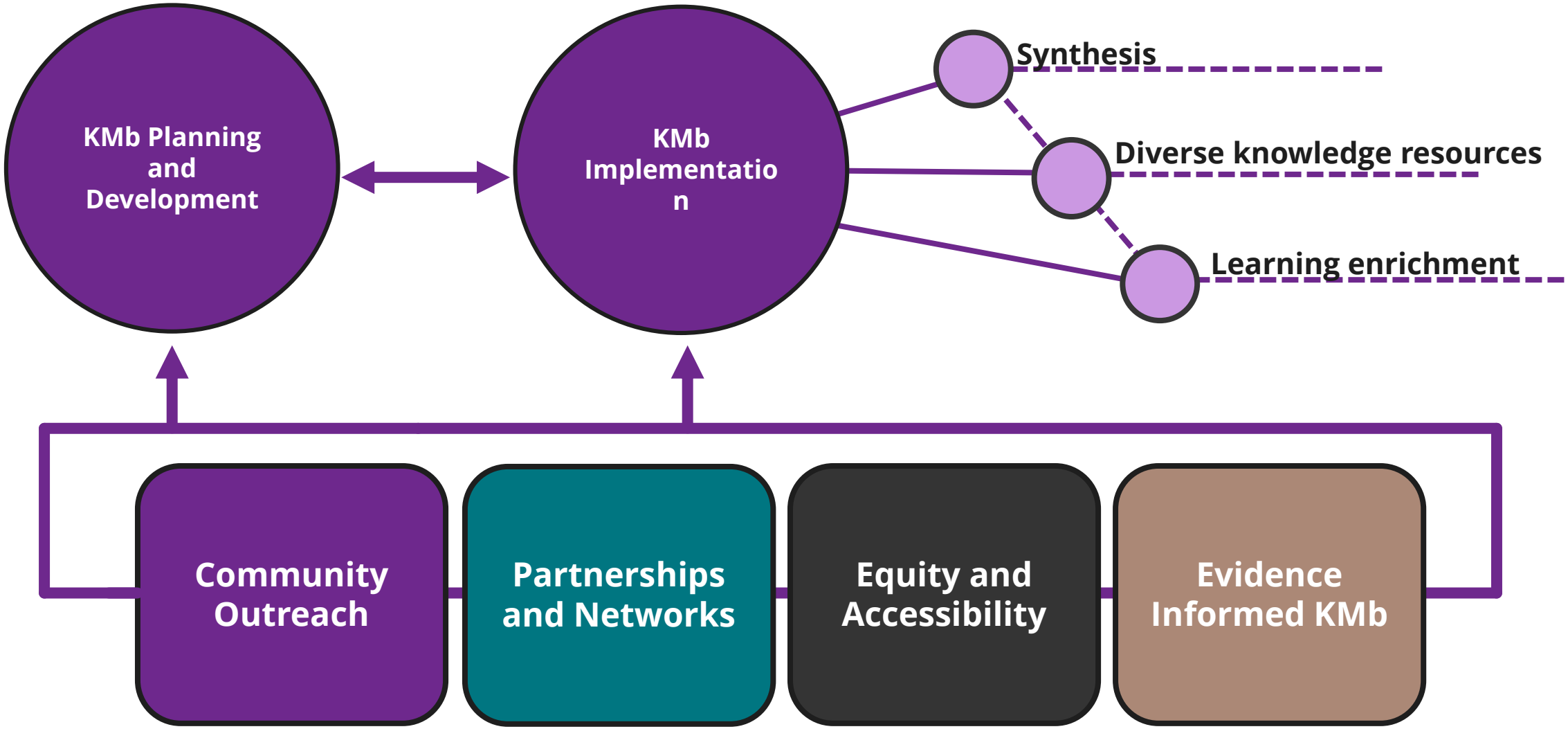
Our Knowledge Mobilization (KMb) team sits within PSSP at CAMH.

PSSP is on the ground collaborating with partners to build a more evidence-informed system, through our work and expertise in:

- knowledge mobilization
- health equity
- lived-experience engagement
- implementation
- data management
- evaluation



KMb integrated functions



The Centre for Youth Bipolar Disorder

The Centre for Youth Bipolar Disorder is a fully integrated clinical-research program that seeks to generate discoveries that are uniquely relevant to youth with bipolar disorder. CYBD's focus is on the full spectrum from biology (e.g., genetics, imaging) to clinical trials of pharmacological and psychotherapeutic interventions. CYBD is also committed to advocacy, stigma reduction and education in the field of youth bipolar disorder. You can find us at www.camh.ca/CYBD and @CYBDatCAMH.

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About the speakers

Our speakers

Tera Armel is a second year medical student at Queen's University and was originally diagnosed with bipolar disorder in Grade 12. She has since become a dedicated mental health advocate and feels that sharing her experiences provides her with a greater understanding of her own journey. She hopes she can empower others through her work as a Jack Talks speaker, President of the Jack.org Queen's Chapter and Consumer Collaborator with the Centre for Youth Bipolar Disorder.

Our speakers

Dr. Benjamin Goldstein is a child-adolescent psychiatrist and the director of CYBD. He is also a Professor of Psychiatry and Pharmacology at the University of Toronto and an Adjunct Professor of Psychiatry at the University of Pittsburgh. He completed medical training at the University of Calgary, followed by residency training in general and child-adolescent psychiatry at the University of Toronto. Dr. Goldstein holds the RBC Investments Chair in Children's Mental Health and Developmental Psychopathology at the Centre for Addiction and Mental Health.

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Introduction to Youth Bipolar Disorder

Welcome to the CYBD Webinar Series

A partnership between EENet and the Centre for Youth Bipolar Disorder

Webinar 1

SAVE THE DATE

CENTRE FOR YOUTH BIPOLAR DISORDER CELEBRATES WORLD BIPOLAR DAY!

EVENING OF

MARCH 28, 2024

Free event, open to the public

Knowledge ~ Research ~ Lived Experiences

camh | Centre for Youth Bipolar Disorder

Introduction to Youth Bipolar Disorder

Benjamin I. Goldstein, MD, PhD, FRCPC

RBC Investments Chair in Children's Mental Health & Developmental Psychopathology

Director, Centre for Youth Bipolar Disorder, Centre for Addiction and Mental Health

Professor of Psychiatry & Pharmacology

University of Toronto Temerty Faculty of Medicine

TEMERTY FACULTY OF MEDICINE
UNIVERSITY OF TORONTO

camh Centre for Addiction and Mental Health

Early-onset in Adult Bipolar Disorder

- 32-65% of adults have onset ≤18yo
- More comorbid anxiety, substance abuse
- More episodes and symptoms
- More psychosis, suicidality, and violence
- Longer delay until treatment
- Greater functional impairment
- Earlier recurrence after remission
- **Less time well**

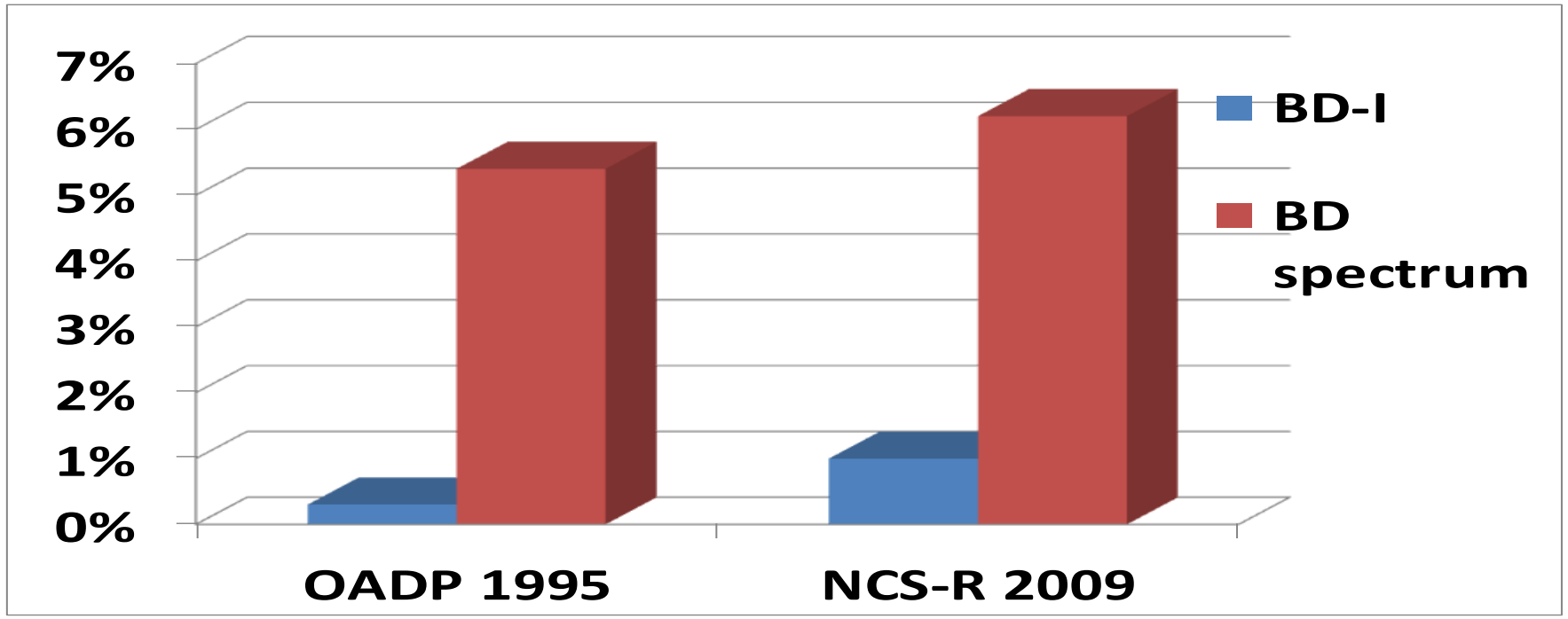
Goldstein & Levitt, *Am J Psychiatry 2006*; Leverich et al. *J Pediatr* 2007; Perlis et al. *Biol Psychiatry* 2004; Perlis et al, *Bipolar Disord* 2009

Complexity and Under-treatment of Bipolar Disorder in Canadian Youth

	15-18yo	19-24yo
Female	**64.9%**	52.3%
Anxiety disorder	**41.8%**	48.6%
Substance abuse	**32.1%**	46.0%
Suicidality	**54.6%**	48.6%
Received treatment	**45.8%**	60.3%

Kozloff et al, *J Affect Disord* 2010

"Epidemic" of Youth Bipolar Disorder?



NCS BD-I or BD-II:
13-14yo: 1.9%
15-16yo: 3.1%
17-18yo: 4.3%

- Lifetime bipolar disorder in adolescents = 2.7%
- No significant increase over time
- No significant difference of U.S. vs. elsewhere

Lewinsohn et al, *JAACAP* 1995; Kessler et al, *JAACAP* 2009; Van Meter et al. *J Clin Psych* 2011

BIPOLAR DISORDERS
AN INTERNATIONAL JOURNAL OF PSYCHIATRY AND NEUROSCIENCES

COMMENTARY

Questions in psychiatry (QuiP): Is paediatric bipolar disorder a valid diagnosis?

Gin S. Malhi, Erica Bell

Paediatric bipolar disorder: What are the dangers of treating a hypothetical disorder as a real disease?

Stephen Allison[1], Peter Parry[1,2], Leigh Roeger[1] and Tarun Bastiampillai[1,3]

Reflections

ANZJP

Paediatric Bipolar Disorder: prepubertal or premature?

Gin S. Malhi[1,2,3], Erica Bell[1,2,3], Amber Hamilton[1,2,3] and Grace Morris[1,2,3]

Australian & New Zealand Journal of Psychiatry
2020, Vol. 54(5) 547–550
DOI: 10.1177/0004867420920365

Century-old Perspectives on Pediatric Bipolar Disorder
(from someone who knew a bit about bipolar)

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

--Emil Kraepelin, 1921

Symptoms of Mania

"A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and persistently increased activity or energy", plus:

- Increased self-esteem, grandiosity
- Decreased need for sleep
- More talkative or pressure to keep talking
- Racing thoughts, stream of ideas
- Distractible
- Increased purposeful activity
- Risky, thrill-seeking behaviors

Symptoms of Depression

"Five (or more) of the following symptoms present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure."

- Low mood or sadness
- No interest in fun activities
- Increased or decreased appetite and weight changes
- Sleeping too much or too little
- Changes in activity level
- Fatigue and loss of energy
- Feel guilty or worthless
- Difficulty concentrating
- Suicidal thoughts or actions

DSM-5 Bipolar Disorders

Bipolar I Disorder

- At least 1 Manic or Mixed Episode

Bipolar II Disorder

- At least 1 Hypomanic Episode, AND
- At least 1 Major Depressive Episode

Cyclothymic Disorder

- At least 1 year with numerous periods of hypomanic & depressive symptoms

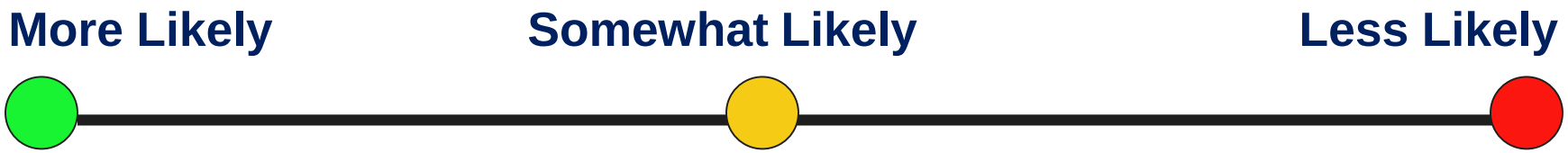
"Other Specified Bipolar and Related Disorder"

- Example: recurrent 2-day hypomanic episodes

Why is this a Challenging Diagnosis?

- Symptom overlap with other disorders
- Less time well vs. adults
- More likely to have “mixed” states, involving both manic and depressive symptoms
- Historical recall affected by current mood
- Often need repeated visits, follow-up

“Does this Youth Have Bipolar Disorder?”



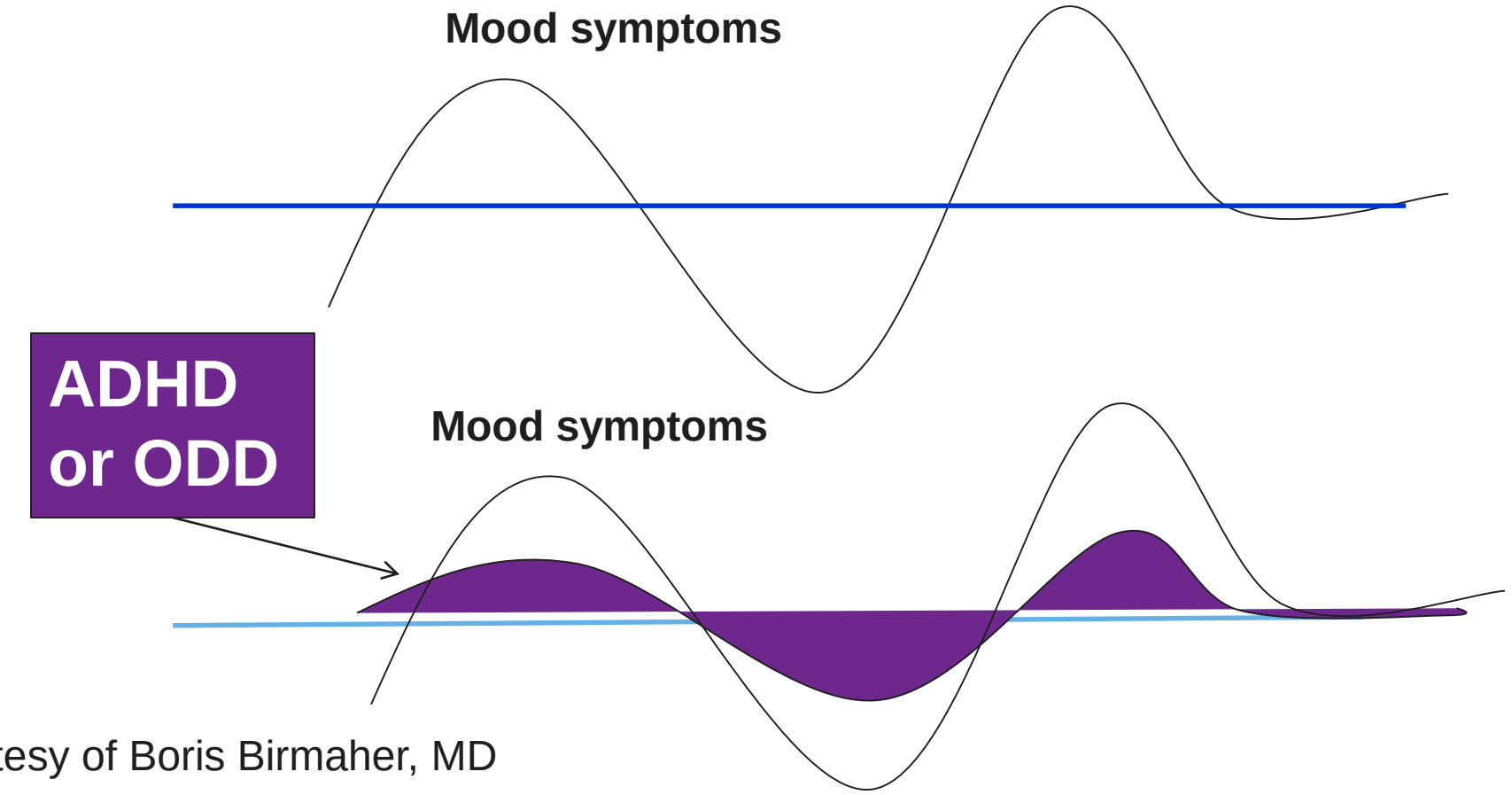
Elated, euphoric	Only Irritable
Clear periods of euthymia	Chronic mood symptoms
Previously well	“always been this way”
Family history of bipolar	Family history nonspecific
Distinguishing symptoms	No distinguishing symptoms
Clear “switch” on medication	Improves with SSRI or stimulant

Clinical Assessment Checklist

- Establish a “baseline”
- Identify an episode
- Look for a change in trajectory
- Determine onset, including precipitants
- Ensure there’s “enough”:
  - Enough symptoms
  - Enough duration
  - Enough functional impact, noticeability
  - Enough distinctiveness from comorbidities

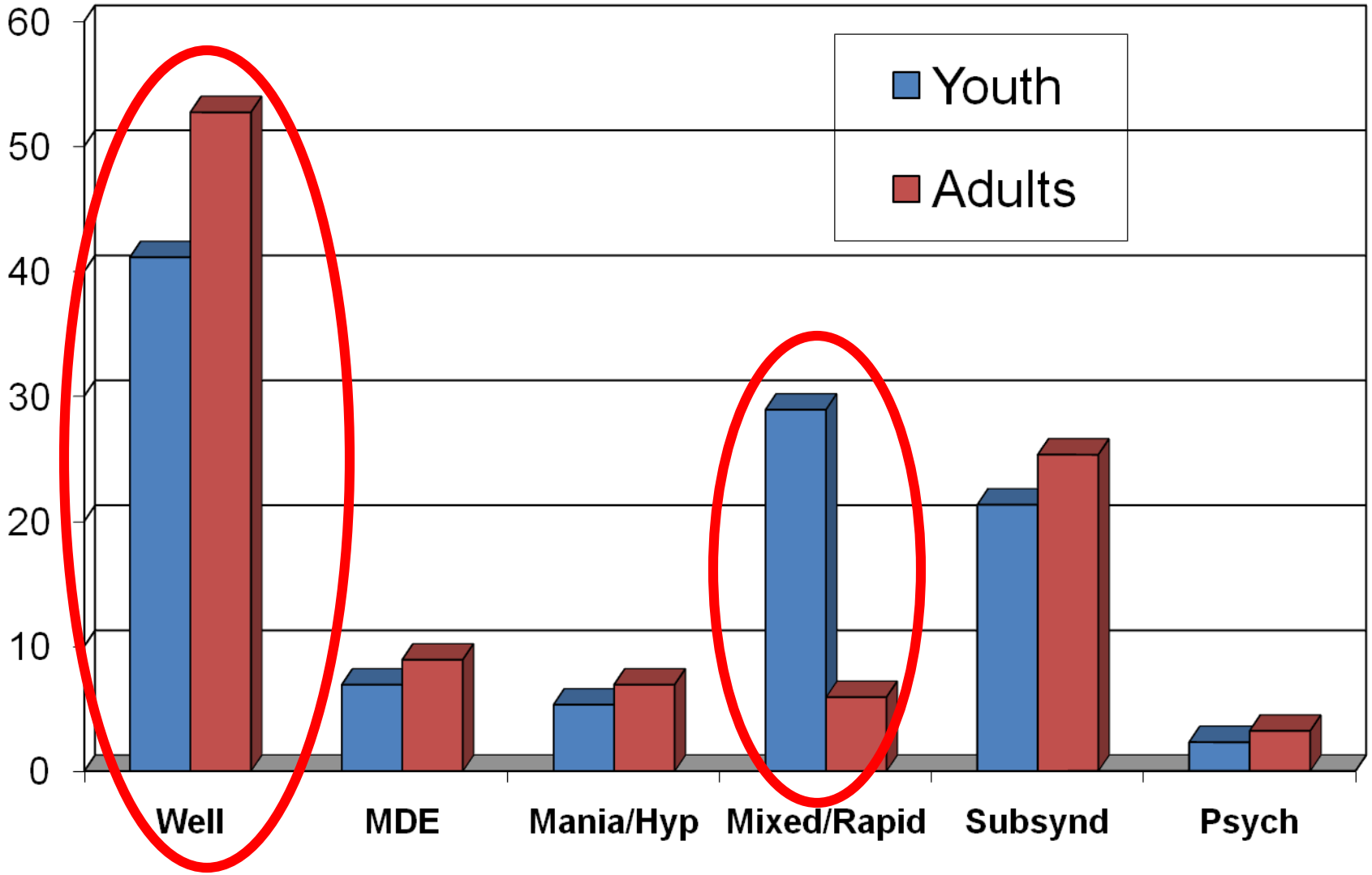
Mood Symptoms Fluctuate and are Above and Beyond Comorbid Psychiatric Disorders

For example:

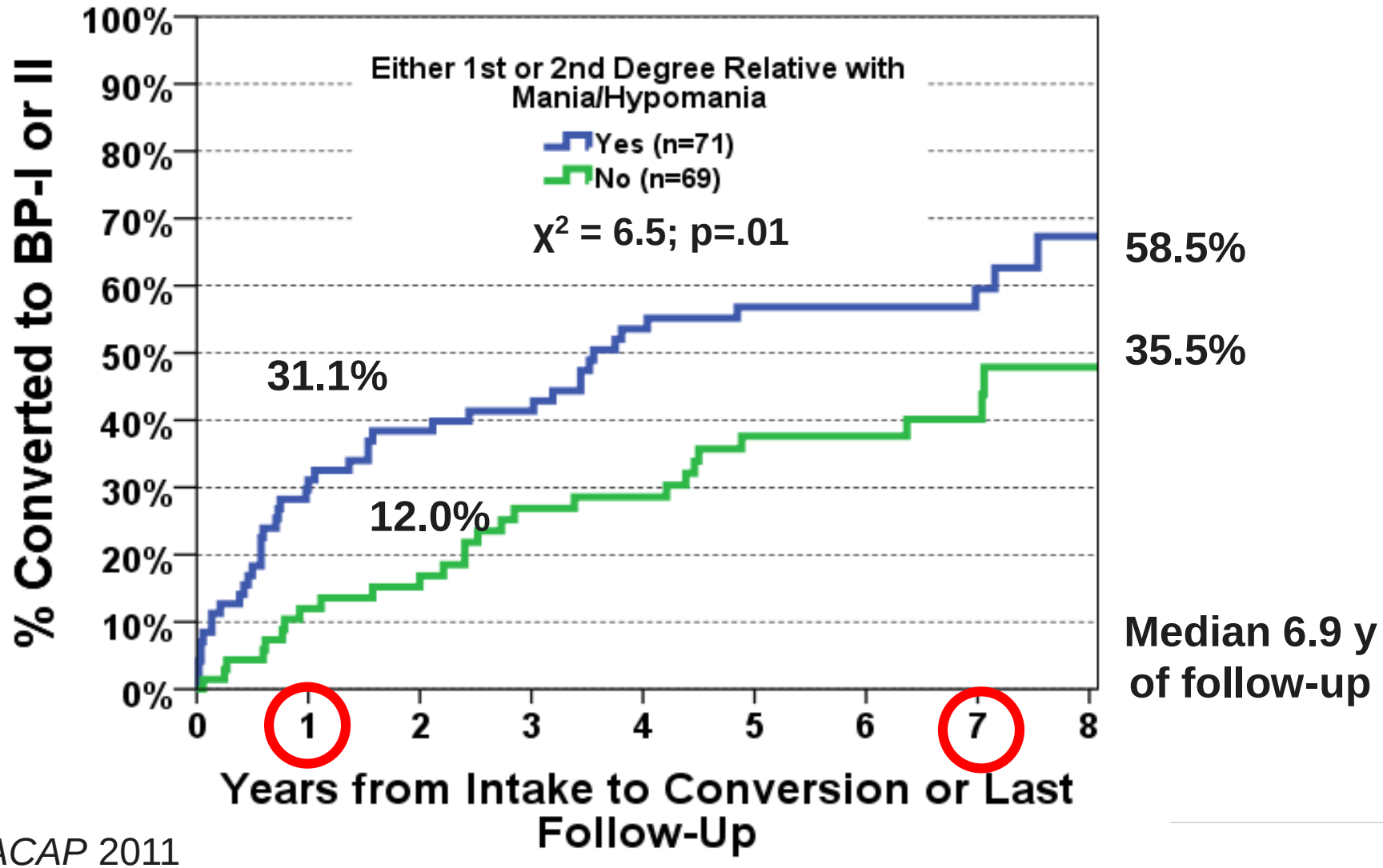


Slide courtesy of Boris Birmaher, MD

Weekly Symptoms Status Comparing Youth with BP-I (Birmaher et al., 2006) vs. Adults with BP-I (Judd et al., 2002)

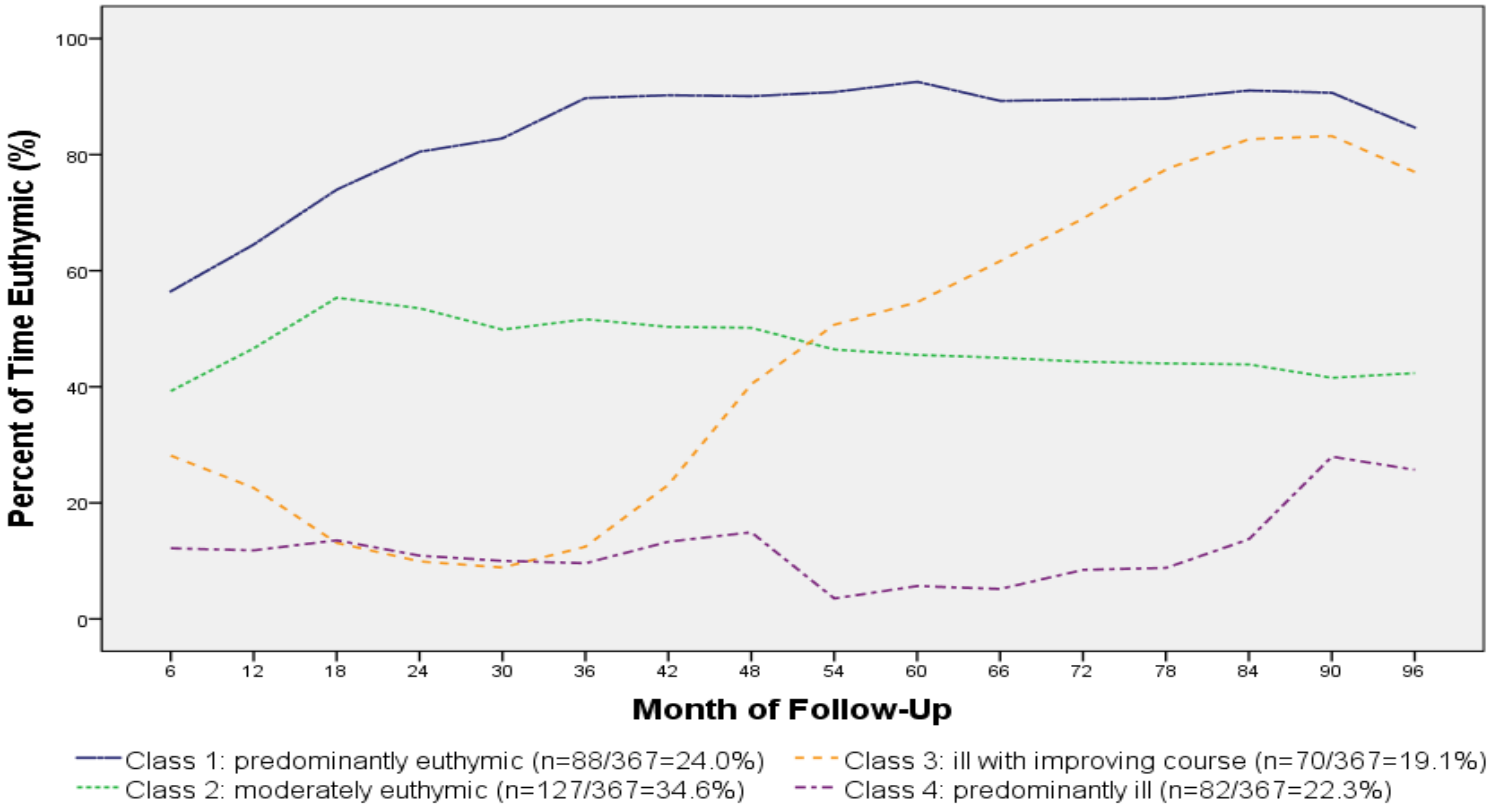


Family History Predicts Conversion from BD-NOS to BD-I or -II



Axelson et al, *JAACAP* 2011

Eight-Year Trajectories of Youth Bipolar Disorder



After 8 years: almost 50% doing very well, 25% so-so, 25% rarely well

Comparing Referred Youth with vs. without Bipolar Disorder: Findings from the Centre for Youth Bipolar Disorder 2009-2020

394 youth (mean age 16.7 years) referred to a subspecialty clinic for assessment of bipolar disorder

255 confirmed bipolar disorder

- **28% BD-I**
- **33% BD-II**
- **39% BD-NOS**

139 without bipolar disorder

Park et al, *under review*

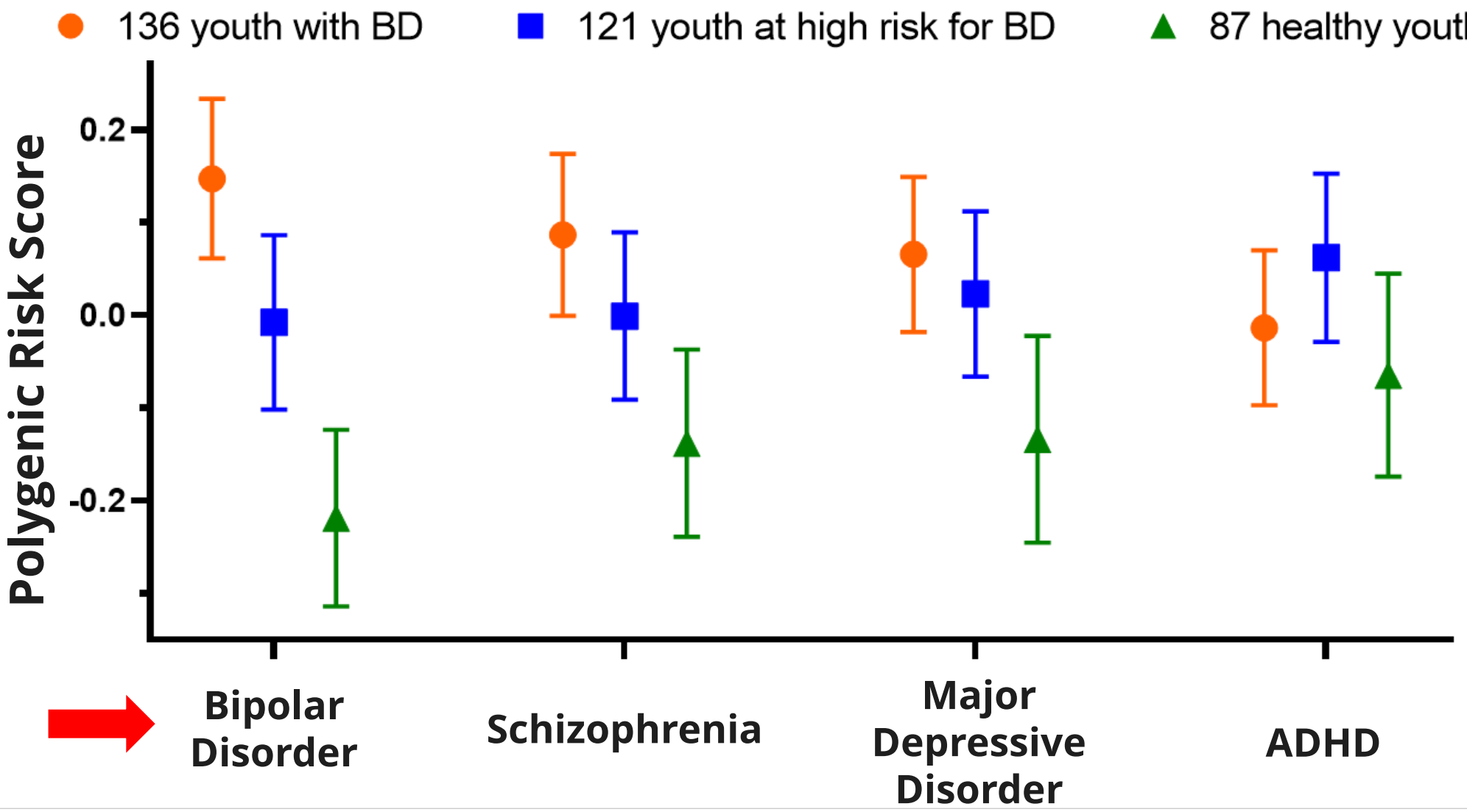
	Bipolar Disorder	Non-Bipolar Disorder	p-value
Oppositional defiant disorder	29.8%	45.3%	0.002
Bulimia nervosa	7.8%	0.7%	0.003
Current mania symptoms	17.7±13.1	7.7±8.4	<0.001
Most severe mania	29.7 ± 9.3	12.0 ± 9.2	<0.001
Most severe depression	30.8 ± 10.8	28.0 ± 9.4	0.003
Most severe global functioning	41.9 ± 8.9	46.0 ± 9.8	0.001
Family history bipolar disorder	44.7%	20.9%	<0.001
Lithium	19.2%	6.5%	0.001
Psychiatric hospitalization	48.2%	28.8%	<0.001

Reasons Bipolar Disorder Diagnosis was Not Given for 139 Participants without Bipolar Disorder

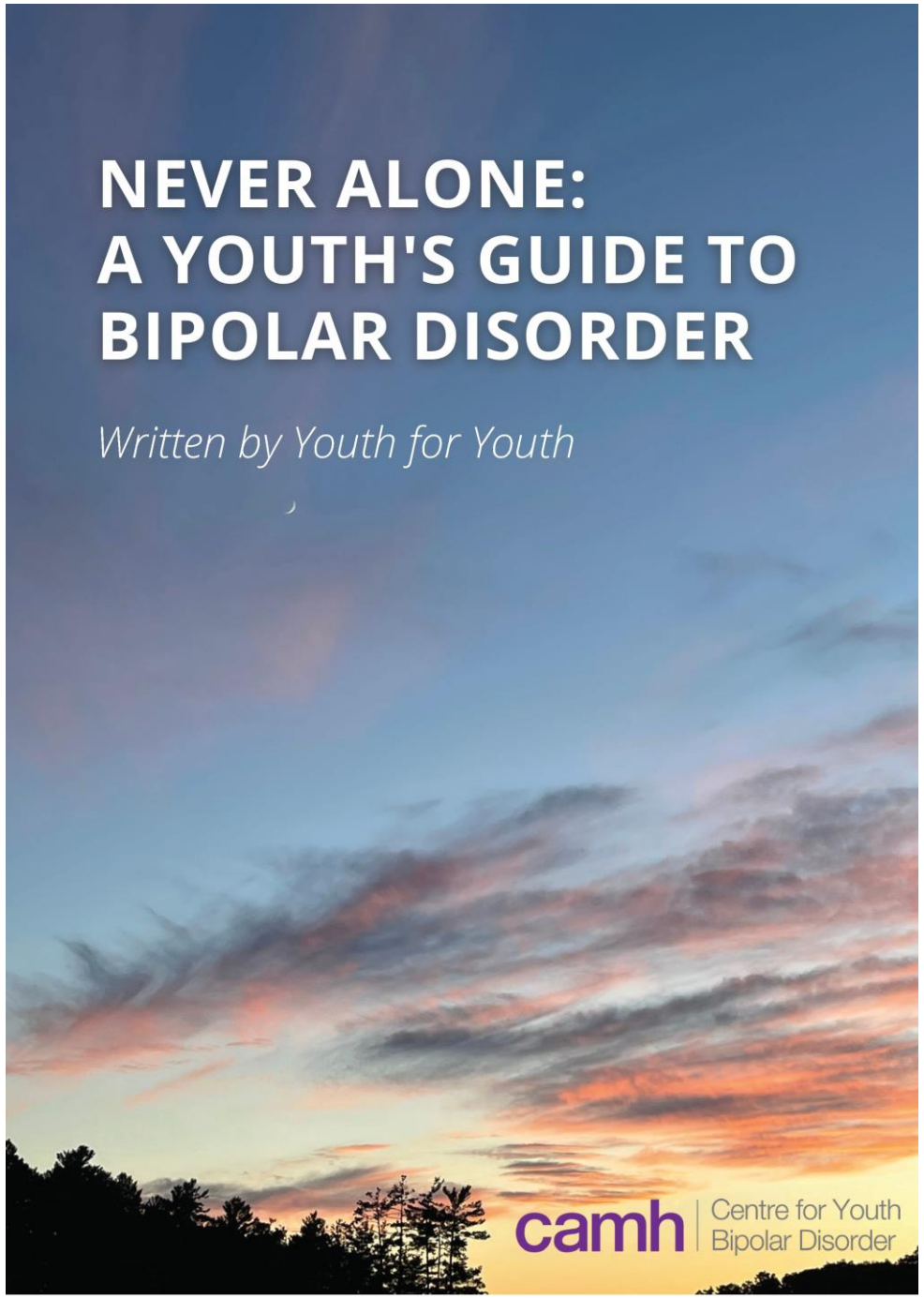
	N (%)
• Symptoms **cannot be differentiated** from other psychiatric disorders (i.e., ADHD, ODD, CD, MDD, ASD)	71 (51.1%)
• **Never experienced ≥4 hrs of manic symptoms** in 24-hr period	35 (25.2%)
• **<4 cumulative lifetime day(s)** meeting manic symptom criteria	12 (8.6%)
• The **history was not sufficiently detailed and/or reliable** to confirm BD diagnosis	32 (23.0%)
• Manic symptoms **solely in the context of psychotropic medication** (stimulants, antidepressants)	15 (10.8%)
• Manic symptoms **solely in the context of substance use**	5 (3.6%)

Park et al, *under review*

Specifically Elevated Polygenic Risk for Bipolar Disorder among Youth with Bipolar Disorder



Jiang et al, *under review*



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https://t.co/fobpyu7TtR

Summary and Conclusions

- No significant change in prevalence of pediatric bipolar disorder, no significant international difference (accounting for measurement of BD-I vs BD spectrum)
- Less common in children vs. adolescents, nonetheless children can and do experience classical mania
- BD-NOS shares many similarities with BD-I/BD-II and predicts future BD-I/BD-II, especially in presence of family history
- Youth referred with the query of BD share many similarities, whether or not diagnosed with BD; this includes clinical characteristics, family history, genetics
- There are risks of false positives and false negatives; to optimize diagnostic reliability/validity consider: adherence with DSM-5, ensure observability, establish minimum quality of narrative, consider plausibility

Acknowledgments

Patients, research participants, and their families

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Thank You to the CYBD Team

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Keep up-to-date on the latest information and findings about youth bipolar disorder!

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Q&A

Thank You

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