Irritability, Aggression Rule in Early Bipolar

**Co-Occurring Mental Illness: Early Intervention Matters**

**By Patrice Wendling**
Chicago Bureau

New York — Significant differences are apparent in the rates of mania and types of externalizing comorbidity by higher, adolescent, and adults with bipolar disorder, Dr. Gabrielle A. Carlson reported at a psychopharmacology update sponsored by the American Academy of Child and Adolescent Psychiatry.

The onset of bipolar disorder (BD) also seems to vary depending on gender, said Dr. Carlson, professor of psychiatry and pediatrics and director of child and adolescent psychiatry at the State University of New York at Stony Brook.

Among adults, the mood changes characteristic of mania include grandiosity, marked euphoria, and irritability, with associated racing thoughts, mood lability, and increased psychomotor activity. But symptoms differ among younger patients with the disorder. “It’s irritability and aggression that’s grabbing us by the lapels with bipolar disorder in children and adolescents,” Dr. Carlson said. “It’s not that they’re coming in euphoric—saying, ‘I’m on cloud nine or president of the United States.’”

A growing body of evidence also suggests that differences exist in bipolar disorder based on age at onset, Dr. Carlson said. A recent study by Dr. Gabriele Mani and colleagues involved 136 consecutive patients, including 80 with BD onset before 12 years of age and 56 with adolescent-onset BD (J. Child Adolesc. Psychopharmacol. 2006;16:679-85). Compared with the adolescent-onset BD patients, there was significantly more likely to be male (67.5% vs. 48%) and to have a comorbidity with ADHD (39% vs. 9%) and oppositional defiant disorder (ODD) (36% vs. 11%).

An episode rather than a chronic course also was significantly more likely to occur in adolescents with the disorder than among children with it (77% vs. 42.5%).

Similar trends were identified in a study now in press by Dr. Carlson and her colleagues that compared 89 patients with BD onset at ages 15-28 years and 34 patients with BD onset after age 30. The patients with earlier-onset BD were twice as likely to be male than were the adult-onset patients (55% vs. 26.5%); and had significantly higher rates of ADHD or ODD or conduct disorder (26% vs. 9%).

Prospective data are limited, but juvenile-onset BD appears to be more chronic and treatment refractory than does adult-onset BD.

Unpublished secondary analyses of an earlier study by Dr. Carlson and colleagues (Am. J. Psychiatry 2002;159:307-9) identify significant differences by age of onset in functional outcomes after a bipolar episode. Among 89 patients with BD onset at 15-29 years, 15% had a Global Assessment of Functioning score of less than 50 after an episode, compared with 12% of those with BD onset after age 30 years.

“The combination of externalizing symptoms (ADHD and ODD) and serious mood lability is noxious, impairing, and often enduring,” Dr. Carlson said. “Intervention is clearly justified, prevention is clearly justified. But we cannot conclude that classic manic depression is the outcome and lifetime medication is justified.”

**Don’t Overlook Infrequent Adolescent Smokers for Cessation Counseling**

**By Damian McNamara**
Miami Bureau

Miami — Co-occurrence of mental health and substance use disorders is a substantial problem among American adolescents, Jorielle R. Brown, Ph.D., said at the annual conference of the American Society of Addiction Medicine.

Many teenagers go untreated for mental health disorders, even though about half of all lifetime mental illness begins by age 14, and some turn to illicit drugs to self-medicate, she said.

Mood disorders top the list of co-occurring disorders (CODs). For example, a major depressive episode is reported by 44% of adolescents with substance use disorders, especially in the older age range. In certain populations, the prevalence is even higher. For example, mood and anxiety disorders are the leading co-occurring mental health conditions in incarcerated youths with a substance use disorder, affecting nearly 33% of these teenagers.

Among 12- to 17-year-olds who report having used illicit drugs in the past year, 32% also have mental health problems, according to 2005 data from the Substance Abuse and Mental Health Services Administration (SAMHSA). Those adolescents who reported a major depressive episode in the past year were more likely to report illicit drug use in the past year, as well as daily cigarette use and heavy alcohol use in the past month.

Physicians can intervene early and make a difference, Dr. Brown said. For example, there is a need to identify the “diagnostic orphans.” These are the teenagers who meet only one or two criteria for alcohol dependence and none for abuse, but who will later develop a more serious problem. Screening can identify these patients, she said.

When working with teenagers, address specific, real-life problems early in treatment, plan for cognitive and functional impairments; and use support systems to maintain and extend treatment effectiveness. “With our youth, we often have to be very creative in finding their support system if the family is not there,” said Dr. Brown, a public health advisor at SAMHSA’s Co-Occurring Centers for Excellence.

Early identification of adolescents at risk may reduce the number of referrals from the juvenile justice system, Dr. Brown said. The fact that criminal justice is the leading source of adolescent referrals for addiction treatment is “very depressing, for me,” she continued. “COD is not addressed until someone does something criminal. We see [it] in schools, but we don’t do anything until they steal something or hurt someone.”

Another reason that physicians should screen for CODs is that “treatment works. And the earlier the treatment, the better the outcomes,” Dr. Brown said.

Use of medications also must be part of a comprehensive treatment plan that includes nonbiologic interventions, she added.

Although there is paucity of data on medications for COD in adolescents, fluoxetine, for example, appears promising for the treatment of depression with co-occurring alcohol use, Dr. Brown said. In addition, case reports indicate that bupropion might benefit patients with both attention-deficit/hyperactivity disorder and drug dependence. Medications to treat alcohol-related cravings, such as naltrexone, also have been effective in adolescent case reports, she said.

For more information, call SAMHSA’s Center for Substance Abuse Treatment National Helpline at 800-662-4357 or visit www.substanceabuse.gov and search the site’s list of Quick Guides for Clinicians, which address substance abuse treatment for persons with co-occurring disorders.