Current Psychiatry

Overlooked diagnoses

"Not all mood swings are bipolar disorder" (Current Psychiatry, February 2011, p. 38-52) is a highly relevant and helpful article with a glaring omission. There is no mention of the emotional lability and behavioral dyscontrol associated with abuse, trauma, and invalidation. "Mood swing" symptoms are prominent in developmental trauma disorder and complex posttraumatic stress disorder, although these diagnoses are not yet in the DSM. Unfortunately, the effects of abuse, trauma, and invalidation often are unrecognized in the differential diagnoses of these children and too often the "knee-jerk" diagnoses of bipolar disorder, oppositional defiant disorder, and attention-deficit/hyperactivity disorder are inappropriately assigned, delaying the implementation of trauma theory-informed therapy.

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The authors respond

We thank Dr. Schwartz for his comments regarding emotional lability and behavioral dyscontrol associated with children who have experienced trauma, abuse, and invalidation. An assessment for possible trauma always is part of the initial assessment of each child referred to our program. None of the patients discussed in our article had a history of abuse or trauma. Referrals to our pediatric mood disorders program initially are screened through the Cincinnati Children's Hospital Psychiatric Intake and Response Center, which functions as triage, gathering psychiatric history, including assessing trauma, and children with a history of abuse and trauma are referred to other clinicians specializing in this area. But Dr. Schwartz's point is well taken—trauma or abuse always should be part of the differential diagnosis of children and adolescents referred for mood swings.

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Mood swings and BPD

I thought Dr. Kowatch and colleagues took an important first step in pointing out that not all mood swings in children and adolescents are symptoms of bipolar disorder ("Not all mood swings are bipolar disorder," Current Psychiatry, February 2011, p. 38-52). They reviewed some of the other psychiatric conditions known to cause labile moods. One glaring omission is borderline personality disorder (BPD).

I am the medical director of a specialized unit that uses dialectical behavioral therapy (DBT) to treat children and adolescents with BPD. We have treated approximately 300 young women on the residential unit and many present similarly: multiple hospitalizations, multiple robust yet failed medication trials, severe and recurrent self-injury, suicide attempts, and a large degree of hopelessness. Most arrive with previous diagnoses of mood disorder not otherwise specified, bipolar disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder, and others. It is when their outpatient psychiatrists and mental health teams have grown frustrated at the lack of enduring progress and are faced with the treatment demands of the borderline patient that a BPD diagnosis is considered. Even though research suggests that BPD—or at least some of its symptoms—begins in the late latency period of childhood,[1] treatment typically is not sought until late adolescence. This is the case despite the fact that BPD has a better prognosis than other serious mental illnesses, such as bipolar disorder.[2,3] Adult BPD patients almost universally recognize that their inability to regulate their mood started in late childhood and early adolescence. Structural and functional neuroimaging has revealed a dysfunctional network of brain regions that seem to mediate important aspects of BPD symptomatology.[4-6]

These children have marked mood swings and great difficulty regulating their moods. The mood swings of BPD are not responsive to current medication unless there is comorbid bipolar disorder, in which case treatment with mood

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stabilizers helps improve vegetative symptoms such as sleep and energy, and reduce racing thoughts, pressured speech, and irritability. What these medications do not treat is the "reactive" mood swings that are characteristic of BPD. The mood reactivity often is triggered by interpersonal or intrapersonal conflict and rarely is long-lived.

Many children and adolescents are moody and most do not have a major psychiatric disorder. Of those who do, it is a great risk to patients' health to not consider BPD, especially given new and empirically validated treatments, such as DBT. Astute clinicians should keep this diagnosis in mind when treating adolescents with moodiness, particularly when the mood is predominantly reactive to life's stressors, when other features of the presentation do not fit neatly into a bipolar picture, and when multiple medications fail. On our unit, we have seen that the cognitive-behavioral strategies of DBT help patients even when BPD is not the diagnosis.

I would like to thank Dr. Kowatch and colleagues for expanding our thinking on mood swings and encourage readers to go one step further.

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The authors respond

We welcome comments about the importance of a thorough diagnostic evaluation to tease out possible etiologies of "mood swings," including psychosocial factors, as in personality disorders. Nevertheless, the debate about diagnosing personality disorders in children and adolescents is not settled. Developmentally, children and adolescents have continuous changes in biology and brain function. There is significantly more empirical evidence of reactive attachment disorders in childhood and adolescence that integrate the affective changes seen in children who live in chaotic environments. DSM defines BPD as a pervasive pattern of instability of interpersonal relationships that begins by early adulthood.[1] Many children with diagnoses of posttraumatic stress disorder, mood disorder, bipolar disorder, oppositional defiant disorder, attention-deficit/hyperactivity disorder, etc. also can have difficulties in relating to others caused by their neurobiologic deficits, which also may limit response to medication. Furthermore, children with learning disorders also can misperceive motives of others and thus have pervasive patterns of relational instability.

The research Dr. Aguirre suggested is based on treatment histories and not rigorous study methodology. Most empirical evidence of personality disorders is strongly influenced by psychoanalytic literature regarding object relations, which is in flux because of emerging attention to attachment theory and progress in neurologic studies in the evaluation of temperamental variations related to the influence of mirror neurons.[2]

We also take issue with the comment that "BPD has a better prognosis than other serious mental illnesses, such as bipolar disorder." There have been significant efforts in studying the role family can have in the outcomes of mood disorder treatment.[3]

Finally, there is evidence that in adults medication can be beneficial in treating the affective deregulation of patients with BPD who do not have comorbid disorders.[4]

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Mood swings and ODD

I needed an intellectual oasis to deal with the anguish and frustration triggered by the monumental amount of misleading information that was included in the well-written article "Not all mood swings are bipolar disorder" (Current Psychiatry, February 2011, p. 38-52). Fortunately, a commentary by Dr. Irene Abramovich ("Breaking the box," Comments & Controversies, Current Psychiatry, February 2011, p. 59) appeared as a therapeutic elixir. I believe that the "mood swings" article is filled with examples of how dangerous "cookbook" medicine can be.

Dr. Kowatch and colleagues use an expression that can be applied to the so-called diagnoses oppositional defiant disorder (ODD) and conduct disorder (CD): "Mood swings are analogous to a fever in pediatrics—they indicate something potentially is wrong with the patient, but they are not diagnostic as an isolated symptom." A similar concept was my position in a debate titled "Childhood conduct disorder and oppositional-defiant disorders are common manifestations of bipolar disorder" in which I argued that ODD and CD are behavioral expressions of genuine diagnoses.[1] Besides bipolar disorder, I also have seen obsessive-compulsive disorder, social anxiety disorder, and even sexual abuse labeled as "ODD" because the child refuses to be around people (such as a classroom) or is distracted by intrusive thoughts or flashbacks and turns hostile when reproached in front of the class.

In my view, Dr. Kowatch and colleagues give undeserved credit to the behavioral scales (the "cookbooks" of psychiatry) to make diagnoses and seem to miss warning signs in patients' family history, ie, "history of depression and anxiety" (many times this translates as agitated/dysphoric mania) and "drinking problems," which frequently is found in undiagnosed bipolar spectrum patients who use alcohol to "shoot down" racing thoughts that interfere with normal sleep.

From January 2010 to February 2011, I reviewed charts and interviewed patients and families of 1,654 patients with diagnoses of attention-deficit/hyperactivity disorder comorbid with ODD, bipolar disorder, generalized anxiety disorder, and even 2 diagnoses that are not allowed by DSM rules: autism and mental retardation. The data from this study, which covers 12 counties that represent the 5 geographical areas of Florida, are being analyzed. In the meantime, I refer readers to my poster presentation from the 2010 U.S. Psychiatric and Mental Health Congress "Extinction of oppositional-defiant symptoms following treatment with mood stabilizers."[2] In this study 44 patients were followed for at least 5 years (10 patients were observed for 7 years and a similar number for 6) and none had "oppositional" behavior after the diagnoses were treated. One caveat is that I placed antipsychotics in the same category as conventional mood stabilizers because 5 patients considered to be "inattentive" and "oppositional" actually had schizophrenia.

I oppose the authors' assertion that "it can be difficult to differentiate the mood swings and symptoms of ODD from those of pediatric BD." My experience is that it is simple if we consider all diagnostic possibilities and obtain a thorough family history, which usually includes alcoholism, cannabis abuse, moodiness, suicide completion, unstable lifestyle, etc.

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The authors respond

We never suggested that clinicians use "cookbook medicine." The "behavioral scales" we recommended in our article are well-validated and reliable tools that allow a clinician to effectively elicit a great deal of useful information from patients and their parents about presenting problems and symptoms. This information can be used with other clinical information to make an accurate diagnosis and subsequent treatment plan.

The purpose of our article was to share our experiences in the differential diagnosis of mood swings in children and adolescents and to suggest that there are other diagnoses that cause mood swings besides bipolar disorder. Although a family history of mood disorders is important, it is also important to recognize that a recent, state-of-the-art study by Birmaher et al[1] reported that 10% of children of parents with bipolar disorder had a bipolar spectrum disorder. That means that 90% did not have bipolar disorder. It is important to remember this when evaluating children of parents with bipolar disorder. Although these children's risk for developing bipolar disorder is increased compared with the general population, it is more likely that they will not develop bipolar disorder.

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To read "Not all mood swings are bipolar disorder," visit CurrentPsychiatry.com