Predictors, Criteria, and Treatment Response

This month's Focus on Childhood and Adolescent Mental Health section provides clinically useful information about predictors of bipolar disorder and suicidality, revised criteria for posttraumatic stress disorder (PTSD), and treatment response in youth with comorbid bipolar disorder and attention-deficit/hyperactivity disorder (ADHD).

There is substantial comorbidity between bipolar disorder and ADHD in youth. Identification of those children with ADHD who are at risk for development of bipolar disorder is an issue of concern for clinicians and parents. Biederman and colleagues evaluated the predictive utility of the Child Behavior Checklist-Pediatric Bipolar Disorder (CBCL-PBD) profile to identify those children at risk for bipolar disorder. The CBCL-PBD was administered to 204 children, aged 6 to 18 years old, at baseline. The children were divided into groups based on their CBCL-PBD score, positive if the sum of the CBCL-PBD subscales attention problems, aggressive behavior, and anxious-depressed was ≥ 210 or negative if below this cutoff. The children were followed up over an average time of 7 years. By age 25 years, those youths with ADHD who had a CBCL-PBD positive score had a significantly increased risk for bipolar disorder (36% vs 22%). In addition, they were also at higher risk for major depressive disorder (56% vs 29%) and conduct disorder (60% vs 27%) compared to those with a CBCL-PBD negative score. Psychosocial functioning was also more impaired in the CBCL-PBD positive group compared to the negative group. Clinicians may find the CBCL-PBD to be useful to identify children with ADHD who have a potential risk for the development of bipolar disorder. However, it is important to recognize that most of the children in the study who had a positive CBCL-PBD score did not develop bipolar disorder.

Identification of predictors and antecedents of suicidal events in adolescents is a clinically important issue for clinicians who treat depression in youth. Vitiello and colleagues analyzed the Treatment for Adolescents with Depression Study (TADS) database to identify potential predictors and antecedents of suicidal events (attempts and ideation). TADS was a 36-week randomized controlled trial of fluoxetine, cognitive-behavioral therapy, and their combination for the treatment of 439 adolescents with major depressive disorders (the first 12 weeks included a placebo-control condition). During the trial, 44 patients (10%) had at least 1 suicidal event (no suicides). The following factors were associated with suicidal events: higher levels of self-reported suicidal ideation (Suicidal Ideation Questionnaire adapted for adolescents score ≥ 31) and self-reported depression (Reynolds Adolescent Depression Scale score > 90) at baseline, minimal improvement in depression and still at least moderately depressed, and an acute interpersonal conflict (youth-parent conflict in 84% and youth-peer conflict in 16% of cases). No association was found between the following factors and suicidal events: clinician-assessed baseline severity of depression, hopelessness, anxiety, irritability, mania, sleep problems, family conflict at baseline, history of substance abuse, or comorbidity with ADHD, oppositional defiant disorder, or conduct disorder. Moreover, the time to suicidal event was variable, ranging from the first week to 6 months after starting treatment, and did not differ among the treatment

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groups. Contrary to prevailing beliefs, the investigators found that there was no evidence to support medication-induced behavioral activation as a predictor of suicidal events in depressed adolescents.

Posttraumatic stress disorder has symptom overlap with other anxiety disorders and depression. A revised symptom criteria set that eliminates this overlap has been assessed in adults, and Ford and colleagues have tested this revision in adolescents. The 2-factor PTSD model includes an intrusive re-experiencing factor (with the same 5 symptoms as in *DSM-IV* PTSD criteria) and a second avoidance/hyperarousal factor that deleted symptoms that overlapped with other anxiety disorders or depression, for example, diminished interest in activities, irritability, and difficulty concentrating. The investigators found that the 2-factor model reduced PTSD depression comorbidity by 9% to 14% in adolescents compared to the 3-factor *DSM-IV* model. These results are very timely since they may have implications for the *DSM-V* revision.

Is aripiprazole effective in the treatment of youth with bipolar disorder and comorbid ADHD? Tramontina and colleagues conducted a pilot double-blind placebo-controlled trial of aripiprazole for the treatment of 43 children and adolescents with bipolar I or II disorder and comorbid ADHD. Patients were randomly assigned to aripiprazole (n = 18) or placebo (n = 25) for a 6-week trial. The mean daily dose of aripiprazole was 14 mg (range, 5–20 mg). There was a significant reduction in Young Mania Rating Scale scores from baseline to endpoint in the aripiprazole group compared to the placebo group. However, there was no significant difference in changes in ADHD symptoms from baseline to endpoint as assessed by the Swanson, Nolan, and Pelham Scale-Version IV. There has been some controversy about whether antimanic agents are as effective for children with bipolar disorder who have comorbid ADHD compared to those without ADHD comorbidities. This study provides preliminary evidence that aripiprazole has efficacy in the treatment of manic symptoms for children with comorbid ADHD. The findings from this study need to be confirmed in a large controlled trial before any definitive conclusions can be drawn.

Karen Dineen Wagner, MD, PhD
Deputy Editor
kwagner@psychiatrist.com