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MOOD DISORDERS IN ADOLESCENTS: CONCEPTS AND INTERROGATIONS AMONG FRANCOPHONE PSYCHIATRISTS

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SUMMARY

Background: *With the publication of DSM III, the nosology of children and adolescents' disorders has evolved differently in Francophone and Anglo-Saxon countries. We want to 1 / familiarize readers with the nosographic concepts of mood disorders and bipolar disorders in the Francophone world of Adolescent Psychiatry; 2/ highlight the major current issues of concern to both Francophone and Anglo-Saxon adolescents' psychiatrists.*

Method: *A review of the literature in PubMed, PsycINFO and PsycARTICLES, but also of Francophone journals or textbooks not included in these databases nor distributed outside Francophone countries.*

Results: *Although Francophone adolescents' psychiatrists still rely on the DSM II, particularly in reference to the transitory dimension of problems during adolescence, the DSM III led to a tightening of criteria for bipolar disorder in the Anglo-Saxon countries. These disorders have become rare in the 2000s while still common in Francophone countries. Nowadays the evolution of current criteria in Anglo-Saxon countries tends to bring the diagnostic criteria closer to the Francophone's one even though important differences still persist.*

Conclusion: *Despite differences between these two approaches in Psychiatry, there is agreement regarding the poor prognosis of type I bipolar disorder, particularly when psychotic traits are observed. Early diagnosis and treatment are therefore a challenge for both, but their limitations are inherent to their respective approaches. In Anglo-Saxon countries, if the criteria are met for bipolar disorder, treatment is decided at the risk of over-diagnosis and stigmatization of false positives. In Francophone countries, even if the criteria for bipolar disorder are met, it is still necessary that the psychopathological analysis of the disorder in the developmental framework of adolescence confirms that the disorder is stable, at the risk of later treatment and of increase of insufficiently treated false negatives. A reconciliation of these fields may limit the above side effects.*

Key words: *mood disorder – bipolar disorder – adolescence – nosography*

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INTRODUCTION

Adolescents' psychiatrists in the Francophone world have always had difficulty with the DSM classification system since the publication of its third version. This is true in general, and particularly for mood disorders including bipolar disorder. These psychiatrists kept relying on the DSM II system because of its psycho-dynamic-like dimension. According to their most salient criticism, in the revision of the DSM-II under the influence R. L. Spitzer (1968) toward an Kreapelinian nosography, the notion of "adolescent crisis" had disappeared. The Kraepilinian system of the DSM III differs from the more nomothetic Psychodynamically influenced system of the DSM II, by putting more emphasis on objective rather than subjective symptoms. Therefore, the highly subjective concept of "crisis" could not subsist in the revised nosography. Although "adolescent crisis" does not appear as such in the DSM II, it is always present in the coding system that requires the clinician to determine the reactive nature of the observed disorders. In the DSM II, there are three ways to code a set of symptoms displayed by an adolescent.

- At its first level of coding, the DSM II defines "transient situational disorders" as any symptomatic expression, provided it appears as transient and in reaction to adaptation stresses associated to a developmental stage in the subject's life. Hence, the DSM II distinguishes the adjustments that characterise early childhood, childhood, adolescence, adulthood and late life.
- Behavioural disorders of childhood and adolescence constitute the second level of coding. They must be more stable, more structural, and more resistant than the previous, but less so than definitive disorders.
- The third level of diagnosis involves the use of adult classification. In order to be able to use that level of classification, the disorder must have a more definitive structure.

It is against this flexibility left to the clinician, both in assessing the reactive and transient nature of the disorder, and at the level of diagnostic criteria that define membership to one of these three degrees, that the DSM III brings constraints.

First, the transient reaction conditions disappear and become adjustment disorders whose criteria are not slices of life but any psychosocial stressor, and especially whose symptoms cannot be those of an adult disorder. The symptoms can be only partial compared to the whole picture of the disorder. Adjustment disorders are first categorized according to symptoms and stressors, and not anymore based on slices of life.

The second possibility of coding is also profoundly changed. Indeed, the behavioural disorders of childhood

and adolescence in the DSM II gave way to "disorders occurring during the first and second childhood, or adolescence." If the definition of the DSM II provides the clinician with the flexibility to include clinical pictures that can be found in adult age, this is excluded from the DSM III nosology, which only allows for specific disorders to be coded. If the symptoms correspond to an adult disorder, they must be coded in the adult nosology. Moreover, while for each diagnostic subgroup in the DSM II, the term "reaction" is used in the name of the disorder, it disappears from the DSM III. It is this lack of freedom of clinicians that is highlighted in Strober' study (1981) on mood disorders, and schizophrenia as well as on anxiety disorders, although he found a satisfactory level of reliability to these new classes.

This change in diagnostic system led to the relative disappearance of some disorders. Indeed, the new requirement to meet the entire diagnostic criteria of the adults' nosology reduced the incidence of certain disorders such as bipolar disorders. Conversely, in the Francophone world, the diagnostic criteria have not changed and bipolar disorder has kept, as in adults, an approximate incidence of 1%. Realizing the impact of this underestimation, our Anglo-Saxon colleagues in child psychiatry are currently readdressing the diagnostic criteria for children and adolescents. In that respect, Professor E. Weller has contributed to reconciling these trends while arguing in 1986 against the undervaluation of these disorders in adolescents in the US.

In this article, we propose:

- to familiarize the readers with the nosographic concepts of mood disorders, particularly bipolar disorder in the Francophone world of adolescents' Psychiatry;
- to highlight the major issues currently driving both Francophone adolescents' Psychiatrists and their Anglo-Saxon colleagues about bipolar disorder.

METHODS

The main difficulty we faced in writing this article was that if many articles are published in English, they also often are of Anglo-Saxon psychiatric inspiration. Francophone Psychiatrists publish little and / or are not published in Anglo Saxon reviews. Their articles are therefore available only in French, Italian or Spanish, i.e. in journals that are not to be found on Pub Med and sometimes not even referenced on Psyclist, or Psyarticle. Some textbooks, also only published in French, constitute however a reference in the Francophone world.

RESULTS

Mood disorders among Francophone adolescents' Psychiatrists

In Francophone countries the diagnosis of a mood disorder in adolescence requires two prerequisites. On the one hand, the adolescent person is conceived as a subject wholly psychically instable, and on the other hand, adolescence is perceived as a depressing developmental stage (Zdanowicz et al. 1996).

Because of the psychic reorganization related to this slice of age, Francophone psychiatrists believe that teens can display a lot of different clinical pictures including of adult disorders. The above clinical pictures may be partial in terms either duration or number of symptoms, but they can also be thorough, and different clinical pictures may follow each other at a high pace (from one week to the next). In most cases, Francophone clinicians consider that these disorders are neither as serious nor require the same treatment or suggest similar prognosis as those of adults. This instability causes them to make diagnoses they call "states" to distinguish them from the same constellation of symptoms which in adults constitute "disorders", and to underscore the instability of Psychopathology (e.g. a schizophrenic state rather than a schizophrenic disorder). However, if the clinician considers that the condition is stable, the disorder (rather the state) is diagnosed. What determines the stability of the disorder (therefore, its seriousness) are psychodynamic criteria, i.e. data on the adolescent's subjectivity. In this conception, normality and pathology are not defined by a ratio of exclusion but by a ratio of continuity. Being considered the essence being a human, "Pathos" is one of the possible modes of the human psyche's functioning. The criteria of normality in this case are "stuck" on the one hand in the subject's inner world (subjectivity) comprising instinctual life and coping mechanisms, and on the other hand, in the external reality, i.e. the objective symptoms (Bergeret 1974). For Francophone psychiatrists, the presence of objective symptoms is not enough to establish that a teenager displays a psychiatric disorder in the full sense of its definition for adults; internal criteria are still required. These internal criteria for adolescents mainly include the existence of psychological distress and stereotyped coping mechanisms, but also a blockade in the subjective process of the acquisition of autonomy. Diatkine (1972) thus observes that any new situation requires a new mental equilibrium, and that a sense of the subject' self-appreciation is expressed about whether the process was successful or not. Adolescence is seen as a depressive episode, not only because it includes a process of separation from childhood, but also because this forsaking is necessary for the child to redefine him/herself as a future adult. Unlike depression and grief in adults that result in loss, grief-depression in adolescents has a good prognosis, mainly because it opens way to the adult world, richer in potential than that of childhood. Hence, depression in adolescence would be frequent and even necessary. For Francophone psychiatrists one must distinguish normal adolescent "depressive mood" from major depressive disorder. According to the Francophone Psychiatrist, depressive symptoms among adolescents are common and mundane. The diagnosis of major depressive episode is made even more complex as the number of

depressive symptoms increases between 12 and 17, and in the range 17-18, they are so frequent that the boundary between "depressive mood "and major depression becomes tenuous. This conception of depression in adolescence has led some authors to hypothesise a normal dysthymia of adolescence (Marcelli & Braconnier 2008). Francophone nosography not only also includes forms of mood disorders that have never existed in the DSM such as abandonment depression, or depression of inferiority, but also bipolar disorders in more various forms according to their paradigmatic view of psychopathology.

Since the DSM III, bipolar disorders belong to the category of mood disorders. The former classification insisted much more on the psychotic dimension of these disorders, therefore, in the DSM II, they were classified as "affective psychoses." Today, this above psychotic dimension is only present in the schizoaffective disorder. Francophone psychiatrists, particularly those working with adolescents, have remained much attached to the old conception of manic-depressive psychosis that covers two distinct phenomena: those that occur in the context of a normal personality, and those occurring in the context of psychotic traits. Faced with a teenager who displays bipolar symptoms, Francophone psychiatrists must answer several questions pertaining to their diagnostic process, assessment of severity of the disorder, and treatment options:

- Is the disorder stable or is it just a temporary state (see above)?
- If the disorder is stable are there reasons to believe that the adolescent patient is psychotic? If yes (it is more frequently the case with type 1 bipolar patients), the diagnosis is of manic-depressive disorder. This diagnosis requires a more intense treatment in terms of neuroleptics.
- Is the adolescent patient displaying traits of psychotic functioning? If not (as often in hypomania BP II), then the diagnosis is rather conceived in terms of a counter-depressive reaction, and antidepressant treatment is more important than the antipsychotic one.
- Is the delusional aspect of the symptoms the most salient of the clinical picture? If so, the diagnosis is that of a schizoaffective disorder.

The characteristics of the Francophone classification system are summarized in Table 1.

Table 1. Characteristics of the Francophone classification system

The diagnostic at ’adolescence is instable
The depressive experience is indissociable from adolescence
The criteria of bipolar disorder have not been «tightened»
Bipolar disorder occurs in the context of a personality that is - normal; - psychotic

Current Issues on bipolar disorder

Notwithstanding these differences between Francophone and Anglo-Saxon psychiatrists, the issues that arise in relation to bipolar disorder are almost identical in the two trends of adolescent psychiatry. They include:

- Prevalence;
- Diagnostic criteria;
- Co morbidities, particularly in relation to ADHD;
- Therapeutic strategies.

Prevalence

Professor Weller has revealed that in 1986, many U.S. adolescents suffering from a bipolar disorder were wrongly diagnosed with schizoaffective disorder (Weller & Weller 1986). Although bipolar disorder was under-diagnosed at that time, between the years 94 and 2003, we observed an "epidemic" of bipolar disorder diagnoses for the same cohort. In 10 years, in the U.S., the estimated annual number of youth below 20 with a diagnosis of bipolar disorder increased from 25 (1994-1995) to 1003 (2002-2003) office-based visits per 100,000 population (Moreno et al. 2007).

Diagnostic criteria

Beyond the under-diagnosis in previous years, one reason for this "epidemic" undoubtedly lies in the great variability of diagnostic criteria used by researchers. They indeed had to leave the strict confines of the DSM as "officially" this condition does not require a description different from that of adults (the only specific remark to that age found in the DSM is that mixed disorders seem more common among adolescents and young adults). In 2001 the National Institute of Mental Health Research Roundtable on prepubertal bipolar disorder "is considering a new classification for youth offering a subdivision of the disease in terms of " narrow "," broad ", and "mixed" phenotypes.

- The "narrow" entity refers to the DSM-IV-TR bipolar disorders I and II.
- The "broad" entity includes bipolar disorder not otherwise specified (NOS) with two phenotypes: the intermediate and broad.
  - Intermediate: the symptoms that are necessary to the diagnosis are present but either do not meet duration criteria, or conversely, duration criteria are met, but all the necessary symptoms for the diagnosis could not be observed.
  - Broad: the disorders identified with the broad entity show a phenotype of severe irritability, without episodic nature of the condition, ideas of grandeur, or high mood.
- The mixed states fall on a continuum between manic symptoms and concomitant depression, forming either a homogeneous episode, or a more heterogeneous pattern whereby mania and depression are present simultaneously, with at each moment, the predominance of one over the other.

This classification and the creation of a scale of prodromes (Bechdolf et al. 2010) obviously represent a significant advance for early diagnosis. However, Francophone clinicians are left wanting in two areas: 1) they still do not recover the old concept of crisis (formerly the old Transient Situational Disturbances of the DSM II) even if the concept of bipolar spectrum of Akiskal (Akiskal 2007) is closest to it, and 2) Van Os' hypothesis (Van Os 2009) of bridges between bipolar disorder, schizophrenia and schizoaffective disorder, do not appear in this classification.

Co morbidities, particularly in relation to ADHD

The co morbidities are many, to name a few:

- Anxiety disorders, and ADHD among younger adolescents;
- Drug Use and Antisocial Behaviors among older adolescents.

Co morbidity with ADHD presented a particular interest among Francophone psychiatrists, since 85% of young people with ADHD also meet the criteria for bipolar disorder. This is strange because the dual diagnosis is more common than the diagnosis of the single entity. Various explanations have been proposed to account for that peculiarity (Zdanowicz & Myslinski 2010) in the international literature.

- A partial overlap of symptoms between ADHD and BP disorders causes diagnostic errors
- Treating ADHD with psycho stimulants can induce a bipolar disorder.
- ADHD may be a prodrome of BP disorder.
- Various arguments advocate for the existence of a new "ADHD-BP" disorder.

On their part, Francophone psychiatrists suggest two other explanatory factors. First, they are struggling with the existence of ADHD itself. They have acknowledged its existence until very late (late nineties) and even today, the diagnosis rate is surprisingly low compared to other countries. Besides the difficult differential diagnosis with BPD, they consider that the other difficult differential diagnosis in adolescence refers to behavioural disorders, particularly antisocial behaviour. They note that for many years, hyperkinetic children were primarily considered "poorly educated", i.e. lacking boundaries in their education. It is probably in that category that many adolescents are diagnosed in Francophone countries, and whom Anglo-Saxons Psychiatrists would have diagnosed with ADHD. Moreover, there is a current view according to which, even if ADHD does exist, it is unclear whether its treatment falls within the scope of Psychiatry. This trend underlines that the main complaint about these children and adolescents is first expressed by parents and teachers, and is often associated with lack of school performance. Psychiatrists identified with that perspective wonder if by "doping" these children, Psychiatry is not acting as a science of social profitability than of mental illness. The second explanatory factor refers to explanations 3 and 4 mentioned above: ADHD would be a possible means of displaying bipolar disorder at this age.

Therapeutic strategies

What are the secure and effective therapeutic strategies? Regardless of these differences, there is unanimity on the poor prognosis of bipolar disorder I in adolescence, and especially, according to Francophone psychiatrists, if the disorder is accompanied by psychotic features. Indeed, the return to euthymia is slower, the rate of remission is lower, and relapse is more frequent than in the adult form of the disorder. This affliction seems even more deleterious in that it hampers a crucial stage of the adolescent's development toward becoming an adult. Dawn (Dawn et al. 2004) argues that the evolution of bipolar disorder in early life is characterrized by a greater number of mixed episodes or rapid cycling, and greater symptomatic periods. The first episode is often manic, with a time of remission of five weeks to six months, and a relapse twenty-three months later. Regarding treatment, one must obviously take into account the fact that studies of safety and effectiveness are rarer than in adults.

The current consensus among Anglo-Saxon and Francophone psychiatrists in relation to bipolar disorders in adolescents:

Acute manic or mixed phase

- Without psychotic symptoms, the first choice is monotherapy. Several molecules are more or less well documented: lithium, valproate, carbamazepine, olanzapine, risperidone, quietapine. Only in the case of successive failures of three monotherapies will a combination of a mood-regulator with an atypical neuroleptic be attempted.
- In the case of psychotic symptoms, the first choice is the combination of a mood-regulator with an atypical antipsychotic. If no therapeutic effect can be observed, another association of two molecules of the same family must be attempted. The lack of response causes the transition to another association where the mood-regulator is maintained, but the antipsychotic is changed.

Depressive phase

The treatment of this phase does not benefit from clear guidelines. It often involves lithium in combination with an SSRI. Lamotrigine raises encouraging results during adolescence, especially when combined with an antidepressant, especially venlafaxine.

Maintenance treatment

It is believed that the medication that helped control the manic phase should be continued for 12 to 24 months. The relapse rate decreases if, in addition to lithium, atypical antipsychotics are associated. In the absence of clear consensus and safety studies, the risk / benefit ratio should be investigated each time before deciding on the maintenance of long-term medication. If interruption is decided, it must occur at a time when the risk of an unfavourable change seems small, in a stable environment, and under close supervision.

Bipolar disorder NOS

There is no consensus on Bipolar disorders NOS, mainly because of its many encountered forms. The

intervention focuses on the predominant symptoms in the clinical picture, co morbidities, and issues of concern of the social environment.

Psychotherapeutic intervention

Apart from the interest of psycho education, the authors point out that bipolar disorder in adolescence, affects a highly strategic period of individual building, and of the development of both patients' functioning, and social network. The consequences are therefore very harmful to patients by hampering the process of their personal evolutionary process, as well as by disconnecting them from the outside world. Individual psychotherapy can help patients develop individual abilities, provide support, and accompany their development. Psychosocial intervention is often recommended to maintain or restore patients' relationship with the outside world.

DISCUSSION

The evolution of diagnostic criteria in Anglo-Saxon countries seems to allow some level of reconciliation between nosographies with the Francophone trend, even if their respective conceptions of psychopathology in adolescence or mood disorders still divide them. It is certain that a prompt diagnosis and early treatment are an asset in the treatment of young bipolar I patients. Even though the two psychiatric paradigms agree on this point, their respective attitudes toward young people with bipolar disorder are different. It is at this level that the above two systems of thought reach their limits. In Anglo-Saxon countries, if the criteria for bipolar disorder are met, the treatment is decided upon at the risk of over-diagnosis and of stigmatization of false positives. In Francophone countries, even if the criteria are met, it is still necessary that psychotic features be present and that the psychopathological analysis of the disorder in the developmental framework of adolescence confirms that the disorder is stable at the risk of later treatment and increase of insufficiently treated false negatives. If these two psychiatric trends could meet, we could increase the sensitivity and specificity of diagnostic criteria.

CONCLUSION

Despite differences between these two approaches in Psychiatry, there is agreement regarding the poor prognosis of type I bipolar disorder, particularly when psychotic traits are observed. Early diagnosis and treatment are therefore a challenge for both, but their limitations are inherent to their respective approaches. A reconciliation of these fields may lead to new diagnostic criteria with higher sensitivity and sensibility.

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