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Diagnosis of manic episodes in adolescent inpatients: structured diagnostic procedures compared to clinical chart diagnoses

David L. Pogge^{a,b}, Douglas Wayland-Smith^{a,b}, Michele Zaccario^{a,b},
Susan Borgaro^c, John Stokes^d, Philip D. Harvey^{e,*}

^aFour Winds Hospital, Katonah, NY, USA

^bFairleigh Dickinson University, Rutherford, NJ, USA

^cBarrow Neurological Institute, Phoenix, AZ, USA

^dPace University, New York, NY, USA

^eDepartment of Psychiatry, Box 1229, Mt. Sinai School of Medicine, New York, NY 10029, USA

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Abstract

This study examined the accuracy of clinical chart diagnoses of manic episodes in adolescent psychiatric patients, as well as treatment selection and patient outcome. A consecutive sample of 120 consenting adolescent patients was assessed at admission, discharge, and 30 and 120 days post-discharge. Clinical chart diagnoses were compared to research-quality diagnoses involving structured interview, chart review, and consensus. Agreement statistics were computed, and the symptom and treatment differences were compared between patients for whom there was and was not diagnostic agreement. Clinical diagnoses of manic episodes were more common than research diagnoses, and the rate of agreement between diagnoses was low ($\kappa = 0.15$). Patients diagnosed as experiencing a manic episode by the clinical chart, but not via the research procedure, had reduced severity scores on elation and activity, and higher scores on depression. These patients also had more severe scores on depressive symptoms at follow-up. Manic episodes were diagnosed more frequently by clinicians relative to research-quality procedures. Patients who were diagnosed as experiencing manic episodes by the clinician, but not the research procedure, appeared to have depression and hostility, but not elation. The depression in these patients may not be adequately treated, and there are potential clinical implications of over-diagnosis of manic episodes in adolescents. © 2001 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Bipolar disorder; Diagnosis; Outcome; Diagnostic interview for children and adolescents

* Corresponding author. Tel.: +1-212-659-8713; fax: +1-212-860-3945.

E-mail address: pdharvey@compuserve.com (P.D. Harvey).

1. Introduction

The occurrence of bipolar disorder in children and adolescents was reported as early as 1921 by Kraepelin, and recent epidemiological data (Carlson and Kashani, 1988; Lewinsohn et al., 1995) and adult retrospective reports (Joyce, 1984; Lish et al., 1994) continue to document the presence of bipolar disorder in adolescents. Prevalence estimates between 6 (Lewinsohn et al., 1993) and 7% have been reported in adolescents (Kashani et al., 1987), and some researchers have suggested a possible recent increase in the overall incidence of adolescent-onset bipolar disorder (Geller and Luby, 1997). Other researchers have reported peak risk rates for the onset of bipolar disorder between 15 and 19 years of age and a median onset of 19 years of age, indicating that roughly half the cases of bipolar disorder have onset during the teenage years or even earlier (Burke et al., 1990). This research, together with significant advances in diagnostic nomenclature, has contributed to an increased recent awareness of the prevalence and characteristics of bipolar disorder in young people.

Several authors have previously written about the under-recognition and under-diagnosis of bipolar disorder in children (e.g. Weller et al., 1986, 1994) and adolescents (Carlson and Kashani, 1988). For instance, many adolescents and children who met formal criteria for bipolar disorder were found to be receiving clinical treatment for other disorders, such as attention-deficit disorder. In addition, the use of structured diagnostic interviews, such as the K-SADS (Ambrosini, 2000), has resulted in the identification of cases of adolescent bipolar disorder missed by clinical diagnosticians (Gammon et al., 1983).

A specific focus of the present study was on the identification of manic episodes. Bipolar disorder is intrinsically variable in its clinical presentation and a manic episode is required for the diagnosis of bipolar I disorder according to DSM-IV criteria. An individual with a history of a manic episode who is later found to be depressed will be given a diagnosis of bipolar disorder at subsequent episodes of depression. Consequently, the identi-

fication of a history of a manic episode will have a marked impact on treatment planning and future expectations regarding prognosis and outcome. Little direct information on the accuracy of identification of current manic episodes in adolescents is available and this study presents preliminary data regarding this issue.

In the present study, we examined the clinician versus research-derived diagnoses of bipolar disorder, manic type, in a consecutive sample of 120 adolescent psychiatric inpatients using a highly standardized data-collection procedure. All patients were examined with a structured diagnostic interview, comprehensive chart review, and informant interview while in the hospital. This information was presented at a consensus meeting with a senior clinician who reviewed all of the information and discussed each case in detail with the diagnostic rater. After this procedure, an 'expert consensus' diagnosis was generated and this diagnosis was compared to clinician diagnoses recorded in the chart. The treatments received by the patients in this study were examined and their 120-day outcome after discharge was also examined. Among the outcome measures collected were levels of severity of affective and non-affective psychiatric symptoms, readmission to inpatient psychiatric care, and compliance with medication and psychotherapy recommendations that were made at the time of discharge from the hospital.

Several specific questions were addressed:

1. What was the rate of clinician diagnosis of a manic episode in this sample of 120 consecutive admissions?
2. What was the rate of agreement between research-quality diagnostic procedures and clinician chart diagnoses?
3. What were the research-based diagnoses of subjects on whom there was diagnostic disagreement?
4. What treatments did the patients diagnosed as experiencing a manic episode by their clinical staff receive?
5. What was the clinical outcome as a function of diagnostic agreement?

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