Bipolar Disorder Assessment in Adolescents

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Section A: Population and Clinical Issue (Literature Review)

Adolescence Through a Developmental Lens

Adolescence, typically spanning from ages 12 to 18, represents a key transitional period marked by rapid biological, cognitive, emotional, and social development. Erikson (1968) conceptualized adolescence as the stage of "Identity vs. Role Confusion," during which, individuals explore personal values, social roles, and long-term goals. Successful navigation of this stage results in the formation of a stable identity, while failure can lead to confusion, instability, and difficulty establishing a coherent sense of self. This vulnerability makes adolescents more likely to develop psychiatric disorders such as mood disorders.

Bipolar Disorder in Adolescents

Bipolar disorder (BD) is a chronic and severe mood disorder characterized by episodes of depression and mania or hypomania. While BD was historically considered an adult-onset disorder, well-documented research has established that onset often occurs in adolescence or early adulthood, with a median age of 17.5 years (Keramatian et al., 2023). In pediatric populations, the presentation of BD can differ significantly from adult cases. Rather than the manic "euphoria" seen in adults, adolescents more frequently present with irritability, agitation, and rapid mood fluctuations (Guidetti et al., 2024). These atypical features contribute to a high rate of misdiagnosis, with many adolescents being incorrectly diagnosed with unipolar depression or behavioral disorders (Keramatian et al., 2023).

Early-onset BD is associated with a more severe clinical course, including greater functional impairment, higher hospitalization rates, and an increased risk of suicidality (Hsu et

al., 2024). Neurobiological findings further support the seriousness of pediatric BD. For instance, Hsu and colleagues found that adolescents with BD exhibit appetite hormone dysregulation (e.g., insulin, leptin) and executive dysfunction, suggesting that the disorder affects not only mood regulation but also cognitive control systems vital for adaptive functioning.

Impact and Clinical Presentation

Adolescents with BD face significant impairments across multiple domains. Socially, they may struggle with peer relationships, exhibit impulsivity or aggression, and withdraw from meaningful activities. Hsu et al. (2024) found that adolescents with bipolar disorder and disruptive mood dysregulation disorder exhibit significant executive dysfunction, particularly in areas such as inhibitory control and working memory, which may impact emotional regulation and academic functioning regardless of mood state. Moreover, early experiences of emotional maltreatment further complicate the clinical picture. Qian et al. (2024) found that childhood emotional maltreatment is strongly associated with increased severity of depressive symptoms, heightened emotional dysregulation, and poor coping skills. These symptoms frequently resemble, or overlap with, typical adolescent behavior or other psychiatric conditions, which can delay the accurate diagnosis.

Moreover, mood episodes in adolescents are often misinterpreted as situational or behavioral issues rather than psychiatric symptoms. Guidetti et al. (2024) demonstrated that youth who eventually developed BD often showed early signs such as elevated mood and psychomotor activation, but these signals were frequently unrecognized or attributed to external causes. This highlights the need for tools that detect mania even when depression appears first.

Challenges in Clinical Assessment

Given the complexity of adolescent mood presentations, a comprehensive, developmentally sensitive approach to assessment is essential. Clinical assessment should incorporate multi-informant data (e.g., adolescent, caregiver, teacher), semi-structured interviews, and screening tools designed to differentiate between unipolar and bipolar depression. However, as Keramatian et al. (2023) note, there are significant delays in diagnosis and treatment for pediatric BD, with some youth waiting over a decade from symptom onset to appropriate intervention. These delays are influenced by system-level factors (e.g., access to care), provider-level factors (e.g., diagnostic uncertainty), and patient-level factors (e.g., communication barriers, stigma).

To support early identification, clinicians must rely on validated screening instruments that can flag manic symptoms even in the context of a depressive episode. One such tool is the Mood Disorder Questionnaire (MDQ).

The Mood Disorder Questionnaire in Adolescent Assessment

The Mood Disorder Questionnaire (MDQ) is a 13-item self-report screening tool originally developed for adults to identify bipolar spectrum symptoms. While not designed for adolescents, research by Wang et al. (2020) supports its use in this population, showing consistent sensitivity and specificity across mood states, such as depressive and euthymic (i.e. emotionally balanced) presentations, where manic symptoms may be obscured. Cantone et al. (2025) and Carta et al. (2024) argue that the MDQ's tendency to produce false positives, particularly in individuals with anxiety, personality, or stress-related disorders, creates concerns

about its diagnostic specificity. These findings have informed the development of alternative conceptual frameworks, such as DYMERS, which will be explored further in Section C. Despite these concerns, the MDQ remains a widely used screening tool and will be evaluated in this paper with a critical understanding of its limitations and appropriate clinical context.

Section B: Initial Assessment

Initial Assessment Meeting

The initial assessment session is a critical phase in counseling, particularly when working with adolescents presenting mood-related symptoms. The initial session with an adolescent should prioritize rapport-building and accurate data collection, using techniques that are developmentally appropriate and respectful. Adolescents are often in emotionally vulnerable states, and their behaviors may be misinterpreted if adult norms are applied too rigidly. As Whiston (2017) summarizes, citing Merrell (2007), counselors should (1) consider the degree of emotional lability and stress, (2) avoid making judgments based solely on adult norms, and (3) show respect in all interactions (p. 146). These recommendations are particularly important during early assessment, where the clinician's tone, posture, and questions set the stage for the adolescent's trust and disclosure. For adolescents, this includes developmental history, academic functioning, peer and family relationships, substance use, and medical/psychiatric background.

Since adolescents are in the identity versus role confusion stage of development (Erikson, 1968), it is essential to approach the interview in a manner that supports autonomy and trust. Whiston emphasizes the importance of explaining the assessment process clearly and setting confidentiality boundaries, especially around topics like suicidality or abuse. Adolescents are

more likely to engage honestly when they feel respected, safe, and aware of what will be shared with caregivers.

In cases involving suspected mood disorders, the initial interview should include a timeline of mood symptoms, past treatment efforts, sleep patterns, and energy fluctuations. Gathering information from multiple sources, such as parents, teachers, and medical records, can help clarify the presence of cyclical patterns or behavior shifts that the adolescent may not report.

Identifying Trauma and Abuse, and Reporting Abuse

A trauma-informed approach is essential when working with adolescents, especially given the high co-occurrence of trauma exposure and mood disorders. Qian et al. (2024) emphasize that exposure to emotional maltreatment in childhood is a critical risk factor for complex and reactive depressive symptoms in youth. These clients may present with heightened sensitivity to stress, internalized shame, or relational withdrawal. Whiston (2017) stresses the importance of screening for abuse sensitively, using developmentally appropriate language and tools. Symptoms such as irritability, withdrawal, emotional dysregulation, and physical complaints may reflect trauma just as much as underlying mood-related conditions.

When abuse is disclosed or suspected, clinicians are mandated reporters and must follow legal procedures for reporting to child protective services. Whiston underscores the need for accurate documentation, respectful communication with the adolescent, and collaboration with authorities to ensure the client's safety. It's also important to provide emotional support during this process, as disclosure can be a highly vulnerable experience for the adolescent.

Clinicians must also differentiate between trauma-related symptoms and mood disorders. For example, a traumatized adolescent might present with symptoms that can mimic or coexist with depression or bipolar disorder, such as emotional numbing, dissociation, or rage.

Assessing Risk of Aggression, Danger to Others, or Danger to Self

Adolescents with mood disorders are at increased risk for self-injury, suicidal ideation, and aggressive behavior, especially during depressive or mixed episodes. Whiston (2017) recommends using structured risk assessment tools, such as the Columbia-Suicide Severity Rating Scale (C-SSRS), alongside clinical judgment to evaluate immediate and long-term safety risks.

The assessment should cover:

- Suicidal thoughts, plans, intent, and access to means
- History of self-harm or attempts
- Aggression toward others or violent ideation
- Protective factors (e.g., family support, future orientation, coping skills)

Risk should be reassessed regularly, especially in clients with mood instability or a history of rapid cycling. Documentation of all findings is essential, as is communication with caregivers and collaboration in developing a safety plan when needed. The adolescent's developmental stage should be considered. This means that impulsivity and poor judgment, common in teens, may increase the likelihood of acting on suicidal or aggressive impulses.

Ethical and Culturally Relevant Strategies

Ethical assessment with adolescents involves respecting client autonomy, obtaining both informed consent from guardians and meaningful agreement from the adolescent, and using non-

discriminatory practices. Whiston (2017) highlights the necessity of choosing assessment tools that are culturally valid, developmentally appropriate, and aligned with the client's linguistic and sociocultural background.

Cultural competence in assessment means recognizing how cultural identity may shape the adolescent's expression of distress, their comfort with authority figures, and their expectations of mental health treatment. For instance, some adolescents may describe emotional pain in physical terms or may underreport symptoms due to stigma. Counselors should be careful not to label culturally normal behaviors as problems and should try to understand symptoms in the context of the client's life and background.

Ethically, counselors are responsible for maintaining transparency about the assessment process, test limitations, and how results will be used. Adolescents should be active participants in the process to the extent that is developmentally appropriate, reinforcing their sense of agency and respect.

Section C: Mood Disorder Questionnaire Screening Assessment

Reliability and Validity

The Mood Disorder Questionnaire (MDQ) is a brief, self-report screening instrument designed to identify symptoms indicative of bipolar spectrum disorders. Developed by Hirschfeld et al. (2000), the MDQ is composed of three sections. The first includes 13 yes/no items assessing the presence of manic or hypomanic symptoms. The second inquires whether these symptoms occurred during the same time period, and the third asks whether they resulted in moderate or serious impairment. According to Wang et al. (2020), the standard scoring method requires:

- At least seven positive responses on the symptom items,

- Affirmation that symptoms occurred simultaneously, and
- Endorsement of moderate or severe impact on functioning.

While the MDQ was originally developed for adults, Wang et al. (2020) found that its screening accuracy remains consistent across different mood states, including euthymic, depressive, and manic or hypomanic presentations. This supports its usefulness in clinical settings regardless of the client's current symptom phase, which makes it particularly useful in early identification contexts where adolescents may present primarily with depressive symptoms, potentially obscuring the bipolar nature of their mood disorder.

Reasons for Instrument Selection

The MDQ was selected due to its accessibility, ease of administration, and robust validation across multiple populations. It is available through reputable sources such as the International Bipolar Foundation and is referenced widely in both clinical and educational settings. In school counseling contexts (where time and resources are often limited) the MDQ offers a valuable first step in identifying adolescents who may be at risk for bipolar disorder and in need of further assessment.

Importantly, the MDQ supports early detection, which is essential for adolescents given the often long delay between symptom onset and diagnosis (Keramatian et al., 2023). As Guidetti et al. (2024) emphasize, early warning signs of BD are often subtle and may resemble normative adolescent behavior or unipolar depression, increasing the risk of misdiagnosis. The MDQ helps draw attention to patterns of mood elevation or impulsivity that may not be otherwise discussed or recognized in standard interviews.

Benefits

The MDQ serves as a structured and efficient screening tool that can:

- Help differentiate between unipolar and bipolar mood presentations,
- Provide counselors with a data-driven rationale for further referral,
- Create opportunities for psychoeducation and open dialogue about mood regulation and mental health,
- Prompt early intervention, which is known to improve prognosis and reduce functional impairment, regardless of current mood state (Wang et al., 2020).

In school settings, the MDQ can also facilitate conversations with parents or guardians and support school-wide mental health initiatives by integrating evidence-based screening practices into student support services.

Additional Information

While the MDQ offers several advantages, its administration with adolescents requires careful consideration of developmental and contextual factors. Adolescents may lack the insight or emotional vocabulary to interpret questions accurately, particularly when describing elevated mood states that may have felt subjectively normal or even positive. As Whiston (2017) notes, counselors must ensure that test items are explained in developmentally appropriate language and may need to paraphrase or clarify items to support accurate self-reporting.

While the Mood Disorder Questionnaire (MDQ) is widely used and validated, it is not without limitations, especially when applied to adolescent populations. Adolescents often experience rapid shifts in emotional state/mood, behavior, and energy, and the MDQ's binary response format may fail to capture the subtleties of these changes. Furthermore, the MDQ's criteria that symptoms occur together and cause noticeable problems may overlook adolescents who show milder but still important signs of hypomania.

Cantone et al. (2025) and Carta et al. (2024) propose the DYMERS construct (Dysregulation of Mood, Energy, and Social Rhythms Syndrome) to explain the MDQ's high false-positive rates in individuals with anxiety, stress-related, or personality disorders. The construct highlights a clinically significant group of individuals whose emotional and behavioral dysregulation mimics bipolar symptoms without meeting full diagnostic criteria. While the MDQ can still offer value in initial screenings, this critique emphasizes the importance of using it alongside more comprehensive methods such as structured interviews, behavioral observations, and contextual evaluation. Clinicians must remain mindful that a positive MDQ screen does not equate to a bipolar diagnosis but may instead reflect broader dysregulation patterns better captured by emerging frameworks like DYMERS.

Counselors should also be attentive to cultural influences on symptom expression. For instance, adolescents from collectivist backgrounds may downplay individual symptoms, or cultural stigma around mental illness may result in underreporting. Therefore, culturally sensitive administration and interpretation of the MDQ is essential.

Ethical Considerations

Obtaining informed consent, and ensuring the student understands and agrees to participate, is an essential ethical step in school settings, where confidentiality policies, parental involvement, and institutional guidelines can vary. The MDQ should never be used in isolation to make a diagnosis; rather, it should be part of a broader assessment process that includes clinical interviews, behavioral observations, and input from teachers, parents, or other professionals.

Communicating MDQ results to adolescents should be handled with clarity, compassion, and developmental sensitivity. Counselors must emphasize that the MDQ is a screening tool, not

a diagnostic instrument, and that further evaluation by a mental health professional may be warranted if the results suggest risk for bipolar disorder.

To avoid inducing fear or reinforcing stigma, counselors should present results as a starting point for understanding experiences and identifying support needs. Encouraging adolescents to reflect on how mood symptoms affect their relationships, school performance, and well-being can foster self-awareness and promote engagement in further services. The next steps should be referral to a psychologist/psychiatrist and continued emotional support throughout the process.

Section D: Conclusion

Adolescence is a complex developmental stage in which mood disorders often emerge in nuanced and easily misunderstood ways. Bipolar disorder in particular can be difficult to identify due to overlapping symptoms with other conditions, variability in presentation, and developmental factors. The Mood Disorder Questionnaire (MDQ), though originally designed for adults, has demonstrated reliability across mood states and remains a useful screening tool when applied with clinical judgment. However, its limitations such as the potential for false positives in adolescents with anxiety or personality disorders, must be acknowledged. Effective counseling practice with this population depends on developmentally appropriate, trauma-informed, and culturally responsive assessment strategies that combine structured tools like the MDQ with clinical interviews, behavioral observations, and contextual understanding to support early intervention and accurate diagnosis.

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