Pediatric Bipolar Disorder

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ABSTRACT

Clinicians are less sensitive in considering the diagnosis of mania in children because of the variations in clinical presentation and because of the high comorbidity with other psychiatric disorders. More often than the elated and expansive mood, irritability and significant aggression may be the presenting symptoms in these cases. One such case report is discussed highlighting the clinical aspects of pediatric bipolar disorder.

Key words: Mania in children

INTRODUCTION

Pediatric bipolar disorder (PBD) is among the most active and controversial areas of child and adolescent psychiatry research, particularly with regard to appropriate limits of diagnosis.[1,2] Bipolar disorder has been recognized in children since 1990s; even then, there was intense debate whether it could occur prior to the age of 12 years.

The 3 diagnostic dilemmas in pediatric PBD are 1) whether elevated mood vs. irritable mood is essential for diagnosis, 2) minimum duration of manic episode and 3) comorbid diagnosis.

Phenomenology of childhood mania, especially in younger children, can vary from the classic description of bipolar disorder in adults. Diagnostic criteria in DSM-IV was developed for adults; children with bipolar disorder do not always meet these criteria.[3] Manic episode in children is characterized by the presence of an elated, expansive or irritable mood, which represents a change from baseline, lasting for more than 7 days for manic episode or more than 4 days for hypomanic episode and the presence of neurovegetative symptoms.

In children, compared to the elated mood, irritability is a fairly more ubiquitous feature — that the irritability should follow an episodic course and be accompanied with other neurovegetative symptoms such as decreased need for sleep, grandiosity, flight of ideas, etc. Moreover, irritability must be noticeable to others for a diagnosis of hypomania; and impairing, for a diagnosis of mania. It can be noted that most of the pediatric PBDs fall under the category of bipolar disorder not otherwise specified (NOS).

In general many children typically present with atypical or mixed features like irritability; labile mood; rapid cycling course; and behavioral problems, which include school problems like fighting, substance abuse and sexual behavior. The course is often nonepisodic and chronic. There is wide developmental variability in presentation. Normal imaginary play, boastfulness, overactivity and grandiosity may be mistaken for symptoms of bipolar disorder. Adolescent presentation may be bizarre, mood incongruent and/or paranoid. Schneiderian first-rank symptoms occur in 20% of cases; early-onset bipolar disorder may be missed in 50%.4,5]

It is difficult to diagnose bipolar disorder in children because many of the symptoms can be caused by other disorders such as ADHD, panic disorder, conduct disorder and substance use disorder, or in fact these disorders may be comorbid with bipolar disorder in children.
CASE REPORT

A 13-year-old male, class VIII student, was brought by his parents with symptoms of scholastic backwardness; sleep disturbances; running away from school; spending his time mostly in drawing, painting, scribbling in notebook; and with increased communication. He refused to do school assignment, homework and was relatively slow in completing them. His symptoms started when he was in class VI, and they became gradually worse. While in class VI, he attended classes for hardly 3 months and ran away from school, leaving his school bag at his uncle’s place 15 km away from his school. Within 20 days of this incident, he got Rs. 300 from his father to pay for school fees and wandered away to Madurai to worship at Meenakshi temple and then returned home.

A month later, he repeated this behavior of absenting from school; and this time, he again went to his uncle’s home. All these wandering episodes were aimless and purposeless. However, he attributed his behavior of absconding from school to the torture by school teachers, their compelling him to do homework and his dislike towards schooling. Parents changed the school; and for his class VIII, he was put in a school that followed the state syllabus. In this school also, he started spending most of his time scribbling and drawing various pictures in his notebook. He had projected his wild imagination and fantasy in the colorful drawings [Figures 1-4]. He wrote poems also. His drawings included all things associated with an imaginary magic kingdom and utopia — a magic fort; flag; magic soul; rivers; weapons; paleological buildings; sorcery; and demons, whose functions were to provide security and safety. He titled this as “dream world and kavithai ulagam (world of poems)”. He felt this dream world was a separate country and was to come into existence in the near future. He narrated that the dream world had mostly paleological weapons rather than nuclear missiles. There was no poverty in this world and each one lived like a millionaire. There were neither cultural nor community differences. Since he depicted these in almost all the class tests and examinations in schools, he was referred for psychiatric assessment and management.

Figure 1: Magic soul and weapons

Figure 2: Palleological buildings

Figure 3: Dream world

Figure 4: Imaginary magic kingdom
At the time of consultation, besides the above, his parents reported that he was very irritable most of the time; aggressive at times; and when controlled, he was prone to tantrum behaviors. Psychiatric assessment showed that he had a happy mood but silly in nature. The irritable mood was evident especially when he was restrained or interfered with. He had a tendency to become aggressive when enquired about studies, school or home assignment. He detailed his drawings he had made on the dream world and he had difficulty in distinguishing fantasy from reality. The expressed grandiosity certainly exceeded the normal imaginary play of a child. He spoke in a soft tone, and racing of thoughts was evident. At times, he was prone to distraction too. He attributed his behavior of absconding from school to his urge for exploration and discovery. He did not manifest hallucinations or had thought alienation, thought broadcasting, passivity or depersonalization. He had no inappropriate or precocious sexual behavior.

Prior to the onset of illness, he was a boy of timid nature—shy, reserved, having no intimacy with others in school, having very few friends. He had good faith and belief in God and used to offer daily prayers and visit temples often. There was no history of delinquent behavior, bed-wetting, sleep talking, seizure, substance abuse and head trauma. His physical examination—EEG and CT brain were normal and noncontributory. He was submitted for psychometric investigation with Binet-Kamat test of mental ability, Wechsler intelligence scale for children (WISC), Rorschach inkblot test. There were no schizophrenic indicators in inkblot test. His IQ was around 90, with above-average intelligence. Based on the clinical and psychometric assessment, a diagnosis of pediatric bipolar disorder (PBD) was made, and he was started on lithium therapy. His response to lithium was good, and he was maintained with lithium therapy and follow-up.

**DISCUSSION**

It is difficult to diagnose bipolar disorder in children because many of the symptoms can be caused by other disorders such as ADHD, panic disorder, conduct disorder and substance use disorder, or in fact these disorders may be comorbid with bipolar disorder in children.

The present case clearly meets the diagnostic criteria of DSM-IV for a diagnosis of pediatric bipolar disorder. The interesting observation is that the illness manifested by the age of 11 years and was continuous, not episodic to the core of cycling — rapid, ultra or ultradian. The presence of wild imaginations that manifested in the drawings and scribbling was not due to childhood psychosis, and there was lack of Schneiderian first-rank symptoms or other schizophrenic symptoms. His running away from school on 3 occasions was not due to comorbid conduct disorder but was part of illness itself. Conduct disorder according to ICD-10 should start before the age of 6; and according to DSM-IV, before the age of 7.

In children, mania has considerable symptomatic overlap with ADHD. It has been estimated that over half of the patients with pediatric mania also have ADHD. The diagnostic symptoms of distractibility, motor hyperactivity and talkativeness overlap with both mania and ADHD and are also due to true comorbidity. In such patients, it is necessary to stabilize the mania before treating ADHD symptoms to get the best results and also to combine mood stabilizers with ADHD treatment.

In children, conduct disorder is also associated with mania. Most patients with mania qualify for the diagnosis of conduct disorder. It is to be noted that physical restlessness and poor judgments are more common in comorbid cases of conduct disorder, rather than in cases of mania alone.

Finally anxiety disorders, especially panic disorder and agoraphobia, are frequently comorbid with mania in children.

It is well known among clinicians that if a child is treated with stimulant or antidepressant medication and if there is an underlying bipolar disorder, the medication can induce mania with very severe consequences.

The psychopharmacological interventions for childhood mania include lithium, valproate and/or atypical antipsychotics. All mood stabilizers and antipsychotic agents are commonly used for early-onset bipolar disorder in clinical settings. Lithium has been found to be therapeutically effective in the management of pediatric bipolar disorder. In a short-term study, 20 children and adolescents (mean age, 14-1 year) with mania were treated with lithium (mean dose, 1125 ± 106 mg). At follow-up (15 days), the recovery rate was 63.5%. Longer duration and greater severity of the episode predicted a poorer response. Rajeev et al. performed a retrospective review of 139 consecutive juvenile bipolar disorder patients. (age, <16 years) and found that 96% of them recovered from the index episode; 90% were on a mood stabilizer (usually lithium or valproate).

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