Pediatric Bipolar Disorder

What Is It, and How Is It Diagnosed?

Pediatric bipolar disorder (BD) is a serious psychiatric illness that impairs children's emotional, cognitive, and social development. It is marked by severe mood instability that manifests in chronic irritability and episodes of rage and tearfulness (West & Pavuluri, 2009).

According to Sadock and Sadock (2007), the diagnosis of bipolar disorder is the same for children and adolescents as adults. The criteria for diagnosis include a distinct period of abnormally elevated, expansive, or irritable mood that lasts at least a week or for any period if hospitalization is required and that is also accompanied by any three of the following symptoms: inflated self esteem, decreased need for sleep, pressure to talk, flight of ideas or racing thoughts, distractibility, increase in goal directed activity, and excessive involvement in pleasurable activities that may result in painful consequences (Sadock & Sadock, 2007). Other symptoms of pediatric BD include initiating behavior with poor judgment, hypersexual behavior, and suicidal intent (Robb & Reber, 2007; Sadock & Sadock, 2007; West & Pavuluri, 2009).

BD symptoms can look very similar to those of attention deficit hyperactivity disorder (ADHD), and with comorbidity with ADHD of up to 60 percent, diagnoses of BD are often missed or delayed (National Institute of Mental Health, [NIMH], 2010). Some of the main symptoms that differentiate BD from ADHD are that BD is episodic where ADHD is not (DuVal, 2005). Mood dysregulation is key to BD but not to ADHD (Carbray & McGuinness, 2009). A child with BD may display dysphoria, or abnormal depression and disconnect, whereas a child with ADHD usually has a good mood and disposition unless something specific makes the child upset (DuVal, 2005). Additionally, a child with BD is also more likely to display extreme

irritability or rage of longer than 30 minutes while a child with ADHD would be less likely to display rage for that length of time (Duval, 2005; Kutscher, 2005).

A diagnosis of BD requires an in-depth evaluation of the current presenting problem, as well as a history of mood episodes during the child's lifetime to assess chronicity and episodicity (West & Pavuluri, 2009). A clinical interview is suggested, as well as a diagnostic clinical interview. Specific tools that could be used are the Kiddie Schedule for Affective Disorders and Schzophrenia (KSAIDS), the Children's Interview for Psychiatric Syndromes, or the Child Mania Rating Scale-Parent version (CMRS-P) (Carr, 2009; West & Pavuluri, 2009).

Etiology

There is a heritable link for BD, but few studies have concentrated on pediatric BD (Carr, 2009; DuVal, 2005). The chances of a child having some mood disorder, not necessarily a bipolar disorder, is 25 percent if one parent has Bipolar I and 50 percent to 70 percent if both parents have a diagnosis of bipolar I (Sadock & Sadock, 2007). West and Puvuluri (2009) stated the heritability risk for BD at 15 percent to 42 percent in first-degree relatives.

What Population Does It Affect?

There is still no authoritative data on the prevalence of pediatric BD, in part because it depends on whether the disorder is defined as a narrow or broad phenotype (West & Pavuluri, 2009). BD is estimated variously to affect between one percent and three percent of the general population at some time in their life (Carr, 2009; NIMH, 2007; Sadock & Sadock, 2007). Women are two times more likely to have BD than men (Sadock & Saddock, 2007).

How Is Pediatric Bipolar Disorder Treated?

Pediatric BD is usually treated through multimodal chronic care programs involving medication and family psychotherapy (Carr, 2009; West & Pavuluri, 2009). The principal

medications for BD are mood stabilizers, such as lithium, anti-depressants, and antipsychotics (Hamrin & Pachler, 2007; Sadock & Sadock, 2007). These may be prescribed singularly or in various combinations because according to Carr (2009) about 50 percent of bipolar cases with mania do not respond to lithium alone. Due to side effects such severe weight gain, rashes, and cognitive dulling, children should be closely monitored and a six to eight week period is considered an appropriate time in which to evaluate responsiveness to a drug therapy (Carr, 2009). DuVal (2005) also mentions close monitoring of side effects children as some antidepressant and stimulant medication used for ADHD can worsen symptoms of BD. According to NIMH (2011), behavioral and psychological treatment may also be used, and very early intervention could potentially head off depression later in life.

Long-term Prognosis

The prognosis is highly dependent on circumstances such as the individual's responsiveness to the various medications, dosage, accuracy of the diagnosis, and availability of treatment and monitoring by staff with a positive relationship with the client to detect small changes in mood. According to a study by NIMH (2006), outcomes for those with BD differ greatly, but those having a younger age of onset, low socioeconomic status, and psychotic symptoms had worse outcomes. Hamrin and Pachler (2007) talk in terms of remission and not cure. If the diagnosis is correct, early-onset BD is a lifelong disorder that needs to be managed.

Areas of Occupation and Client Factors Impacted

Carr (2009) stated that evidence from studies of both adults and children suggest that stressful life events may affect the course of bipolar disorder. So there is a potentially circular relationship between the disease and its symptoms. Just about all activities of daily living and instrumental activities of daily living—including bathing, dressing, eating, and personal

hygiene—can be widely affected, in addition to rest and sleep, education, play, leisure, social participation, body function, and values and beliefs.

Family and environmental aspects play an important role in the health of a child with pediatric BD and both can be profoundly disrupted by the disorder (DuVal 2005).

Interventions

Kutscher (2005) provides a number of steps that can be used to help children and their caregivers develop routines that accommodate the needs of the child with BD. An occupational therapist's (OT) role in setting such a routine would include training parents, caregivers, and teachers on how to implement the routine, as well as tuning the steps in their own services with the child. Steps include: setting predictable routines and keeping to a schedule; making adequate notification before transitions; providing extra time for transitions; allowing planned and needed breaks; providing signals, such as hand codes, so a child can give teachers and others warnings when something is not going correctly or may be upsetting them; and allowing a child to pull back from an activity when necessary (Kutscher, 2005).

DuVal (2005) suggests having a child attend a peer social skills group, with a concentration on friendship skills, increasing empathy, cooperative problem solving, identification of feelings, and relaxation and calming skills. Social skills groups are an area where an OT can serve as provider, organizer, or resource referral. Both Kutscher (2005) and DuVal (2005) expect a child with BD to have come to the attention of educators and have an individual education plan (IEP), an area that would again most like involve OT.

Interesting Related Information

Controversy surrounds the subject of pediatric BD. NIMH (2010) reports a 40-fold increase in the diagnosis of child and adolescent BD between 1994-1995 and 2002-2003. The

main reason mentioned for this increase is that prior to about 1995, BD was not recognized in children in adolescents (Hamrin & Pachler, 2007). While the scientific community is researching the change in diagnosis and whether BD can present earlier than previously thought, Bosselwitch (2010) attributes this high rate of diagnosis in America to three items: adults disapproval and unwillingness to accept young peoples' behavior, and desiring it to be ascribed to an illness instead of poor self-control; the need of pharmaceutical companies to extend soon to be off-patent drugs by getting approval to have them prescribed for different diagnoses; and teachers no longer being formally responsible for teaching children how to recognize and manage their emotions.

The research of Gogtay et al. (2007) shows that the brains of children with BD have a distinct neurotrajectory from those with schizophrenia, which appears to be the beginnings for establishing a neurological basis for early-onset, or pediatric, BD.

What is clear is that there are children who have signs of BD that were once attributed only to adults. It is important to watch the symptoms with which children present so as to make the correct diagnosis of illness as soon as possible and to treat appropriately through multimodal interventions and close monitoring of the health of the child and their families.

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