Pediatric Bipolar Disorder: A Case Presentation and Discussion

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KEY WORDS
Behavior, depression, mania, mood, pediatric bipolar disorder

Bipolar disorder is a mood disorder characterized by periods of mania, hypomania, and depression that interfere with the child's daily functioning (American Psychiatric Association, 2013; Birmaher, 2013). There are subtypes of bipolar disorder, such as bipolar I disorder, bipolar II disorder, cyclothymic disorder, and other specified bipolar and related disorders (American Psychiatric Association, 2013; Birmaher, 2013). Pediatric bipolar disorder has a more tenuous disease course compared with adult onset disorder with many associated comorbidities (Frías, Palma, & Farriols, 2015; Post et al., 2017). Therefore, early recognition of the disorder using diagnostic criteria is paramount. Criteria for diagnosis of the different types of bipolar disorder are outlined in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. (*DSM-5*; American Psychiatric Association, 2013). A pediatric bipolar case is discussed in relation to these criteria.

Bipolar I disorder is characterized by a history of at least one manic episode with possible psychotic features, whereas bipolar II disorder features hypomania and depressive episodes without mania or psychosis (American Psychiatric Association, 2013; National Institute of Mental Health, 2016). In cyclothymic disorder, the child has persistent, alternating periods of chronic hypomania and depression that do not meet the full criteria for bipolar disorder; these symptoms must be persistent for 1 year with no more than 2 symptom-free months (American Psychiatric Association, 2013). In bipolar disorder, symptoms during an episode cannot be due to any other circumstance, such as a medical condition (i.e., brain tumor) or substance (i.e., marijuana; American Psychiatric Association, 2013).

Currently, the prevalence rate for bipolar disorder in children is not known (National Institute of Mental Health, n.d.). However, there are data to suggest that there is a higher diagnosis rate of childhood bipolar disorder in the United States compared with other countries (James et al., 2014; Post et al., 2017). In a comparison of American and English hospital discharge rates for pediatric bipolar disorder from 2000 through 2010, the United States had a discharge rate for pediatric bipolar disorder of 100.9 per 100,000 population, and this rate was 12.5 times higher than in England (James et al., 2014). In addition, higher rates of childhood bipolar disorder have been noted in the United States compared with Europe and Canada (Post et al., 2017). With an increase in childhood mental health problems, many mental health visits for children are being conducted by nonpsychiatric providers (Olfson, Blanco, Wang, Laje, & Correll, 2014). This emphasizes the need for pediatric providers in the United States to be aware of bipolar disorder. Although pediatric providers need to recognize mental health disorders, consultation with a psychiatric specialist is needed for provision of best evidence-based treatment (Olfson et al., 2014).

CASE PRESENTATION

The following case presentation used information from the American Psychiatric Association (2013) and Birmaher (2013) to formulate an example of a case of pediatric bipolar disorder. A 10-year-old boy presented to his

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primary care provider (PCP) for unusual mood and behavior. He presented with his mother, who stated the chief complaint of "My son has not been acting like himself." The history of present illness included symptoms of elevated mood, grandiosity, decreased need for sleep, and increased goal-oriented activity. This history, combined with physical examination findings, showed mania symptoms consistent with bipolar disorder (American Psychiatric Association, 2013; Birmaher, 2013).

History of Present Illness

The mother described that the patient's abnormal mood and behavior have been persistent for 1 week. During this time, he has only been sleeping for about 4 hours at night without seeming tired during the day. He has been leaving the house late at night to practice baseball batting in the yard, which prompted complaints from the neighbors. His teacher reported that he has been disruptive in class, excessively talking with spontaneous bouts of laughter. He has also been to the principal's office after jumping from a tall tree near the playground and encouraging others to try it as well. These behaviors are the opposite of his usual behavior: he is a shy child who is well behaved, performs well in school, and has many friends on his baseball team. The mother reported that he had an episode where he seemed "down" a month ago. During this time, he was very tired, not waking in the mornings for school, not interested in playing baseball, and easily irritated. This episode lasted 2 weeks and self-resolved without health care professional advice or treatment.

Past Medical History, Family History, and Social History

The past medical history results were negative for any medical or psychiatric conditions. The boy does not take any daily medications. The family history was significant for patient's 35-year-old father having bipolar I disorder, which was diagnosed when he was 24 years old. According to the social history, the patient lives with his mother and maternal grandmother in a suburban neighborhood. His mother and father divorced 2 years ago, and he stays with his father every other weekend. There are no siblings. The patient has never had any developmental concerns. He is in the fifth grade at a public elementary school.

Review of Systems

In the review of systems, the boy's mother denied that the boy had ever expressed suicidal ideation or attempted suicide. She also denied known substance use or environmental stressors. Supporting a lack of organic cause for symptoms, his mother denied that the patient had seizures, headaches, visual changes, nausea, vomiting, fatigue, weakness, problems with coordination or balance, or a history of head injuries. Without the patient's mother present, the patient was also asked about substance use and suicidal ideation, which he denied. Finally, because bullying is a risk factor for mental illness (Arseneault, 2017; Copeland, Wolke, Angold, & Costello, 2013), the patient was asked if he has been bullied or if he has bullied others, which he denied.

Physical Examination

The patient was healthy and had normal findings for all body systems except neurologic. He jumped from one topic to the next and could not be interrupted. He described that he was the "best baseball player in the world." Other than the patient's flight of ideas, grandiosity, and elevated mood, the rest of his neurologic examination results were within normal limits. Because of these subjective and objective findings, patient was referred to a child psychiatrist for diagnostic evaluation for bipolar disorder.

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Diagnosis

The *DSM-5* outlines specific criteria to make a diagnosis of one of the bipolar disorder types, and these criteria are currently being used to diagnose children (American Psychiatric Association, 2013; Renk et al., 2014). Therefore, the PCP must understand the *DSM-5* terminology and bipolar symptoms as the basis for diagnosis. Mania, hypomania, and major depression are symptoms that these patients experience (American Psychiatric Association, 2013).

Mania symptoms must be present for at least 1 week and should include symptoms of elevated mood and/or irritability (American Psychiatric Association, 2013). If an elevated mood is present, there must be at least three additional symptoms, or if an irritable mood is present, there must be at least four additional symptoms, including grandiosity, elevated mood, being extra talkative, decreased need for sleep, flight of ideas, hypersexuality, being easily distracted, and increased goal-oriented behaviors (American Psychiatric Association, 2013). Some mania symptoms coincide with normal behavior for children, such as elation or feeling like they are the best at something (Birmaher, 2013). Thus, the clinician must focus on whether the behaviors are normal for the situation or not and whether they indicate a change from the child's usual behavior (Birmaher, 2013). Demeter et al. (2013) performed assessment on six different age groups from 4 through 17 years of children with bipolar disorder and found that certain mania symptoms, such as motor activity, aggression, and irritability, were more prominent in younger age groups.

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