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Bipolar Type I Disorder in Children

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ABSTRACT

Bipolar disorder in children and adolescents is a clinical disorder that causes public mental health problems that need attention. In the last decade, bipolar disorder in children and adolescents has become a trendy field, both in the clinical area and in research, especially in terms of diagnosis, which is still controversial. The controversy that remains is whether it is possible to diagnose bipolar disorder in prepubertal children. Based on the DSM-IV-TR diagnostic criteria, the prevalence of the bipolar disorder in children scarce rare. Epidemiological studies report the lifetime prevalence of bipolar I and II disorders in late adolescence is about 1 per cent. Various studies in a large population have shown a prevalence rate of 0.1% - 2%. The onset of bipolar disorder in children and adolescents is often accompanied by a more severe disease course, compared to bipolar disorder with onset in adulthood. This case report presents a case of bipolar 1 in children accompanied by comprehensive management.

1. Introduction

Patients who only had major depressive episodes were said to have a major depressive disorder or unipolar depression. Patients with both manic and depressive episodes or patients with only manic episodes are said to have bipolar disorder (bipolar disorder). The terms "unipolar mania" and "pure mania" are sometimes used for patients who are bipolar but do not have a depressive episode.

A manic episode is a period characterized by the irregular, expansive, high, persistent, abnormal mood that lasts for one week, or less if hospital admission is required. Based on the DSM-IV-TR, bipolar I disorder is defined as a mood disorder in which the clinical course has one or more episodes of mania, may also be accompanied by depressive episodes. A mixed episode is characterized by both manic and significant depressive episodes that occur almost daily, for a minimum period of 1 week. A variant of bipolar disorder characterized by episodes of major depression and hypomania is known as bipolar II disorder. The diagnostic criteria for bipolar disorder in children are the same as those used in adults.

Family studies consistently show that children of parents with bipolar disorder have a 25% chance of developing mood disorders. Meanwhile, children of both parents with bipolar disorder have a 50% to 75% risk of experiencing mood disorders.

Neurobiological disorders of bipolar disorder in children and adolescents occur during fetal growth. Several studies in children with bipolar disorder have shown dysfunction in the neural circuits in the amygdala, striatal, thalamic, and prefrontal structures of the brain. Children and adolescents with bipolar disorder make more mistakes in emotion recognition.

The diagnostic criteria for bipolar disorder in

children and adolescents on the DSM -IV-TR are the same as those used in adults. The clinical picture of bipolar disorder in children and adolescents is quite complicated because other conditions often accompany it. Bipolar disorder in children and adolescents can be compatible with ADHD. Bipolar disorder in children and adolescents is characterized by severe and persistent irrationality, including outbursts of aggression and violent behaviour. Between the aggressiveness and violent behaviour, children with this disorder will continue to feel angry or dysphoric. A child with bipolar disorder may exhibit great ideas or a euphoric mood. Mostly, children with this disorder experience fluctuating emotions with negative moods.

2. Case presentation

In this case, the patient boy, MFH, ten years old, went for treatment on October 25, 2010, with the chief complaint of taking a walk while the lesson was in progress. From autoanamnesis, the patient said he felt happy. The patient said he was doing well, got second place in school, and got a hundred marks in science, math and English.

From alloanamnesis, it was found that the patient had experienced a change in behaviour for one year, which was worsening since four months ago. The patient walks around the school when the other students are studying; the patient cannot be silent and feels bored. Patients sometimes sing while banging the table. The patient also gets angry quickly. The patient will be angry with the person who reprimands him for doing something. The patient had spat on and said he wanted to kill the person who rebuked him. Patients often wake up from 10 pm to 2 pm; when they wake up, the patient only plays alone.

About one week of changing behaviour, the patient begins to experience frequent seizures. The patient experiences seizures while falling asleep, experiences seizures if during the day the patient is angry with other people or has too much activity. The seizures experienced by the patient consisted of clenched fists and a forward gaze. The duration of seizures is about 1 minute; in one week, the patient will experience seizures approximately 2-3 times. EEG examination within normal limits. A neurology colleague with idiopathic epilepsy diagnosed the patient. When the patient's mother is pregnant with the patient, the patient's biological father leaves the patient's mother who is pregnant. The patient's birth mother hates the womb. The patient's biological mother had said she wanted to abort her womb by taking herbs. The patient's biological mother said she would dispose of the child when it was born.

The patient received pharmacotherapy 0.5 mg 1 - 0 - 1 risperidone, lorazepam 0.5 mg 0-0-1 prn, and valproic acid 250 mg 1-0-1. Meanwhile, the psychosocial intervention carried out was to create a good report card to increase medication adherence, providing psychoeducation to families about bipolar disorders. Psychoeducation to families can include the importance of regular treatment, early detection of new episodes, monitoring children's mood and behaviour, introducing regular sleep and activity patterns, increasing the ability to adapt to the psychosocial effects of bipolar disorders, and minimizing academic, social and academic dysfunction. Interpersonal due to bipolar disorder.

After being treated for seven days, the patient did not experience seizures again, the behaviour improved, the irritability decreased. In control on November 24, 2010, the patient's behaviour was getting better, treatment was added with aripiprazole 3 mg 1-0-0. In December control, the patient returned to attend school lessons.

3. Discussion

Bipolar symptoms in children and adolescents

usually manifest as mood swings that are rapidly fluctuating, making diagnosis difficult to establish. Many children with this disorder do not meet the diagnostic criteria specified in the DSM-IV, i.e. the duration of symptoms does not meet the criteria for bipolar 1 or 2 disorder. The most common symptoms in children and adolescents with bipolar disorders are very moody unstable and explosive, irritable, uncontrollable behaviour and aggression.[1,2]

Symptoms that can be found in these patients are euphoric, unstable and irritable mood, the idea of greatness, considerable talk, increased psychomotor and decreased sleep time. In this patient also found uncontrolled behaviour and aggressiveness. Recent research has shown that there is no significant difference between bipolar disorder and ADHD, in terms of irritability, excessive talk, distracted attention, and excessive energy. The presence of symptoms of inflated self-esteem, and increased goal-directed activity in this patient, distinguishes it from ADHD.[3]

This patient also has idiopathic epileptic disorders, in which epileptic seizures can be triggered by changes in the patient's mood and excessive activity. In this case, epileptic seizures are triggered by symptoms of bipolar disorder.

The pharmacological therapy given to patient included risperidone 0.5 mg 1–0-1, which is quite responsive and has been recommended by the FDA. After one month of treatment, risperidone was replaced with aripiprazole 3 mg 1-0-0, which has also been recommended by the FDA. It is hoped that aripiprazole will have a special effect. This patient was also given valproic acid 250 mg 1-0-1, where apart from being a mood stabilizer, valproic acid could act as an anti-epileptic. Meanwhile, lorazepam 0.5 mg 0- 0-1 prn, if needed, is given to treat sleep disorders.[4]

Pharmacological therapies commonly used for episodes of bipolar mania in children include lithium, epilepsy drugs (valproate and carbamazepine), antipsychotic drugs (risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole); which can be added other medications as indicated. The FDA recommends lithium for children over 12 years of age, while children over ten years of age can be given risperidone or aripiprazole.

Practical guidelines for specific interventions that are important in managing child bipolar disorder are: enforcing report cards, monitoring children's mood and behaviour, providing information to families about bipolar disorder, increasing medication adherence, introducing regular sleep and activity patterns, increasing the ability to adapt to the psychosocial effects of bipolar disorder, early detection of new episodes, minimizing academic, social and interpersonal dysfunction due to bipolar disorder.[4,5]

4. Conclusion

The clinical and phenomenological characteristics of bipolar disorder in children and adolescents are unique. Due to this unique clinical picture, it is necessary to identify cases and treat them as early as possible. Bipolar disorder in children can be chronic, with frequent and severe recurrences, resulting in developmental disorders and impaired psychosocial functioning. Therefore, the management of children with bipolar disorder is not only aimed at controlling the symptoms of the disease, but also at the child's psychosocial function.

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