

Jorge Gómez-Arnau¹
Javier San Sebastián²

Controversies regarding bipolar disorder in preschool age: case report

¹Servicio de Psiquiatría
Hospital Universitario Ramón y Cajal
Madrid

²Psiquiatría Infanto-Juvenil. Servicio de Psiquiatría
Hospital Universitario Ramón y Cajal
Madrid

There is some discussion concerning the phenomenology of pediatric bipolar disorder. This condition is marked by irritability and sudden mood swings, and has no specific diagnostic criteria. Disagreement is even greater for bipolar disorder in preschool age.

We report the case of a child of four years and nine months with diagnosis of bipolar disorder not otherwise specified. Predominant symptom presents as irritability with outbursts of anger, verbal aggression and strange and grandiose utterances, all of them with a very fluctuating temporal pattern.

We found similar cases and discrepancies in previous publications. It has been suggested that patients with non-episodic irritability may receive a diagnosis of severe mood dysregulation disorder. Further studies on mood disorders in preschool children are required.

Key words: Child psychiatry, Bipolar disorder, Irritability, Severe mood dysregulation disorder

Actas Esp Psiquiatr 2013;41(5):311-3

Controversias en relación al trastorno bipolar en edad preescolar: a propósito de un caso

Existe cierto debate en cuanto a la fenomenología del trastorno bipolar en edad pediátrica, entidad que se caracteriza por la irritabilidad y las oscilaciones bruscas del ánimo y que carece de criterios diagnósticos específicos. El desacuerdo es aún mayor para el trastorno bipolar en población preescolar.

Correspondence:

Jorge Gómez-Arnau Ramírez
Servicio de Psiquiatría. Hospital Universitario Ramón y Cajal
Carretera de Colmenar Viejo km 9,100
28034, Madrid, Spain
E-mail: jorgegarnau@gmail.com

Describimos el caso de un niño de cuatro años y nueve meses al que diagnosticamos de trastorno bipolar no especificado. Presenta irritabilidad como síntoma predominante, explosiones de ira, agresividad verbal y verbalizaciones extrañas y grandiosas, todo ello con un patrón temporal muy fluctuante.

Encontramos casos similares y discrepancias en publicaciones previas. Se ha propuesto que los pacientes con irritabilidad no fásica podrían ser diagnosticados de trastorno de disregulación emocional. Se requieren más estudios sobre trastornos del humor en niños preescolares.

Palabras clave: Psiquiatría infantil, Trastorno bipolar, Irritabilidad, Trastorno por disregulación emocional

INTRODUCTION

There has been an important increase in the diagnosis of bipolar disorder in children in recent decades.^{1,2} In spite of this, childhood bipolar disorder continues to be an entity generating controversy, both in regards to levels of prevalence, with important discrepancies between different media and authors, and phenomenological characteristics of the picture.³ This lack of consensus may largely be due to the absence of specific diagnostic criteria of bipolar disorder in children in the current classifications (ICD-10 and DSM-IV-TR).

It is accepted that bipolar disorder in the pediatric age is generally a differentiated clinical presentation regarding that described in adults. Irritability seems to be the most characteristic symptom, often occurring with sudden mood swings, ultradian rhythm, while the euphoric states are less common. Grandiosity and hypersexuality occur inconsistently. Shorter sleep duration is not always present.^{4,5}

The panorama becomes complicated when we only refer to the pre-school population. Added to the smaller number

of publications in this age, most of these being case series or clinical notes, is the disagreement among authors regarding the clinical characteristics of the disorder is even greater.⁶

A CASE REPORT

This is a four year, nine month old boy who came to the child psychiatry consultation after being referred by his pediatrician for study of behavior disorders.

The patient had been studied in neuropsychiatry, where a brain MRI and EEG had been requested. No alteration was found, neurological or structural pathology of the CNS being ruled out. The patient had no other relevant medical-surgical backgrounds.

He is an only child and lives with his two parents and maternal grandmother in a peaceful family environment. He is a wanted child.

The patient had been achieving the different milestones of psychomotor development in the usual periods. He had rich symbolic play from the first year of life and had developed speech with normality. In school since 25 months of age, he had not had learning problems and had easily related with his peers.

His parents define him as an affectionate child, who seeks contact and responds to gestures of affection. He does not seem especially rigid or routine and is also not absent-minded. In general, he does not have problems to carry out tasks that require sustained attention. He generally prefers quiet entertainment to games that imply greater physical activity.

During the last months of pregnancy and puerperium, the patient's mother suffered a moderate depressive picture, with data of affective endogeneity. This required antidepressive treatment and progressively decreased until abating *ad integrum*. There is no other family psychiatric history in childhood or adult age.

The patient's parents brought him to the consultation because they were concerned about his mood changes, which were very frequent and exaggerated. Standing out were intense irritability, that occurred in different time periods with almost daily frequency, outburst of anger accompanied by psychomotor restlessness and distractibility and that arose suddenly, as reaction to minimum mishaps or lacking apparent cause. During them, the patient subjected his setting to important physical and above all verbal violence, directing death threats against his family (e.g. "I am going to cut off your head"). During these episodes, the patient also verbalized unusual contents, which were impressive for their grandiloquence, many times expressing his own omnipotence (e. g., "I am going to destroy the sun

and moon with evil spell spray," "I am going to eliminate all the clocks in the world and no one will know what time it is"). With usually serious expression, on these occasions, he showed an unmistakable expression of rage.

In other moments, the patient had maintained episodes of crying, that could continue, at intervals, for several hours, and during which, according to his parents, he seemed sad and melancholic. The time pattern of these described mood changes is unclear. The fits of irritability and crying attacks occur more in the late evening but have also been reported in the school. His parents have observed how during several days in a row, he has more intense and frequent mood changes than that occurring in other periods in which the patient has a more stable mood. They say the picture started about three and a half years ago.

The patient does not seem to have maintained behavior hyperactivity. He also does not have sleep rhythm or eating alterations.

His physical examination is insignificant. In the interviews, the patient does not provide a consistent explanation for his mood swings. In general, he is calm, without data of restlessness or other psychomotor alterations. Normal sex drive. He does not express ideas with pathological or unusual content for his age and his speech does not suggest psychoticism. Apparently normal mood during the interviews, with congruent and resonant affect.

We used the *Child Mania Rating Scale-Parent Version* (CMRS-P), simple to apply in young children, and validated as a complementary instrument to the clinical history in screening of pediatric mania,⁷ obtaining a score of 26.

DISCUSSION

We are dealing with an example of severe and fundamental mood alteration in a very young child. His extreme irritability with grandiloquence, suggestive of pediatric mania, and high mood swings, have led us to consider the diagnosis of bipolar disorder as plausible. Since the episodes do not meet the time criteria of the classical bipolar forms (type I or II), we decided on the diagnosis of not otherwise specified bipolar disorder, common in the practice and research in child psychiatry, lacking a more adequate category.⁸

We have found notable coincidences on the psychopathological level between our case and that described by Danielyan et al. in a series of 26 cases of bipolar disorder in pre-school age, with irritability and aggressiveness as predominant manic symptoms.⁹ However, other authors have studied cases of bipolar disease in pre-school children, finding a significant proportion of patients with euphoric mood and well-defined phases that meet the DSM-IV-TR

time criteria.^{10,11} These discrepancies could be partially explained by the small sample sizes and absence of specific diagnostic criteria, which give rise to heterogeneous series.

For some years, it has been proposed to include emotional dysregulation disorder in childhood (*severe mood dysregulation*) as a new category that would include pediatric patients with predominance of irritability that is not clearly phasic, fits of rage and hyperactivation.¹² Although arguments that support the independence of this entity regarding child bipolar disorder have been presented,¹³ in individual cases, the differential diagnosis may be difficult, as they frequently share one same symptomatic nucleus, irritability. In our case, although highly specific symptoms such as hypersexuality or shorter sleep duration are lacking,⁴ we consider that sufficiently differentiated manic episodes exist (both phenomenologically with megalomania and temporally) to lean towards a bipolar disorder. Unfortunately, other factors proposed to distinguish between both entities, as the conversion rate to classical bipolar forms, greater in otherwise not specific bipolar disorder,¹⁴ are not cross-sectionally evaluated.

Given the possibility of incorporating a variant of emotional dysregulation as a diagnostic category into the DSM-5 (*temper dysregulation with dysphoria*),¹⁵ some authors have warned about the scarce specificity of this syndrome regarding other already existing diagnoses in child psychiatry such as the oppositional defiant disorder.¹⁶ In our case, the syndromic overlapping with not otherwise specified bipolar disorder, constituted around the dysphoria symptoms, is that which casts doubts on its nosological independence. We hope that future studies will make it possible to more solidly define the mood disorders in pediatric patients and more specifically, in pre-school ones.

REFERENCES

- Moreno C, Laje G, Blanco C, Jiang H, Schmidt AB, Olfson M. National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Arch Gen Psychiatry*. 2007 Sep;64(9):1032-9.
- Blader JC, Carlson GA. Increased rates of bipolar disorder diagnoses among U.S. child, adolescent, and adult inpatients, 1996-2004. *Biol Psychiatry*. 2007 Jul 15;62(2):107-14.
- Soutullo CA, Chang KD, Díez-Suárez A, Figueroa-Quintana A, Escamilla-Canales I, Rapado-Castro M, et al. Bipolar disorder in children and adolescents: international perspective on epidemiology and phenomenology. *Bipolar Disord*. 2005 Dec;7(6):497-506.
- Kowatch RA, Youngstrom EA, Danielyan A, Findling RL. Review and meta-analysis of the phenomenology and clinical characteristics of mania in children and adolescents. *Bipolar Disord*. 2005 Dec;7(6):483-96.
- Youngstrom EA, Birmaher B, Findling RL. Pediatric bipolar disorder: validity, phenomenology, and recommendations for diagnosis. *Bipolar Disord*. 2008 Feb;10(1Pt 2):194-214.
- Goldstein BI, Birmaher B. Prevalence, Clinical Presentation and Differential Diagnosis of Pediatric Bipolar Disorder. *Isr J Psychiatry Relat Sci*. 2012;49(1):3-14.
- Pavuluri MN, Henry DB, Devineni B, Carbray JA, Birmaher B. Child mania rating scale: development, reliability, and validity. *J Am Acad Child Adolesc Psychiatry*. 2006 May;45(5):550-60.
- Axelson D, Birmaher B, Strober M, Gill MK, Valeri S, Chiappetta L, et al. Phenomenology of children and adolescents with bipolar spectrum disorders. *Arch Gen Psychiatry*. 2006 Oct;63(10):1139-48.
- Danielyan A, Pathak S, Kowatch RA, Arszman SP, Johns ES. Clinical characteristics of bipolar disorder in very young children. *J Affect Disord*. 2007 Jan;97(1-3):51-9.
- Dilsaver SC, Akiskal HS. Preschool-onset mania: incidence, phenomenology and family history. *J Affect Disord*. 2004 Oct;82(Suppl 1):S35-43.
- Luby J, Tandon M, Nicol G. Three clinical cases of DSM-IV mania symptoms in preschoolers. *J Child Adolesc Psychopharmacol*. 2007 Apr;17(2):237-43.
- Leibenluft E, Charney DS, Towbin KE, Bhangoo RK, Pine DS. Defining clinical phenotypes of juvenile mania. *Am J Psychiatry*. 2003 Mar;160(3):430-7.
- Leibenluft E. Severe mood dysregulation, irritability, and the diagnostic boundaries of bipolar disorder in youths. *Am J Psychiatry*. 2011 Feb;168(2):129-42.
- Towbin K, Axelson D, Leibenluft E, Birmaher B. Differentiating bipolar disorder-not otherwise specified and severe mood dysregulation. *J Am Acad Child Adolesc Psychiatry*. 2013 May;52(5):466-81.
- DSM-5 Childhood and Adolescent Disorders Work Group. Justification for Temper Dysregulation Disorder With Dysphoria. Washington, DC: American Psychiatric Association, 2010.
- Axelson DA, Birmaher B, Findling RL, Fristad MA, Kowatch RA, Youngstrom EA, et al. Concerns regarding the inclusion of temper dysregulation disorder with dysphoria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. *J Clin Psychiatry*. 2011 Sep;72(9):1257-62.