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Review Article

Why it is so Important to Diagnose Bipolar Disorder in Children and Adolescents?

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Abstract

The diagnosis of bipolar disorder in children and adolescents has not progressed among child psychiatrists despite increasingly solid data. It is unipolar depression, anxiety disorders including panic attacks and of course hyperkinesia with attention deficit disorder that are at the top of the bill. This is how adult psychiatrists inherit bipolar patients whose diagnosis was ignored in childhood or adolescence, often dormant for years. The diagnostic guidelines, although not perfect, quickly lead to the diagnosis of bipolar disorder, especially as when parents are questioned, there are arguments leading to family disease. If mood stabilizers are little or no effective before the age of 12, they can be used successfully after that age. Behavioral therapies can take over or methylphenidate in the case of obvious school problems.

Key words: bipolar disorder; children; adolescents; ADHD

Introduction

Despite Esquirol's 1838 description of mania in school-age children and Kraeplin's detailed description of depressions and manias in children and adolescents as early as 1899, bipolar disorder was long considered to appear around the age of 20 years old and very rarely in young people under 12 years old [1].

Recent interest in bipolarity in children, which for a long time was considered rare, began more explicitly, notably in 1997, which summarizes the knowledge on the subject over the last 10 years [2]. The success is resounding and rekindles the interest of researchers, knowing that very serious studies were published in the 1980s [3].

In 1999, Demitri and Janice Papolos published the book "The Bipolar Child" [4]. The work aroused genuine media interest, thus making it possible to publicize the disorder. In addition, epidemiological data shows that bipolar disorder begins in more than two-thirds of cases before the age of 18. It is from this moment that his results sparked the emergence of many new researches in this sector. For Joseph Biederman, an American child psychiatrist whose work has focused on bipolarity in young people, it can appear at birth "as soon as the child opens his eyes".

A better understanding of these disorders, at the clinical, etiopathogenic (genetic) and therapeutic levels, and the advanced importance of an early diagnosis have led, over the last 30 years, to the proliferation of work on bipolar disorders in patients. the child and the adolescent [5].

Current scientific knowledge as well as clinical experience shows that psychiatric disorders often have their roots in childhood. Parents of bipolar children always end up telling us that at their age they were sort of the same. They had the same manifestations as their children, whether the intensity was the same or less [6]. Al though the forms that bipolar disorder can take in childhood may be different from the adult form, although we sometimes see the appearance of a few symptoms that are not sufficient to diagnose all of these manifestations. As young and motley as they are, these manifestations must be taken into account and require intervention to avoid the worsening of symptoms and to try to provide a better prognosis for the progression of the disorder [7].

The main manifestations of bipolarity during childhood

1- Sudden changes in mood / permanent emotional lability

The child exhibits disproportionate emotional reactions. His mood changes very quickly, sometimes for no obvious reason in the surroundings. It alternates in an extreme way, between different states:

-moments of depression: with symptoms such as sadness, psychomotor slowing down, and sometimes the presence of black thoughts or even morbid and suicidal

-hypomanic moments: with euphoria, tachypsychia, increased energy, logorrhea, impulsivity, hyperactivity. This state is usually very exhausting for those around you.

-mixed moments: where either he is both sad with a lot of tension in his body, or he is slowed down in his body, but his head is spinning at full speed
-explosive temper tantrums that can last more than half an hour with self-aggressive and straight-aggressive behavior, often triggered by situations of change, the unexpected, or frustration intolerance.
These mood variations are not necessarily visible and sometimes result in behaviors of impertinence, restlessness, refusal to do homework, etc.
We also note in certain clinical forms, the presence of a constant emotional lability (not episodic) from early childhood (generally around the age of 6) with the onset of problematic behaviors during adolescence (around the age of 15).
2- Difficulties of tolerance and regulation of frustration
3- Difficulties falling asleep and waking up (with energy and excitement in the evening and fatigue and difficulty emerging in the morning)
4- Problematic behaviors such as systematic opposition, provocation, refusal of authority
5- Comorbid disorders (which sometimes dominate the clinical picture) such as OCD (obsessive-compulsive disorder), ADHD (attention deficit hyperactivity disorder), separation anxiety disorder, school phobia, emetophobia (obsession with vomit) etc. behaviors during adolescence (around the age of 15). [8,9].
What is particularly complicated for the observer is that these signs are labile, particularly hypomania, which is also found in type 2 bipolar disorder in adults. Depression can seem omnipresent, but rather the lack of energy associated with tachypsychia.

The need to intervene without too much delay

Early-onset bipolar disorder is now considered underdiagnosed, knowing that specific research into this diagnosis leads to an increase in its prevalence in child psychiatry services [10]. Bipolarity being a chronic disorder, and perhaps the most common psychiatric disorder among young people, it is necessary to identify and identify children at risk, intervene young to prevent brain fire or the phenomenon known as kindling or delay it as much as possible [11].
Several studies show the link between the age of onset and the severity of bipolar disease [12]:
-in retrospect: more episodes, more comorbidities, more rapid cycles without forgetting the negative psychological and socio-professional impact;
-prospectively: more severe manias, depression and fewer days when the person feels good).
In addition, the younger the bipolarity appears, the longer the period of access to the first treatment, estimated on average at over 16 years! [13].
Juvenile bipolarity is a cross between a genetic disposition and a regular stressful environment that could precipitate the onset of the disorder; working on the "stressful" part could allow the child to develop in a healthier way [14].
It is often considered that the first mode of intervention would be psychotherapy, which would be essentially for prophylactic purposes. It enables them to be informed about mood changes and to make them aware of their regulation. However, pharmacology is often necessary as well as psychoeducation with parents [15]. The use of mood stabilizers in children under 12 is often ineffective. As these children often present cognitive disorders with more or less hyperkinesia, it is indicated to prescribe methylphenidate to curb school problems. It is also important to reduce daily stress and / or work on improving strategies to cope with it.
Family therapy is proving to be a tremendous tool [16].
-information on bipolar disorder
-management of mood swings
- crisis management
-learning of a new mode of communication between the different members of the family (including siblings) technique of management of family problems.
- Mood stabilizers are very effective after puberty, but antidepressants are usually contraindicated [17]

Differential diagnosis

Due to a comorbidity of up to 90% in children under 12 years of age, bipolar disorder must be differentiated from different presentations of attention deficit disorder with hyperkinesia (ADHD), which presents a challenge for the child psychiatrist. Between 70% and 90% of bipolar children also have comorbid ADHD. The difficulty of the differential diagnosis is twofold: While the diagnostic inflation of recent years around ADHD has masked many bipolar children and adolescents under this diagnosis, one should avoid labeling true hyperactive children with the diagnosis of bipolar disorder.
We also find a marked comorbidity with panic disorder; it is very common to see adolescents with panic attacks that often mask a mood disorder. Asperger's syndrome and borderline personality [18]. But you should also know that the diagnosis of schizophrenia is often advanced instead of bipolar disorder in adolescents [19].
In addition, frequent comorbidities (Table 1) lead to diagnostic difficulties for non-specialists, while the diagnosis of bipolar disorder in children is based on solid foundations [20,21 22]

Prevalence of comorbidities (after 23**)**
- Attention deficit hyperactivity disorder (90% comorbidity in children under 12)
-Substance abuse and dependence (8-60% more common in boys)
-Alcohol abuse and dependence (39-61%, more common in boys)
- Suicides: 44.4% of adolescent suicide attempts are due to BD, 50% of bipolar adolescents evoke traumatic and problematic suicidal events, while 32% acted out (study carried out on 405 young people between 7 and 17 years)
- Impulse control disorders (13-23%). 37 At least 20% of incarcerated adolescents suffer from bipolar disorder
-Conduct disorders (90% among children under 10) and risky behavior (endangerment, sexual promiscuity, etc.)
-Anxiety disorders (17-16%, more common in girls)
-Depressive disorders: 22.2% of major depressions among adolescent girls are due to TBEA
-Obsessive-compulsive disorder (8-35%)
-Eating disorder (12-15%, more common in girls)
-Personality disorders
-Tourette's Disorder
Table-1

Conclusion

Bipolar disorder in children and adolescents is poorly understood and underdiagnosed in the affected population.

- Genetic factors (history of bipolar disorder in one or both parents). The risk of developing bipolar disorder is four times higher when it has been diagnosed in one of the parents. However, contextual elements (living with an affected parent) and early trauma should also be taken into account [5].

-Vulnerability is linked to pregnancy (maternal smoking), childbirth (prematurity), as well as psychological trauma during childhood. These have also been shown to lead to a more serious course (suicides) and a higher incidence of bipolar disorder A family history of an affected first-degree relative, with perinatal problems in the child, may increase the risk of developing bipolar disorder. The presence of these factors, especially in the context of clinical signs of affect and behavioral disturbances, should alert the clinician to the search for bipolar disorder.

- A family history of bipolar disorder or mood disorders occurring in the context of conduct disorders, ADHD, substance abuse (especially cannabis) or a history of suicide attempts.

- Last but not least, we currently know that the presence of certain prodromes (the warning symptoms of the disease), although not specific, constitutes the common background of many young people concerned.

We can therefore say that the clinician must be particularly attentive when prodromal symptoms appear in children or adolescents from high-risk families (both parents), and all the more so if the clinic also reports drug addiction and / or suicide attempts [24].

In clinical practice it is often a bipolar parent coming in for consultation with the child who says, "I was like him when I was little." It is also early childhood educational difficulties that lead to the diagnosis of attention deficit disorder, which over time most often reveals itself as true bipolar disorder.

More and more researchers and clinicians seem to be unanimous in advocating early screening and treatment to deal with the heavy burden of bipolar disorder, particularly in children [25].

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