CHILDREN'S
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BIPOLAR DISORDER WITH EARLY ONSET: A CASE REPORT

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The concept of childhood bipolar disorder finds more and more supporters despite all controver-sies surrounding the paradigm of an early onset of this debilitating psychiatric condition. Still main attention is drawn to pubertal children (Carlson 1984, Biederman et al 2001, Wozniak et al. 1995) including the description of the clinical picture and suggested treatments. Kaplan and Saddock in "Synopsis of Psychiatry" indicate that mood disorder in general is extremely rare in preschool children and do not even consider the possibility of manic episodes. In her lectures in Tufts University, Dr. Wozniak spoke about onset of bipolar disorder at as early as less than one year of age, which caused an outraged response from Child Advocate (June 3,2001). Dr. Wozniak was accused "of promoting dangerous and irresponsible drugging of children." Unfor-tunately, her opponent in his/her sarcastic retort distorted and mixed up normal developmental lines and pathological symptoms. The truth is, there are substantial and understandable difficul-ties in diagnosing bipolar disorder in young children, who in the course of perfectly normal development are prone to affective lability, rapid shifts of moods (which makes it possible for parents to placate them), silly behavior and temper tantrums (if for example they do not have their favorite brand of cereal for breakfast). Because of anatomical immaturity of their nervous system they do not sustain their moods for a long time and could be easily reduced to tears or make laugh. The classical diagnosis of bipolar disorder requires the combination of clinical symptoms and their durations, none of which is attainable in preschoolers. It certainly does not help that youngsters cannot express their feelings the same way older children or adults can, and it is their behavior that mostly becomes the object of clinical scrutiny rather than the description of how they feel.

In our assessments of children parents frequently indicate that their child was born with the same problems he or she presents now, but the family never sought help until the child completely failed at school or got into some sort of trouble. It is not uncommon to find that the child was treated with stimulants at age 4 or 5 with no improvement or even increase of symptoms. Two following case reports illustrate some challenges of diagnosis and treatment of bipolar disorder in preschoolers.

Case1. "Sam" is a four- year-old youngster coming from a broken family with a significant load of substance abuse and severe psychiatric problems across several generations. He is a product of normal pregnancy and delivery. He was a happy baby with normal developmental milestones. At 2, he showed changes of behavior, which soon became dangerous and unmanageable. He also developed difficulties falling asleep, and had violent nightmares. His mood became extremely unstable with wide amplitude of mood swings, from happy, loving and affectionate to extremely angry with intense physical aggression and self-mutilation. His mood swings rolled over him spontaneously at least several times a day and were not provoked by any triggers. On the other hand, he could not be distracted or switched to any different activity if he got angry or upset. When angry, he screams, yells, hits, punches, pushes and gets severely agitated. He also bites himself leaving bite marks, grabs and squeezes his genitalia. On one of such occasions he was taken to ER for a medical evaluation because of the genital bleeding after he grabbed himself. He also repeatedly on purpose threw himself off the bicycle, totally indifferent to any injuries he sustained as a result of his behavior. He was not eligible for any day care and had to stay home with his mother. He did not have any friends because of his behavior and inability to connect socially with peers. His mother had to watch him constantly: if not supervised he was dangerous to himself and to his younger brother. He could not concentrate and process any instructions and did not respond to any limit setting or redirection. It appeared that a "no" made him angrier and more agitated as much as any punishment. At three, he was diagnosed with ADHD and ODD and prescribed Paxil, which further increased his agitation and aggression. In his therapy ses-sions he gradually disclosed auditorial and visual hallucinations along with delusional

ideas. Despite good physical and intellectual development he was not able to sustain any learning or productive activity for any length of time. His speech was disconnected and at times senseless. He stared back as if not hearing the question and, if talked, did not refer to the topic of the con-versation. Sam was started on Risperidone with a gradual increase of the dose up to 1 mg at night, when his behavior and presentation changed dramatically. He fell asleep and stayed asleep without nightmares. His aggressive and self-mutilating behavior stopped and he was able to talk about it and identify triggers for it. He reported no psychotic symptoms and his speech became goal oriented and related to the conversation he had. He was safe to ride his bicycle and started sharing with his brother. He still had mood swings, but they lost their intensity and be-came less erratic and frequent. His mother registered him for preschool in the spring.

Case 2. " Josh" is a four-year-old child. He comes from a broken home with substance abuse history. He is a product of a normal pregnancy and normal delivery. Since his babyhood he has always been hyperactive, restless, difficult to placate and moody. He had periods of unexplain-able crying spells, sadness and withdrawal followed with hyperactivity, impulsivity, angry out-bursts and aggression interposing several times a day. He severely hurt an older child at school, which was totally unprovoked. He did not do well academically, constantly requiring one-to-one attention because of his unpredictable at unsafe behavior. He did not sleep for more than 5-6 hours since he was an infant, but never appeared to be tired or exhausted. He talked very fast, slurring words and poorly articulating them. He constantly shifted from one activity to another and could not focus on one particularly task. Josh was diagnosed with ADHD and suggested to take a stimulant, but his mother refused, disagreeing with the diagnosis. After our evaluation Josh was started on Risperidone with a gradual increase of the dose to 1 mg at night. His condi-tion improved noticeably. For the first time in his life he started sleeping 9 hours. His aggres-sion stopped and he was able to play with other children. His speech became understandable and clear. He could focus on any activity for a long enough time and was able to participate in his counseling sessions talking about his behavior. He showed progress at school, improved academically and caught up with his peer group. He still had mood swings, becoming excessively energetic and clowny at times, but even at the height of his energy rushes he still was more responsive to limit setting.

These two vignettes are similar in several aspects: two 4-year-old boys present with an early onset of severe mood swings with high level of aggression and/or self-mutilation. Their mood swings still have a common denominator with a conventional presentation of Bipolar disorder reflecting in inexhaustible level of energy despite decreased sleep, pressured speech and other formal thought disorder, unproductive activity along with periods of depressed mood and social withdrawal. They are different though in terms of extremely rapid changes of moods. In both cases they were misdiagnosed with ADHD, based on the superficial observation that they could not pay adequate attention. Both children have psychiatric problems in family history. When put on Risperidone both showed improvement with a significant decrease of aggression, im-provement of sleep and ability to pay attention and process information. What was taken for "ADHD" was thought disorder, which showed progress when adequately treated. Still Risperi-done did not fully addressed mood swings, which continued to persist. To a degree Risperidone helped with a psychopharmacological analysis of these cases, "peeling off" the first layer of agitation, aggression and psychotic symptoms and exposing the more deep-sitting core of pure mood swings. Both youngsters were put on a mood stabilizer.

These cases show that young children do develop bipolar mood disorder, which have a different presentation from adult or adolescent type of a similar condition. An accurate diagnosis and appropriate treatment help to decrease the intensity of symptoms and return youngsters and their families to normal lives, preventing further developmental delays.

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