Assignment 3

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## Bipolar Disorder in Children

Historically, bipolar disorder was only thought to occur in adults and its prevalence in children and adolescents was regarded as a rare phenomenon. Recently, there has been a pretty significant increase in the diagnostic rate of the disorder in children and adolescents. A study conducted for the purpose of meta-analysis revealed the prevalence of the symptoms to be as high as 1.8%. Nevertheless, the diagnostic criteria still remains a vague area, even though a lot of collective efforts have been targeted in this domain to determine the symptoms, root causes and potential treatment strategies of bipolar disorder.

The identification of symptoms related to depression and mania can be traced back to Ancient Greece and the symptomatology is quite recent in children. Until the 19th century, advancements in the categorization and classification of the symptoms started to occur. At the beginning of the 20th Century, Emil Kraepelin made use of a unifying approach to classify the disorders related to the mood which resulted in the incorporation of bipolar disorder in the category of manic-depressive insanities. It is noteworthy to mention that Kraepelin also alluded to the rare possibility of the occurrence of this disorder in children (Kraepelin, 1921).

In an attempt to theorize bipolar symptoms in children, a starry constellation of psychoanalytic theorists and thinkers, particularly, Karl Abraham and Melanie Klein first referred to the prevalence of manic-depressive symptoms in children (Glovinsky, 2002). These studies led child psychiatrists to look for specific symptoms of bipolar disorder in their young patients. Various case studies established that these indications were rare occurrences in children and even if there was some possibility, it did not surface in the life of a child until he or she reached late adolescence (Carlson, 2005). However, in the early 1970s, the interest of psychologists and psychotherapists was piqued towards the understanding and identification of bipolar disorder in children. The DSM-III and DSM-V bipolar disorder criteria comprised of hyperactivity and/or euphoric or irritable behavior as the diagnostic symptoms proposed by Weinberg and Brumback (Weinberg, 1976). As a consequence, an increasing acceptance prevailed among masses regarding the presentation of bipolar symptoms in children. Hyperactivity, attention deficit disorders, irritability, agitation, and grandiosity, decreased the need of sleep, goal-directed activities, and pressure speech are some patterns of symptoms that were diagnosed as indications of bipolar disorder (Cullen, 2016).

## Over-diagnosis of Bipolar Disorder in Children

This paper attempts to demonstrate that bipolar disorder is a misused diagnosis in children. A 40% increase has been reported in the diagnosis of bipolar disorder among children from 1994 to 2003, and this statistic has led to achieving the position of the topmost disorder being diagnosed in children under the age of 12. Some psychiatrists have suggested that the majority of these cases require immediate hospitalization and the symptoms are even apparent before birth, in utero (Beal, 2011). If the behavior of any child falls outside the contours of socially acceptable behavior and the common parameters, the likelihood of the diagnosis of the bipolar disorder increases to a maximum. There is also a lot of controversial debate regarding the methodology and assessment criteria used in the DSM-V to diagnose the disorder in children. Mostly, after the misdiagnosis, children are treated with antipsychotics and mood stabilizers. There is a great possibility that these medications may lead to a potential decline in the mass of the brain and its functions. Additionally, these medications and therapies at a tender age can interfere with the normal processes of growth and development (Garcia-Amador, 2015). Medical surveys and pediatric records in the psychiatric departments of some renowned medical facilities establish that children, who have previous records of getting diagnosed with attention deficit hyper disorder, the disorder of problematic conduct and behavior, and oppositional-defiant disorder are also “re-categorized” as having the symptoms of bipolar disorder (Bastiampillai, 2019).

## Differences in Medication Treatment between Adults and Children

### For Children

Doctors and child psychiatrists chiefly rely on information from the treatment of adults in the pursuit of helping children and adolescents who suffer from bipolar disorder. Baseline assessment which determines the physical and mental health of the child is conducted by the psychiatrist before starting any particular medication. Follow-up visits at regular intervals are mandatory for evaluating the progress. Children with accurate symptoms of bipolar disorder may need life-long medication to help them attain a decent living standard. To gauge the effectiveness of a specific medication, a child may have to take it for several months. Most frequently, the symptoms presented by the children are not complicated so they need more than one type of medicine for quick relief. A child may also respond in an eccentric way to his therapist given their naivety and innocence. Psycho-education, cognitive behavioral therapy, social rhythm therapy, and family-focused therapy can be effective for treating the symptoms of bipolar disorder in children.

### For Adults

Intensive psychotherapy and specific medication, if continued for about a year, can assist adults to recover from these symptoms. The response of adults towards psychotherapy is comparatively better and this is established from many studies, as they are able to express their emotions adequately as compared to children. Bipolar disorder is different in adults in its nature of occurrence, being more episodic and less persistent. Unlike children, adults are also able to hide their emotions and symptoms in specific disguises of their personality, therefore, relatively more aggressive approaches are used for diagnosing and treating the symptoms in adults.

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