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REVIEW ARTICLE

Management of care for children with bipolar affective disorder

Gestión de la atención a niños con trastorno afectivo bipolar

Gestão do cuidado de crianças com transtorno afetivo bipolar

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Abstract

This study described the management of health care for children with bipolar affective disorder. This was descriptive-qualitative research, carried out integrative of the literature through the Virtual Health Library, Google Scholar, and SciELO platforms, carried out in November 2022. Ten articles that met the determined inclusion criteria were analyzed. The search was carried out considering articles in Portuguese and English, with free articles attached and indexed in the virtual platforms of academic studies between the years 2012 to 2022. The objective of this research was to describe the care and treatments from a multidisciplinary perspective existing in the health area and the child's coping with the defensive issue of neurons after prolonged use of psychotropic drugs.

Descriptors: Child Behaviors; Childhood Bipolar Affective Disorder; Psychiatry; Mental Health; Pediatrics.

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Resumén

Este estudio describió la gestión de la atención médica para niños con trastorno afectivo bipolar. Se trató de una investigación descriptiva-cualitativa, realizada integrando la literatura a través de la Biblioteca Virtual de Salud, Google Académico y SciELO, en noviembre de 2022. Se analizaron diez artículos que cumplieron con los criterios de inclusión. La búsqueda se realizó considerando artículos en portugués e inglés, con artículos gratuitos adjuntos e indexados en plataformas virtuales de estudios académicos entre los años 2012 y 2022. El objetivo de esta investigación fue describir la atención y los tratamientos desde una perspectiva multidisciplinaria en el área de la salud, y el afrontamiento del niño con el problema defensivo de las neuronas tras el uso prolongado de psicofármacos.

Descriptores: Conductas Infantiles; Trastorno Afectivo Bipolar Infantil; Psiquiatría; Salud Mental; Pediatría.

Resumo

Este estudo descreveu a gestão do cuidado à saúde destinada a crianças acometidas por transtorno afetivo bipolar. Tratou-se de uma pesquisa descritivo-qualitativo, realizado integrativa da literatura através da plataforma Biblioteca Virtual em Saúde, *Google Scholar* e SciELO, realizada em novembro de 2022. Foram analisados 10 artigos que atenderam aos critérios de inclusão determinados, a busca ocorreu considerando artigos na língua portuguesa e inglesa, com artigos livres anexados e indexados nas plataformas virtuais de estudos acadêmicos entre os anos de 2012 a 2022. O objetivo desta pesquisa foi descrever os cuidados e tratamentos na ótica multiprofissional existentes na área da saúde e enfrentamento da criança na questão defensiva dos neurônios após uso prolongado de psicotrópicos.

Descritores: Comportamentos Infantis; Transtorno Afetivo Bipolar na Infância; Psiquiatria; Saúde Mental; Pediatria.

Introduction

When reflecting on scientific research as a means of professional development for individuals in organizations, bipolar affective disorder (BAD) is classified by Psychiatry as a mental disorder that expresses a serious, chronic, recurrent, and disabling condition and that represents a major health problem. It is characterized by two types of conditions: (a) mania and (b) depression. These symptoms significantly influence the lives of individuals diagnosed with BAD, both in symptomatic presentation and when subjected to treatment strategies. BAD is diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD)[1,2].

The topics covered are related to adherence to medication treatment, problem-solving training, and healthy habits. Since this is a recent area of scientific research, the results of this review provide a general overview of intervention research to treat BAD, as well as its limitations and benefits. These results can be used by researchers and professionals in the field as a means of information and updating on the scientific production of this disorder in childhood and adolescence. Despite the existing controversies regarding the way to diagnose BAD, there are pharmacological and non-pharmacological intervention strategies for treatment in this population, which will be briefly described below. There are pharmacological and psychosocial treatment strategies for BAD[2,3].

Bipolar disorder is a disorder that affects the patient's nervous system. In this case, the individual becomes very depressed or very agitated, and insomnia is also common. During these episodes, called mania, changes occur in the patient's brain and body. The disease is hereditary and affects 2% of the population. Anyone can get the disease, but it is more common in those who already have a family member with the problem. The objective of this research was to describe the care and treatments from a multidisciplinary perspective in the health area and how children deal with the issue of neuron defense after prolonged use of psychotropic drugs[4].

Methodology

This study is characterized as an integrative literature review, with a qualitative approach and descriptive character, carried out in November 2022. Data collection was conducted in the databases of the Virtual Health Library (VHL), Google Scholar, and SciELO, using the descriptors "childhood behaviors", "bipolar affective disorder in childhood", and "health care". Scientific articles published between 2012 and 2022, in Portuguese and English, available in full and indexed in academic platforms were included. Exclusion criteria included duplicate studies, non-systematic reviews, and articles that did not directly address care management in children with bipolar affective disorder (BAD). After screening, 10 articles were selected for critical analysis, following the steps of: (1) identification of the research problem, (2) literature search, (3) data evaluation, (4) analysis and interpretation of results, and (5) synthesis of knowledge. Data extraction considered: objectives, methodology, therapeutic interventions (pharmacological and psychosocial), and main findings.

Results and Discussion

There are many medications indicated for adult patients with BD that have also been used in children. These

are called antidepressants, mood stabilizers, antiepileptics, and antipsychotics and can bring clinical improvements and favor the course and prognosis of people affected by BD. The main objective of the medication is to try to reduce the factors that destabilize mood and increase stabilizing strategies. Bipolar disorder initially damages neural connections, and, throughout the disease, there is cell loss and atrophy of specific areas of the brain. In neurochemistry, the loss of connectivity is associated with degeneration. These results reinforce the idea that we cannot put all patients on a single treatment. It is necessary to personalize them because they are different[5].

The best way to prevent this disease or reduce its symptoms is to seek treatment and use the appropriate medication to prevent new outbreaks. The more severe the disease is, the stronger the drug treatment needs to be. Among the main medications are mood stabilizers: lithium, carbamazepine, oxcarbazepine, among others; antidepressants: fluoxetine; antiepileptics: valproic acid, lamotrigine; antipsychotics: quetiapine, olanzapine, topiramate, haloperidol, fluphenazine, risperidone, among others[5,6].

Despite advances in drug treatment, low adherence may occur due to a lack of guidance on the importance of its use. Constant abandonment of treatment may be due to ignorance of the problem or a preference for an euphoric mood. Although drug treatment is associated with relapse prevention and a lower risk of relapse, 60% of patients who use medication have relapses within two years after an acute episode, and at least 50% experience significant symptoms associated with mood swings between episodes, followed by symptom control and mood stabilization. Patients with BAD may also experience significant impairments in school performance and family and social relationships. This condition highlights the limitations of drug therapy, and there is a recommendation for psychosocial interventions in the treatment of BAD[6].

The following are examples of psychosocial interventions for ABD found in the literature, namely: (a) Multi-family Psychoeducational Group, (b) Family-focused Treatment for Adolescents, (c) Dialectical Behavioral Therapy for Adolescents, and (d) Cognitive-Behavioral Therapy focused on the Child and Family, the Multi-family Psychoeducational Group (MFPG); is a type of psychoeducational intervention for parents of children with ABD developed by Fristad. This type of intervention consists of eight 90-minute sessions for parents and simultaneous sessions directed at the children. This strategy aims to teach them about disease, treatment, symptom management, improve problem-solving, communication skills, and support among group members and family members[7].

The use of the strategy presented in the previous paragraph but applied individually. For this reason, it was named by the authors Individual Family Psychoeducation (IFP), the Family-focused Treatment for Adolescents (FFT-A). It is the intervention model that aims to reduce the symptoms of ABD in adolescents through greater awareness to deal with it, reduction of emotional expressiveness on the part of family members and/or caregivers and favoring improvement in problem-solving and development of communication skills. This proposal consists of three components: psychoeducation, positive reinforcement of behaviors compatible with communication, and training of problem-solving skills[8].

Dialectical Behavior Therapy for Adolescents has been adapted for intervention with adolescents with ABD. It consists of two modalities: (a) family skills training and (b) individual psychotherapy with adolescents. The total treatment period is one year, with 24 weekly sessions that alternate between family and individual therapy in the first six months. An additional 12 sessions have been held in the last six months. In a small, preliminary open trial using the above-described treatment strategy in 10 adolescents with ABD, the results found a decrease in suicidal behavior, self-harm, emotional disruption, and depressive symptoms[8,9].

Child and Family Focused Cognitive-Behavioral Therapy (CFF-CBT) was developed to address the specific developmental needs of children aged 8 to 12 years with BD. It involves extensive work with parents, while also working with the children, to identify the therapeutic needs of the child through the parents, and also helping them to develop an appropriate parenting style for their children. A second goal to be highlighted in this treatment strategy is to integrate psychoeducation, CBT, and interpersonal therapy techniques adapted to the needs of the children. This integration can allow for improvements in the pharmacological treatment that is administered simultaneously[9].

All psychosocial strategies used for the treatment of BAD presented in this section include the component of transmission of knowledge and information about the disease. This component appears to be viable and may be useful in adherence to drug treatment and improvement in quality of life, as it addresses specific aspects of the disease, in addition to medication. Children and adolescents with BAD are becoming the target of further investigations, as well as a priority issue in the context of health. General objectives: to identify, through a bibliographic review of empirical studies, which psychosocial interventions conducted in groups and/or individually are used to treat BAD and to analyze the data obtained regarding the objectives, method, themes developed, and results of the interventions[9].

Regarding the topics addressed in the interventions, all studies addressed basic information about BAD. Some interventions used psychoeducational components, others psychotherapeutic components. Although in some of them the authors did not describe their interventions as psychoeducational or psychotherapeutic, it is clear that the concept of the interventions includes the forms of intervention that are components of Cognitive Behavioral Therapy (CBT): Educating patients, their family members and friends about bipolar disorder, its treatment and difficulties associated with the disease; helping to control mild symptoms without the need to change medication; helping to cope with stress factors that can interfere with treatment or precipitate episodes of mania and depression, among others[10].

The following are identified as components of a psychoeducational program: "Concrete information on certain topics such as bipolar disorder and suicide risk; training on symptom management; training on stress management, among others." From these examples, interventions are being called differently, but they address the same points of view[10].

Other perspectives that should be considered concerning the small number of studies found include the fact that, for a long time, BAD has been underdiagnosed, poorly recognized, and confused with other psychopathological conditions. The disorder in question is characterized in the DSM-IV-TR by an alternating and intense combination of mood episodes. However, according to these authors, all children and adolescents certainly present mood changes characteristic of their age group throughout their development. However, as in all disorders, these emotional variations only become clinically significant when they change to the point of causing functional impairment[9].

Comparing the characteristics of BAD in adults with the disorder in children and/or adolescents presents some setbacks, since, depending on their age, children may exhibit some behaviors that are topographically like those described as symptoms of BAD, but which are not. For example, excessive crying or irritability may be due to a difficulty in verbal expression resulting from a learning process[10].

Thus, the author draws attention to the distinction between the behavioral repertoire of adults and children, and it is worth noting that in Diagnostic Manuals, the diagnostic criteria are related to adult behaviors, and, because of this, they are contraindicated for evaluating children and/or adolescents. Given the above in the previous paragraphs on how to diagnose AAD, he suggests that to make a reliable diagnosis of the disorder, it is recommended to: (1) use scales aimed at the child population that assess symptoms, (2) know the life history of the patient and his/her family, as well as (3) use diagnostic manuals. This is because the time allocated for consultation is not enough for this type of procedure to be adopted satisfactorily. Therefore, another factor is noted that it would contribute to a more reliable diagnosis of BAD.

In the interventions carried out, it is possible to verify the existence of some evaluation measures such as inventories, psychometric tests, and scales. The use of these measures, although not yet ideal for evaluation, even due to their generality and scope of disorders that are intended to be detected, has appeared as an attempt at validity. Whatever the form of intervention chosen, it is necessary to ensure that patient education, adherence, symptom control, and prevention of relapses are not enough. This same author also reiterates that education should be an ongoing process, especially as knowledge about this disorder expands; psychoeducation provides a significant instrument that helps in the treatment of bipolar disorder and the management of anxiety, fear, stigma, and low self-esteem. As an intervention strategy, psychoeducation should be used in parallel with drug treatment (mood stabilizers), because it improves its effectiveness. For these authors, and this is also a fact found in the present research, this is the key intervention for the long-term improvement of bipolar disorders[9,10].

Bipolar disorder usually begins in mid-adolescence or early adulthood. Bipolar disorder in adolescents is like bipolar disorder in adults; the cause is unclear, but the predisposition to developing bipolar disorder may be genetic, and chemical and anatomical abnormalities in the brain may be involved. In children with this disorder, stress can trigger attacks. In addition, some other conditions, such as overactive thyroid or attention deficit hyperactivity disorder (ADHD), can cause similar symptoms. Certain drugs and toxins in the environment, such as lead, can cause similar symptoms[10].

Recent research has also shown that adolescents who use cannabis products are at increased risk of certain psychiatric disorders, such as bipolar disorder and schizophrenia. This increased risk cannot be explained by genetic factors. There are concerns that the recent legalization of marijuana may give adolescents (and parents) a false sense of security in using the substance. In many children, the first symptom of bipolar disorder is one or more episodes of depression. The main symptoms are episodes of varying degrees of euphoria and excitement (intense mania and less intense hypomania), alternating with depressive episodes, which may occur more frequently. Children may experience very violent mood swings. During a manic episode, sleep is disrupted, and children may become aggressive, have a very positive or irritable mood, may speak rapidly, and may have big ideas[9,10].

For example, children may think they have extraordinary talents or have made important discoveries. Their judgment may be impaired, and teens may engage in irresponsible behaviors, such as sexual promiscuity or reckless driving. Young children may have dramatic emotions, but they usually last only a moment. School performance often deteriorates[10].

During an episode of depression, children with bipolar disorder, like children with depression alone, feel excessively sad and lose interest in their usual activities. They may think and move slowly and sleep more than usual. Feelings of hopelessness and guilt may overwhelm them. Children with bipolar disorder seem normal between episodes, unlike children with attention deficit/hyperactivity disorder, who are in a constant state of hyperactivity, and symptoms begin slowly.

Before the illness develops, however, children are often very moody and difficult to control. Symptoms, tests for other causes, and doctors diagnose bipolar disorder based on the child's and parents' description of characteristic episodes. Doctors try to determine whether something, such as intense stress, triggered the event. It is important to distinguish bipolar disorder from other disorders.

Drugs used and mechanisms of action

Lithium interferes with the metabolism of inositol triphosphates, resulting in the release of calcium from its intracellular stores, presumably by inhibiting enzymes in the

inositol formation pathway. There are other hypotheses that justify its use as a mood stabilizer: Due to its similarity with other elements (sodium, potassium, calcium and magnesium), it increases serotonin levels and decreases norepinephrine levels, in addition to altering the concentrations of dopamine, g-aminobutyric acid (GABA) and acetylcholine. It inhibits adenylate cyclase and inositol-1-phosphatase, resulting in a decrease in noradrenergic neurotransmission. Inhibition of adenylate cyclase results in a reduction of cyclic adenosine monophosphate (cAMP) through a variety of mechanisms, including inhibition of calmodulin binding to the catalytic unit of the enzyme and the coupling of receptors to G3 proteins; inhibition of inositol-1-phosphatase leads to a relative depletion of inositol and subsequently to changes in the phosphatidylinositol receptor; however, the effects of chronic administration are likely mediated by changes distal to the receptor (e.g., at the G protein level) or by changes in protein kinase-C isozymes that would lead to phosphorylation of nuclear proteins.

Regarding norepinephrine, lithium reduces the stimulation of adenylate cyclase mediated by β-adrenergic receptors and tends to reduce the number of A2 receptors. It also occurs through several mechanisms, such as increased uptake of tryptophan (precursor of serotonin) and decreased activity of inhibitory presynaptic serotonergic receptors and increased serotonin release, especially in the hippocampus[10].

In the hippocampus, 5-HT2 receptors are also reduced, and postsynaptic responses to 5-HT1 receptors are increased. up-regulated) glutamate transport activity. In addition, there is evidence that lithium increases GABA levels and upregulates hippocampal GABA receptors. Carbamazepine Biochemical and neurophysiological effects have been reported for carbamazepine, including stabilization of sodium and potassium channels, reduction of calcium flux, antagonism of peripheral benzodiazepine GABAB receptors (up-regulation), and action as an adenosine antagonist or agonist; its exact mechanism of action as a mood stabilizer is still unknown.

The psychopharmacological effect of divalproex sodium is due to its ability to potentiate GABA function. One hypothesis to explain its efficacy would be a possible relationship between central or peripheral alterations of GABA and the pathophysiology of mood disorders. It has been observed that subchronic use (3 weeks) of valproic acid increased central serotonergic neurotransmission in manic patients. It has been found in the past that the drug could restore the low GABA and serotonin activities found in affective disorders, and that these mechanisms may be related to its efficacy in these disorders[5,10].

Until recently, bipolar disorder was considered relatively rare in childhood and adolescence. The debate over the possible existence of bipolar disorder in children has changed over time, and the importance of early diagnosis has been given to the fact that psychiatrists trained in the diagnosis are increasingly recognizing episodes of symptoms in childhood due to more severe clinical manifestations, poor response to treatment, and poor long-term prognosis. Psychotic symptoms are common, and a significant proportion of children are initially diagnosed with depression. The doctor determines whether the child is taking any medications that may be causing the symptoms. Doctors may also check for signs of other disorders that may be contributing to or causing the symptoms. For example, they may do blood tests to check for an overactive thyroid[10].

The sample size of these studies was limited to ten, at most twenty patients, which excludes from scientific logic the possibility of extrapolating these findings as characteristic of the disease, although some authors suggest this. Regarding genetic studies of BD, there is still no genetic marker directly linked to the onset of the disease. The continuous use of mood stabilizers seems to be essential not only to maintain a stable mood, but also to prevent the onset of biochemical alterations associated with some degree of nerve damage[10].

On the other hand, non-adherence to pharmacological treatment and subsequent worsening of BD can determine secondary cellular damage and consistently alter, sometimes irreversibly, the cognitive process and the course and prognosis of the disease. Studies evaluating the modulation induced by mood stabilizers in neurotransmission and neuroglial neuroprotective systems may provide new insights into neurobiology and help discover new therapeutic options for the treatment of patients with this complex disease. The most consistent and representative neurobiological finding in BHT is the alterations in glial cells. Studies have shown a significant decrease in the number and density of glia (but not in their size) in BHT. Another study also reported a decrease in the density of oligodendrocytes (a type of glial cell) in the same region. This alteration should not be considered as the main neuropathological finding in BHT, but as some neuronal alterations (especially in non-pyramidal GABAergic neurons)[9,10].

As a basis for this argument, there is only one study that demonstrated a reduction in glial density in bipolar patients without the use of mood stabilizers; drug treatment aims to restore behavior, control acute symptoms, and prevent new episodes, polypharmacy, chemical dependency, and other factors that contribute to sampling bias. The sample size of these studies was limited to ten, at most twenty patients, which excludes from scientific logic the possibility of extrapolating these findings as characteristic of the disease, although some authors suggest this.

Conclusion

This study demonstrated that the management of bipolar affective disorder (BAD) in children requires a multidisciplinary approach, integrating pharmacological therapy and psychosocial interventions. The most used drugs include mood stabilizers (lithium, valproate), atypical antipsychotics (quetiapine, risperidone), and antidepressants (fluoxetine), which act on the modulation of neurotransmitters such as serotonin, dopamine, and GABA. However, prolonged use can lead to neuroadaptive effects, requiring strict monitoring. Psychosocial interventions - such

as family psychoeducation, cognitive-behavioral therapy (CBT) and dialectical behavioral therapy (DBT) - have demonstrated efficacy in treatment adherence, reduction of relapses and improvement of functionality. Psychoeducation stood out as an essential strategy to raise awareness among patients and caregivers about the disease, while CBT helped manage residual symptoms and prevent crises. Despite advances, challenges persist, such as underdiagnosis and symptomatic heterogeneity in children, often confused with ADHD or depression. Detailed neuropsychological assessment and therapeutic personalization are recommended, considering factors such as heredity, comorbidities, and impact on development. It is concluded that the association between pharmacotherapy and psychosocial support is essential for a favorable prognosis, reducing cognitive and social impairments. Future studies should investigate biological markers and early interventions, aiming to optimize comprehensive care for this population.

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