



BIPOLAR AND RELATED DISORDERS

OVERVIEW

Families of children with bipolar disorder often notice the child has intense and extreme changes in mood and behavior. This may include the child varying between being excited, highly agitated, and very sad. The two “poles,” or extreme moods, of bipolar disorder are mania and depression. When children with bipolar disorder feel very happy or “up” and are much more active than usual, they are experiencing mania. A manic episode is a period of abnormally and persistently elevated mood. The child exhibits an increase in goal-directed activity or energy that lasts at least one week. Mania is often described as a period of euphoria or excessive cheerfulness, and often it is easily recognized. When the same child feels very sad and “down” and is much less active than usual, he or she is experiencing depression.

Some episodes may be mixed episodes, including both up and down symptoms. Children with bipolar disorder may have more mixed episodes than adults with bipolar disorder.

Table 1 describes some of the symptoms of both mania and depression. The list is not exhaustive.

There are three main types of bipolar disorder:

1. **Bipolar I disorder:** Requires a manic (or mixed) episode lasting at least one week, unless hospitalization is necessary. Depressive episodes are not required.
2. **Bipolar II disorder:** Requires major depressive episodes with at least one hypomanic episode (a lesser form of mania) lasting at least four days. There are no full manic or mixed manic episodes.
3. **Cyclothymic disorder:** Requires at least two years (one year in children and adolescents) of numerous periods of hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods of depressive symptoms that do not meet criteria for a major depressive episode. Cyclothymic disorder is primarily a chronic, fluctuating mood disturbance.

KEY POINTS

- Characterized by episodic mood swings that can include:
 - Abnormally elevated mood (mania)
 - Pronounced sadness (depression)
 - Mixed episodes (both up and down symptoms)
- Many medical and mental health conditions have similar symptoms.
- Associated with an increased risk of suicide.
- No evidence-based treatments at this time; tailored treatment that includes mood stabilizing medication and/or psychotherapy has the best results.

Table 1
Manic and Depressive Symptoms

Manic Symptoms	Depressive Symptoms
<ul style="list-style-type: none"> • Severe changes in mood to either unusually happy or silly, or very irritable, angry, or agitated • Unrealistic highs in self-esteem • Greatly increased energy and the ability to operate on little or no sleep for days • Increased talking • Increasingly distracted, moving from one thing to the next • Repeating high risk behavior 	<ul style="list-style-type: none"> • Irritability, persistent sadness, frequent crying • Thoughts of death or suicide • No longer enjoys favorite activities • Frequent complaints of physical illness, like headaches • Decreased energy level • Major change in eating and sleeping patterns

It is important to note that bipolar disorder in children and, to a lesser extent, in adolescents, can manifest in ways that do not always meet the full criteria described above. For instance, in adolescents, mania is commonly associated with psychotic symptoms (thought and emotions are so impaired that contact is lost with external reality), rapidly changing moods, and mixed manic and depressive features. Mania in younger children is usually defined by erratic changes in mood, energy levels, and behavior. Irritability and mixed manic/depressive episodes are usually more common than euphoria. Also, well-defined and discrete episodes of abnormal mood are often missing in children and adolescents. There is also sparse evidence of the validity of a bipolar diagnosis in pre-school aged children and that diagnosis should be made with extreme caution.

To further complicate diagnosis, there are many conditions and disorders that frequently co-occur with bipolar disorder, including:

- Attention-deficit/hyperactivity disorder (ADHD) (up to 90 percent co-occurrence)
- Anxiety disorders, like separation anxiety (up to 78 percent co-occurrence)
- Substance abuse
- Conduct disorders
- Other mental illnesses, including depression

In addition, many mental illnesses (including those listed above) and medical conditions (such as hyperthyroidism, epilepsy, or head trauma) can have symptoms similar to bipolar disorder, which can lead to misdiagnosis and unnecessary or too aggressive pharmacological treatment. For this reason, it is imperative that children exhibiting bipolar symptoms be thoroughly assessed by a mental health professional specializing in bipolar disorders in youth.

Families should be mindful of the signs and risk factors of bipolar disorder described in Table 2, and should seek assessment for the disorder if they notice any red flags.

Ongoing assessment of suicide risk is important due to the high risk of suicide attempts among youth with bipolar disorder. The lifetime risk of suicide in all individuals with bipolar disorder may be 15 times that of the general population. Information about suicide is provided in the “Youth Suicide” section of the *Collection*.

CAUSES AND RISK FACTORS

The causes of bipolar disorder aren't always clear, and scientists are continually researching possible causes and risk factors. Experts believe that bipolar and related disorders can be caused by several things, including:

- Genetics: A child with a parent or sibling with bipolar disorder is four times more likely to be diagnosed with the disorder. Having a parent or sibling who has schizophrenia is also a risk factor.
- Brain structure and function
- Anxiety disorders
- Gestational influenza: A child whose mother had influenza during pregnancy is four times more likely to be diagnosed with bipolar disorder

Table 2
Red Flags that Can Trigger Assessment for Bipolar Disorder

Red Flag	Description	Reason
Family history of bipolar disorder	Bipolar disorder has a genetic contribution; family environment can amplify risk and affect treatment adherence and relapse	Five to 10 times increase for 1 st degree relative; 2.5 to 5 times for 2 nd degree relative; 2 times for “fuzzy” bipolar disorder in relative
Early onset depression	Onset less than 24 years of age; also, treatment resistant, recurrent, or atypical depression may be more likely to be bipolar	First clinical episode is often depression; 20% to 30% of depression ultimately shows a bipolar course
Antidepressant-coincident mania	Manic symptoms while being treated with antidepressants	The FDA recommends assessing for hypomania and family history of bipolar disorder before prescribing antidepressants
Episodic mood lability (marked fluctuation of mood)	Rapid switching between depressive and manic symptoms, depressive and manic symptoms at the same time	Common presentation; multiple episodes more suggestive of mood diagnosis
Episodic aggressive behavior	Episodic, high-energy, not instrumental or planned, reactive	Not specific to bipolar disorder but common
Psychotic features	True delusions/hallucinations in the context of mood	Delusions/hallucinations common during mood episode; bipolar more common as source of psychosis than schizophrenia in children
Sleep disturbance	Decreased need for sleep; less sleep but maintains high energy	More specific to bipolar disorder; indicates sleep hygiene treatment

Source: Youngstrom, E., Jenkins, M. M., Jensen-Doss, A., & Youngstrom, J. K. (2012). Evidence-based assessment strategies for pediatric bipolar disorder. *Israel Journal of Psychiatry and Related Sciences*, 49(1), 15-27.

TREATMENT

Currently, there are no pharmacological or psychosocial therapies with enough evidence in youth samples to meet the standards for evidence-based treatments, although the treatments discussed in this section have been shown to be probably efficacious. Treatment should be tailored to the individual and based on several different factors, including treatment setting, the chronic nature of the disorder, the age of the child, and the family environment.

Table 3 summarizes the treatments for bipolar and related disorders.

Table 3
Summary of Treatments for Bipolar and Related Disorders

What Works	
There are no evidence-based practices at this time.	
What Seems to Work	
Medication	Mood stabilizers (lithium)/Anticonvulsants Second-generation antipsychotics
Family-focused psychoeducational therapy (FFT)	Helps youth make sense of their illness and accept it and also to better understand use of medication. Also helps to manage stress, reduce negative life events, and promote a positive family environment.
Child- and family-focused cognitive behavioral therapy (CFF-CBT)	Emphasizes individual psychotherapy with youth and parents, parent training and support, and family therapy.
Multifamily psychoeducation groups (MFPG)	Youth and parent group therapy have been shown to increase parental knowledge, promote greater access to services, and increase parental social support for youth.
Not Adequately Tested	
Interpersonal social rhythm therapy (IPSRT)	Works to minimize the effects of life stressors by helping youth establish regular patterns of sleep, exercise, and social interactions.
Omega-3 fatty acids	Unclear if supplementation helps with depressive symptoms when used in conjunction with other treatments.
Topiramate Oxcarbazepine	Anticonvulsants; not proven to be effective in youth or adults.
Dialectical behavior therapy (DBT)	Family skills training and individual therapy; not proven to help with mania or interpersonal functioning.

Pharmacological Treatments

The goal of pharmacological treatment for bipolar and related disorders is to immediately reduce the severity of symptoms. Pharmacotherapy, combined with psychotherapy, offers the best chance for symptom recovery. However, because few large-scale prospective studies have examined pharmacologic treatment for youth with bipolar and related disorders, many of these medications are used without specific FDA approval for youth.

Lithium is currently the most extensively studied medication for use with bipolar disorder. Lithium has been found to be effective in approximately 60-70 percent of adolescents and children with bipolar disorder and remains the first-line therapy in many settings. However, youth experience the same safety problems with lithium that adults may experience, such as toxicity and impairment of renal and thyroid functioning. Lithium is not recommended for families unable to keep regular appointments, which are necessary to ensure monitoring of serum lithium levels in the blood and to manage conflicting side effects. Relapse is also high for those youth who discontinue the medication.

Youth diagnosed with bipolar disorder and comorbid ADHD respond less favorably to lithium treatment than youth who do not have ADHD. However, mood stabilizers show better results than stimulants in youth with bipolar disorder and comorbid ADHD.

Unfortunately, mood stabilizers and atypical antipsychotics have a number of adverse side effects, including, but not limited to, weight gain, drowsiness, decreased motor activity, constipation, increased salivation, rigidity, and dystonia. It is very important that children on these medications be monitored for the development of serious side effects. These side effects need to be weighed against the dangers of the manic-depressive illness itself.

Psychosocial Treatments

Although no psychosocial treatments for bipolar disorder are considered evidence-based, recent evidence has shown that family-focused psychoeducational therapy (FFT), child- and family-focused cognitive behavioral therapy (CFF-CBT), and multifamily psychoeducation groups (MFPG) have promise when used in conjunction with pharmacological treatment. These three treatments have demonstrated symptom improvement and increased functioning in youth with bipolar disorder. The rationale behind these family-focused treatments are to give youth with bipolar disorder and their families knowledge and skills that could help limit the debilitating cycles of relapse and impairment that are characteristic of this disorder.

RESOURCES AND ORGANIZATIONS

American Academy of Child & Adolescent Psychiatry (AACAP)

<http://www.aacap.org>

Bipolar Disorder: Parents' Medication Guide for Bipolar Disorder in Children, & Adolescents

<http://www.parentsmedguide.org/bipolarmedicationguide.pdf>

American Psychiatric Association (APA)

<https://www.psychiatry.org>

American Psychological Association (APA)

<http://www.apa.org/>

Association for Behavioral and Cognitive Therapies (ABCT)

<http://www.abct.org/Home/>

American Foundation for Suicide Prevention (AFSP)

<https://afsp.org/>

Anxiety and Depression Association of America (ADAA)

<https://adaa.org/>

Association for Behavior and Cognitive Therapies (ABCT)

<http://www.abct.org/Home/>

Depression and Bipolar Support Alliance (DBSA)

<http://www.dbsalliance.org>

Effective Child Therapy

<http://effectivechildtherapy.org/>

Juvenile Bipolar Research Foundation

<https://www.jbrf.org/about-jbrf>

Mental Health America (MHA)

Bipolar Disorder in Children

<http://www.mentalhealthamerica.net/conditions/bipolar-disorder-children>

National Alliance on Mental Illness (NAMI)

Bipolar Disorder

<https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder/Support>

National Institute of Mental Health (NIMH)

Bipolar Disorder in Children and Teens

<https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens/index.shtml>

Ryan Licht Sang Bipolar Foundation

<http://www.ryanlichtsangbipolarfoundation.org>

Society of Clinical Child and Adolescent Psychology

<https://sccap53.org/>