3.7 Bipolar Disorder

SURVEILLANCE OR QUESTIONS ABOUT **BIPOLAR DISORDER?**

STOP: Unlikely to be a Bipolar Disorder if…

- Young age (< 10-12 years old)
- Mania symptoms only present in one setting (e.g., only at home)
- Persistently irritable mood between frequent behavioral or emotional episodes (suggestive of DMDD or ODD)

SEE TABLE BELOW

Strongly consider other possible reasons for the symptoms in children and youth under age 12:

- ADHD
- Disruptive Mood Dysregulation Disorder (DMDD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder
- Substance Use Disorder
- Autism Spectrum Disorder
- Major Depression
- ACES or PTSD
- Anxiety or OCD
- Medical causes of mania (e.g., hyperthyroidism)

TREAT THE OTHER CAUSES OF SYMPTOMS
especially if you are unsure of a
Bipolar Disorder diagnosis

ENSURE PATIENT SAFETY

- Suicidal and homicidal ideation
- Experience of current abuse or neglect
- Substance abuse
- Other risky behavior (sexual, financial, antisocial, etc.)

IF STILL CONCERNED ABOUT BIPOLAR DISORDER:

Consider VMAP consult and refer to a mental health specialist for further evaluation and treatment

- Has patient had a clear, distinct period of mania for 4+ consecutive days?
- History of psychosis or suicidality?
- Ever hospitalized for mania?

KEY QUESTIONS: MANIA SYMPTOMS

Abnormally elevated, expansive, or irritable mood + increased goal-directed activity

- Inflated self-esteem; grandiosity
- Decreased need for sleep; wakes feeling rested after very little sleep
- More talkative than usual; pressured speech
- Flight of ideas; racing thoughts; peers say “slow down”
- Poor decision-making; episodic delinquent behavior
- Excessive silliness
- Increase in goal-oriented activity
- Excessive involvement in activities that have a high potential for painful consequences (e.g., sexual indiscretions, physically risky behaviors that indicate sense of invincibility)

Mania Symptoms		Elevated, expansive mood	Irritability	Increased energy	Inflated self-esteem; Grandiosity	Decreased need for sleep	More talkative; Pressured speech	Flight of ideas; Racing thoughts	Distractibility	Increase in goal-directed behavior; Psychomotor Agitation	Involvement in activities with a high potential for painful consequences
Other Conditions to Consider ↑ Always consider medical explanations for mania	**ADHD**	Brief, extreme excitement is common	Poor frustration tolerance is common	Hyperactivity	—	Chronic sleep difficulties are common	Hyperactivity	Hyperactivity	Inattention	Hyperactivity	Impulsivity
	ODD	—	"Often loses temper;" "Touchy or easily annoyed"	—	Defiance can resemble this	—	—	—	—	—	—
	DMDD	—	Persistently irritable or angry mood	Behavioral outbursts can resemble this	Behavioral outbursts can resemble this	—	—	—	—	Behavioral outbursts can resemble psychomotor agitation	—
	MDD	Recovery from depressed mood misinterpreted as euphoria	Irritable mood rather than sad mood	—	—	Insomnia is common	—	—	Difficulties with concentration	Psychomotor agitation is common	Self-harm
	Anxiety	—	Irritability is common	—	—	Sleep difficulties are common	—	Worry can be experienced as racing thoughts	Anxiety impairs concentration	Psychomotor agitation is common	—
	SUD	Euphoric mood while on substance	Irritability while on substance or during withdrawal from substance	Increased energy while on substance	Brief improvement in self-esteem	Decreased need for sleep while on substance	More talkative while on substance	Racing thoughts while on substance	Concentration difficulties while on substance	Increased goal-directed behavior while on substance	Impulsivity while on substance
	ASD	—	Behavior dysregulation resembling irritability	Behavior dysregulation resembling irritability	—	—	—	—	—	—	Impulsivity can resemble this

EVIDENCE-BASED INTERVENTIONS FOR BIPOLAR DISORDER

Pharmacotherapy is essential for the successful treatment of bipolar disorder (Murray, 2017).

Adjunctive behavioral health treatment is effective in optimizing stable mood to prevent relapse. At this time, no behavioral interventions have been found to be effective at reducing acute mania symptoms (Reinares, 2014).

Refer to Mental Health specialist to help with:

First Line Treatments	
Psychoeducation	Provision of information about the nature, causes, course, treatments, and key coping strategies for Bipolar Disorder to the patient and family. The goal is to optimize their detection of prodromes of depression and mania, ongoing stress management, and adherence to medication and psychosocial treatments. Psychoeducation may be delivered individually or in group settings.
Second Line Treatments	
Cognitive Behavioral Therapy (CBT)	CBT works to identify and adjust thoughts and behaviors that contribute emotional distress mood symptoms. Applied to Bipolar Disorder, CBT helps the patient address depressive symptoms and feelings of guilt/shame about manic episodes. Patients also engage in practical problem solving and learn coping strategies to manage strong emotions.
Family-Focused Therapy (FFT)	FFT is based on the idea that patient outcomes are improved with support of family, particularly in families with high expressed emotion. FFT focuses on optimizing communication styles between patients and their family members with the goal of improving relationship functioning.
Third Line Treatments	
Interpersonal and Social Rhythm Therapy (IPSRT)	IPSRT focuses on helping patients regulate their social and sleep rhythms through improving structure of daily routines and emphasizing sleep hygiene practices. It is unclear whether IPSRT represents a “stand-alone” therapy for Bipolar Disorder or if it is better conceptualized as Psychoeducation and behavioral strategies that can be found as essential parts of the therapies listed above.
Peer Interventions	Peer interventions such as peer support groups or individual support have been found to be helpful in reducing stigma of the illness and social isolation. There may be risks if the peers delivering the intervention are not properly trained.

PCP ROLE IN MEDICATIONS WHEN PARTNERING WITH PSYCHIATRY

- Prioritize sleep promotion: Consider a medication choice that is more sedating for a child with increasing manic symptoms.
- Follow closely for symptom progression. Sleep is a useful measure for tracking symptom change over time.
- Collateral information from family is important, since insight gets impaired in active mania.
  - **Medication guidelines will focus on treating mania or hypomania.**
  - **When treating depression in a person with bipolar disorder, avoid using antidepressants without a mood stabilizer. Treating with antidepressants alone can precipitate mania. Maintain communication with psychiatry and/or psychology.**

Name of drug	Starting dose	Target dose	Maximum dose/day	Increase	Monitoring	Considerations (incl. FDA approval age)
Risperidone	0.25mg	2.5mg	6mg	0.25-0.5mg every 3 days	• Weight, fasting lipids and glucose • AIMS (Abnormal Involuntary Movement Scale) • Increases Prolactin level • Can cause priapism • Tardive Dyskinesia	Most risk of extrapyramidal side effects (10+)
Aripiprazole	2mg	10mg	30mg	2mg every 3 days		Akathisia, weight gain more common than with adults (10+)
Lurasidone	20mg	(none identified)	80mg	20mg every 3 days		**Take with 350+ calories of food** (10+)
Asenapine	2.5mg twice daily	2.5-10mg twice daily	20mg	2.5mg every 3 days		Sublingual, twice daily dosing (10+)
Quetiapine	25mg twice daily	up to 400mg daily, divided BID	800mg	25-50mg every 3 days		Orthostatic hypotension and sedation can be notable (10+)
Olanzapine	2.5mg	10mg	20mg	2.5-5mg every 3 days		Most prominent weight gain, very sedating (13+)
Lithium*	300mg, 3 times daily (>30kg), 300mg, 2 times daily (<30 kg)	**Maintenance:** titrate to 0.8 mEq/L serum concentration	**Maintenance:** 1.0 mEq/L **Acute:** 1.2 mEq/L	>30kg: 300mg every 3 days	CBC, TSH, BMP, lithium level (12hr after last dose/right before next dose) HcG test	It works well, but weight gain, increased thirst, renal damage, thyrotoxicity risks exist. Narrow therapeutic range — careful with heat/avoid dehydration, ensure hydration, avoid NSAIDs. Reduces suicide risk. Can worsen acne.

Note: all medication information should be verified using current PDR

*Other mood stabilizers: carbamazepine, lamotrigine, oxcarbamazepine, Divalproax Sodium — significant side effects, requires lab testing.

PROVIDER TIPS & CLINICAL PEARLS

Epidemiology

- **Average age of onset (USA): 20 years old**
- Prevalence: 2.4% (lifetime), 1-2% (adolescents)

Diagnosis of Bipolar Disorder (DSM-5)

At least one episode of mania is required for diagnosis; see DSM-5 for full criteria. This mania episode must be **distinct** and a **clear departure** from the youth's baseline functioning.

Treatment of Bipolar Disorder

- Consider consultation or immediate referral to a mental health specialist, especially if in an active state of mania and/or there are safety concerns. → Refer to nearest emergency department (voluntarily or involuntarily).
- Consider possible medical, substance, or medication causes of mania (e.g., hyperthyroidism, recent substance ingestion, initiation of new psychotropic medication).
- Refer for behavioral health intervention.
- Medication trial will likely prioritize **sedation** and **mood stabilization** (decrease of mania).
- Request a sleep log to monitor sleep time as evidence of symptom improvement/worsening.
- Ensure appropriate sleep hygiene and routinized daily schedule of activities.
- Follow up frequently until mood has stabilized.

ASSESSMENT QUESTIONS TO HELP IDENTIFY POSSIBLE BIPOLAR DISORDER

Assessment Question	Increased Risk for Bipolar Disorder
Is there a family history of bipolar disorder or schizophrenia?	"Yes" to either significantly increases chances of the youth having bipolar disorder.
When did you first notice the symptoms and did they come on suddenly?	Sudden onset within 1-2 days is a more "classic" bipolar presentation.
Did the mania symptoms seem to be a distinct episode with a clear beginning and a clear ending?	An answer of "yes" is more "classic" bipolar presentation.
Is this type of manic mood state common for the youth?	To be bipolar disorder, mania should not be common; it should be a clear departure from baseline behavior.
Did the episode of mania include true elation and euphoria?	Elation during mania is common for children and adolescents; be skeptical of presentations that only include irritability.
Can the youth and family identify 2-3 distinct mood states (i.e., manic/euphoric, baseline/euthymic, depressed/irritable)?	Many individuals with a long history of depression forget what their baseline mood feels like and then mistake their happiness, absence of anhedonia, and renewed energy for mania when the depression episode ends. Depression is not necessary to diagnose a bipolar disorder, but it is common.
Has the youth had a depressive episode? More than one? What were they like?	Most individuals with Bipolar Disorder have at least one major depressive episode before experiencing mania for the first time. Individuals with early age of onset of depression and highly recurrent depressive episodes are more likely to go on to have a bipolar disorder (Schaffer, 2010). Individuals who have depression with psychotic features, psychomotor agitation, and/or atypical depressive symptoms such as hypersomnia and hyperphagia are more likely to go on to have a bipolar disorder (Mitchell, 2008).
If an anti-depressant medication was ever prescribed, did the onset of mania symptoms coincide with initiation of that medication? Did the mania symptoms stop when the medication was discontinued?	Mania symptoms must be present after medication is fully discontinued to warrant concern for a bipolar disorder.

TIPS FOR CAREGIVERS: BIPOLAR DISORDER

What is Bipolar Disorder?

Bipolar disorder is a condition characterized by extreme changes in a person's mood, energy, thinking, and behavior. Children with bipolar disorder have episodes of mania and many also experience episodes of depression.

An episode of mania is where a person's mood is elevated (overly happy), expansive, or very irritable and the person also has increased energy at the same time. These symptoms are present most or all of the day for at least four consecutive days. These symptoms should be a very clear change from the child's normal mood and behavior.

Other mania symptoms may include:

- Unrealistic highs in self-esteem or perceived ability and importance
- Significant increase in energy
- Decreased need for sleep; being able to go with little or no sleep for days without feeling tired
- Increase in talking, including increased rate of speech and difficulty interrupting their talking
- Distractibility — the child's attention jumps frequently from one thing to the next
- Racing thoughts or ideas — for example, thoughts are coming so fast they are hard to describe
- Excessive increase in goal-oriented activity
- Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

Diagnosis

The diagnosis of bipolar disorder in children and teens is complex. The symptoms listed above are often part of other conditions, such as Attention-Deficit/Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Oppositional Defiant Disorder (ODD), anxiety, and substance abuse. This is why it is important to have a psychiatric or mental health specialist involved in diagnosis of Bipolar Disorder.

What causes Bipolar Disorder?

There is no single known cause of Bipolar Disorder. It is likely the case that many factors work together to cause the illness for any given individual. Research suggests that genetics plays a big role in the cause of Bipolar Disorder because the conditions runs strongly in families. Having a parent with Bipolar Disorder makes a child 4-6 times more likely to develop the illness themselves; however, genetics are not the only cause. Clinical experience suggests that trauma or stressful life events can trigger the onset of Bipolar Disorder for people who are genetically vulnerable.

Treatment

Bipolar Disorder can be effectively treated for children and teenagers. Treatment typically includes education for the patient and family about the condition, mood stabilizing medications, and psychotherapy. Medications often help decrease the occurrence of manic episodes and may also help with depression. Psychotherapy helps the patient learn more about stressors that contribute to mood changes, strategies to cope with strong emotions, and ways to improve self-esteem and relationships.

What is the caregiver's role in treatment?

Parents and other caregivers play an essential role in a child's treatment for Bipolar Disorder. Parents must learn about and consider the full range of treatment options. Once a treatment plan is selected, the parent can help their child stay committed to the plan. This may involve providing and overseeing the child taking their medication, scheduling and attending psychotherapy sessions, and regularly checking in with the child's medical doctor about any new symptoms or side effects of medications.

Where can I learn more about bipolar disorder?

Families should start learning about Bipolar Disorder with the following books and websites that provide high-quality, evidence-based information.

Books:

- *The Bipolar Workbook: Tools for Controlling Your Mood Swings*. Second Edition. (2015) By Monica Ramirez Basco (An excellent, practical guide to managing the disorder; based on CBT principles)
- *The Bipolar Teen: What you can do to help you child and your family*. (2007) By David Miklowitz and Elizabeth George (A parent guide to helping their child)
- *An Unquiet Mind.* (1995) By Kay Redfield Jamison. (A memoir written by a bipolar disorder researcher who has the illness herself)

Web resources:

- American Academy of Child and Adolescent Psychiatry Parents' Medication Guide:
  Information including treatments and ways family members can be helpful to their children
- American Academy of Child and Adolescent Psychiatry Bipolar Disorder Resource Center:
  Video clips and many other resource links for families and children
- National Institute of Mental Health — Bipolar Disorder Section
- National Alliance on Mental Illness: www.nami.org/
- Depression and Bipolar Support Alliance: www.dbsalliance.org/