

Child and Adolescent Bipolar Disorder:

An Update from the National Institute of Mental Health



Research findings, clinical experience, and family accounts provide substantial evidence that bipolar disorder, also called manic-depressive illness, can occur in children and adolescents. Bipolar disorder is difficult to recognize and diagnose in youth, however, because it does not fit precisely the symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for normal emotions and behaviors of children and adolescents. But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family. Better understanding of the diagnosis and treatment of bipolar disorder in youth is urgently needed. In pursuit of this goal, the National Institute of Mental Health (NIMH) is conducting and supporting research on child and adolescent bipolar disorder.

A Cautionary Note

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer. In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Symptoms and Diagnosis

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning.

Manic symptoms include:

- Severe changes in mood—either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep—able to go with very little or no sleep for days without tiring
- Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility—attention moves constantly from one thing to the next
- Hypersexuality—increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation

- Disregard of risk—excessive involvement in risky behaviors or activities

Depressive symptoms include:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Symptoms of mania and depression in children and adolescents may manifest themselves through a variety of different behaviors.^{1,2} When manic, children and adolescents, in contrast to adults, are more likely to be irritable and prone to destructive outbursts than to be elated or euphoric. When depressed, there may be many physical complaints such as headaches, muscle aches, stomachaches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure. Other manifestations of manic and depressive states may include alcohol or substance abuse and difficulty with relationships.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar

disorder.^{1,2} When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

Findings from an NIMH-supported study suggest that the illness may be at least as common among youth as among adults.⁵ In this study, one percent of adolescents ages 14-18 were found to have met criteria for bipolar disorder or cyclothymia, a similar but milder illness, in their lifetime. In addition, close to six percent of adolescents in the study had experienced a distinct period of abnormally and persistently elevated, expansive, or irritable mood even though

they never met full criteria for bipolar disorder or cyclothymia. Compared to adolescents with a history of major depressive disorder and to a never-mentally-ill group, both the teens with bipolar disorder and those with subclinical symptoms had greater functional impairment and higher rates of co-occurring illnesses (especially anxiety and disruptive behavior disorders), suicide attempts, and mental health services utilization. The study highlights the need for improved recognition, treatment, and prevention of even the milder and subclinical cases of bipolar disorder in adolescence.

Treatment

Once the diagnosis of bipolar disorder is made, the treatment of children and adolescents is based mainly on experience with adults, since as yet there is very limited data on the efficacy and safety of mood stabilizing medications in youth.⁴ The essential treatment for this disorder in adults involves the use of appropriate doses of mood stabilizers, most typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

NIMH is attempting to fill the current gaps in treatment knowledge with carefully designed studies involving children and

Valproate Use

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20.⁵ Increased testosterone can lead to polycystic ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients taking valproate should be monitored carefully by a physician.

adolescents with bipolar disorder. Data from adults do not necessarily apply to younger patients, because the differences in development may have implications for treatment efficacy and safety.⁴ Current multi-site studies funded by NIMH are investigating the value of long-term treatment with lithium and other mood stabilizers in preventing recurrence of bipolar disorder in adolescents. Specifically, these studies aim to determine how well lithium and other mood stabilizers prevent recurrences of mania or depression and control subclinical symptoms in adolescents; to identify factors that predict outcome; and to assess side effects and overall adherence to treatment. Another NIMH-funded study is evaluating the safety and efficacy of valproate for treatment of acute mania in children and adolescents, and also is investigating the biological correlates of treatment response. Other NIMH-supported investigators are studying the effects of antidepressant medications added to mood stabilizers in the treatment of the depressive phase of bipolar disorder in adolescents.

For More Information

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References

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An NIMH Snapshot

The National Institute of Mental Health (NIMH) is one of 25 components of the National Institutes of Health (NIH), the Government's principal biomedical and behavioral research agency. NIH is part of the U.S. Department of Health and Human Services. The actual total fiscal year 1999 NIMH budget was \$859 million.

NIMH Mission

To reduce the burden of mental illness through research on mind, brain, and behavior.

How Does the Institute Carry Out Its Mission?

- NIMH conducts research on mental disorders and the underlying basic science of brain and behavior.
- NIMH supports research on these topics at universities and hospitals around the United States.
- NIMH collects, analyzes, and disseminates information on the causes, occurrence, and treatment of mental illnesses.
- NIMH supports the training of more than 1,000 scientists to carry out basic and clinical research.
- NIMH communicates information to scientists, the public, the news media, and primary care and mental health professionals about mental illnesses, the brain, mental health, and research in these areas.

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A specific example is:

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Confidential Telephone Counselling and Consulting Services

514-223-1015
1-866-441-8909

lucy@lucymacdonald.com

Telephone counselling can be helpful if you are struggling with:

- Stress at home or work
- Burnout
- Sadness and grief
- Anger
- Divorce or separation
- Family or parenting issues
- Work-life balance
- Lack of assertiveness
- A personal crisis

Making the Decision

The decision to seek counselling is never an easy one. If I can be of help to you or someone you care about call today for assistance, information, or an appointment. You can also reach me via email at

lucy@lucymacdonald.com

Counsellor Practitioner of the Year (2005)

Lucy is the recipient of the 2005 Counsellor Practitioner Award by the Canadian Counselling Association for “excellence in leadership as a practicing counsellor” and her involvement “both within and outside the work community to promote counselling”.

Credentials

- Master of Education – Counselling Psychology , McGill University
- Canadian Certified Counsellor * with the Canadian Counselling Association
- In private practice since 1998

Counselling Approach

I use a brief, solution-focused approach to help people cope with and manage a variety of life challenges.

Counselling Specialty

- Stress management
- Burnout recovery
- Anger Management
- Assertiveness training
- Divorce and separation
- Parenting Concerns

Number of Sessions

You are not required to commit to a specific number of sessions – you are the best judge of what you need.

Telephone Counselling

Consulting via telephone is an alternative source of help when in-person sessions isn't possible or convenient for you. A telephone session saves you time, is more it is often easier to get a

appointment than an in-person session. Telephone sessions are especially useful if you are traveling. You can reach me at 514-223-1015 or 1-866-441-8909

Fees

Telephone sessions: 30 minutes \$45, 50 minutes \$80

Fees are in Canadian dollars and are in effect until Dec 31, 2005.

Fees are paid in advance via PayPal on [Lucy's website](#).

Canceling Appointments

Appointments that are cancelled up to 24 hours prior to the appointment can be re-scheduled.

There is a cancellation fee of \$45. If you schedule another appointment to take place within 48 hours the cancellation fee is waived. Appointments can be cancelled by phone and by email. The receipt of your phone message or email to cancel an appointment will be acknowledged.

Confidentiality and Records

Counseling often involves sharing sensitive, personal and private information. Ethical guidelines require that all interactions, including content of your sessions, your records, scheduling of or attendance at appointments, and personal progress are confidential. No one can have access to any information without your signed consent. Exceptions to confidentiality:

1. A client poses a clear and imminent danger to themselves or to someone else.
2. A client requests release of information.
3. A court orders release of information.
4. Clients raise the issue of their mental health in a law suit.

*** What is a Canadian Certified Counsellor?**

The Canadian Counselling Association (CCA) "identifies to the public, those counsellors who, through a process of credential evaluation, are judged qualified to provide counselling services." As a Canadian Certified Counsellor I am required to continue to develop my expertise and adhere to a code of ethics. If you have any concerns about my professional conduct please call the [Canadian Counselling Association](#) at 1-877-765-5565.