

## **PRACTICE GUIDELINES FOR CHILDHOOD BIPOLAR DISORDER**

*MHNet monitors practitioner's adherence to the following elements in the treatment of Bipolar Disorder:*

- *Psychotherapy*
- *Medication Management*
- *Conjoint Therapy*

The frequency of bipolar diagnosis in adolescents is increasing dramatically. Presumably this is due to increasing recognition of the disorder rather than an increase in prevalence. To date there has been much written about the condition but few well-controlled outcome studies. Basic questions remain to be answered including:

- What are the typical signs and symptoms of the condition in adolescents,
- How can one separate the condition from other childhood disorders (e.g. ADHD, conduct disorder, oppositional defiant disorder), and
- What is the most appropriate treatment? Medications known to be efficacious in adults are being prescribed for adolescents despite few studies of these treatments in the younger population.

### **DIAGNOSIS**

A thorough diagnostic evaluation must be completed before beginning treatment of bipolar disorder. This evaluation should include interviews with the child and at least one parent. Ideally, additional history should be obtained from the child's school. Physical abnormalities need to be excluded (e.g., head injury, hyperthyroidism, temporal lobe epilepsy) along with other diagnostic possibilities (e.g., substance abuse, PTSD, and schizophrenia). Since there is frequent comorbidity of bipolar disorder with ADHD and conduct disorder, the presence of these two diagnoses does not preclude bipolar disorder.

The diagnosis of bipolar disorder is based upon the child demonstrating at least one period of mania, lasting at least a week. During this period the child must demonstrate:

- Elation or euphoria
- Decreased need for sleep
- Grandiosity
- Racing thoughts
- Hypersexuality

Many authors consider irritability to be the most prominent symptom of bipolar disorder in children. Although very common, irritability alone should not be the sole criteria for diagnosing this condition

### **COMORBIDITY AND DIFFERENTIAL DIAGNOSIS**

Diagnosis of bipolar disorder in children is often complicated because symptoms that overlap may be difficult to distinguish from other disorders. Common comorbid disorders with bipolar disorders include ADHD, substance abuse, anxiety disorder, and conduct disorder. Even in the absence of a comorbid condition the range of symptoms associated with younger patients who have a mood disturbance further complicates diagnosis. As a result, bipolar disorder is often confused with conditions that have similar features, such as schizophrenia, schizoaffective disorder, agitated depression, and post-traumatic stress disorder (PTSD). Strict use of *DSM-IV* criteria has been shown to improve the accuracy of the practitioner's differential diagnosis.

### **TREATMENT**

In adults, typical treatment for bipolar disorder involves a mood stabilizer. Possibilities include lithium and several anticonvulsant medications (divalproex (Depakote®), carbamazepine (Tegretol®), lamotrigine (Lamictal®),

oxcarbazepine (Trileptal®), topiramate (Topamax®) and gabapentin (Neurontin®)]. There have been few well-controlled studies of these drugs in children. In adults lithium, Depakote®, and Tegretol® have been consistently shown to be efficacious for acute mania, lithium and Depakote® have shown efficacy for bipolar depression. Lithium, Depakote® and Lamictal® are all effective for prophylaxis of bipolar disorder. Therefore, in the absence of additional data, the use of Topamax®, Trileptal® or Neurontin® in children should be limited.

In adults, acute mania is generally treated with an antipsychotic or benzodiazepine along with a mood stabilizer. Olanzapine (Zyprexa®), ziprasidone (Geodon®), quetiapine, (Seroquel®) and aripiprazole (Abilify®), newer generation antipsychotics, have FDA approval for use in acute mania. They join a long list of older generation antipsychotics that have been routinely used to treat manic episodes in adults. Of the newer generation antipsychotics, only Risperdal® has been shown to be efficacious in treating childhood psychosis. Therefore, the physician must weigh the potential benefit of an antipsychotic, based on adult studies, against the significant side effect profile of these drugs. In particular, the tendency of newer generation antipsychotics to cause significant weight gain, abnormal glucose metabolism and elevation of cholesterol and triglycerides raises serious concerns about their long-term use in children. Benzodiazepines (e.g., Klonopin®) have been used to control adult mania and may be efficacious in children. The potential for disinhibition in a child with a history of violence limits the widespread use of these drugs. Possible impairment of school performance is a concern with benzodiazepines since they can cause cognitive impairment.

Treatment of depression in children with bipolar disorder presents a dilemma. It is unclear whether antidepressants are as effective for bipolar disorder depression as for unipolar depression. Presumably, antidepressants can cause a switch to (or provoke the emergence of) mania in children as they do in adults. Most psychiatrists favor newer generation antidepressants over tricyclics. There are mounting concerns about the potential for SSRI antidepressants to cause agitation and increased risk for suicide. Therefore, these drugs should probably not be used as first line drugs for bipolar depression in adolescents.

Since there are no well-controlled studies of medications in adolescent bipolar disorder, the clinician is forced to make an educated guess and view every patient as a unique clinical trial. Careful attention must be paid to the child's presenting symptoms and they should be the guide for determining treatment response. Ideally, the clinician should develop a symptom checklist for each patient to accurately monitor progress. If the psychiatrist elects to use an antipsychotic it should be discontinued shortly (i.e., 6-8 weeks) after symptoms abate. If maintenance treatment is warranted, mood stabilizers are the drugs of choice.

### **Concomitant ADHD**

Many, perhaps most, adolescents with bipolar disorder have comorbid ADHD. Stimulants, which may be essential to alleviate attention deficit, may provoke mania and psychosis in susceptible individuals. Conversely, mood stabilizers and antipsychotics may make the symptoms of ADHD worse. Therefore, the psychiatrist must carefully balance the relative risks and benefits of the various therapeutic interventions.

### **PSYCHOSOCIAL TREATMENT**

Adolescent bipolar disorder can be a devastating condition. The chronicity and irritability can easily overwhelm the child's support system. Violent aggressive rages are not uncommon. This can lead to suspension from school, parental fear for the safety of their other children and sometimes themselves. Therapy starts with a careful explanation of the disease and expected course. Parents need help in understanding which behaviors are volitional and which are the product of the mental illness. Parents and children should be taught to predict episodic relapse based on a variety of factors such as seasonal or situational changes, sleep deprivation, medication noncompliance, or substance abuse.

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Families taught to predict episodic relapse might experience improved outcomes because of early pharmacologic intervention.

Parents need skills in how to respond to the child's moodiness and irritability. They need assistance in working with the school to maintain the child in the classroom. Lastly, parents need to know what resources are available to assist in times of crisis. Repeated trips to the emergency room and multiple psychiatric hospitalizations are evidence of the failure of the treatment plan to stabilize and maintain the child in the community.

## INTENT

This practice guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The practitioner, in light of the clinical data presented by the patient and the diagnostic and treatment options available, must make the ultimate judgment regarding a particular clinical procedure or treatment plan.

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