Medication and Bipolar Disorder

Research on the effectiveness and safety of medications for bipolar disorder in children and teens is ongoing, and treatment has been based primarily on the experience of medications with adults. Frequently, management of bipolar disorder requires the use of several medications. These include:

- Mood stabilizers, such as lithium, Depakote, Tegretol, and Gabitril, the basic tools for managing the high-risk symptoms of pediatric bipolar disorder. Some mood stabilizers used with adults, such as Valproate, are not recommended for children.

- Antipsychotic medications, such as Risperdal, Zyproxa, and Seroquel, used for manic states, particularly when delusions or hallucinations are present.

- Calcium channel blockers, such as verapamil and irapiprene, currently being evaluated for use as mood stabilizers.

- Anti-anxiety medications, such as Klonopin, Xanax, and Ativan, used to reduce agitation and promote sleep.

The National Institute of Mental Health has issued a cautionary note on the use of antidepressants (without mood stabilizers) or stimulants in the treatment of pediatric bipolar disorder, since they may worsen manic symptoms.

Defining the Problem

Bipolar disorder, formerly called manic-depressive illness, is a chronic condition characterized by extreme fluctuations in mood, energy, thought, and behavior that interfere significantly with normal, healthy functioning. Although the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) currently uses the same criteria to identify bipolar disorder in children and teens as it does in adults, recent research indicates that children with bipolar disorder may not manifest the same precise symptoms.

While adults may experience symptoms of a single mood for an extended period of time, bipolar disorder in children and teens is often continuous and rapid-cycling. The shift from a manic (excitable, elevated, expansive, or irritable) mood to a depressed (sad, low-energy, and uninterested) state can occur several times within a single day. With children, symptoms of both moods frequently occur simultaneously. When manic, children and teens are likely to be irritable and the associated efforts to treat the high moods can result in more symptoms, including depression.

Counseling Children and Teens with Bipolar Disorder

The most effective treatments for bipolar disorder combine medication and psychological interventions. Counseling should be provided for both the child and the family.

- Cognitive behavioral treatments can improve compliance with the medication regimen and reduce the need for hospitalization.
- Support groups can teach coping skills, reduce isolation, and increase social functioning.
- Psychotherapeutic counseling can help the child or teen develop awareness, adapt to stresses, and improve self-esteem.

For the family of the child with bipolar disorder:
- Psychoeducational training can help parents understand the condition, develop strategies for managing behavioral issues, and learn skills for positive parenting.
- Stress reduction training can develop skills, including the use of relaxation techniques, helpful to the child and parent.
- Support groups can assist parents to increase awareness of their own responses and reactions, extend their coping skills, and decrease their feelings of isolation and helplessness.

Goals in Developing a Treatment Plan

- To identify early signs of extreme moods
- To teach children and teens to regulate their moods
- To change cognitive distortions associated with depression
- To develop self-calming techniques for manic or explosive moods
- To recognize signs of severe depressions and suicidal thoughts
- To educate about the risks of alcohol and drug use
- To support the family of the bipolar child or teen
- To develop a closely monitored medication and therapeutic protocol

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Defining the Problem (continued) and explosive, rather than explosive. When depressed, they may complaining of physical ailments, cry frequently, and be unable to engage in school, social, or family activities. The DSM-5 establishes no lower age limit for bipolar disorder, but until recently young people were rarely diagnosed with this condition. Since the initial symptoms of bipolar disorder in children may have many features of attention-deficit/hyperactivity disorder (ADHD) or oppositional defiant disorder (ODD), and these disorders may also coexist with bipolar disorder, identifying bipolar disorder in children has been challenging. However, the decreased need for sleep, grandiose behavior, elated mood, flight of ideas, and hypersexuality associated with bipolar disorder rarely occur in children diagnosed with only ADHD or ODD. Although mood swings are considered a normal part of childhood and adolescent development, the characteristics of pediatric bipolar disorder can be extreme and intense. When depressed, children may be great difficulty getting out of bed and show no interest in play or school. Children in a manic phase may laugh hystericly for no apparent reason. Their distorted cognitions may range from believing that they already know everything they might learn in school to thinking that they can fly. They may exhibit destructive rages, demonstrate precocious sexuality, and experience delusions and hallucinations. Children with bipolar disorder are also at high risk for substance abuse and suicidal behavior. Studies indicate there is a strong genetic component to bipolar disorder. Although the risk of bipolar disorder in the general population is around 1%, when a parent has bipolar disorder the risk is 15%–30%. If both parents have bipolar disorder, the risk increases to 50%–75%. Some evidence indicates that when the disorder begins in childhood or early adolescence it may be a more severe form of the illness.

Fast Facts

- 59% of surveyed adults with bipolar disorder reported that symptoms appeared during or before adolescence.
- The lifetime mortality rate from suicide in bipolar disorder is higher than that for some childhood cancers.
- Famous people with symptoms of bipolar disorder include Abraham Lincoln, Charles Dickens, Ludwig van Beethoven, Winston Churchill, and Virginia Woolf.
- Studies indicate that the majority of teens with untreated bipolar disorder have abused alcohol or drugs.
- Mothers of children with bipolar disorder often report that, in infancy, their children slept erratically, seemed excessively attached, and had frequent uncontrolled tantrums.
- The prevalence of alcoholism among relatives of children with bipolar disorder is two to three times the alcoholism rate of relatives of children without the disorder.
- In a recent longitudinal study, nearly half of the children diagnosed before puberty with major depression developed mania by age 20.

What Parents Need to Know

Research indicates that parental observation provides the most accurate information in determining the diagnosis of bipolar disorder in children and teens. The parent’s role is equally important in the treatment and management of the illness. Because bipolar disorder can result in many high-risk behaviors, it is essential that parents:

- Find the right doctor. If there is a family history of bipolar or other mood disorder, family problems with alcohol or substance abuse, or your child is experiencing possible manic symptoms, you need a doctor experienced in diagnosing and treating bipolar disorder. You can find more information about getting help from the American Academy of Child and Adolescent Psychiatry at www.aacap.org/index.htm.

- Keep your child with bipolar disorder safe. This may involve, among other precautions, storing medications in a locked box, removing weapons from the home, learning proper restraint techniques, listening for suicidal statements, and remaining vigilant about possible drug or alcohol use.

- Assume that your child receives early and regular treatment. This will require medication management, psychological services, and academic accommodation.

- Monitor your child’s moods. You are the best informant about any changes that your child is experiencing and can help to anticipate any needed modifications in the treatment regimen.

- Learn effective strategies. Parents can implement positive parenting skills, establish stress reduction routines as part of the family functioning, and help the child develop useful coping skills.

- Get support and guidance for yourself. Raising a child with bipolar disorder can be challenging and sometimes overwhelming. Getting the proper understanding and assistance can make it rewarding as well.

What Teachers Need to Know

Bipolar disorder, and the medications used to treat it, can affect a child’s attendance, energy, concentration, motivation, problem-solving skills, memory, organization, and responsiveness to light, noise, and stress. The significant impact of bipolar disorder on a child’s ability to function academically and socially requires the teacher to be both sensitive and skilled. The child with bipolar disorder can benefit from:

- A team approach that encourages regular communication about changes in the child’s behavior and needs, and involves parents, teachers, administrators, counselors, therapists, and physicians in formulating and implementing appropriate educational plans and accommodations.

- A classroom atmosphere that is both structured and flexible, so that the routine can reduce stress and the adaptability can accommodate the child’s changing mood state.

- A behavior intervention plan, including staff experienced in verbal de-escalation techniques and restraint training, that can help school personnel control the child’s negative behavior and can help the child learn appropriate techniques to control his or her own actions.

- Accommodations that modify the physical environment, behavioral expectations, and academic requirements to help insure that the child with bipolar disorder has a successful school experience. These accommodations, geared to the specific needs of the individual student, may include:
  - Light adjustment. Children may be agitated by bright light or made sleepy by darkness.
  - Noise control. Earplugs or headphones can minimize distractions.
  - One-on-one classroom aide.
  - Designation of a “safe place” to go when the child is feeling overwhelmed.
  - Unlimited access to drinking water and the bathroom.
  - Extended time for taking tests.
  - Activities that focus on creative expression.
  - Assignment modification. Short, clearly defined assignments and frequent checking can help during both depressed and manic phases.
  - Delayed school-day start time.
  - Consideration of special school placement.

The Dos and Don’ts of Communicating

**DON’T**

- Ignore statements like “I want to be dead.”
- Blame the child or yourself.
- Focus on minor issues.
- Emphasize negative behaviors.
- Overreact to manic symptoms.

**DO**

- Take suicidal statements seriously.
- Stay positive.
- Let go of less important matters.
- Acknowledge accomplishments.
- Maintain a calm, consistent attitude.