Pediatric bipolar disorder: Assessment and diagnosis

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INTRODUCTION

Bipolar disorder in children and adolescents is characterized by recurrent episodes of elevated mood (mania or hypomania) that exceed what is expected for the child's developmental stage and are not better accounted by other psychiatric and medical conditions. In addition, youth with bipolar disorder usually have recurrent episodes of major depression [1-4].

Bipolar disorder severely affects the normal development and psychosocial functioning of the youth and increases the risk for suicide, psychosis, substance abuse, other medical illnesses, and behavioral, academic, social, and legal problems [1,2]. Pediatric bipolar disorder frequently has a variable course with rapid fluctuation in mood symptoms during acute episodes. These factors coupled with developmental issues influencing the clinical picture, the difficulties youth can have verbalizing their emotions, and high rates of comorbid disorders, account for the complexity and controversies in diagnosing children and adolescents with bipolar disorder.

The prevalence of pediatric bipolar disorder in epidemiologic studies is comparable across different countries, with average rates for bipolar I disorder plus bipolar II disorder of approximately 1 to 2 percent [5]. However, there may be variability across countries for diagnosing bipolar disorder, particularly the other specified bipolar and related disorder (bipolar disorder not otherwise specified) subtype [5,6]. As an example, a study of hospital discharge rates for pediatric bipolar disorder in the United States and England found that after adjusting for length of stay, the discharge rate was more than 12 times higher in the United States [7]. This discrepancy was much larger than for other psychiatric diagnoses.

This topic describes the assessment and diagnosis of bipolar disorder in children and adolescents. The epidemiology, clinical presentation, comorbidity, and treatment of pediatric bipolar disorder are discussed separately.

- (See "Pediatric bipolar disorder: Epidemiology and pathogenesis".)
- (See "Pediatric bipolar disorder: Clinical manifestations and course of illness".)
- (See "Pediatric bipolar disorder: Comorbidity".)
- (See "Pediatric bipolar disorder: Overview of choosing treatment".)
- (See "Pediatric bipolar major depression: Choosing treatment".)
- (See "Pediatric bipolar disorder and pharmacotherapy: General principles".)
- (See "Pediatric mania and second-generation antipsychotics: Efficacy, administration, and side effects".)
- (See "Pediatric bipolar disorder: Efficacy and core elements of adjunctive psychotherapy".)

ASSESSMENT

General approach — Despite the serious consequences of bipolar disorder, identification of the illness and initiation of treatment occurs, on average, 10 years after its manifestation [8]. Pediatricians and other primary care physicians should be alert to symptoms suggesting the possibility of the disorder. Diagnosing bipolar disorder in children and adolescents can be complex and has significant consequences. Unless a primary care physician has experience with pediatric bipolar disorder, patients in whom the disorder is strongly suspected should be evaluated by a child psychiatrist or other mental health specialist skilled in making the diagnosis.

Assessment of manic, hypomanic, and depressive symptoms in youth requires careful probing and multiple longitudinal assessments. In addition, it is important to ascertain the frequency, intensity, number, and duration (summarized by the acronym “FIND”) of manic, hypomanic, and depressive mood episodes [9], as well as episodes with mixed features (ie, mood episodes that are accompanied by symptoms of the opposite polarity) [3].

Given that lack of insight can be associated with mania or hypomania, it is imperative to obtain information from caregivers or other adults who know the child well in order to accurately assess symptoms and potential change in functioning. The child’s chronologic age, intellectual capabilities, and environmental factors need to be taken into account when assessing the level of functional impairment or improvement.

Certain symptoms, particularly if they **appear together and are episodic**, should raise the suspicion of pediatric bipolar disorder:

- Persistently increased activity and/or silliness above and beyond what is expected for the developmental age of the child and not accounted by the situation, other psychiatric disorders, or medications
- Decreased need for sleep for several nights (eg, four), especially if the child is not tired or sleepy the day after having slept only three to four hours during the night
- Inappropriate sexual behaviors that are out of character, not expected for the mental/chronological age of the child/adolescent, and occur without a history of exposure to sexual activity (eg, abuse or videos)

In addition, the presence of psychosis (eg, hallucinations and/or delusions) should raise the question of whether the child has bipolar disorder. Longitudinal studies indicate that psychotic symptoms in the context of depression are a strong predictor of bipolar disorder, particularly if there is family history of bipolar disorder [10].

Mild or transient manic symptoms that do not meet the diagnostic threshold for episodes of mania or hypomania may precede or coexist with an episode of depression [1,11]. These subthreshold manic symptoms in depressed patients are associated with poor responses to antidepressants and can be a harbinger of eventual bipolar disorder. Clinicians thus need to probe for a history of manic/hypomanic symptoms in youth presenting with depression.

Evaluation of children and adolescents for bipolar disorder should include a history and examination for the presence of comorbid mental disorders (eg, anxiety disorders and attention deficit hyperactivity disorder), substance use, other medical conditions (eg, obesity), suicidal and homicidal ideation and behavior, family psychopathology, and ongoing negative life events (eg, family conflicts and abuse); assessment of psychosocial functioning; and longitudinal observation of the mood symptoms. In some cases, psychometric testing can be useful for children with learning problems. (See "Specific learning disorders in children: Evaluation", section on 'Psychometric tests'.)

To determine the level of care (eg, hospitalization), clinicians need to assess the severity of mood symptoms; presence of suicidal and/or homicidal symptoms, psychosis, substance abuse, and agitation, as well as parental psychopathology; the child's and parents' adherence to treatment; and family environment.

Assessment instruments — Assessment of mood and other psychiatric symptoms can be facilitated by the use of structured and semi-structured interviews and rating scales. In contrast to the interviews, the rating scales below do not provide a diagnosis, but can reveal symptoms that may alert clinicians to further assess for bipolar disorder. Rating instruments can also be used during treatment to monitor the severity of symptoms over time.

Diagnostic interviews — There are several structured and semi-structured interviews that can be used for diagnosing bipolar disorder, including the Kiddie Schedule for Affective Disorders and Schizophrenia for school age children - Present and Lifetime version (K-SADS-PL) [12]. However, these interviews are lengthy and time-consuming and are mainly used for research.

Clinician-administered rating scales — Clinician-administered rating scales that assess manic symptoms and their severity in youth include the Young Mania Rating Scale (YMRS) [13] and the KSADS Mania Rating Scale (KSADS – MRS; derived from the KSADS-P mania module) [13,14]. However, using these scales requires training.

Youth- and parent-administered rating scales — It appears that parental reports are more effective in identifying mania than youth or teacher reports [13]. The General Behavior Inventory [13], the parent version of the YMRS (P-YMRS) [13], and the Child Mania Rating Scale for Parents (about their children) [13,15] are psychometrically sound and can be used to screen for bipolar disorder symptoms in youth. However, these self-report scales usually do not properly elicit the clustering and periodicity of manic/hypomanic symptoms.

The Child Behavior Checklist (CBCL) is a parent-report instrument that has been used to screen for bipolar disorder in youths by summing the Attention, Aggression, and Anxious/Depressed subscales (CBCL-PBD; pediatric bipolar disorder phenotype) [13]. However, the CBCL-PBD is not specific for assessing mania; rather, it seems to detect mood lability or severe psychopathology [16].

Mood timelines or diaries — Mood timelines or diaries describe the course of a patient's mood symptoms over time. Using school years, birthdays, and holidays as anchor points, timelines and diaries can help assess the onset and course of mood disorders. Timelines use a simple scale showing daily changes in mood (form 1). As an example, they can include a scatter line in which 0 represents feeling very sad, 10 excessively happy and 5 is a normal mood. A mood diary can also include stressors and doses of medications. Multiple smartphone applications are available for tracking mood fluctuations.

DIAGNOSIS

Diagnosis of bipolar disorder and its subtypes begins by diagnosing the manic or hypomanic episodes that determine the diagnosis of this disorder. It is crucial to ascertain whether the symptoms present in clusters above and beyond any other comorbid psychopathology, and whether the manic/hypomanic episodes are cyclic. In addition, the diagnosis requires that clinicians exclude other relevant psychiatric and other medical conditions that can manifest with symptoms that overlap with those of bipolar disorder. (See 'Mood episodes' below and 'Bipolar disorders' below and 'Differential diagnosis' below.)

We suggest diagnosing bipolar mood episodes and disorders according to the criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) [11]. Although the diagnostic criteria were not developed or specifically adapted for use in pediatric populations, it is possible to apply the criteria to children and adolescents by accounting for developmental issues.

A reasonable alternative to DSM-5 is the World Health Organization's International Classification of Diseases-10th Revision (ICD-10) [17]. The two sets of criteria are largely the same.

Mood episodes — Bipolar mood episodes include mania, hypomania, and major depression; however, episodes of major depression are not necessary to make the diagnosis of bipolar disorder [11]. The distinction between the symptoms of these episodes and normal behavior in children is discussed in detail separately. (See "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Clinical presentation'.)

Mania — The diagnostic criteria for manic episodes are described in the table (table 1). The core symptoms of mania are abnormally and persistently [11]:

- Elevated, expansive, and/or irritable mood
- Increased energy or goal directed activity

These symptoms occur for at least one week (or any duration if hospitalization is necessary), nearly every day, for most of the day. During this period of mood disturbance and increased energy or activity, at least three (if elated mood predominates) or four (if irritable mood predominates) of the following symptoms must also be present [11]:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (eg, feels rested after three or four hours of sleep)
- More talkative than usual or pressured speech
- Racing thoughts or flight of ideas (abrupt changes from one topic to another that are based upon understandable associations)
- Distractibility

- Increase in goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg, buying sprees or sexual indiscretions)

A meta-analysis of 20 observational studies evaluated the frequency of manic symptoms in youth with bipolar I disorder and other specified bipolar disorder (total n >2000) [18]. The most common symptoms included increased energy, irritability, mood lability, distractibility, and goal directed activity (each occurred in approximately 75 percent of patients) (table 2). The results of the meta-analysis need to be taken with caution because there were methodologic limitations (eg, studies varied in how they diagnosed bipolar disorder), which led to substantial heterogeneity across studies in the rates of most symptoms.

Another criterion is that the manic symptoms impair psychosocial functioning, necessitate hospitalization, or are accompanied by psychotic features (eg, delusions or hallucinations); in addition, the symptoms are not the direct result of a substance or general medical condition [11]. However, a typical syndrome of manic symptoms, which emerges during antidepressant treatment and persists beyond the physiologic effect of that treatment (eg, more than one week), should be considered as a manic episode if the full criteria are met. Antidepressant-induced activation (eg, increased energy, silliness, and talkativeness) that occurs solely during treatment should not be diagnosed as mania [19].

These symptoms exist as a collection of concurrent symptoms and behaviors. Although a few investigators disagree, the diagnosis of mania requires that the symptoms occur episodically. (See "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Mania'.)

Manic episodes occur with bipolar I disorder. (See 'Bipolar I disorder' below.)

Hypomania — The diagnostic criteria for hypomanic episodes are described in the table (table 3). Hypomania is characterized by an abnormally and persistently elevated or irritable mood, as well as increased energy or goal directed activity, lasting at least four consecutive days, for most of the day, nearly every day [11]. During this period, at least three (if elated mood predominates) or four (if irritable mood predominates) of the additional symptoms that characterize mania must be present. (See 'Mania' above.)

The distinction between hypomanic and manic episodes is based upon the intensity and duration of symptoms. Hypomanic symptoms are less severe than manic symptoms, and according to DSM-5, the diagnosis of hypomania requires at least four days of symptoms, whereas mania requires at least seven days [11]. In addition, psychosocial functioning in hypomania is either mildly impaired or significantly improved, whereas functioning in mania is

impaired. If severe, mania may include psychotic features, which usually are mood congruent (eg, having superpowers or being the messiah) and may lead to hospitalization; by definition, hypomania does not.

Another criterion for hypomania is that the symptoms are not the direct result of a substance [11]. However, a syndrome of hypomanic symptoms, which emerges during antidepressant treatment (eg, pharmacotherapy) and persists beyond the physiologic effect of that treatment, is diagnosed as a hypomanic episode if the full criteria are met.

Hypomania may be difficult to diagnose not only because functioning can improve during an episode, but also because the symptoms need to be differentiated from normal mood and behaviors usually observed in youths.

Whereas manic episodes only occur in bipolar I disorder, hypomanic episodes may occur with bipolar I disorder, bipolar II disorder, or other specified bipolar and related disorder. (See 'Bipolar disorders' below.)

Major depression — Episodes of major depression usually occur in youth with bipolar disorder, but they are not necessary for the diagnosis of bipolar disorder. The diagnostic criteria for major depressive episodes are described in the table (table 4). Major depression is characterized by at least five of the following symptoms for at least two weeks; at least one of the symptoms is dysphoria, irritability, or anhedonia [11]:

- Depressed mood most of the day, nearly every day (dysphoria)
- Diminished interest or pleasure in nearly all daily activities, most of the day, nearly every day (anhedonia)
- Significant weight loss or weight gain (eg, 5 percent within a month)
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Thoughts of worthlessness or inappropriate guilt nearly every day
- Diminished ability to think or concentrate nearly every day
- Recurrent thoughts of death or suicidal ideation, or a suicide attempt

In addition, the symptoms cause significant distress or psychosocial impairment, and are not the direct result of a substance or general medical condition. Although controversial, in DSM-5, bereavement does not exclude the diagnosis of a major depressive episode. Major depressive episodes may occur with bipolar I disorder, bipolar II disorder, or other specified bipolar disorder. (See 'Bipolar disorders' below.)

Depressive symptoms may fluctuate more frequently in depressed children compared with adults, and depressed children may be more reactive than depressed adults. Depressed children may not look or feel depressed but are irritable instead. They can be depressed at school but feel or look happy when they are with their friends or playing games. To consider diagnosing a major depression in youth, it can be useful to evaluate what percent of the time (eg, in a week) they are depressed. Some investigators have suggested that to consider the depression as significant, depression should occur at least 50 percent of the time [20].

Additional information about the clinical features and diagnosis of depression is discussed separately. (See "Unipolar depression in adults: Assessment and diagnosis".)

Mood episode specifiers — DSM-5 utilizes several terms to increase the diagnostic specificity of bipolar mood episodes, including [11]:

- **Psychotic features** – Psychotic features include delusions (false, fixed beliefs), hallucinations (false sensory perceptions), and thought disorder (disorganized cognition and illogical thoughts), any of which can occur at any time during a mood episode (see "Psychosis in adults: Epidemiology, clinical manifestations, and diagnostic evaluation", section on 'Clinical manifestations')

- **Catatonia** – Catatonic features are characterized by prominent psychomotor disturbances that occur during most of the episode (see "Catatonia in adults: Epidemiology, clinical features, assessment, and diagnosis")

- **Anxious distress** – Anxious distress is characterized by the presence of two or more of the following symptoms during most days of the mood episode:

  - Tension
  - Restless
  - Impaired concentration due to worry
  - Fear that something awful may happen
  - Fear of losing self-control

- **Mixed features** – Episodes of mania, hypomania, and major depression can be accompanied by symptoms of the opposite polarity and are referred to as mood episodes with mixed features (eg, major depression with mixed features).

- Manic or hypomanic episodes with mixed features are characterized by episodes that meet full criteria for mania (table 1) or hypomania (table 3), and at least three of the following symptoms during most days of the episode: depressed mood, diminished interest or pleasure in most activities, psychomotor retardation, low energy, excessive guilt or thoughts of worthlessness, and recurrent thoughts of death.

- Major depressive episodes with mixed features are characterized by episodes that meet full criteria for major depression (table 4), and at least three of the following symptoms during most days of the episode: elevated or expansive mood, inflated self-esteem or grandiosity, more talkative than usual or pressured speech, flight of ideas (abrupt changes from one topic to another that are based upon understandable associations) or racing thoughts, increased energy or goal-directed activity, excessive involvement in pleasurable activities that have a high potential for painful consequences (eg, buying sprees or sexual indiscretions), and decreased need for sleep.

- **Melancholic features** – Melancholic features are characterized by at least four of the following symptoms during an episode of major depression; at least one of the symptoms is either loss of pleasure or lack of reactivity to pleasurable stimuli:

  - Loss of pleasure in most activities

  - Unreactive to usually pleasurable stimuli (ie, does not feel better in response to positive events)

  - Depressed mood marked by despondency, despair, or remorse

  - Early morning awakening (eg, two hours before usual hours of awakening)

  - Psychomotor retardation or agitation

  - Anorexia or weight loss

  - Excessive guilt

- **Atypical features** – Atypical features are characterized by at least three of the following symptoms during an episode of major depression; at least one of the symptoms is mood reactivity to pleasurable stimuli:

  - Reactive to pleasurable stimuli (ie, feels better in response to positive events)

  - Increased appetite or weight gain

- Hypersomnia (eg, sleeping at least 10 hours per day, or at least 2 hours more than usual when not depressed)
- Heavy or leaden feelings in limbs
- Longstanding pattern of interpersonal rejection sensitivity (ie, feeling deep anxiety, humiliation, or anger at the slightest rebuff from others) that is not limited to mood episodes, and which causes social or occupational conflicts

- **Peripartum onset** – Peripartum onset refers to onset of mood episodes during pregnancy or within four weeks of childbirth (see "Bipolar disorder in postpartum women: Epidemiology, clinical features, assessment, and diagnosis")

Bipolar disorders — The diagnosis of bipolar disorder and related conditions are described here; further information on their clinical presentation is discussed separately. (See "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Clinical presentation'.)

The types of bipolar disorder that are described in DSM-5 include [11]:

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymic disorder
- Other specified bipolar disorder

Difficulties in diagnosing bipolar disorder may lead clinicians to under-diagnose or over-diagnose the disorder. Misdiagnosis is due in part to the overlap between the symptoms of bipolar disorder and the symptoms of other psychiatric disorders, particularly attention deficit hyperactivity disorder. Distinguishing bipolar disorder from other illnesses is discussed elsewhere in this topic. (See 'Differential diagnosis' below.)

Bipolar I disorder — Recurrent episodes of mania (table 1); episodes of hypomania (table 3) and major depression (table 4) generally occur as well

Bipolar II disorder — Recurrent episodes of hypomania (table 3) and major depression (table 4), and the absence of manic episodes (table 1)

Cyclothymic disorder — Cyclothymic disorder is characterized by numerous periods of hypomanic symptoms that fall short of meeting criteria for a hypomanic episode and numerous periods of depressive symptoms that fall short of meeting criteria for a major depressive episode [11,21]. The symptoms recur over a time interval of at least one consecutive year,

during which patients are symptomatic at least half the time and are not symptom-free for more than two consecutive months.

Other specified bipolar and related disorder — Other specified bipolar disorder applies to patients with bipolar symptoms that cause significant distress or impair psychosocial functioning but do not meet the DSM-5 criteria for a specific bipolar disorder due to an insufficient number of symptoms and/or an insufficient duration of the symptoms [11,22]. Clinicians record the diagnosis "other specified bipolar disorder," followed by the reason that the presentation does not meet full criteria for a specific bipolar disorder. Examples of syndromes that can be specified when using the diagnosis, other specified bipolar disorder, include:

- Short duration hypomanic syndromes (two to three days) and major depressive episodes – This other specified bipolar disorder diagnosis is the most common and applies to patients with a lifetime history of at least one major depressive episode who have never met full criteria for mania or hypomania, but have experienced two or more periods that lasted for only two or three days, which otherwise met full criteria for a hypomanic episode. These short duration hypomanic syndromes do not overlap in time with the major depressive episodes, so the disorder is not diagnosed as major depressive episode with mixed features.

- Hypomanic symptoms and major depressive episodes – Other specified bipolar disorder applies to patients with a lifetime history of at least one major depressive episode who have never met full criteria for mania or hypomania but have experienced at least one period that lasted for at least four consecutive days, during which the patient had hypomanic symptoms insufficient in number to meet full criteria for a hypomanic episode. These hypomanic symptoms do not overlap in time with the major depressive episodes, so the disorder is not diagnosed as major depressive episode with mixed features.

- Hypomanic episodes without prior major depressive episode – Patients with a lifetime history of one or more hypomanic episodes, who have never met full criteria for mania or major depression, are diagnosed as other specified bipolar disorder, hypomanic episodes without prior major depression.

- Short duration cyclothymia – Patients who meet criteria for cyclothymic disorder with the exception that the syndrome has lasted for less than 12 consecutive months are diagnosed as other specified bipolar disorder, short duration cyclothymia.

Youth with other specified bipolar disorder have a poor prognosis that is comparable to youth with bipolar I disorder or bipolar II disorder [3,22,23]. In addition, the three disorders are

comparable with respect to psychosocial difficulties, comorbidity, and family history of bipolar disorders. Patients with other specified bipolar disorder are at risk to develop bipolar I disorder or bipolar II disorder, and thus need to be diagnosed and treated [24].

Mood disorder specifiers — DSM-5 uses the following terms to specify the course of illness in bipolar I or II disorder [11]:

- **Rapid cycling** – Rapid cycling is defined as four or more mood episodes (mania, hypomania, or major depression) during a 12-month period. (See "Rapid cycling bipolar disorder: Epidemiology, pathogenesis, clinical features, and diagnosis".)

- **Seasonal pattern** – Seasonal pattern refers to a regular temporal relationship between the onset of at least one type of mood episode (mania, hypomania, or major depression) and a particular time of year, for the past two years. Remission (or change in polarity) also occurs at a specific time of year. The other types of episodes need not follow a seasonal pattern. As an example, episodes of bipolar II major depression may begin each winter and remit in spring, whereas hypomanic episodes do not have to occur at one specific time of year. In addition, the lifetime number of seasonal manias, hypomanias, or depressions substantially outnumbers the nonseasonal episodes.

  Seasonal pattern is not used as a specifier if a type of mood episode occurs in response to a seasonally related psychosocial stressor (eg, parental unemployment every winter leads to depression), or if episodes occur at other times of the year as well as seasonally. A seasonal pattern may be more common in bipolar II disorder than bipolar I disorder.

  In bipolar disorder with seasonal pattern, depressive episodes occur more often in winter than summer [25]. By contrast, hypomanic/manic episodes occur more often in spring and summer, compared with fall and winter.

Diagnostic challenges — Accurate diagnosis of bipolar disorder in children and adolescents is critically important. A misdiagnosis of bipolar disorder may label children with a diagnosis that has lifelong implications and expose them to medications with risk of serious side effects and little benefit. Conversely, failing to identify bipolar children leaves them with an untreated illness that may affect their normal development and may expose them to the adverse effects of medications for inaccurately diagnosed conditions. Variability in the clinical presentation of bipolar disorder can make diagnosis difficult. The diagnosis may also be obscured by the presence of comorbidities and overlapping symptoms with other psychiatric disorders. (See "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Clinical presentation' and 'Differential diagnosis' below.)

The diagnosis of bipolar disorder in youth may be further complicated by the effects of development on symptom expression, children's difficulty expressing their symptoms, the social context in which the bipolar disorder is developing (eg, the presence of family conflicts), and if the child is on medications, their potential effects on the child's mood. Distinguishing manic and depressive symptoms from normal behavior in children is described separately. (See "Pediatric bipolar disorder: Clinical manifestations and course of illness", section on 'Clinical presentation'.)

The challenges in diagnosing pediatric bipolar disorder underscore the need for comprehensive cross-sectional and longitudinal assessments. (See 'Assessment' above.)

Differential diagnosis — The main psychiatric conditions that can be difficult to differentiate from bipolar disorder in youth are:

- Attention deficit hyperactivity disorder (ADHD)
- Autism spectrum disorder
- Conduct disorder
- Disruptive mood dysregulation disorder (DMDD)
- Oppositional defiant disorder
- Schizophrenia
- Substance use disorder
- Unipolar depression

Borderline personality disorder can also be difficult to distinguish from bipolar disorder, and some teens with bipolar disorder, particularly those with bipolar II disorder, may be misdiagnosed as having borderline personality disorder [1,2]. The differential diagnosis can be complicated in youth with bipolar disorder who also have subsyndromal or syndromal borderline personality disorder [26,27].

Family history of bipolar disorder, especially if the parents developed bipolar disorder early in life and the youth has a history of significant mood lability, depression/anxiety, and subsyndromal manic/hypomanic symptoms, suggests that the child/adolescent may have or be at risk to develop bipolar disorder [28].

ADHD, conduct disorder, oppositional defiant disorder, and DMDD — Attention deficit hyperactivity disorder (ADHD), conduct disorder, oppositional defiant disorder, and disruptive mood dysregulation disorder (DMDD) are the conditions most likely to be confused with bipolar disorder in youth. (DMDD is a relatively new and controversial diagnosis in DSM-5 that essentially includes youths with severe oppositional defiant disorder.) Clinical features that help distinguish bipolar disorder from these other disorders are listed in the tables (table 5 and

table 6 and table 7). Symptoms occurring mainly in bipolar disorder and very rarely in these other conditions include:

- Euphoria
- Grandiosity
- Decreased need for sleep
- Hypersexuality (in the absence of a history of sexual abuse or exposure to sexual activity)
- Hallucinations and/or delusions

In addition, the course of symptoms over time helps differentiate bipolar disorder from ADHD, conduct disorder, oppositional defiant disorder, and DMDD. In general, chronic symptoms such as hyperactivity, distractibility, or recklessness should not be considered evidence of mania unless they occur episodically, in clusters, and clearly intensify with the onset of abnormal mood. Prolonged presentations of manic-like symptoms that do not change in overall intensity should raise the possibility of a psychiatric diagnosis other than bipolar disorder.

The diagnosis of ADHD is discussed separately. (See "Attention deficit hyperactivity disorder in children and adolescents: Clinical features and diagnosis".)

Unipolar major depression — Most depressed youths seen in psychiatric settings are experiencing their first lifetime episode of depression [10]. However, the clinical manifestations of bipolar major depression and unipolar major depression are similar and it is very difficult to differentiate them, even with close longitudinal follow-up [11,29-31]. The presence of psychosis or a family history of bipolar disorder, particularly a parent with early onset bipolar disorder (eg, <25 years old), may indicate susceptibility to eventually developing bipolar disorder [32,33]. In addition, presence of subsyndromal symptoms of mania, mania or hypomania in response to antidepressant treatment that persists after discontinuing the antidepressant, and history of parental early-onset bipolar disorders may indicate the presence of underlying bipolar disorder [28,30]. Depressed youths thus need to be followed longitudinally with ongoing assessment for the presence of manic or hypomanic symptoms.

The diagnosis of pediatric unipolar major depression is discussed separately. (See "Pediatric unipolar depression: Epidemiology, clinical features, assessment, and diagnosis", section on 'Unipolar major depression'.)

Schizophrenia — Schizophrenia (table 8) is very rare in children. If a youth presents with symptoms of psychosis, mood disorders need to be ruled out. If a youth has symptoms of schizophrenia that only occur during a mood episode, clinicians should evaluate the patient for the diagnosis of **schizoaffective disorder**. (See "Schizophrenia in children and adolescents: Epidemiology, clinical features, assessment, and diagnosis".)

Autism spectrum disorder — Youth with subsyndromal symptoms of pervasive developmental disorder or mild autism may have mood lability, aggression, and agitation, which may be misdiagnosed as bipolar disorder. (See "Autism spectrum disorder in children and adolescents: Clinical features" and "Autism spectrum disorder in children and adolescents: Evaluation and diagnosis".)

Substance abuse — Substance abuse can induce severe mood changes that may be difficult to differentiate from bipolar disorder. Youth with mood disorders are at higher risk for using illicit drugs or alcohol, which sometimes can be explained as a way to deal with their mood and daily problems [34,35]. (See "Substance use disorder in adolescents: Epidemiology, clinical features, assessment, and diagnosis".)

Medication reactions — Medications such as antidepressants may unmask or trigger a manic or hypomanic episode in susceptible individuals [36]; one review found that up to 10 percent of youth treated with antidepressants may develop mania/hypomania [37]. However, most youth who become agitated or giddy and excited with antidepressants or other medications (eg, bronchodilators, corticosteroids, and stimulants) do **not** have bipolar disorder [38]. As an example, selective serotonin reuptake inhibitors (SSRIs) may induce activation (the patient becomes more hyperactive, giddy, silly, talkative, disinhibited, and inattentive), which is distinct from mania/hypomania [2]. Antidepressant-induced activation may occur in up to 15 percent of children and adolescents treated with antidepressants [19,37]. Activation associated with the use of SSRIs typically improves quickly once the dose of the SSRI is lowered or the SSRI is discontinued. Nevertheless, it is important to carefully evaluate patients who become activated. Family history of mania and the severity, length, and characteristics of the medication induced symptoms may help differentiate bipolar disorder from agitation or activation induced by medications.

Other medical conditions — Other medical and neurologic illnesses (eg, head trauma, brain tumors, and hyperthyroidism) may be accompanied by symptoms that mimic bipolar disorder.

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Bipolar disorder".)

SUMMARY

- Primary care clinicians should be alert to symptoms suggesting the possibility of bipolar disorder. Diagnosing bipolar disorder in children and adolescents can be complex and has significant consequences. Unless primary care clinicians have extensive experience with pediatric bipolar disorder, patients in whom the disorder is strongly suspected should be evaluated by a mental health specialist (eg, child psychiatrist) skilled in making the diagnosis. (See 'Assessment' above.)

- The following symptoms should raise the clinician's suspicion of pediatric bipolar disorder (table 7), especially when they occur in clusters and episodically and if a parent has history of early onset bipolar disorder:

  - Increased activity and/or silliness beyond what is expected for the child's developmental age and not accounted for by the situation, other disorders, or medications

  - Decreased need for sleep and the youth is not tired the next day

  - Inappropriate sexual behaviors without a history of exposure to sexual activity (eg, abuse or videos)

  - Psychosis (eg, hallucinations and/or delusions)

(See 'Assessment' above.)

- Assessment of youth for bipolar disorder should include a history and examination for the presence of comorbid mental disorders, substance use, general medical conditions, suicidal and homicidal ideation, psychosocial functioning, presence of family psychopathology (particularly bipolar disorder), and ongoing negative life events (eg, family conflicts and abuse). Multiple assessments are required to make the diagnosis. (See 'Assessment' above.)

- The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is generally used to diagnose bipolar mood episodes, including mania (table 1), hypomania (table 3), and major depression (table 4). (See 'Mood episodes' above.)

- Bipolar I disorder is diagnosed in patients with one or more manic episodes. Nearly all patients also suffer at least one episode of major depression, and hypomania often occurs as well. (See 'Bipolar I disorder' above.)

- Bipolar II disorder is diagnosed in patients with a history of at least one hypomanic episode and at least one major depressive episode, and no history of manic episodes. (See 'Bipolar II disorder' above.)

- Cyclothymic disorder is diagnosed in patients with periods of hypomanic symptoms that fall short of meeting criteria for a hypomanic episode and periods of depressive symptoms that fall short of meeting criteria for a major depressive episode. Symptoms recur over a time interval of at least one year, during which patients are symptomatic at least half the time and are not symptom-free for more than two consecutive months. (See 'Cyclothymic disorder' above.)

- Patients with recurrent manic/hypomanic symptoms that cause significant distress or impair psychosocial functioning but do not meet the full criteria for a specific bipolar disorder are diagnosed with other specified bipolar disorder. (See 'Other specified bipolar and related disorder' above.)

- The diagnosis of bipolar disorder in youth can be complex because youth with bipolar disorder frequently have a variable course with rapid fluctuation in mood symptoms during acute episodes, developmental issues that complicate the assessment of symptoms and behaviors, and difficulty verbalizing their emotions. In addition, bipolar disorder is often accompanied by comorbid disorders. (See 'Diagnostic challenges' above.)

- Attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, and disruptive mood dysregulation disorder are the conditions most likely to be confused with pediatric bipolar disorder (table 5 and table 6 and table 7). The differential diagnosis of bipolar disorder also includes unipolar major depression, schizophrenia, autism spectrum disorder, substance abuse, medication reactions, and general medical illnesses. (See 'Differential diagnosis' above.)

Topic 83083 Version 16.0