



# Bipolar Treatment Guide

## DSM IV Criteria for Bipolar

### Criteria for Manic Episode

- A.** A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- B.** During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable ) and have been present to a significant degree:

- |   |  |
|---|--|
| 1) inflated self-esteem or grandiosity                                      | 5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)  |
| 2) decreased need for sleep (e.g., feel rested after only 3 hours of sleep) | 6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation   |
| 3) more talkative than usual or pressure to keep talking                    | 7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments) |
| 4) flight of ideas or subjective experience that thoughts are racing        |  |

- C.** The symptoms do not meet criteria for a Mixed Episode.
- D.** The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or unusual social activities or relationship with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- E.** The symptoms are not due to the direct psychological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressants treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

### Hypomanic Episode

- A.** A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
- B.** During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

- |   |  |
|---|--|
| 1) inflated self-esteem or grandiosity                                      | 5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)  |
| 2) decreased need for sleep (e.g., feel rested after only 3 hours of sleep) | 6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation   |
| 3) more talkative than usual or pressure to keep talking                    | 7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments) |
| 4) flight of ideas or subjective experience that thoughts are racing        |  |



## DSM IV Criteria for Bipolar

### Hypomanic Episode

- C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
- D. The disturbance in mood and the change in functioning are observable by others.
- E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
- F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

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### Types

**Bipolar I Disorder** is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.

**Bipolar II Disorder** is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.

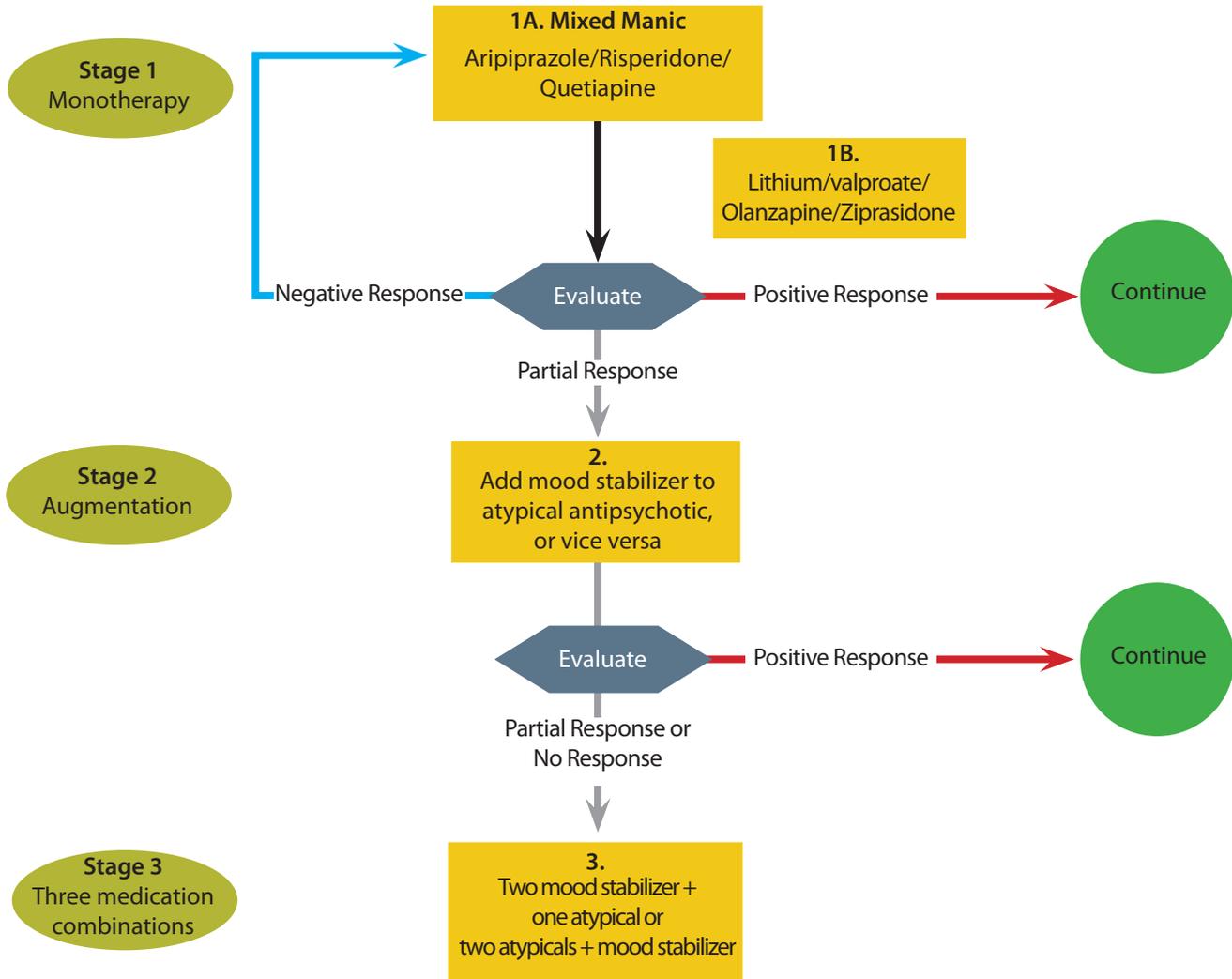
**Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.

**Cyclothymic Disorder, or Cyclothymia**, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years. However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.

**Rapid-cycling Bipolar disorder** is when a person has four or more episodes of major depression, mania, hypomania, or mixed symptoms within a year.



# Medication Management



**Stage 1.** Consider patient's experience with antipsychotics, body weight, and family history when choosing first-line monotherapy (1A). Quetiapine poses low risk for extrapyramidal symptoms and tardive dyskinesia. Aripiprazole and ziprasidone pose relatively low risk of weight gain. Risperidone is potent at low doses but increases prolactin levels (long-term effect unknown). Second-line choices (1B) are mood stabilizers lithium and valproate (because of lower potency than atypical antipsychotics), and olanzapine (which—although potent—causes substantial weight gain). In case of lack of response or intolerable side effects with initial agent, select an alternate from 1A or 1B. If this is not effective, move to Stage 2.

**Stage 2.** Consider augmentation for patients who show partial response to monotherapy (in your clinical judgment "mild to moderately improved" but not "much or very much improved").

**Stage 3.** Combination therapy could include 2 mood stabilizers (such as lithium and valproate) plus an atypical antipsychotic; 2 atypical antipsychotics; or other combinations based on patient's past responses. No research has shown these combinations to be efficacious in bipolar children and adolescents, but we find they sometimes help those with treatment-resistant symptoms.

**Duration.** Maintain psychotropics 12 to 18 months. When patient is euthymic, slowly taper 1 medication across several months. If symptoms recur, reintroduce the mood-stabilizing agent(s).

Source: Adapted and reprinted with permission from Kowatch RA, Fristad MA, Findling R, et al. Clinical manual for the management of bipolar disorder in children and adolescents. Arlington, VA: American Psychiatric Publishing, Inc.; 2008



# Evidence-Based Psychosocial Therapies

■ According to the National Alliance on Mental Illness (NAMI), no controlled studies of psychosocial interventions for youth with bipolar disorder have been done. However behavior therapy, family education, and other support benefit youth and families and improve relationships.

■ The American Academy of Child and Adolescent Psychiatry (AACAP) cites a study conducted by the National Institute of Mental Health (NIMH) that found adults with bipolar disorder taking medications to treat bipolar disorder are more likely to get well faster and stay well longer if they also receive intensive behavioral therapy. AACAP also contends “most doctors agree that the same conclusion holds true for children, especially for those with significant emotional and behavioral issues.”

## Practice Guidelines

### American Academy of Child and Adolescent Psychiatry (AACAP)

#### Phase 1

1. Psychiatric Assessments for Children and Adolescents Should Include Screening Questions for Bipolar Disorder.
2. The DSM-IV-TR Criteria, Including the Duration Criteria, Should Be Followed When Making a Diagnosis of Mania or Hypomania in Children and Adolescents.
3. Bipolar Disorder NOS Should Be Used to Describe Youths With Manic Symptoms Lasting Hours to Less Than 4 Days or for Those With Chronic Manic-Like Symptoms Representing Their Baseline Level of Functioning.
4. Youths With Suspected Bipolar Disorder Must Also Be Carefully Evaluated for Other Associated Problems, Including Suicidality, Comorbid Disorders (Including Substance Abuse), Psychosocial Stressors, and Medical Problems.
5. The Diagnostic Validity of Bipolar Disorder in Young Children Has Yet to Be Established. Caution Must Be Taken Before Applying This Diagnosis in Preschool children.

#### Phase 2

6. For Mania in Well-Defined DSM-IV-TR Bipolar I Disorder, Pharmacotherapy Is the Primary Treatment.
7. Most Youths With Bipolar I Disorder Will Require Ongoing Medication Therapy to Prevent Relapse; Some Individuals Will Need Lifelong Treatment.
8. Psychopharmacological Interventions Require Baseline and Follow-up Symptom, Side Effect (Including Patient’s Weight), and Laboratory Monitoring as Indicated).

#### Phase 3

9. For Severely Impaired Adolescents With Manic or Depressive Episodes in Bipolar I Disorder, Electroconvulsive Therapy (ECT) May Be Used If Medications Either Are Not Helpful or Cannot Be Tolerated.

#### Ongoing

10. Psychotherapeutic Interventions Are an Important Component of a Comprehensive Treatment Plan for Early-Onset Bipolar Disorder.
11. The Treatment of Bipolar Disorder NOS Generally Involves the Combination of Psychopharmacology With Behavioral/Psychosocial Interventions.

SOURCE: Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder (AACAP).

SEE ALSO: Collaborative Role of the Pediatrician in the Diagnosis and Management of Bipolar Disorder in Adolescents (American Academy of Pediatrics).

NOTE: This resource is for reference purposes only and should not be used to replace medical information from prescribing health care professionals or pharmacies.