PAEDIATRIC BIPOLAR DISORDER (PBD)

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Why

1. - negative outcomes:
   - difficulties in academic achievement
   - interpersonal relationships, family conflict, peer rejection
   - psychosis, increased use of health services
   - high rates of suicide attempts
   - increased substance abuse
   - obesity in 42%
   - increased risk of mixed mood states (combined symptoms of depression and mania and rapid cycling): 3 episodes of mania in 1 year.

2. hard to distinguish PBD from other disorders

3. course of illness more severe, chronic, and refractory

4. increased risk of mixed mood states

5. prevalence of BPI in adolescents is approximately 1%, whereas the prevalence in children is 0.2-0.4%.

6. The second most common age group at presentation is 15–19 years.

7. 20% of adults with bipolar disorder had symptoms beginning in adolescence.

8. 20% of youths in whom a major depressive disorder was previously diagnosed develop symptoms consistent with a manic state at a later age.


10. The National Comorbidity Survey for Adolescents 6.2% lifetime prevalence of BP disorders, as they included subthreshold BP in a sample of 10,148 adolescents between 13 and 17 years of age.

11. The National Comorbidity Survey for Adolescents 6.2% lifetime prevalence of BP disorders, as they included subthreshold BP.

12. The 12-month rates of mania with and without depression 2.2 and 1.3%, Canadian study in 2010.

13. Bipolar spectrum DSM-5
   - Bipolar I: the occurrence of at least one lifetime manic episode; the manic episode may occur before or after hypomania, depression or a mixture of these states, or the disorder can remit and the person can function as normal.
   - ICD requires multiple episodes of mania to confirm a diagnosis of bipolar.

Making a Bipolar Diagnosis in Youth

- Cannot be diagnosed until first manic episode
- Depression, anxiety, ADHD often precede
- Substance abuse onset is common in pre-onset and early years
- Identify a manic episode using DSM-5
- Must have a distinct mood change (remember: irritability is a depression criterion in kids)
- Excessive amount of energy and not simply baseline ADHD
- Dysphoria, euphoria, and irritability (e.g., again, must be episode)
- Differences from adults
- Mixed states may be more common
- Neurovegetative signs may be less common (e.g., sleep disruption)
- Creat may be less abrupt and course less episodic (but episodes could be present)

Bipolar spectrum DSM-5

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Challenges of Diagnosis

- Symptoms shared with other mood disorders
- Conceptual problems
- Clinicalvalue
- Difficulty of discriminating between a hyperactive episode
- Feints or overdiagnosis of a hyperactive episode
- Need to employ a detailed lifetime current diagnosis criteria.
- Bipolar II: the symptoms have met full criteria for both a hypomanic episode and a major depressive episode at some time.
- Either or both of the hypomanic and depressive episodes can carry the ‘mixed specifier’. If the symptoms have met criteria for a full manic episode, the diagnosis changes to bipolar I disorder.
- DSM-5 added the condition ‘hypomania under antidepressant treatment’ explicitly as a form of bipolar II disorder – provided that mood/energy problems continue at fully syndromal levels beyond the physiological effect of the treatment.

- Cyclothymic hypomanic and depressive symptoms for an extended period of time (more than 1 year in youths), with symptoms present more than 50% of the time and not the individual not being symptom-free for more than 2 months.
- Cyclothymic: difficult to diagnose.
- The hypomanic symptoms cannot become too severe or pronounced; full mania results in the diagnosis of bipolar I. By the same token, the depressive symptoms cannot progress to a full-blown major depressive episode; if so, it either results in the diagnosis of bipolar II or a major depressive episode, perhaps with a mixed specifier.

- Other specified bipolar & related disorders DSM-5 renamed BP-NOS as OS-BRD, emphasizing a change in energy as a key feature and adding the mixed specifier.
- In addition to three other prototypes:
  - Short-duration hypomanic episodes of 2–3 days.
  - Hypomanic or manic episodes with an insufficient number of symptoms.
  - Recurrent hypomanic episodes without history of major depressive episode.
- OS-BRD also adds a fourth prototype of short-duration cyclothymia for presentations lasting less than 12 months in youths.

- DMDD, that evolved from severe mood dysregulation (SMD) which was added to DSM to avoid a growing tendency to misdiagnose troubled, disruptive kids with bipolar disorder.
- Symptoms overlap with ODD. The core feature of DMDD is chronic, severe, persistent irritability. This severe irritability has two prominent clinical manifestations: frequent temper outbursts and chronic severe non-compliance. These outbursts typically occur in response to frustration and can be verbal or behavioural (aggression against property, self or others).
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- Pathophysiology (biomarkers):
  - Smaller subfield hippocampal volumes impact long-term functioning in adolescents.
  - Alterations in functional connectivity of areas of the brain involved in executive functioning, decision making, default and salience networks.
  - Clinical implications of impaired default mode and salience network functioning (reduced antecorrelation between default mode and salience networks) in bipolar disorder may be helpful in both diagnosis and treatment of mania, especially in the presence of co-morbid ADHD as well as possible biomarkers of the disorder.
  - Magneto(MEG), to look at preattentive auditory dysfunction as a potential trait marker of severe bipolar disorder symptoms reflected by the presence of reduced pitch-MMN responses.
  - Reduction in grey matter volume and decreased amygdala and prefrontal functional connectivity.
  - Injection by misinterpreting the emotional valence of others and, specifically, facial emotional expression, abnormal fearful activation surfaces with negative emotions along with face-processing deficits.
cognitive inflexibility measured using NIHT (a lack of appropriate activation in response to reward, negative feedback, and novel stimuli), and youth had a DH D.

- High-risk offspring had an increased lifetime risk of a broad spectrum of disorders, including bipolar disorder, major depressive disorder, anxiety, sleep, and ADHD.

- Children with bipolar disorder show a higher incidence of psychotic features than older children or adults.

- Family risk

  - Adolescents who have onset of true mania with childhood-associated symptoms are at a greater genetic risk for bipolar disorder than adolescents with more adult-related psychotic symptoms.

- Symptoms Predictors

  - Bederman at al stated that the combination of Conduct disorder and major depression in adolescence could be predictive of bipolar disorder.

- Trait marker

  - In summary, sustained symptoms of conduct and impulse control disorder (CD/ODD) in children with mania had a reduction in Young Mania Rating Scale (YMRS) score with increased brain activity in the ventral striatum/striatal circuits also the left inferior frontal gyrus.

- Major comorbidity with PBD

  - ADHD-62%-63% of youthwith ADHD also met BP diagnosis, both ADHD and psychiatric symptoms appear to be distributed along a continuum rather than in categories or distinct clustersflowing from the same developmental pathological process.

- Use of medications that facilitate the regulation of neurotransmitters, such as receptor sensitivity and perhaps other biochemical modulators to restore normal mood and cognition.

- Medication and deep relaxation, regular exercise, and meditation are some of the potential abnormalities in the prefrontal cortex, as well as neurotransmitter levels impacting endogenous opioid and nicotinic receptor function.

- Socioeconomic status lower

- Prevalence of trisomy 21 (down syndrome).

- Lower (mean full scale IQ) for ADHD alone.

- Decreased protein kinase in platelets, and dopamine D-2 receptor genotype and abnormalities of the dopamine transporter gene SLC6A3.

- Overall, the combined symptoms of severe social, language, and motor development delays (mean full scale IQ) lower (mean full scale IQ) among those patients.
Differential diagnoses

1. Psychiatric Conditions
   - ADHD may have a prodromal phase in early life that appears to be ADHD or another behavioral disturbance or whether many simply have bipolar disorder and comorbid ADHD with a higher rate of familial transmission.
   - Conduct disorder.
   - Childhood-onset schizophrenia or schizoaffective disorder.
   - PTSD
   - Drug or alcohol abuse, or anxiety states (e.g., generalized anxiety disorder, social anxiety disorder and Selective Mutism).

Self-esteem
   - Inflated
   - Deflated
   - Inflated and/or deflated

Pleasure
   - Euphoric in mania
   - Dysphoric in mixed or depressed state
   - Often dysphoric or euthymic
   - Pleasure in violating societal norms, especially if not caught in the act

Attention
   - Distractible
   - Deflectible
   - Variable

Hyperactivity
   - Goal directed
   - Variable
   - Unproductive
   - Goal directed

Sleep
   - Episodic
   - Often poor
   - Chronic

Diagnosis and assessment

- Brief rating scales combined with information about risk factors and prevalence, the developmental course and common comorbidities are sufficient to rule PBD out in most settings.
- Semi-structured interview tools such as K-SADS, MINI-Kid.
- Jacobson et al. developed a psychometrically informed framework for evaluating clinically significant change. There are two parts to their definition: reliable change and moving past a benchmark.
- Assessing depression and mania, identifying symptoms and triggers, changes in drug use and suicidal ideation.

Manic Behaviors and Overlapping Diagnoses

<table>
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<th>Distractible</th>
<th>Deflectible</th>
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<td>X</td>
<td>X</td>
<td>3</td>
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<tr>
<td>Episodic disturbance</td>
<td>3</td>
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Differential Diagnosis

2. Medical conditions
   - Antidepressants: amphetamines, LSD, sympathomimetics.
   - Endocrine: hyperthyroidism.
   - Neurologic: TBI, stroke, left hemisphere lesions, seizures, tumors.

Clinical triggers

- Triggers: a thorough evaluation of possible PBD
- Table: Clinical triggers for the differential evaluation of possible pediatric bipolar disorder.
- Bipolar disorder: an acute onset, often with a pre-illness phase.
- Antidepressants: rapid changes between depression, mania, and euthymia.
- Stimulants: long-term effects may include mood swings, impulsivity, and aggressive behavior.
- Antipsychotics: rapid changes in mood, aggression, and irritability.
- Benzodiazepines: mood swings, aggression, irritability, and decreased self-esteem.
- Mood stabilizers: rapid changes in mood, aggression, irritability, and decreased self-esteem.
- Cognitive-behavioral therapy: rapid changes in mood, aggression, irritability, and decreased self-esteem.
- Psychodynamic therapy: rapid changes in mood, aggression, irritability, and decreased self-esteem.
- Interpersonal therapy: rapid changes in mood, aggression, irritability, and decreased self-esteem.

Propose measures such as the Youth Top Problems scale can also be a method of monitoring for relapse.
Work up

- First step is to ensure that no medical condition or substance abuse.
- Sleep pattern.
- Sexual and/or physical abuse is common with bipolar disorder, especially in (6 years) and in individuals with comorbid (PTSD), psychosis, or conduct disorder.
- A positive family history of abuse may increase the risk for suicide.
- Polymorphism of the Val66Met BDNF gene may be associated with early experiences of adversity and maladaptive rumination, increasing the risk of suicide for some individuals.
- Many persons with bipolar disorder exhibit excessive risk-taking behaviors, predisposing them to injury or dehydration.

Integrated Approach to Management

Psychotherapy

Pharmacotherapy

Approach Considerations

- Psychotherapy and psychopharmacology
- Rehabilitation
- Baseline laboratory studies
  - CBC
  - Kidney F
  - Liver F
  - Thyroid F
  - Electrolytes
  - ECG

- Drug level monitoring

- Family consent, patient assent, explaining condition and medication side effects
- Lithium salts
- Carbamazepine
- Valproic acid
- Clonazepam
- ECT
- Angel warning hotline

- Family consent, patient assent, explaining condition and medication side effects

Goals of Treatment

- Achieve remission.
- Prevent relapse.
- Prevent recurrence.
- Development of personality.
several factors need to be addressed, including medication, family issues, social and school function, and substance abuse. Adult bipolar disorder is continuous with pediatric bipolar disorder. 4-phase process:

1. Evaluation and diagnosis of presenting symptoms.
2. Acute care and crisis stabilization for psychosis or suicidal or homicidal ideas or acts.
3. Movement toward full recovery from a depressed or manic state.
4. Attainment and maintenance of euthymia to minimize the number of needed hospitalizations, to eliminate or minimize medication adverse effects, and to optimize QOL.

QOL issues for a young person include meaningful relationships with family, peers, coaches, and teachers; optimal academic performance; and optimal occupational performance as it pertains to endeavors such as music, art, dance, athletics, or other personally rewarding areas from which the adolescent derives a sense of competency, mastery, and pleasure.

Multimodal Approach

High degree of co morbidity.

Psychosocial consequences.

Academic consequences.

Psychological "scars" in youths.

Untreated depression increases likelihood of personality disorders.

Inpatient indications:

- Present at times of family or youth despair or family crises surrounding their behaviors.
- Psychotic features and suicidal or homicidal ideations or plans, have access to firearms in their homes or communities and in those who abuse substances, particularly alcohol.

Inpatient treatment usually requires locked-unit care to assist in safety regulation. Rarely are young persons physically restrained in hospitals, but seclusion rooms should remain available in the event of severely agitated states that may culminate in threats or overt expression of physical aggression to self or others.

Pharmacotherapy

- Higher metabolism than adults because of the efficiency of their hepatic functions.
- Faster renal clearance rates than adults. For example, lithium carbonate has an elimination half-life of 30-36 hours in an elderly patient, 24 hours in an adult, 18 hours in an adolescent, and less than 18 hours in children.

Steady states are also achieved earlier in children than in adolescents and earlier in adolescents than in adults. Therefore, plasma levels may be drawn and assessed earlier in children and adolescents than in adults.

The efficient metabolizing and clearance systems of young individuals have important consequences.

Anticipated peak plasma drug levels may be higher in young patients than in adults.

Anticipated plasma trough levels may be lower in young patients than in adults. Therefore, children may require increased dosages of medications (mg/kg/d) to attain a therapeutic response. Special precautions must be taken when one doses psychiatric medications to treat adolescents and children to achieve therapeutic effect while staying safely below toxic levels.

Pharmacotherapy

- Use of medication with a low (single digit below 10) desirable NNT (number needed to treat) compared with placebo and high NNH (number needed to harm; above 10 desirable). 

Pediatric treatment guidelines. The Child Psychiatric Workgroup on Bipolar Disorder established guidelines involve algorithm-based use of mood stabilizers and atypical antipsychotic agents alone or in various combinations.

- Mood stabilizers for control of manic episodes, according to Basel requirements:
  - Lithium carbonate is effective in 60-70% and remains the first-line therapy for long-term prophylaxis in classic bipolar disorder with euphoric mania.
  - Treat acute mania, though it cannot be up titrated to an effective level as quickly as valproic acid.
  - Antisuicide effect.
  - Berk et al. suggest that lithium may be more effective by slowing or reversing the core brain dysfunction found in neuroimaging causing acute mania: reduced grey matter in the orbitofrontal cortex, anterior cingulate, inferior frontal gyrus, and cerebellum, and reduced internal capsule white matter volume.
  - Lithium therapy can restore white matter microstructure (fractional anisotropy in cingulum hippocampus white matter was significantly lower), improved scores on Clinical Global Impressions ratings in relation to depression and mania severity at Week 8.
Lithium has FDA approval for bipolar I disorder in youths aged 12 years and older. Finding et al investigated the efficacy of Lithium for the treatment of youths aged 7 to 17 years with bipolar I disorder, mixed or manic episode in an 8-week double-blind study. 

- The Lithium-treated youths had a significantly greater change in Young Mania Rating Scale (YMRS) scores and positive association with aggression, irritability, and/or menopause.
- Close associations of lithium with aggression, irritability, and/or menopause.
- The most common adverse effects of Lithium were vomiting, nausea, headache, increase in hemoglobin concentration (3%), 12% of children receiving Lithium have enuresis, primarily nocturnal enuresis. In those whose condition does not respond to Lithium, sodium valproate is generally the next agent of choice.
- Lithium may be an alternative for youths who experience significant weight gain with an atypical antipsychotic.

- Monitoring of blood levels is critical.

Sodium valproate (VPA) decreases amygdala volume, lateral orbito-frontal region, the medial orbitofrontal, the caudal anterior cingulate, and the posterior cingulate region over a 6-week treatment period in children with bipolar disorder, according to Friston et al (1995).

- Although Lithium for the acute treatment of manic episodes has demonstrated efficacy in pediatric bipolar disorder, VPA is often moreeffective as an add-on therapy.

- Treatment and preventing mania, used alone or in combination with Lithium. It is useful in treating rapid cycling bipolar disorders and has been used to treat aggression or behavioral problems.

- A combination of VPA with Lithium and valproate has been effective in treating patients in manic phase, with a success rate of 80%

- VPA is a treatment of choice for increased weight and decreased total red blood cell, hemoglobin level, hematocrit, and albumin level.

Carbamazepine is effective in cases that do not respond to Lithium therapy. It has been shown to provide protection against sudden or dramatic mood swings. The dose of carbamazepine average 1,800 mg/day. Olanzapine is approved for the treatment of rapid cycling bipolar disorder. It may be used alone or combined with Lithium or valproate.

- Asenapine antagonizes dopamine and serotonin effects. It is a new antipsychotic used for long-term treatment in adults with bipolar disorder. It may be used alone or combined with Lithium or VPA. It is not a first choice due to an increased risk of Stevens-Johnson syndrome and/or possible association with agranulocytosis and/or thrombocytopenia.

- Carbamazepine is a potent enzyme inducer that can induce its own metabolism. Because of potentially serious adverse effects and interactions, blood counts and liver function studies should be performed periodically during treatment.

- Beta-blockers are effective in preventing mania in patients with bipolar I disorder who are beginning to show the potential usefulness of these medications in pediatric patients with bipolar disorder.

- Add-on treatment is often used in children with bipolar disorder. Lamotrigine is not a preferred choice due to an increased risk of Stevens-Johnson syndrome and/or possible association with agranulocytosis and/or thrombocytopenia and/or Stevens-Johnson syndrome and/or agranulocytosis and/or thrombocytopenia.

- Other antiepileptic medications (eg, gabapentin, oxcarbazepine, topiramate) are beginning to show the potential usefulness of these medications in pediatric patients with bipolar disorder.

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Depressive episodes are frequently the first presentation of bipolar disorders in youths. Clonazepam may be preferred because of the effectiveness and the lowered risks of abuse by the patient or others. Clonazepam can be dosed in the range of 0.01–0.04 mg/kg/d and it is often administered once or twice per day. Lorazepam is dosed to 0.04–0.08 mg/kg/d and administered 3 times per day because of its short half-life.
Complications of treatment

- Side effects such as weight gain and acne are particularly problematic with lithium, olanzapine, and valproate.
- Therapy with atypical antipsychotics may predispose to neuroleptic malignant syndrome (NMS) in children and adolescents; patients should be closely monitored for such effects.
- Caution should be used when anticonvulsants and atypical antipsychotics are administered together because of the increased risk of serotonin syndrome, side effects. Administration of multiple classes of anticonvulsants together should be avoided, when possible.
- Family conflict may decrease response to medication treatment and should be addressed in a timely fashion.

ECT

- Although ECT is well documented as an effective and safe treatment option in patients with depression or psychotic states, most clinicians do not consider it a first-line intervention in children or adolescents.
- ECT is often initially administered on an inpatient basis, can be in a day treatment setting, involves consultations with a neurologist, nephrologist, cardiologist, or other specialists.
- Therapy requires at least a 4-hour visit for pre-ECT preparations, delivery of the ECT, and monitoring during recovery from both ECT and anesthesia. An ECT treatment episode may involve 3–5 or more sessions, usually at a rate of 3 sessions every other day or 3 sessions per week. Despite the rapid effect of ECT on mood and psychotic symptoms, medications are still required in the maintenance phase of treatment.
- ECT is a therapeutic option in adolescents and children, more rapid than medications (days rather than weeks). One drawback is the associated memory loss surrounding the time just before and after treatments.

Prognosis

- Early identification of medication non-responders by genomewide association studies (GWAS) would be helpful in the treatment of bipolar disorder to exclude mood.
- A GWAS study in China differentiated patients with a good response and those with a poor response to lithium with a sensitivity of 92% and showed the strongest association with a response to lithium when the sample was stratified by gender, and part of the sample was also sequenced for a single-nucleotide polymorphism (SNP) of two NPF in high-density linkage disequilibrium, rs7026658 and rs7026653, that are located in the GAD11.

complementary medications

- Omega-3 fatty acids (PUFA) to reduce symptoms of depression with less risk of mania and herbal preparations to increase sleep. Concomitant long-term exposure risks associated with these medications and biopsychosocial aspects.
- During inpatient manic states lead to evaluation of nutritional assessment, vitamin D, vitamin B12, and biological matrixes to increase the risk of vitamin deficiency, hypoglycemia, or hyperglycemia.
- Higher neuroleptic treatment during pregnancy associated with lower rates of aggression in children, and life consumption pattern of caffeine is lower in blood of both caused major depression and violence.
- High levels of omega-3 (fish oil) are a significant characteristic of patients with bipolar disorder. Choice of fish—canola oil, salmon—may help other patients. From other studies, a realistic time interval between initial contacts and clinical follow-up is strongly associated with BMI.
- Deep brain stimulation for refractory depression, as this treatment may potentially lower the risk of mania.
- Higher rates of suicide in patients with bipolar disorder than later onset; therefore, individuals are at increased genetic and familial risk from the beginning of life.

Prevention

- Avoidance of prescription medications that can precipitate acute mania if a diagnosis of bipolar disorder is uncertain.
- Avoidance of medications including substances a drug that precipitate or aggravate the mood state, such as work or recreation that can expose patients to deep sleep deprivation or significant alterations of sleep patterns.
- Prompt medical and psychological attention upon development of symptoms such as increased sleep, fatigue, or lack of mood for deep or short sleep.
- Adjunctive therapy with a mood-stabilizing or mood altering medication to prevent or treat sleep.
- Consultation with a neurologist, nephrologist, cardiologist, or endocrinologist may be needed if the patient fails to respond to the line of treatment, or if the patient has symptoms that are not addressed by medications. Psychosocial factors and lifestyle may be indicated.
Studies in USt shown that many persons with serious mental illness (estimates 40%), especially psychosis, obtain substandard medical care owing to noncompliance with medical treatment or the lack of resources to obtain needed treatment.

Episodic mood events should be anticipated throughout the life cycle after bipolar disorder is diagnosed. The frequency and severity of each episode are not readily predictable, but trends have emerged. In the presence of medication and treatment compliance, relapses may occur, and hospitalization may be required. In the absence of compliance, the course of the illness can be more severe than it would be under the influence of medication and treatment.

A potentially reassuring aspect of bipolar disorder is that patients may potentially have a full and normal life during the periods between mood swings. Therefore, many persons with bipolar disorder may continue their college education and careers with success, and they may foster and nurture strong relationships.

Inpatient and outpatient psychiatrists, psychologists, social workers, and other therapists involved in the care of the youth and the family should be able to aid the patient and family in the understanding and management of bipolar disorder in a loved one.

### Considerations for treating comorbidities

#### Hierarchy
1. Address manic or psychotic symptoms.
2. Treat depression.
3. Focus on symptoms of anxiety and ADHD.
4. Combined treatment is often necessary.

### What to do

1. Optimize mood stabilizers. Untreated psychosis/mania can mimic ADHD traits.
2. Add ADHD if potential benefits outweigh risks.
3. In history of remote psychosis, prophylactic neuroleptics are given first.
4. Start ADHD titrate lower doses and increase cautiously. TDD and ADHD can be safely treated with mood stabilizer and mood stabilizers.

Mood stabilizers alone are not effective in treatment of co-morbid ADHD.

Mood stabilizers or atypical antipsychotics.

Adolescents with childhood ADHD who develop BPD respond poorly to lithium.

### Psychotherapy helps patient and family to

- Consolidate learned skills.
- Cope with psychosocial sequelae.
- Address environmental stressors.
- Understand inner conflicts.
- Foster medication compliance.
- Recognize early signs of relapse.

To conclude

- Affective illnesses are first treated.
- When effective and stable, treat comorbidity.
Behavioral Therapy

- Long-Term Monitoring
- Randomized controlled trials have recommended individual cognitive behavior therapy in children and adolescents to focus on suicide prevention, as well as to monitor and manage medication if family conflict and negative expressed emotions are absent.
- Parent-focused interpersonal therapy and guidance are important when one or both parents have a significant mood and/or anxiety disorder. If there is negative emotional expressivity in family interactions, family therapy should be added.
- Social rhythm therapy (SRT), PBT, CBT, family therapy, group therapy, supportive psychotherapy or psychoanalysis should be reserved for individuals who are more likely to respond to those therapies.

family therapy

The goals of individual therapy and family therapy should be individualized. Common goal themes include: (1) helping the child to identify the connections between their thoughts and behaviors, (2) reducing the frequency and severity of behaviors associated with bipolar disorder, (3) helping the child and families to develop strategies to manage stress and promote positive coping strategies, (4) helping the family to understand, manage, and support the child’s illness, (5) helping the family to understand and manage their own reactions to the child’s illness, and (6) helping the family to build a strong, supportive, and positive relationship with the child.

The patient and family need general information about bipolar disorder and its management, including management of mood stability and affective swings, and ways to cope with stress and trigger factors. A plan for the treatment of bipolar disorder should include medication management, psychotherapy, social support, and education about bipolar disorder and its management. The patient and family should be encouraged to focus on their own well-being and to develop healthy coping strategies to manage their illness.

A focus on prevention is an important aspect of offering an adolescent or child in a hospital or residential setting. The patient’s family must be given relevant information on prevention and early intervention strategies. The patient and family must be prepared for the possibility of relapse, and strategies to prevent relapse should be developed and implemented as needed.