Table 18-2 Mania Symptoms

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 irritability) and are present to a significant degree:
1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., easily drawn to unimportant or irrelevant external stimuli)
6. Increased goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation
C. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish investments)
D. The symptoms do not meet criteria for a mixed episode.
E. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning, usual social activities or relationships with others or to necessitate hospitalization to prevent harm to self or others, or with psychotic features.
F. The symptoms are not due to the direct physiologic effects of a substance or a general medical condition. Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy) should not count toward a diagnosis of bipolar I disorder.

within 5 years of a depressive episode. Features associated with switching include early-onset depression, psychomotor retardation, psychosis, mood lability, seasonal pattern, family history of BD or mood disorders, and antidepressant-induced hypomania. A *mixed episode* requires 1 week of symptoms of both a manic and major depressive episode. *Dysphoric mania* is another term used to describe periods of mania that are accompanied by "bad feelings." *Hypomania* is used to describe a period of more than 4 but fewer than 7 days of manic symptoms. It also is used less specifically to describe less intense mania. The prevalence of psychosis in adolescence (often auditory hallucinations) is 16% to 60%. Although high, it is still less than its prevalence in adult BD.

Bipolar II disorder includes at least one full major depressive episode and at least one period of hypomania. **Bipolar disorder not otherwise specified** is used to describe prominent symptoms of BD that do not meet full diagnostic criteria or when historical information is unclear.

Cyclothymic disorder is characterized by 2 years or more (1 year in children) of numerous periods of hypomania and depression that do not meet full criteria for either a manic or a major depressive episode.

BD occurs in up to 4% of the general population. It is estimated that 1% of children and adolescents meet diagnostic criteria for BD. According to retrospective studies, 60% of BD onset occurs before 20 years of age. Although BD in adults tends to be gender neutral, it is estimated that prepubertal BD is almost four times more frequently diagnosed in boys. This may be because aggression is the main reason for referral for psychiatric services.

The etiology of BD is multifactorial. Studies in BD point to a highly familial etiology with family history of mental illness, including major depression, BD, schizophrenia, or ADHD. A first-degree relative with BD leads to a 10-fold increase in a child's chance of developing BD. An earlier onset of BD in a parent increases the risk of early onset BD in offspring with a more chronic and debilitating course that may be less responsive to treatment.

The differential diagnosis for BD includes ADHD, major depression, conduct disorder (CD), mood disorder due to a general medical condition, substance-induced mood disorder, pervasive developmental disorder, and schizophrenia.

Patients with BD often have concurrent conditions that warrant treatment. ADHD occurs in approximately 60% to 90% of children with BD. Anxiety disorders also commonly occur with BD and do not respond to antimanic agents. Substance abuse can precipitate and perpetuate mania and depression. The alteration between highs and lows related to some types of substance abuse often mimics BD. Patients with BD may also self-medicate in attempts to alleviate symptoms. Many patients with BD may commit crimes and meet criteria for CD due to aggression and impulsivity. Prominent symptoms of mania assist in differentiating between CD and BD. Patients with BD generally exhibit reactive aggression, whereas those with CD are more likely to preplan and develop a typical pattern of crimes.

No laboratory or imaging studies can diagnose BD. Physical examination, careful history, review of systems, and laboratory testing are done to rule out suspected medical etiologies, including neurologic and substance-induced disorders.

Treatment of BD includes decreasing acute symptoms. The FDA has approved lithium, divalproex sodium, carbamazepine, olanzapine, risperidone, quetiapine, ziprasidone, and aripiprazole for adults with BD. Lithium is the oldest proven treatment for mania in adults and has been used effectively in children and adolescents for years. Common side effects of lithium include hypothyroidism, polyuria, and acne. Divalproex is also a first-line agent (preferable for mixed or rapid cycling cases) for adults. It has been used effectively for decades in youth, but it is not FDA-approved. Periodic monitoring of blood levels for select medications (lithium and divalproex sodium) can help ensure both treatment safety and the receipt of therapeutic amounts of the medication. Antipsychotics (risperidone, olanzapine, quetiapine, aripiprazole, and ziprasidone) have had positive results in youth with BD. It is likely that newer antipsychotics will also be effective in BD.

Treating comorbid psychiatric disorders must be done carefully. Stimulants may be used to treat ADHD once the patient has been stabilized on a mood stabilizer. Antidepressants should be avoided; if the youth is depressed or has significant anxiety and is not responsive to other pharmacotherapy, cautious use of antidepressants may be necessary. Careful monitoring for manic reactivation, cycling, and suicidality is needed.

Cognitive and behavioral therapies are aimed at improving adherence to medication treatments and ameliorating anxiety and depressive symptoms. Psychoeducation and family therapy are needed to stabilize the patient's environment and improve prognosis. There should be continuous ongoing safety assessment. Because developmental delays are also common in young children with BD due to poor learning while symptomatic, collaboration with school regarding behavioral management, special educational needs, and an appropriate individualized educational plan is also needed.