

Bipolar Disorder (Acute Mania or Mixed Episodes) in Children and Adolescents Ages 6 to 17 Years Old

Level 0

Comprehensive assessment. Use systematic interview covering mania and depression symptoms, family history of psychopathology including depression and mania, and information from teachers if possible to establish duration of manic symptoms over the day.

- ◆ Classic bipolar disorder has clear episodes representing a change from usual behavior; DSM-5 symptoms consist of elevated and/or irritable mood and increased energy occurring most of the day, every day; co-occurring symptoms include grandiosity, decreased need for sleep, rapid speech and flight of ideas (no current validity under age 6).
- ◆ If ADHD is comorbid with bipolar I or II disorder, symptoms should intensify with the episode. If it is truly comorbid, mania should be treated and stabilized before treating ADHD.
- ◆ If the diagnosis of mania cannot be distinguished from ADHD, and especially combined ADHD and Oppositional Defiant Disorder, ADHD should be treated first with discussion with family members about advantages and disadvantages. Refer to ADHD guidelines on pg. 16.
- ◆ If rage outbursts are the primary focus of treatment, track the frequency, intensity, number and duration of episodes. Rule out Disruptive Mood Dysregulation Disorder (DMDD).
- ◆ If DMDD is present, refer to those guidelines on pg. 40; otherwise, treat the primary disorder first and then treat the aggression, referring to the aggression treatment guidelines.



Level 1

Monotherapy with one of these four agents (FDA approved for youth between the ages of 10-17):

- ◆ Aripiprazole
- ◆ Risperidone
- ◆ Quetiapine
- ◆ Asenapine
- ◇ For euphoric mania in adolescents, consider lithium.

Bipolar Disorder (Acute Mania or Mixed Episodes) in Children and Adolescents Ages 6 to 17 Years Old (*continued*)

➔	Level 2 If there is partial response to a single atypical antipsychotic, augment with a mood stabilizer (lithium, VPA/divalproex). If monotherapy with atypical antipsychotic listed in Level 1 is not effective: <ul style="list-style-type: none">◆ 2a. Switch to another antipsychotic listed in Level 1 or olanzapine.◆ 2b. Switch to a mood stabilizer (lithium, VPA/divalproex).
➔	Level 3 Monotherapy with antipsychotic (except clozapine) not listed in Level 1 or 2, or combination with mood stabilizer(s).
➔	Level 4 Re-assess the diagnosis. Consider clozapine or ECT in adolescents.
Not Recommended: Two antipsychotics.	



Dosing Recommendations for Atypical Antipsychotics in Bipolar Disorder in Children and Adolescents Ages 6 to 17 Years Old*

Clinicians should realize that data below age 10 for treating mania and mixed states are limited and caution in using pharmacological treatment below age 10 is warranted.

Table 11.

Dosing Recommendations for Atypical Antipsychotics and Mood Stabilizers in Bipolar Disorder			
Drug Name	Starting Dose	Maximum Dose	FDA Approved Age Range
Citalopram			
Lithium	300–600 mg/day Goal: acute mania: Blood level 0.8 – 1.2 mEq/L Goal maintenance: Blood level 0.6 – 1 mEq/L	Blood level: 1.2 mEq/L	12–17 years old
Valproate	10–15 mg/kg/day in divided dose Goal: 80 –125 mcg/mL	Dose determined by blood level. Max blood level should be 125 mcg/mL	Not approved in children or adolescents
First generation (typical) antipsychotics			
Haloperidol	Children: 0.25–0.5 mg/day Adolescents: 0.5–1 mg/day	Children: 4 mg/day Adolescents: 10 mg/day	Not approved for pediatric mania
Chlorpromazine	Children: 25–50 mg/day Adolescents: 25–100 mg/day	Children (under 12): 200 mg/day Adolescents: 500 mg/day	Not approved for pediatric mania
Second generation (atypical) antipsychotics			
Aripiprazole	2-5 mg/day	30 mg/day	10–17 years old
Risperidone	Children: 0.25 mg/day Adolescents: 0.5–1 mg bid	Children: 4 mg/day Adolescents: 6 mg/day	10–17 years old
Quetiapine	Children: 12.5 mg bid Adolescents: 25 mg bid	Children: 400 mg/day Adolescents: 600 mg/day	10–17 years old
Asenapine	2.5 mg sublingually twice a day After 3 days, may increase to 5 mg sublingually twice daily, and after an additional 3 days up to 10 mg twice a day, as needed and as tolerated. Avoid food and liquids for at least 10 minutes before and after administration.	10 mg twice a day	10–17 years old
Olanzapine	2.5–5 mg once daily Weekly titration by 2.5–5 mg increments	20 mg/day	13–17 years old

Dosing Recommendations for Atypical Antipsychotics in Bipolar Disorder in Children and Adolescents Ages 6 to 17 Years Old*

MINIMIZING SIDE EFFECTS WHEN SWITCHING PSYCHOTROPIC MEDICATIONS:

- Start low. Go slow. Stop slowly. Avoid abrupt stopping, starting, and/or switching to reduce risk of rebound and withdrawal phenomena.
- Do not switch until the primary disorder has been treated according to target disorder guidelines at adequate dose and duration.
- Only stop and/or switch abruptly if a serious adverse effect necessitates it (i.e., severe neutropenia, agranulocytosis, diabetic ketoacidosis, neuroleptic malignant syndrome, acute pancreatitis, lithium toxicity, Stevens-Johnson syndrome, etc.).
- Slow switch using cross-titration is the preferred method; an even slower switch can be done using the plateau-cross titration method, with therapeutic dose overlap of medications (when switching to a less sedating cholinergic medication, or one with a much longer half-life).
- If time permits, do not reduce the first medication by more than 25–50% per 5 half-lives.

ADDITIONAL CONSIDERATIONS:

- When switching medications, the more different the binding affinity for the same receptor (between the two drugs), the greater risk for side effects and rebound and withdrawal phenomena (especially sedating; anti-cholinergic; dopaminergic).
- The more different the half-life of the medications with the same physiological effect (desired or undesired), the greater the risk for rebound and withdrawal phenomena. Withdrawal and rebound phenomena are most likely when discontinuing from a short half-life medication.
- Withdrawal and rebound phenomena are most likely to occur when switching from a strongly antihistaminergic (sedating) or anti-cholinergic medication (i.e., clozapine, olanzapine, quetiapine), to a less strongly binding medication (i.e., haloperidol, molindone, paliperidone, aripiprazole, ziprasidone); or from a strongly binding anti-dopaminergic (i.e. FGA AR risperidone, paliperidone) to a less strongly binding antipsychotic (i.e., clozapine, quetiapine, clozapine); or a full antagonist, to a partial agonist (aripiprazole).
- Insufficient efficacy or increased side effects may occur during a switch when medications metabolized by cytochrome P450 liver enzymes are paired with a medication that affects that same enzyme.
- Never discontinue lithium or clozapine abruptly to avoid potentially severe rebound of mania or psychoses.
- Quetiapine and mirtazapine can lead to more sedation at lower doses (below 250–300 mg for quetiapine and below 15 mg for mirtazapine) because of its high affinity for histamine receptors. This is offset by increased alpha adrenergic activity at higher doses that counteract this.

For a full list of references, visit <http://medicaidmentalhealth.org/>.