

Differentiating Bipolar and DMDD

Giving an accurate diagnosis does not always mean giving the popular, familiar, or expected diagnosis. An accurate diagnosis is the one that fits the child in front of you. Getting it right shapes treatment, prognosis, and how families understand their child's needs.

Confusion about the differences between bipolar disorder (BD) and disruptive mood dysregulation disorder (DMDD) is one of the most confusing and controversial diagnostic dilemmas in pediatric psychiatry. Misdiagnosis in either direction can have devastating consequences. Children with unrecognized bipolar disorder given antidepressants or stimulant medications are at real risk of triggering a manic episode, a mixed state, or hospitalization.

In the modern healthcare system, diagnosis dictates treatment options. Getting it right means conducting a complete differential diagnosis, knowing what to look for, and understanding how to distinguish overlapping symptoms from one another.

Children's Mental Health Resource Center provides education for providers and families to support accurate identification and management of mood disorders including bipolar disorder and DMDD. Learn more at cmhrc.org. Whether you are a family or a practitioner, remember: You are not alone. We are here to help.

The Concepts That Matter Most

Much of what differentiates bipolar disorder from DMDD hinges on two foundational concepts. The first is the difference between **episodic** and **chronic** irritability.

Bipolar: Mood changes are periods of elevated or depressed moods that can be euphoric, expansive, or irritable. They must represent a clear departure from the child or teen's baseline mood. After those episodes end, there is a return to a stable, and usually pleasant baseline.

DMDD: The baseline is chronic irritability. Although punctuated by outbursts, there is no period of time that is meaningfully symptom-free, and outbursts are an escalation of irritability, not a deviation from it.

*"My child isn't always like this.
Where has my child gone?"*

PARENTS OF CHILDREN WITH
BIPOLAR DISORDER

*"This is just how my child has
always been."*

PARENTS OF CHILDREN WITH DMDD

Additionally, it is essential to be able to identify a manic or hypomanic episode in a child. Knowing the signs and symptoms of mania and hypomania in children is straightforward when you can recognize how symptoms differ in children and teens versus in adults.

*If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned. **DSM-5-TR, P. 178***

This is the clinical compass for this differential diagnosis:

1. Chronic vs. Episodic Irritability
2. Manic or Hypomanic Episodes



Is DMDD just the childhood version of bipolar disorder?

NO This is one of the most common misconceptions in pediatric psychiatry. The research is clear: DMDD is not the childhood version of bipolar disorder. Children with DMDD have different neurobiological profiles, family histories, and outcomes pointing toward depression and anxiety in adulthood, not bipolar.

Can bipolar disorder be diagnosed in young children?

YES A diagnosis of bipolar disorder can be made at any age. A skilled clinician will differentiate it from developmentally expected behaviors by understanding its key characteristics that are consistent over time.

If my child has DMDD now, will they develop bipolar disorder later?

NO Children who have DMDD are 50 times less likely to go on to experience a manic or hypomanic episode than children correctly diagnosed with bipolar disorder. They are more likely to develop difficulties with depression and anxiety in adulthood.

Can a child be diagnosed with both DMDD and bipolar disorder?

NO DMDD cannot be comorbid with bipolar disorder. If there has ever been a manic or hypomanic episode, then the bipolar diagnosis takes precedence. DMDD can, however, co-occur with ADHD, major depression, anxiety disorders, and conduct disorders.

Are the treatments for bipolar and DMDD the same?

NO The treatments are meaningfully different. For DMDD, psychosocial interventions are considered first-line, with stimulants and SSRIs used to treat co-occurring symptoms. For bipolar disorder, mood stabilizer medications are the first-line intervention, with psychotherapies playing a supporting role. Applying the wrong treatment can cause real harm.

Should I seek a second opinion if my child's diagnosis seems uncertain?

YES Second opinions are your right as a family. Good clinicians welcome a second opinion and collaboration with other clinicians to ensure the patient is on the right path. It is unethical for a clinician to discharge a patient because the family seeks a second opinion.

DIAGNOSING DURING CRISIS IS NOT APPROPRIATE

Families reach out most often when they are in acute distress. Therefore, a clinician is seeing that parent and child at their most overwhelmed and dysregulated. That is not comprehensive data for a differential diagnosis. A diagnosis should be reserved until data has been gathered over time and across settings.

Common errors in differential diagnosis include misidentifying manic episodes as hyperactivity or temper tantrums, and looking for adult presentation of mania and hypomania in children and teens.

BIPOLAR MANIA IN CHILDREN

Symptoms of mania can be missed in pediatrics. Hypersexuality, goal-directed activities, grandiosity, manic irritability and other manic symptoms look different in children because of their stage of development. Additionally, mood shifts happen more frequently for kids, with "ultradian cycling" where moods can shift multiple times in a single day.

FIVE CRITICAL ERRORS TO AVOID

1. Misidentification of mania as hyperactivity or tantrums.
2. Failing to map episodic vs. chronic irritability over time.
3. Relying on a single source of information.
4. Universally applying research from white samples.
5. Diagnosing during a crisis before the full picture is available.

Not all tantrums are manic episodes and not all manic episodes are tantrums.

ON OUTBURSTS VS. EPISODES**How to Tell Them Apart**

Both disorders involve irritability. The key distinction is not just *whether* irritability is present, but *what kind* of irritability it is. Ask a parent: "What does a good day look like for their child?"

THE ESSENTIAL CLINICAL QUESTION

With DMDD, the child will likely be described as irritable or on edge even on good days. With bipolar disorder, a good day means the child is back to normal, without irritability. Their answer gives you vital diagnostic information.

Look for the following differences:**BIPOLAR DISORDER**

- Distinct highs and lows, no irritability in between
- Has mania or hypomania
- Frustration and inattention occur only during frustrating tasks, are mood dependent
- Hyperactivated amygdala
- If at least one parent has bipolar there is a 33.3% chance of the child having bipolar
- Continue to have manic and depressive episodes in adulthood

DMDD

- Baseline is chronically irritable
- No mania or hypomania
- Frustration and inattention occur regardless of whether a task is frustrating or neutral, are not mood dependent
- Hypoactivated amygdala
- If a child has DMDD there is only a 2.7% chance they have a parent with bipolar
- Likely to have depressive episodes in adulthood

The Right Treatment for the Right Diagnosis

Diagnosis dictates treatment. That's why it's so important to get it right.

Treatment For DMDD

- **Parent Management Training:** reduces explosive behavior
- **Cognitive Behavioral Therapy (CBT):** targets frustration and emotional regulation
- **Dialectical Behavioral Therapy (DBT):** addresses distress and emotional regulation
- No FDA-approved medication exists for DMDD; SSRIs and stimulants target comorbid conditions

Treatment For Bipolar

- **Mood stabilizers:** lithium is "gold standard"; paired with anti-seizure meds — lamotrigine for depression or oxcarbazepine for mania and aggression
- **Avoid SSRIs and stimulants:** can trigger mania, mixed episodes, and hospitalizations
- **Family Focused Therapy (FFT):** reduces relapse; improves functioning

"Medication, psychoeducation, therapy, and lifestyle changes are all critical components of any treatment plan."

ON TREATMENT

It is not hard to love, support, or root for these children. **They** and their families need providers who will do the hard clinical work to find the correct diagnosis so treatment can reduce symptoms and improve quality of life.