CHILDREN'S MENTAL HEALTH RESOURCE CENTER

Bipolar vs. Trauma

Telling the Difference

A clinical overview of how to distinguish bipolar symptoms from trauma responses, why accurate diagnosis matters, and key differences in onset, symptoms, and treatment.

Bipolar disorder and trauma responses can be mistaken for one another because symptoms of each can appear to be overlapping. Distinguishing between them requires looking not just at what symptoms are present, but from where those symptoms originate, what, if any, external antecedents exist as triggers for symptoms, and how those symptoms respond to treatment.

Complicating identification and treatment is the reality that a child or teen can have both bipolar disorder and a trauma history at the same time. Early childhood adversity is a known risk factor for bipolar, but it does not mean that every person with trauma will also have bipolar or that every person with bipolar will also have trauma in their background. The distinction matters because effective treatment is different for each condition.

> **Treating bipolar with trauma interventions, or trauma with bipolar interventions, does not provide effective treatment. Aligning diagnosis with proven, gold-standard treatments is what makes recovery possible.**

Once you know what to look for, the distinctions become clear and accurate diagnosis and effective treatment are possible.

Children's Mental Health Resource Center provides guidance and education for families and providers on mood disorders in childhood. You are not alone. We are here to help.

FOR FAMILIES AND CLINICIANS

Why Accurate Diagnosis *Matters*

This brochure is for families and providers who are seeking to understand how to tell bipolar disorder and trauma apart in children and teens, what causes it, and what an accurate diagnosis means for treatment and for a child's future. It offers research-backed, practical guidance for parents and caregivers and actionable diagnostic information for providers navigating treatment for children who have mood disorders and/or trauma.

Bipolar disorder symptoms originate internally, driven by biological and metabolic processes that occur outside the individual's control. Trauma responses originate externally, triggered by a preceding event in the environment.

Both disorders are serious, both are manageable, and both require different treatment approaches. Neither is "worse" or "better" than the other. The sooner a provider can identify the correct diagnosis, the sooner effective treatment can begin.

DIAGNOSIS & TREATMENT

Delaying an accurate diagnosis is a contributing factor to long-term negative impacts of both bipolar disorder and untreated trauma.

⚠ **DIAGNOSIS DELAYED IS TREATMENT DENIED**

Not providing an accurate diagnosis allows a condition to worsen, limiting treatment options or preventing recovery.

CHILDREN'S MENTAL HEALTH RESOURCE CENTER

— GUIDANCE. COMMUNITY. HOPE. —

COMMON QUESTIONS ANSWERED

Can a child have both bipolar disorder and a trauma history at the same time?

YES Comorbidity is real. Childhood adversity is a known risk factor for bipolar. But having one disorder does not mean the other is also present. They can coexist, each requiring its own treatment approach.

Are mood swings always a sign of trauma or a mood disorder?

NO Mood swings can be part of normal development. As the adolescent brain grows, the amygdala (emotions) develops faster than the prefrontal cortex (logic), creating instability that is developmentally expected.

Are the origins of bipolar symptoms the same as trauma-related symptoms?

NO Bipolar symptoms are almost always internally driven and often have no reasonable or identifiable external trigger. In trauma, symptoms are tied to specific triggers linked to the traumatic event.

Can nightmares help distinguish bipolar from trauma?

LIKELY In bipolar, nightmares are often violent, unrelated to real experiences, and may not be remembered. In trauma, nightmares replay the traumatic event and the child wakes remembering them clearly.

Does CBT (Cognitive Behavioral Therapy) work for both disorders?

NO CBT is effective for trauma but not for bipolar when symptoms are active. Because bipolar symptoms are biologically driven, DBT and somatic approaches are more effective during symptomatic periods. Trauma-informed CBT, EMDR, and exposure therapy are effective for trauma recovery.

Is it possible to diagnose bipolar in a child?

YES There is a misconception that bipolar cannot exist in children, or that it is not appropriate to give a child such a diagnosis. This denial of an accurate diagnosis supports and promotes stigma associated with mental illness.

Are both bipolar and trauma manageable conditions?

YES Both disorders are equally serious and equally manageable. Neither is a life sentence. With appropriate, diagnosis-aligned treatment, individuals with bipolar disorder or trauma can achieve stability and a healthy life.

FOR CLINICIANS AND CAREGIVERS

TRAUMA CHANGES THE BRAIN

Trauma causes the amygdala to increase in size, widening the gap between emotional reaction and logical reasoning. Children with trauma in their history observe situations through a lens of that trauma and fear that it will repeat.

A trauma-affected brain means changed behavior, and changed behavior requires changed parenting. What works for neurotypical children will not always work with children and teens who live with trauma.

FELT SAFETY

Children with trauma and bipolar disorder need to feel safe, not just be told that they are safe. Felt safety is a deep state of psychological calm created when the parasympathetic nervous system perceives the environment is safe. It promotes social engagement and de-escalates defenses, allowing the body to feel secure, grounded, and present rather than operating in fight-or-flight mode.

What creates felt safety differs for every child, but building trust is a good place to start. Building trust takes time, patience, and consistent, predictable responses from authority figures. With children and teens with mood disorders, double or triple your usual rapport-building timeline. They must experience you as trustworthy over time before the therapeutic relationship can take root.

> *What creates that feeling differs for every child. Building trust takes time, patience, and consistent, predictable responses from caregivers and providers.*
>
> ELIZABETH ERRICO, CMHRC EXECUTIVE DIRECTOR

UNDERSTANDING THE DIFFERENCES

How the Symptoms *Differ*

Bipolar disorder and trauma responses both have symptoms that can appear from the outside to overlap. But the causes, patterns, and responses to treatment differ significantly for these symptoms depending on whether they are trauma driven or mood disorder based. The key question is: **where does the symptom originate?**

ONSET AND PATTERN

Bipolar often has a gradual, prodromal onset: symptoms were present for years before a full diagnosis. Trauma onset follows a preceding event, though delayed onset is possible. Bipolar symptoms cycle; trauma symptoms decrease with appropriate treatment but triggers may persist lifelong.

Bipolar symptoms are internally driven by biological and metabolic processes. Trauma symptoms are responses to external triggers in the environment. When there is no identifiable external cause for a child's behavior, this points toward a mood disorder.

Key differences in symptom presentation:

1. **Self-Harm**
   - *Bipolar:* Driven by the pain of symptoms and the energy of mixed mood episodes.
   - *Trauma:* Relates to impacted self-worth from the traumatic event.
2. **Aggression**
   - *Bipolar:* Territorial and reactive, with no predictable pattern or identifiable external trigger.
   - *Trauma:* Tied to perceived danger and specific environmental triggers.
3. **Nightmares**
   - *Bipolar:* Often violent, are not based on personal experience, and may not be remembered.
   - *Trauma:* Replay the traumatic event.
4. **Avoidance**
   - *Bipolar:* Adults and observers often cannot find a consistent cause and effect pattern for avoidance.
   - *Trauma:* Typical avoidance is of specific triggers.

THE PATH TO ACCURATE DIAGNOSIS

Gold Standard *Assessment*

Regardless of the diagnosis that is being considered, accurate assessment requires a thorough structured interview of one to two hours, often across multiple sessions. Part of differentiating bipolar and trauma is attempting to identify a specific or a repeating pattern of traumas that can trigger symptoms. Providers should not rely solely on the most recent months of symptoms but look back to find an identifiable trauma or prodromal symptoms of a mood disorder.

A comprehensive assessment includes:

- → Full developmental and biological history from parents, pediatricians, teachers, and non-parental caregivers
- → Detailed family psychiatric history, since bipolar disorder has strong genetic components that can be used as data to support a diagnosis of bipolar
- → Review of all previous interventions, including medications tried and their effects
- → Medical records review to rule out other conditions such as thyroid disorders
- → A true differential diagnosis: ruling in or out every condition that could explain the symptoms
- → Structured assessment tools such as the Child Bipolar Questionnaire (CBQ) and the Jeannie and Jeffrey Illustrated Interview for Children
- → The ACE (Adverse Childhood Experiences) questionnaire from the Kaiser Permanente study for trauma screening

> *"Every provider my son saw said he was 'complex.' They couldn't figure out if his symptoms were from something that happened to him or from something happening inside of him. It took years before someone finally sat down and did the work to figure out which was which. Once they did, everything changed — because for the first time, he was getting the right treatment for the right thing."*
>
> REBECCA, MOTHER OF A CHILD WITH BIPOLAR DISORDER