Bipolar Disorder in Young Children: Identification, Symptom Presentation, and Early Intervention

Executive Summary

This white paper addresses the identification of bipolar disorder in children ages 10 and younger, with particular attention to how symptom presentation in this population differs markedly from adult presentations. The diagnosis of bipolar disorder in young children remains one of the most contested and underrecognized challenges in pediatric mental health. Persistent diagnostic skepticism, combined with the field's historical reliance on adult-derived diagnostic criteria, has left countless children without accurate diagnosis or appropriate treatment. This paper reviews the research literature on the phenomenology of early-onset bipolar disorder,[2,3,5,6,7,12,13] addresses the clinical significance of irritability as the primary affective presentation in both mania and depression in children,[4,6] and examines age-appropriate manifestations of classic manic symptoms including hypersexuality, risk-taking behaviors, and goal-directed or mission-driven activities.[2,3,13,21] It concludes with a call for timely, evidence-based intervention, including the use of mood stabilizers such as lithium carbonate, which has demonstrated both safety and disease-modifying properties in the treatment of bipolar disorder.[1,8,9,14,22]

Introduction

Bipolar disorder is a serious, heritable mood disorder characterized by episodic disturbances in mood, energy, cognition, and behavior. While it has historically been considered a disorder of adulthood, a substantial body of research now confirms that bipolar disorder can and does present in childhood, including in children under the age of 10.[12,13] Retrospective studies consistently show that a significant proportion of adults with bipolar disorder report the onset of symptoms before age 13, and many before age 10.[5,7]

Despite this evidence, diagnosis in young children is frequently delayed, contested, or missed entirely. Children are instead diagnosed with attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), anxiety disorders, or simply labeled as having behavioral problems.[6,12,13] These diagnostic errors carry serious consequences: without accurate identification, children cannot receive appropriate treatment, and the disorder progresses. As Post and colleagues have demonstrated, each successive mood episode increases the risk of cognitive dysfunction and treatment resistance,[1,18] making early identification and intervention not merely helpful but essential.

The challenge of diagnosing bipolar disorder in children under 10 is real but surmountable. It requires clinicians, educators, and families to understand that the disorder does not present in children the way it presents in adults. The textbook adult presentation of discrete, sustained episodes of elevated or euphoric mood alternating with periods of depression is rarely what clinicians encounter in the prepubertal child.[2,3,4] What they encounter instead is a presentation shaped by developmental stage, neurological immaturity, and a symptom profile that requires its own framework for recognition.[6,12]

Why Young Children Are Frequently Missed or Misdiagnosed

The Problem with Adult-Centric Diagnostic Criteria

The DSM-5-TR criteria for bipolar disorder were developed and validated primarily in adult populations. The cardinal manic symptom listed first, "expansive or elevated mood," reflects the euphoric, grandiose presentation most recognizable in adults. Yet research consistently demonstrates that in prepubertal children, euphoric mania is the exception rather than the rule.[2,3,4] When adult criteria are applied rigidly to children, the majority of affected children will fail to meet the threshold, not because they do not have the illness, but because the instrument was not designed for them.[4,6]

Geller and colleagues conducted foundational research on the phenomenology of childhood bipolar disorder using developmentally sensitive instruments. Their studies found that the most common presentation of mania in children was not euphoria but rather an irritable, explosive, and chronically dysphoric mood state, often with rapid cycling between extreme states and ultra-rapid or ultradian cycling patterns not commonly seen in adults.[2,3] Children in their studies cycled between mood states multiple times within a single day, a presentation virtually absent in adult populations but characteristic in prepubertal cases.[2,21]

Overlapping Diagnoses and Symptomatic Masking

ADHD is the most common misdiagnosis given to children who are later identified as having bipolar disorder.[6,12,13] Both conditions share features including distractibility, hyperactivity, impulsivity, and difficulty with sustained attention. However, the behavioral presentation of bipolar disorder is episodic and mood-driven, whereas ADHD is chronic, relatively stable, and not anchored to mood states. The critical distinguishing features of bipolar disorder, grandiosity, hypersexuality, decreased need for sleep without fatigue, and pressured goal-directed behavior are not features of ADHD.[2,13] Additionally, there is no evidence to suggest a diagnosis of "extreme ADHD," and when aggression, suicidal ideation, homicidal idetaion, and other acts of harm against self or others are not characteristic of ADHD. When present, a diagnosis of mood disorder must be considered first. Geller and colleagues found that the presence of elated mood and grandiosity were among the most discriminating features between pediatric bipolar disorder and ADHD.[2]

Stimulant medications, frequently prescribed for ADHD, present a significant risk in unidentified bipolar disorder. A large 2016 review by Viktorin and colleagues found that adults with bipolar disorder who were treated with methylphenidate experienced a markedly increased risk of manic episodes.[10] The same risk applies to children, and adverse reactions to stimulant medications including mood destabilization, increased aggression and irritability, and sleep disruptions should be recognized as clinical indicators that the diagnosis of ADHD may be incorrect and that bipolar disorder should be evaluated.[10]

Similarly, antidepressants prescribed for anxiety or depression carry serious risks when bipolar

disorder is the underlying condition. Antidepressant-associated mania (AAM) has been documented in children and adolescents, with a 2020 meta-analysis by Melhuish Beaupre and colleagues identifying younger age and history of rapid cycling as risk factors.[11] If bipolar disorder is suspected, or if a first-degree relative carries a diagnosis of bipolar disorder or a related mood disorder, antidepressants should be avoided.[11]

Irritability as the Primary Presentation: Mania and Depression in Children

Irritability in Childhood Mania

The most important clinical reorientation required for identifying bipolar disorder in young children is the recognition that irritability, not euphoria, is the hallmark presentation of mania in prepubertal children.[2,3,4,6] This irritability is not the ordinary frustration or moodiness of childhood. It is a severe, pervasive, and often explosive irritability that is grossly out of proportion to any precipitant, can last for hours, and is experienced by families as qualitatively different from typical childhood behavior.[4,13]

Leibenluft and colleagues have described this presentation in detail, noting that in young children mania frequently manifests as prolonged, intense "affective storms" or rages that are neurologically driven rather than behaviorally motivated.[4] These episodes are involuntary, children are not choosing to behave this way and are frequently remorseful and frightened by their own responses afterward. This distinction is clinically important: the behavior is a symptom of a neurobiological disorder, not a discipline problem, and behavioral modification strategies that treat it as willful misconduct are not only ineffective but potentially harmful, eroding self-esteem and self-efficacy while leaving the underlying illness untreated.[4,19]

Parents frequently describe their young child during rages as "absent behind their eyes" or "not themselves."[19] The child may become physically aggressive, destructive, or verbally abusive during these episodes and may appear unable to hear or respond to redirection. The duration, intensity, and apparent involuntary quality of these episodes distinguish them from typical childhood tantrums or oppositional behavior.[4,13,19]

Irritability in Childhood Depression

In adult depression, the primary affective presentation is sadness, hopelessness, and anhedonia. In children, and particularly in children with bipolar disorder, depressive episodes frequently present with irritability as the leading feature rather than overt sadness.[6,7] The depressed child with bipolar disorder may appear chronically cranky, easily angered, intolerant of frustration, emotionally raw, and reactive. Caregivers and teachers may perceive this as oppositional or defiant behavior, again leading to misdiagnosis.[6,12]

The DSM-5 does acknowledge that in children and adolescents, irritable mood can substitute for depressed mood in the diagnosis of a major depressive episode. However, this provision is underutilized in practice, and the clinical significance of irritability as a bipolar marker, rather than a feature of unipolar depression, ODD, or ADHD, is frequently overlooked.[4,6] In the context of bipolar disorder, depressive episodes characterized by irritability are often followed or

preceded by periods of manic or hypomanic irritability, creating a picture of chronic emotional dysregulation that can appear continuous rather than episodic.[5,7,21]

Manic Symptoms in Children Under 10: Developmental Context

Grandiosity and Mission-Driven Activity

In adults, grandiosity presents as inflated self-esteem and unrealistic assessments of one's abilities, importance, or destiny. In young children, this same symptom manifests in developmentally appropriate forms that can be mistaken for healthy imagination or play.[2,13,19] The child's grandiosity is qualitatively different: it is not the ordinary magical thinking of early childhood but a fixed, intense conviction that they have special powers, a special mission, or a unique destiny.[2,13] The child may insist they can fly, that they are superheroes or chosen figures, or that they must accomplish a specific grand task.[19] They may also simply be unable to recognize adult authority, and view and verbalize that they are of equivalent status to adults and caregivers.

Associated with grandiosity is the phenomenon of goal-directed or mission-driven activity. In a manic or hypomanic state, a child may become intensely and exclusively focused on a project, plan, or goal that consumes their attention to the exclusion of sleep, eating, and ordinary daily activity.[2,3] This is not the passionate enthusiasm of a curious child; it is driven, pressured, and resistant to interruption. The child may become explosive when the activity is interrupted. The project itself may be elaborate, unrealistic, and pursued with a sense of urgency that has no clear external cause.[2,19]

Hypersexuality in Young Children

Hypersexuality is among the most distressing and misunderstood manic symptoms when it appears in young children. Its presence in a prepubertal child frequently triggers concerns about sexual abuse, and while such concerns must always be taken seriously and ruled out, it is essential that clinicians recognize hypersexuality as a documented symptom of childhood mania.[2,13] Geller and colleagues found that hypersexuality was present in a significant proportion of their prepubertal bipolar cohort in the absence of any history of sexual abuse or inappropriate sexual exposure.[2]

In young children, hypersexuality may present as preoccupation with sexual themes in play or drawing, making sexual comments or gestures, exposing themselves, or compulsive masturbation.[2,13,19] These behaviors are ego-dystonic, they cause the child distress, and they are not typical expressions of healthy curiosity. They are neurobiologically driven and will not respond to behavioral redirection alone. They require appropriate clinical identification as manic symptoms and treatment of the underlying mood disorder.[2,19]

Decreased Need for Sleep

One of the most reliably observed manic symptoms across all ages is a decreased need for sleep, not insomnia (the inability to sleep despite wanting to), but a genuine reduction in sleep requirement without daytime fatigue.[2,3,6] In adults, this is typically a discrete episodic change. In

young children with bipolar disorder, disrupted sleep can be a pervasive and chronic feature.[21] Affected children may be unable to fall asleep for hours after bedtime, may awaken in the middle of the night and be fully energized, or may consistently require substantially less sleep than age-typical norms without appearing tired the following day.[2,19] Sleep disturbance of this quality in a young child, particularly when associated with irritability, hyperactivity, or other mood symptoms, should prompt evaluation for bipolar disorder.[6,22]

Risk-Taking Behaviors

Adult mania is associated with reckless spending, sexual indiscretion, and impulsive decision-making with potential for serious consequences. In children under 10, risk-taking behaviors take forms appropriate to the developmental stage: climbing to dangerous heights, jumping from elevated surfaces, running into traffic, engaging in aggressive physical acts without apparent awareness of consequences, or instigating dangerous situations with other children.[2,13,19] These behaviors are not driven by impulsivity alone as seen in ADHD, but by a manic sense of invulnerability and excitement that overrides fear responses.[2,4] Parents often describe these episodes as terrifying, noting that ordinary safety warnings have no effect during the behavioral surge.[19]

Racing Thoughts and Pressured Speech

Young children who experience racing thoughts may report that their brain "won't stop" or "won't be quiet," or they may be unable to articulate the experience verbally but demonstrate it through pressured, rapid, difficult-to-interrupt speech that jumps from topic to topic.[2,3,6] This flight of ideas can appear in a young child as torrential storytelling, incessant questioning, or a verbal stream that appears driven and unstoppable.[2,19] Teachers may describe the child as "talking over" others, unable to wait their turn, or appearing not to listen because they are too preoccupied with their own internal experience.[6,13] Parents often describe feels as though their child is talking “at” them, rather than “to” them.

The Course of Untreated Childhood Bipolar Disorder and the Case for Early Intervention

The consequences of delayed identification and treatment are well-documented. Post and colleagues have established that each successive mood episode in bipolar disorder is associated with increasing cognitive dysfunction and progressively greater treatment resistance.[1,18] In a landmark 2025 analysis, Post and colleagues asserted that lithium "acts like a disease-modifying drug" because it affects mechanisms at a cellular level and at the levels of brain structure and function.[1] Lithium has been associated with neuroprotective changes including cortical thickening and hippocampal volume preservation, and has been shown to ameliorate abnormal brain function in regions implicated in emotional regulation and cognition, effects that go beyond mere symptom suppression.[14,20]

The implications for children are urgent. A child whose bipolar disorder goes unidentified from age 6 to 16 has experienced a decade of untreated mood episodes, cognitive disruption, social impairment, educational derailment, and medication trials that may have actively worsened the

illness.[7,18] The same child identified at age 6 and treated appropriately with a mood stabilizer has a fundamentally different trajectory.^{1,8,22}

A 2025 population-based cohort study by Oliva and colleagues demonstrated that sustained lithium exposure significantly lowers the risk of all-cause mortality in bipolar disorder, while partial or intermittent exposure does not confer the same protective effect.[9] This finding reinforces the clinical imperative to begin appropriate treatment early and maintain it consistently.[9]

Lithium carbonate is the gold standard mood stabilizer for bipolar disorder in adults, and its use in the pediatric population is supported by a growing body of evidence.[1,8,22] Dr. Robert Post, who spent 35 years at the National Institute of Mental Health including 20 as Chief of the Biological Psychiatry Branch, has stated directly that with respect to lithium use in children with bipolar disorder, "we need to think about it early and more continuously to avoid disability."[1] His further observation, that the more episodes a patient experiences, the greater the cognitive dysfunction, applies with full force to children, in whom developmental trajectories can be permanently altered by untreated illness.[1,18]

Papolos and colleagues concur, specifying in a 2025 paper that mood stabilization in early-onset bipolar disorder typically requires lithium titrated to clinical response, usually at levels of 1.0 to 1.2 mEq/L, with oxcarbazepine as an alternative if lithium is not tolerated.[8] The therapeutic range for children, as reported in *The Bipolar Child*, is typically 0.8 to 1.2 mEq/L, and titration should be calibrated to clinical response rather than to a predetermined blood level.[19]

Antipsychotic medications, while frequently used as a first-line intervention in children with mood disorders, do not demonstrate robust long-term mood-stabilizing effects and are associated with significant metabolic consequences including increased risk of metabolic syndrome and shortened lifespan.[16,17] Smith and colleagues found that mood stabilizers outperformed antipsychotics in preventing relapse of both mania and depression,[15] while Kusumakar reported in an 8-year study that antipsychotics reduced mania but increased depressive episodes.[16] These findings argue strongly against the routine use of antipsychotics as primary treatment for pediatric bipolar disorder in the absence of mood stabilization.[15,16,17]

Conclusion

Bipolar disorder in children under 10 is real, identifiable, and treatable.[2,3,6,7,12,13] The failure to identify it is not a consequence of its rarity or its absence from the research literature, it is a consequence of diagnostic frameworks that were not built with young children in mind, and of persistent, evidence-resistant skepticism about the existence of early-onset presentations.[4,6,12] This skepticism costs children years of their development, exposes them to inappropriate and potentially harmful medications,[10,11] and sets the stage for a more severe, more treatment-resistant disorder in adolescence and adulthood.[1,7,18]

The Clinical Obligation is Clear:

1. Learn to recognize bipolar disorder as it presents in children through
    a. irritability rather than euphoria,[2,4]
    b. age-appropriate expressions of grandiosity and risk-taking,[2,13,19]
    c. hypersexuality that has no basis in abuse,[2]
    d. sleep disruption, pressured speech, and mission-driven behaviors.[2,3,6]

2. Rule out other causes.

3. Partner with families who are the first and most reliable observers of their child's mood and behavior.[19,22]

4. When the presentation is consistent with bipolar disorder, do not delay appropriate treatment.
    a. Lithium, titrated carefully and monitored consistently, is a safe, effective, and potentially disease-modifying intervention that can change the trajectory of a child's life.[1,8,9,14]
    b. There is no justification for withholding it out of diagnostic hesitation when the evidence is present.

References

1. Post RM, Li VW, Berk M, Yatham LN. Lithium as a disease-modifying drug for bipolar disorder. *Lancet Psychiatry*. 2025;12(11). doi:10.1016/S2215-0366(25)00097-5
2. Geller B, Zimerman B, Williams M, et al. DSM-IV mania symptoms in a prepubertal and early adolescent bipolar disorder phenotype compared to attention-deficit hyperactive and normal controls. *Journal of Child and Adolescent Psychopharmacology*. 2002;12(1):11–25. doi:10.1089/10445460252943533
3. Geller B, Tillman R, Craney JL, Bolhofner K. Four-year prospective outcome and natural history of mania in children with a prepubertal and early adolescent bipolar disorder phenotype. *Archives of General Psychiatry*. 2004;61(5):459–467. doi:10.1001/archpsyc.61.5.459
4. Leibenluft E, Charney DS, Towbin KE, Bhangoo RK, Pine DS. Defining clinical phenotypes of juvenile mania. *American Journal of Psychiatry*. 2003;160(3):430–437. doi:10.1176/appi.ajp.160.3.430
5. Faedda GL, Baldessarini RJ, Glovinsky IP, Austin NB. Pediatric bipolar disorder: phenomenology and course of illness. *Bipolar Disorders*. 2004;6(4):305–313. doi:10.1111/j.1399-5618.2004.00128.x
6. Axelson D, Birmaher B, Strober M, et al. Phenomenology of children and adolescents with bipolar spectrum disorders. *Archives of General Psychiatry*. 2006;63(10):1139–1148. doi:10.1001/archpsyc.63.10.1139
7. Birmaher B, Axelson D, Strober M, et al. Clinical course of children and adolescents with bipolar spectrum disorders. *Archives of General Psychiatry*. 2006;63(2):175–183. doi:10.1001/archpsyc.63.2.175
8. Papolos DF, Teicher MH, Post RM. Treatment of early-onset specified and unspecified bipolar disorders: a systematic review and strategies for identifying and managing a thermally dysregulated subtype in children. *Acta Psychiatrica Scandinavica*. 2025;152(3):156. doi:10.1111/acps.13817
9. Oliva V, De Prisco M, Anmella G, et al. Patterns of lithium exposure and mortality in bipolar disorder: a population-based cohort study. *European Psychiatry*. 2025;68(1). doi:10.1192/j.eurpsy.2025.10090
10. Viktorin A, Rydén E, Thase ME, et al. The risk of treatment-emergent mania with methylphenidate in bipolar disorder. *American Journal of Psychiatry*. 2016;173(11):1091–1096. doi:10.1176/appi.ajp.2016.16040467
11. Melhuish Beaupre LM, Tiwari AK, Goncalves VF, et al. Antidepressant-associated mania in bipolar disorder: a review and meta-analysis of potential clinical and genetic risk factors. *Journal of Clinical Psychopharmacology*. 2020;40(2):180–185.

doi:10.1097/JCP.0000000000001186

12. Geller B, Luby J. Child and adolescent bipolar disorder: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1997;36(9):1168–1176. doi:10.1097/00004583-199709000-00008

13. Wozniak J, Biederman J, Kiely K, et al. Mania-like symptoms suggestive of childhood-onset bipolar disorder in clinically referred children. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1995;34(7):867–876. doi:10.1097/00004583-199507000-00010

14. Diniz BS, Machado-Vieira R, Forlenza OV. Lithium and neuroprotection: translational evidence and implications for the treatment of neuropsychiatric disorders. *Neuropsychiatric Disease and Treatment*. 2013;9:493–500. doi:10.2147/NDT.S33086

15. La S, Smith LA, Cornelius V, Warnock A, Bell A, Young AH. Effectiveness of mood stabilizers and antipsychotics in the maintenance phase of bipolar disorder: a systematic review of randomized controlled trials. *Bipolar Disorders*. 2007;9(4):394–412.

16. Kusumakar V. Antidepressants and antipsychotics in the long-term treatment of bipolar disorder. *Journal of Clinical Psychiatry*. 2002;63(Suppl 10):23–28.

17. Ballon JS, Pajvani U, Freyberg Z, Leibel RL, Lieberman JA. Molecular pathophysiology of metabolic effects of antipsychotic medications. *Trends in Endocrinology and Metabolism*. 2014;25(11):593–600. doi:10.1016/j.tem.2014.07.004

18. Yatham LN, Kozicky J, Torres IJ, et al. Cognitive change in the year after a first manic episode: association between clinical outcome and cognitive performance early in the course of bipolar I disorder. *Journal of Clinical Psychiatry*. 2014;75(6):587–593. doi:10.4088/JCP.13m08928

19. Papolos DF, Papolos J. *The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder*. Third ed. Broadway Books; 2006.

20. Bergamelli E, Del Fabro L, Delvecchio G, D'Agostino A, Brambilla P. The impact of lithium on brain function in bipolar disorder: an updated review of functional magnetic resonance imaging studies. *CNS Drugs*. 2021;35(12):1275–1285. doi:10.1007/s40263-021-00869-y

21. Findling RL, Gracious BL, McNamara NK, et al. Rapid, continuous cycling and psychiatric co-morbidity in pediatric bipolar I disorder. *Bipolar Disorders*. 2001;3(4):202–210. doi:10.1034/j.1399-5618.2001.30405.x

22. Kowatch RA, Fristad M, Birmaher B, et al. Treatment guidelines for children and adolescents with bipolar disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2005;44(3):213–235. doi:10.1097/00004583-200503000-00006