CHILDREN'S MENTAL HEALTH RESOURCE CENTER

Antidepressants and Bipolar Disorder

in Children and Teens

When a child is diagnosed with a mood disorder, the medications prescribed can shape the entire course of their illness, treatment, and stability. Antidepressant medications carry significant risks for children and teens with bipolar disorder that every family deserves to understand.

Bipolar disorder is frequently misdiagnosed as depression, ADHD, anxiety, DMDD, or ODD. This is especially true in children. Because misunderstood manic episodes, interpreted as hyperactivity or anxiety, are often what bring a child to clinical attention, antidepressants are commonly prescribed first, often in conjunction with stimulant medication. **This is one of the most consequential errors in pediatric psychiatry.**

When antidepressants are prescribed to a child who actually has bipolar disorder, the results can be severe: triggered manic episodes, rapid cycling, mixed states, and hospitalizations.

> **The goal is not to alarm you. It is to ensure that bipolar disorder is carefully ruled out before antidepressants are prescribed, and that you are a fully informed partner in that decision.**

CMHRC's role is not to prescribe or advise on individual treatment plans, but to provide education on how medications work, what the research shows, and what questions are worth asking, so that families can engage as fully informed partners in the decisions that matter most.

FOR FAMILIES

A Guide to *Antidepressants* in Treating Bipolar Disorder

When a child or teen is diagnosed with a mood disorder, medication decisions are among the most significant a family will face. Understanding why antidepressants are not a safe first-line treatment until after bipolar has been considered and ruled out is essential to making informed choices.

This brochure offers research-backed information on antidepressants, how they differ from mood stabilizers, and what families and providers need to know.

> **Rx** "Antidepressants can destabilize a patient with bipolar. Mood stabilization must come first."

Being informed means being equipped, not being alarmed. As a caregiver or patient you should never be pressured into accepting a medication that does not feel right, that you do not understand, or that you are uncomfortable giving to your child. You have the right to know the potential risks, benefits, and to be prepared for possible side effects.

> **You are your child's voice when talking to a prescriber. Do not be afraid to persist until you fully understand why a medication has been prescribed, what it is intended to treat, and how you can know if it is working or not.**
>
> ON ADVOCATING FOR YOUR CHILD

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— GUIDANCE. COMMUNITY. HOPE. —

COMMON QUESTIONS ANSWERED

Can antidepressants cause harm in a child with bipolar disorder?

YES Antidepressants can trigger manic episodes, mixed states, and rapid cycling in children with bipolar disorder. Research published in the American Journal of Psychiatry confirms this is a well-documented risk, not a rare side effect.

Is it possible to mistake bipolar disorder for depression alone or something else?

YES This is one of the most consequential diagnostic errors in pediatric psychiatry. Children with bipolar disorder are frequently first seen during manic episodes that are mistaken for extreme anxiety or hyperactivity. Studies show an average delay of 8 to 10 years between symptom onset and correct diagnosis, which is a childhood lost.

Should bipolar disorder be ruled out before antidepressants are prescribed?

YES Ruling out a mood disorder before prescribing antidepressants is the recommended standard of care. The correct sequence is differential diagnosis first, treatment second. Families are entitled to ask whether this step has been completed and if their provider has experience in recognizing and treating bipolar disorder in children and teens.

Are antidepressants ever appropriate in bipolar disorder?

WITH CAUTION Some guidelines allow short-term antidepressant use alongside mood stabilizers in specific circumstances. However, most experts, including the International Society for Bipolar Disorder task force, caution against antidepressant monotherapy in bipolar disorder.

If my child is already taking an antidepressant and I have concerns, should I just stop giving it?

NO Never stop a medication abruptly. Instead, contact your child's prescriber right away to share your observations. Track and report any changes in mood, sleep, energy, or behavior. Ask directly whether a full mood disorder evaluation has been completed.

Are mood stabilizers a safer first-line treatment for possible bipolar disorder?

YES Mood stabilizers, particularly lithium, are the evidence-based first-line treatment for bipolar disorder at any age. They address both the highs and the lows, and do not carry the risk of triggering mania that antidepressants do.

THE CLINICAL EVIDENCE

A DOCUMENTED, SERIOUS RISK

When a child who actually has bipolar disorder is given antidepressants, the medication acts on a brain already vulnerable to dysregulation. Research shows antidepressants can accelerate cycling and worsen the long-term course of the illness (Ghaemi et al., 2003; El-Mallakh et al., 2008).

The kindling effect compounds this risk: each triggered mood episode lowers the threshold for future episodes, making them more frequent, more severe, and harder to treat over time.

WHAT RESEARCH TELLS US

A landmark review by Ghaemi and colleagues (2003) in the American Journal of Psychiatry found that antidepressants induced mania or hypomania in 25 to 40% of bipolar patients. A 2008 study by El-Mallakh found that long-term antidepressant use may cause a condition of "tardive dysphoria" -- worsening depression over time rather than relief.

Heritability research on bipolar disorder has consistently shown a child's risk of having bipolar is 15–30% higher than the general population if one biological parent has the disorder. That risk rises to 50–60% if both biological parents live with bipolar. So family history is an essential factor that must be considered during diagnosis and treatment planning.

> *"Everyone said it was depression and my child was prescribed an antidepressant. Within weeks she was up for days, not sleeping, her behavior became frightening. She was later correctly diagnosed with bipolar disorder. I wish someone had told us sooner."*
>
> A PARENT'S EXPERIENCE

UNDERSTANDING THE OVERLAP

Why Bipolar Disorder Gets *Missed*

Unipolar depression and bipolar depression share many symptoms: low mood, fatigue, difficulty concentrating, sleep changes, and loss of interest. But bipolar also includes mania, which in childhood involves distinct episodes of elevated or irritable mood that may be mistaken for anxiety, hyperactivity, or oppositional behavior. When these episodes are mistaken for unipolar depression and anxiety, providers reach for antidepressants which can treat those disorders.

THE DIAGNOSTIC CHALLENGE

Children with bipolar disorder often cycle rapidly, sometimes multiple times per day. Irritability, not euphoria, is frequently the dominant mood during manic episodes in children, and hypersexuality, grandiosity, and decreased need for sleep (key distinguishing signs) may present in unexpected ways in pre-pubescent children. Accurate diagnosis is a complex process and needs thorough evaluation before any antidepressant is prescribed.

Research from Lish and colleagues (1994) found that the average time from first symptoms to correct bipolar diagnosis is 8 to 10 years, during which patients often receive multiple incorrect diagnoses and ineffective or harmful treatments.

Five critical errors to avoid in differential diagnosis:

- → Failing to distinguish episodic mood changes from chronic depression
- → Looking for adult-style mania in children and teens
- → Attributing irritability, aggression, and rage to “extreme” depression or ADHD
- → Underestimating the importance of family history with bipolar disorder
- → Failing to make note of pleasant mood states between episodes

THE STANDARD OF CARE

Rule Out Bipolar Disorder *First*

Before any antidepressant medication is prescribed to a child or teen presenting with depression, anxiety, hyperactivity, or oppositional behavior, a thorough evaluation for bipolar disorder is the recommended standard of care. This requires gathering longitudinal information from family and caregivers about the child's mood patterns, going back years, not just a few months, and definitely not only during a single office visit.

> *“Physicians should consider bipolar disorder in any patient presenting with depression.”*
>
> AMERICAN ACADEMY OF FAMILY PHYSICIANS

A thorough evaluation should include:

- → Family history: Bipolar disorder has a strong genetic component. A first-degree relative with bipolar disorder raises a child's risk to anywhere between 15–60%
- → Sleep patterns: Decreased need for sleep without fatigue is a hallmark sign of mania, distinct from ordinary insomnia
- → Mood episode patterns: Look for distinct periods of irritable, elevated, or expansive mood that differ from the child's normal baseline, which may be pleasant
- → Assessment of aggression: Physical or verbal aggression and suicidal or homicidal ideation are not characteristic of unipolar depression, ADHD, or anxiety
- → Multiple informants: School reports, parent observations, and the child's own account across time all must be taken into account in the process of determining an accurate diagnosis

If you are unsatisfied with the evaluation, a second opinion is your right. Good clinicians welcome collaboration to ensure the patient is on the right path. You are your child's voice in this process.

> *You have the right to ask your child’s prescriber: “Has bipolar disorder been ruled out before starting this medication?” That question belongs in every conversation.*
>
> ON ADVOCATING FOR YOUR CHILD