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Pediatric Bipolar Disorder: Underdefined and Overdiagnosed

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Abstract

This article reviews literature surrounding the controversy of pediatric bipolar disorder (PBD). This is a topic that has been discussed and researched for decades and is still subject to debate. The validity of PBD as a diagnosis is examined, along with recurrent issues found in the disorder. These issues include the definitional, misdiagnosis, comorbidity, and pharmacological issues as well as the decision on whether to delay diagnosis and treatment in the childhood bipolar population.

Keywords: pediatric bipolar disorder, validity, mood disorders

A consistent debate in the field of psychopathology has been over pediatric bipolar disorder. Researchers have questioned the diagnosis, validity, and treatment of the mental illness (Carlson, 2022; Duffy, 2021; Malhi, 2021). Bipolar I disorder, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR), requires at least one lifetime manic episode and manic/depressive symptoms not better explained by another mood disorder such as schizophrenia (First and APA, 2022). A manic episode lasts at least one week and consists of three or more symptoms including grandiosity, decreased need for sleep, racing or flighty thoughts, distractibility, increase in goal-directed activity, and extreme involvement in high risk/harm activities (First and APA, 2022). When this diagnosis is given to children, it becomes a bit more difficult to distinguish. Mood lability, or rapid changes in mood, is common among those with bipolar I, but extreme happiness or irritability in a child is more expected. When those extreme emotions become consistent, differs from the child's normal behavior, and are accompanied by increased energy levels, it becomes clearer that a pediatric bipolar diagnosis can be made (First and APA, 2022).

This article reviews the literature regarding pediatric bipolar disorder (PBD), specifically focusing on the validity of the diagnostic criteria and assessment. This review presents four issues raised by psychologists about the validity of pediatric bipolar disorder (PBD) as a diagnosis. These issues have been identified from previous articles and studies discussing the recurrent debate surrounding this topic and include definition, misdiagnosis, comorbidity, pharmaceutical use and delayed treatment. The most common issue debated in the literature pertains to the definition and criteria of pediatric bipolar disorder Carlson, 2022; Duffy, 2021; Malhi, 2021. Pharmaceutical and treatment issues seem to occur as a result. Duffy (2021) describes some of the issues that arise including the use of diagnostic tools that have found reliable results that are not necessarily valid, as well as economic motivations to reduce the costs associated with research studies such as employing trained raters versus clinicians, health insurance, and pharmaceutical connections and/or interests.

The question of whether the validity of the diagnosis actually matters is often raised when discussing PBD (Duffy, 2021). Why does the diagnostic label matter if it results in children and families getting the help they need? To understand the importance of clear diagnostic criteria and validity, Mahli and Bell (2021) presents a good metaphor: If we assume we are fishing in the right part of the sea, do we have the best net to capture the fish, or know that the fish caught by that tool are the one's we are intending to catch? In other words, are the individuals identified in PBD research an accurrate representation of the group receiving the diagnosis or is the diagnosis leaving out others that should be included in the construct of pediatric

bipolar disorder. It is imporant to understand the validity of the PBD diagnosis in order to correctly identify individuals who meet the criteria for diagnosis, provide the best understanding of the illness to children and their families, decide the best treatment, and pursue further research into the illness.

Definitional Issues

While PBD is described under both the Bipolar and Related Disorders and the Depressive Disorders sections of the DSM-5-TR, there is no official diagnosis of pediatric bipolar disorder (APA, 2022). This lack of determined criteria for a diagnosis can mean that the diagnosis of PBD can be inconsistent among clinicians and researchers. Having the criteria for a disorder is beneficial for the development of diagnostic tools and assessment. Malhi and Bell (2021) claim that clinicians often make the diagnosis of pediatric bipolar disorder without using the proper assessment instruments or having specialized expertise. They refer to this diagnosis as PBud, or pediatric bipolar unconfirmed disorder. They posit that one of the issues they have with pediatric bipolar disorder is not that a diagnosis cannot be made but that it is often PBud diagnosed. Miller and Barnett (2008) suggest that the loose interpretation of the criteria for PBD is a major contributing factor to the increase in diagnosis. PBD should be diagnosed by a specialist using forms of assessment that are not only reliable, but valid so that there is accuracy among those providing such a diagnosis. Another issue raised by Malhi and Bell (2021) is that symptoms, such as irritability, may identify an illness, but not necessarily distinguish it.

Since the symptoms of mania and depression present differently in adolescents compared to adults, can it be as simple as being an adolescent or childhood form of adult bipolar disorder? Making valid and reliable diagnoses becomes even more complex once the impact of development on the presentation of mood disorder symptoms is considered. Carlson (2022) brings to the conversation a question of who the term “pediatric” refers to. Unless specified, it could refer to a young child, child or an adolescent. Research has shown that the peak onset age of bipolar and other related disorders is 19.5 years old (Carlson, 2022). This suggests that bipolar may begin early in life but is far less frequent in younger children. If an individual experiences a manic episode later in adolescence, one might look back at a depressive episode they experienced five years prior and consider if it was a prodromal, or initial, symptom showing early signs of bipolar onset (Carlson, 2022). Individuals diagnosed with bipolar have remembered symptoms beginning in childhood, often recalling depression, but there is no way to be confident in a pediatric bipolar disorder diagnosis until a manic outburst occurs (Carlson, 2022).

A study by Geller et al. (2008) addressed the following questions: “what predicts 8-year outcome?”, “what will be the characteristics of postbaseline episodes?”, and “will subjects with child Bipolar-I continue to have Bipolar-I as adults?” The last of Geller et al.’s research questions addresses the definitional concerns of PBD. Consistency between a pediatric bipolar disorder diagnosis and an adult bipolar diagnosis would suggest that the pediatric form of the disorder is predictive of the adult form, whereas an inconsistent diagnosis might suggest that what we consider PBD is not an earlier form of the adult disorder, but another childhood conduct disorder. The Geller et al. (2008) study used data from a prospective, controlled, blindly-rated National Institute of Mental Health funded study, “Phenomenology and Course of Pediatric Bipolar Disorders,” which has been ongoing since 1995. The study included both males and females aged 7 to 16 years old who had a current diagnosis of bipolar I, manic or mixed phase, for two weeks or longer, and at least one cardinal symptom. The cardinal symptom approach avoids diagnosing mania on symptoms that overlap between mania and attention-deficit hyperactivity disorder (ADHD) by requiring at least one cardinal symptom (grandiosity or elation) (Geller et al., 2008). The assessment involved a Children’s Global Assessment Scale, requiring a score of 60 or less to signal clinically significant impairment, a semi structured interview, WASH-U-KSADS, which has high reliability for mania symptoms, mood diagnoses, daily cycling, and time frames, as well as the Psychosocial Schedule for School-Age Children-Revised, which is used to obtain information from the mother and child about the child’s relationships. These assessment were administered by blind research nurses to both mothers about their children and the children about themselves. The baseline instruments were administered again at the 6-, 12-, and 18-month and 2-, 3-, 4-, 5-, 6-, and 8-year follow ups. Different raters were used when assessing a mother and child in the same family to avoid bias and new raters were brought in for the follow ups at years 6 and 8. The results of this study found that 28.4% of subjects who were originally diagnosed with ADHD switched to a bipolar I diagnosis during follow up assessments (Geller et al., 2008). At the 8-year follow up, there was a mean of 2.0 manic or mixed mania episodes among subjects which were characterized similarly to the first baseline episode but were significantly shorter in duration. The idea of continuity between child and adult bipolar I is supported by the 44.4% frequency of manic episodes found in subjects who had reached 18 years or older by the end of the study, which is considerably higher than population prevalences (Geller et al., 2008). These subjects who were 18 years or older also scored significantly lower on the CGAS during the second and third episodes.

An additional issue regarding the defined criteria of pediatric bipolar disorder are the phenomenological issues of episodes and cyclicity discussed by Miller and Barnett (2008). They question whether discrete episodes are necessary to make a diagnosis, how long symptoms must endure, and at what point does an illness become chronic. An episode is the period that a

mood state or ultra rapid cycling lasts, with a minimum of two weeks. A cycle is the frequency of mood changes occurring during an episode which can range from several times a day to every couple of days (Miller & Barnett, 2008). Frequent and severe changes in mood, or mood lability, among adolescents with bipolar can suggest a chronic state or suggest a new cycle of illness with each mood change. In the DSM-5, it is stated that bipolar disorders are episodic, whereas a new addition to the depressive disorders category, disruptive mood dysregulation disorder, consists of persistent severe irritability. This means that mania requires fluctuations in mood and the irritability present in pediatric bipolar disorder must differ from the child's usual baseline state.

Diagnostic Reliability or Validity

Understanding the defining criteria of pediatric bipolar disorder is important in providing diagnostic reliability and validity. Duffy (2021) suggests that an unwarranted or premature diagnosis of PBD might lead to a misunderstanding of the problem resulting in medications that are not necessary or will not address the underlying issues and therefore cause potential long-term effects on development. Carlson (2022) provides an example of how "different lenses view the same data and draw different conclusions" meaning that two different sources or observers (such as parent and child or parent and practitioner) might see the same behavior and come to different conclusions about the child's illness.

Additionally, reconciling information from multiple sources does not always lead to a consistent diagnosis (Carlson, 2021). Malhi et al. (2023) claims that results within the same cohort can vary depending on who is conducting the assessment. A parent or caregiver might report signs of PBD in their child who is then admitted to an inpatient or day program to be observed by trained staff. According to Carlson (2022), over the course of a month of inpatient observation, a third of children hospitalized with PBD have the diagnosis ruled out.

An article by Singh et al. (2020) shows support for the validity of pediatric bipolar as a diagnosis. They state that most researchers in the field of PBD agree on the use of systemized, semi-structured interviews to make a diagnosis. This approach is often not utilized in clinical care settings due to time constraints, but there are a variety of other accessible scales that have been tested and offer large improvements in accurate diagnosis. Other authors question the use of epidemiologically developed instruments in clinical practice because diagnosis in epidemiological studies is often made based on one interview that does not include assessment of mental state. The results of these studies can therefore differ from the findings in a clinical setting that has more contextual information about a patient and more interview opportunities to make a diagnosis. This suggests that there might be an inconsistency in who might be diagnosed in an epidemiological setting versus a clinical setting.

A longitudinal study conducted by Biederman et al. (2009) examines the predictive efficacy of the Child Behavior Checklist Pediatric Bipolar Disorder (CBCL-PBD) profile in a sample of ADHD adolescents. The CBCL-PBD is a questionnaire that can be beneficial for more easily recognizing youth at risk of developing bipolar disorder since it does not require clinical administration or interpretation. The researchers hypothesize that a positive CBCL-PBD profile would predict a bipolar disorder diagnosis as well as being associated major depression, conduct disorder, and psychiatric hospitalization due to the high rates of comorbidity with PBD. A significant increase in risk for bipolar, major depression, and conduct disorders was found among participants with a positive CBCL-PBD score compared to those with a negative score (Biederman et al., 2009). Biederman et al. (2009) states that these findings support the use of CBCL-PBD to indicate future risk for a bipolar diagnosis and therefore be used as a tool to predict a bipolar disorder diagnosis. While the CBCL-PBD profile may indicate risk, it is not an assessment that should be used for a diagnosis (Biederman et al., 2009). Many of the participants who had a positive profile in Biederman et al.'s study did not receive a bipolar disorder diagnosis. This calls into question the relatedness of pediatric bipolar disorder and adult bipolar disorder, and whether the former is an earlier form of the latter or just indicative of it's development.

Another key issue in the validity of the pediatric bipolar disorder diagnosis is the high rates of comorbidity with other conditions that can blur the lines of which illness a symptom might indicate. According to Carlson (2021) and other PBD research, there are high rates of comorbidity with ADHD, anxiety, and other neurodevelopmental disorders among children with pediatric bipolar disorder. Carlson discusses a meta-analysis regarding rates of bipolar disorder and ADHD in adults, the results of which find that pooled comorbidity of any ADHD diagnosis in the bipolar sample was 17.11% (95% CI:13.05-221.59) and rate of bipolar in the sample of ADHD individuals was 7.95% (95% CI: 5.31-11.06). It is more likely to identify a comorbid diagnosis of ADHD in those diagnosed with bipolar than it is to identify a comorbid diagnosis of bipolar I in a sample of ADHD individuals, suggesting that the likelihood of over diagnosing PBD in children with the symptoms that overlap in PBD and ADHD is low. Carlson (2021) suggest that there are many potential reasonings for the heterogeneity such as having more informants lowers the rate of diagnosis.

Malhi et al. (2023) states that symptoms that are not specific to bipolar and are typical in children can conceal signs of the illness, especially if they receive treatment for such symptoms. This is another reason that it is important to have clear understandings of the criteria for diagnosis. Since mood swings and varying sleeping and eating habits can be common

adolescent behavior, additional symptoms of hyperactivity might be looked at by itself and result in a child receiving an ADHD diagnosis. Or a child with disguised mania symptoms could receive treatment for depression which would only resolve the depressive aspect of bipolar disorder. It is not easy to distinguish manic symptoms that could easily be confused with symptoms of other conditions.

Misdiagnosis

In the Malhi and Bell (2021) article, they assert that many adults diagnosed with bipolar have precursors in childhood that are not captured by PBD or PBud and are therefore misdiagnosed or missed altogether. Some children with ADHD as well as irritability might be diagnosed with PBD (Miller & Barnett, 2008). There is research looking at what specific symptoms might distinguish PBD from other disorders such as ADHD. The symptoms to make this distinction likely include mania criteria such as elated mood, grandiosity, decreased need for sleep, etc. Research has found that these mania symptoms are more significantly common in bipolar children when compared with children with ADHD. For example, in a sample of bipolar and ADHD diagnosed children grandiosity has been found to be a symptom in 85% of bipolar children compared to 6.7% of those diagnosed with ADHD. There is potential that this support makes these symptoms better distinguishers of bipolar than symptoms such as increased energy and distractibility which often occur in both mania and ADHD (Miller & Barnett, 2008).

Miller and Barnett aim to understand whether pediatric bipolar disorder should require a presentation of euphoria and/or grandiosity to be diagnosed. The concern is that irritability is not exclusive to PBD and can occur in a variety of other conditions and should not be assumed to be a symptom of PBD. It has been found that irritable mood alone was more commonly found in children with bipolar I than irritable mood plus euphoria, and much less common for reports of euphoria with no irritability (Miller & Barnett, 2008). However, this could also suggest that there is potentially an overdiagnosis of PBD given to children who report symptoms that might identify PBD, but do not report symptoms of bipolar I that can distinguish PBD as the correct diagnosis.

If mania symptoms such as grandiosity can help distinguish bipolar, what are the criteria used to define these symptoms? This is another question that requires clearly defined criteria for mania. The symptoms of mania seem to be the best factors in determining a bipolar I diagnosis in children, but like other aspects of pediatric bipolar disorder there seem to be inconsistencies in what behaviors or mentalities fall under those terms. What someone, such as a parent, defines as mania, might differ from staff at an inpatient psychiatric facility. Research has found that manic symptoms are more highly reported by parents (>80%) in a pediatric inpatient psychiatric population compared to only 62.5% of the patients evaluated as manic by research staff (Miller & Barnett, 2008). Another study discussed by Carlson (2021) looking at bipolar disorder in adults using structured interviews found that the diagnosis lacked stability with half the sample having a shift in their diagnosis over a 10 year period, as well as one third shifting to a schizophrenia spectrum disorder and another third failing to be diagnosed.

Misdiagnosis can also occur in the opposite direction. Malhi et al. (2023) state that early in life the illness is only starting to present itself with mood disorder symptoms. These subtle symptoms can often be disguised by developmental changes that are normal in this stage of adolescence. This makes diagnosis of pediatric bipolar that much harder than adult bipolar. Irritability for example can be mistaken for adolescent angst. Other signs of bipolar such as varied eating and sleeping habits can be accounted for by a normal adolescent experience. Pediatric bipolar disorder is not a homogenous category due to the developmental context that needs to be considered when making a diagnosis (Malhi et al., 2023). Pre-adolescent children have limited experiences and the language to communicate their emotions and mental state compared to an adult or even a 17-year-old. It might be reasonable to place an emphasis on the symptoms that are clearly evaluated in children as they are easier to identify compared to more cognitive and emotional symptoms of mania. This would include decrease in eating and sleeping habits compared to racing thoughts.

The Malhi et al. (2023) article also discusses the ongoing concern over the misdiagnosis of childhood and adolescent bipolar disorder and the approach to classification and diagnosis. Clinicians, researcher and taxonomists operate interdependently as the work done in each field impacts the others and is assuming that the experts in each field are operating with the same understanding of bipolar disorder. Malhi et al. claims this assumption is incorrect, leading to inconsistencies in the criteria of research participants and clinical patients. The authors attempt to determine the prevalence of pediatric bipolar disorder, a question raised and critiqued in prior studies. The study finds that there is significant variance in the reporting of PBD's prevalence which is likely due to a lack of consistency in applying definitions (Malhi et al., 2023). It is an issue that clinicians often rely on their clinical judgement to make a diagnosis, suggesting the patients with subjective clinical diagnoses will not be captured by research studies that use different inclusion criteria.

Pharmaceutical Issues

According to Malhi and Bell (2021), by using treatments meant for bipolar in adults for what is supposedly an earlier form of the illness, it is assumed that PBD and bipolar in adults are the same illness. This allows for pharmacotherapy developed to address adult bipolar to be administered to younger patients. The controversy surrounding this is whether psychotherapeutic drugs should be administered to adolescents whose brains have not fully developed. Malhi & Bell claim that the diagnosis of PBD is flawed and that there is not enough research determining that the underlying emergent pathology is similar to that of established bipolar in adulthood. To put it differently, there is not enough support to determine if the set of symptoms identifying pediatric bipolar disorder is due to the same illness as the adult form of bipolar I, or if it should be considered its own disorder that requires its own research and treatment.

Treatments of bipolar have not been adequately researched in the adolescent demographic to fully understand the long-term effect of pharmacotherapeutic drugs on the brains and bodies of children. According to Miller & Barnett, a bipolar diagnosis might lead to treatment with a mood stabilizer and/or antipsychotic which are common medications used for bipolar. However, these drugs are associated with a large risk of adverse effects among children and adolescents. The risks associated with drug treatments are an important consideration if a patient's diagnosis is not 100% certain given the potential harm developmentally. Children and adolescents are a demographic that deserve to have proper research conducted to determine the best course of action regarding PBD, whether that's therapeutic or pharmacotherapeutic. Proper research on pediatric bipolar disorder to develop treatments cannot be done until the experiences of those who have it is better understood.

Delayed Treatment

By not providing a pediatric bipolar disorder diagnosis, there is a possibility that treatment is delayed. There are pros and cons to this delay of treatment. On one hand, it allows for symptoms to more fully develop allowing for more clear boundaries of the illness. By waiting before prescribing medications, unnecessary harm might be avoided. On the other hand, it is commonly argued that delaying treatment can "increase the risk of morbidity, mortality and illness progression" (Singh et al., 2020). If PBD is treated when it first emerges, then it can reduce the stress on the child and their family, prevent disruptive behavior, and avoid more mental harm.

In response to an earlier Malhi et al. article, Singh et al. (2020) agrees that the definition of PBD should reflect the experience of patients and have clinical utility as to not misdiagnosed. They also argue that the 'wait and see' method proposed by Malhi et al. results in a delayed treatment, which dismisses the harm associated with PBD. In response to Singh et al., Malhi & Bell (2021) argue that the 'wait and see' approach that they suggest does not mean that nothing can be done in terms of treatment, but it is more simply waiting to label the illness with a diagnosis. The method allows clinicians to treat the symptoms that can be addressed with behavioral interventions to minimize harmful side effects as well as allow for time to see how the illness presents and progresses.

In support of their argument, Singh et al. (2020) discuss the frequency with which bipolar disorder runs in families. When the context of family history is considered, childhood manic symptoms are likely to be an early age onset of bipolar. With that understanding, being able to identify PBD in children with a family history of bipolar disorder should allow for quicker treatment and remission of symptoms so the child can live as normal a life as possible. The current pharmacological therapies used for adult bipolar disorder can lead to side effects such as increased weight gain and other developmental risks. Singh et al. Argues that these risks should be balanced against the risk of suicide and psychosocial harm from a lack of treatment.

In support of their argument, Malhi et al. (2023) suggests not diagnosing bipolar disorder prior to puberty to account for natural changes in development and to simply maintain awareness of the range of symptoms that may develop into bipolar. This would mean addressing the symptoms themselves through other means such as therapy, while watching for mania that is a clear separation from adolescent angst and irritability.

Malhi et al. (2023) also discuss how bipolar often first presents as depressive episodes, and only later does mania begin to present. A definitive diagnosis of bipolar cannot be made until then. There are no means of distinguishing major depression from bipolar depression, which is why it is often first misdiagnosed as depression and delays treatment of the true underlying illness. It would in that case be more harmful to prematurely diagnose an illness since it would result in a later diagnosis of the bipolar illness. In cases where mania happens to present first, the criteria for mania cannot be directly applied to children due to the difference in how symptoms are experienced at different ages. In adulthood, mania in the form of impulsivity or grandiosity can have harmful risks financially or to their relationships. In childhood, these risks are less of a concern or less noticeable due to the lack of responsibilities held at a young age.

If it were possible to make a clear definition of pediatric bipolar disorder and identify the group that requires treatment, the question to ask is: do the benefits outweigh the risks to develop a new effective treatment for bipolar in the adolescent demographic?

Conclusion

To summarize the points of the literature reviewed in this article, there is much debate regarding the diagnosis of pediatric bipolar disorder. The common points discussed by the experts in the field surround the definitional issues (including the validity of assessments), misdiagnosis, comorbidity, use of pharmacological treatments, and the delay in diagnosis and treatment. The definitional issues are found to be a lack of consistency in clinical and epidemiological interpretation of the bipolar I disorder criteria and their application to children and adolescents. The misdiagnosis issues are due to the overlapping symptoms of bipolar disorder and other conditions such as anxiety, depression and attention-deficit hyperactivity disorder. These conditions are often found to be comorbid with pediatric bipolar disorder and can lead to blurred diagnostic lines. Pharmacological treatments are under researched among children and adolescents with bipolar disorder, leading us to have a lacking understanding of the effects the treatments have on development. A delay in treatment might lead to progressing illness and disruption in a child and their families lives, but it could also allow time for further understanding of the child's experience and symptoms.

This review finds that the boundaries and criteria should be more clearly defined to avoid misdiagnosis and to conduct research using the most accurate sample of the pediatric bipolar population. It is important to have a clear understanding of the problem that is being assessed, and the diagnosis being made.

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