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Debate: Fomenting controversy regarding pediatric bipolar disorder

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Abstract

Does bipolar disorder exist in children? How common is childhood-onset bipolar disorder among adults? Are bipolar spectrum conditions relevant? Answers to these questions are key drivers of the design and interpretation of epidemiologic studies of pediatric bipolar disorder. In our commentary, we assert that Parry and colleagues have selectively attended to certain findings that support their thesis, while ignoring contradictory findings, and that they have assigned excessive meaning to relatively pedestrian methodologic limitations. Their singling out of the United States is done with criticism but without critical appraisal. We highlight the flawed logic and inferential leaps that sustain Parry et al's criticism despite contradictory information dating back over a century.

Keywords

Bipolar disorder; adolescence; paediatrics; stigma; epidemiology

The article by Parry et al. (Parry, Allison & Bastiampillai, 2018) meanders from epidemiologic studies, to administrative claims and hospitalization datasets, to commentaries regarding some of the American clinical studies from a quarter century ago that brought the concept of childhood bipolar disorder to the fore. Parry et al selectively focus on certain facts while ignoring others, providing the appearance of a rationale for their outdated invective regarding the concept of bipolar disorder in a child. Titles of Parry et al.'s prior publications refer to pediatric bipolar disorder as “a hypothetical disorder” and “a controversy from America”, reflective of “mindless psychiatry”. This type of uninhibited

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Ethical Approval

No ethical approval was required for this commentary.

vitriol is also evident, albeit in a somewhat more buttoned-down fashion, in their current article. The current article is *prima facie* anti-psychiatry and stigmatizing to patients and families, replete with toxic biases for which science and sincere discourse have no antidote. We applaud the measured, thoughtful, and restrained response by Van Meter et al. (Van Meter, Moreira & Youngstrum 2019), and highlight here three additional areas of concern regarding the article by Parry et al.

1. Espouses doubts regarding the existence of bipolar disorder in children

The article by Parry et al has “paediatric bipolar disorder” in quotes. The quotation marks in this instance are equivalent to saying so-called pediatric bipolar disorder. Certainly, there is a paucity of literature regarding the epidemiology of bipolar disorder in pre-pubertal children. As a result, it is less clear how common bipolar disorder is in children as compared to adolescents and adults. However, as clinicians who have treated children with bipolar disorder, and seen the impact of this condition on them and their families, and as researchers who are keenly aware of astounding delays in treatment among adults with childhood-onset bipolar disorder, we take exception with those who question the very existence of bipolar disorder in children. Parry et al, believing as they do that pediatric bipolar disorder does not exist, or is exceedingly rare, have assigned excessive meaning to pedestrian methodologic limitations in epidemiologic studies that yielded findings discordant with their views. We remind them that similar claims were made regarding pediatric depression not long ago, whereas, WHO reports confirm that depression is the leading cause of disability worldwide starting at age 10.

2. Makes false assertions regarding expected age of onset and prevalence of bipolar disorder:

Peppered throughout the manuscript are declarative statements about what the typical onset age of bipolar disorder is and ought to be. Those statements are aside from the point of the manuscript, and serve to confirm that the article was written with an anti-pediatric bipolar disorder slant. Parry et al’s abstract concludes “the reanalysis suggests that bipolar disorder is rare before the expected age of onset in later adolescence”. Kraepelin himself stated that the peak onset of bipolar disorder begins at age 15, and acknowledged occurrence in childhood. Perhaps Parry et al would characterize Kraepelin as a “mindless” psychiatrist—we do not. Numerous adult bipolar disorder studies, including representative epidemiologic studies and large-scale clinical studies, report retrospectively determined age of onset in childhood, and in such cases treatment delay is prolonged and the severity of bipolar disorder is greater—and remains greater over prospective follow-up (Goldstein & Levitt, 2006). Post and colleagues have examined factors that may underlie the higher rates of childhood-onset bipolar disorder in the United States as compared to Germany and the Netherlands, and these include greater loading of psychiatric disorders among parents and grandparents, greater childhood adversity, and increased medical burden (Post et al., 2017).

Even if it was true that the prevalence of bipolar disorder in children is meaningfully higher in the U.S. than in other places, why would that undermine the validity of the diagnosis? There are major spikes in suicide among Japanese adolescents related to the return to school on September 1st (Matsubayashi, Ueda & Yoshikawa, 2016). Similarly, Canada has the highest rates of multiple sclerosis in the world. Yet no one would add insult to injury by attributing these incidences to “controversies from Japan/Canada”.

3. Minimizes the impairment and severity of the bipolar spectrum:

Bipolar spectrum conditions in youth (i.e. distinct episodes of hypomania that fall short of the number, duration, and/or severity of full-fledged manic symptoms) have as much comorbidity, impairment, and family history of bipolar disorder as compared to bipolar I disorder (1,6). The burden of bipolar spectrum conditions is also seen in adults internationally. As Merikangas concluded in a worldwide epidemiologic study on the topic, “despite cross-site variation in the prevalence of bipolar spectrum disorder, the severity, impact, and patterns of comorbidity were remarkably similar internationally” (Merikangas, 2011). An added concern in youth is that bipolar spectrum conditions have high rates of diagnostic conversion to bipolar I or II disorder (Axelson, 2011). It is clear that there are diagnostic, prognostic, and therapeutic implications of bipolar spectrum conditions, and for the majority of individuals with bipolar spectrum conditions--who go untreated--rhetoric will not help.

Conclusion

Worldwide, including the U.S., there are low rates of treatment and prolonged treatment delays for people with bipolar disorder. Even with appropriate treatment, a substantial proportion of people with bipolar disorder remain impaired with mood symptoms combined with anxiety, substance use disorders, and neurocognitive dysfunction—this is especially true for those with early-onset bipolar disorder. Let us agree that more work needs to be done to establish reliable and valid estimates of the prevalence of bipolar disorder in children; but let us first begin with the acknowledgment that childhood bipolar disorder exists. *We are baffled by the fact that this needs to be said in 2018.* There are also gaps in epidemiologic data regarding stroke and multiple sclerosis in children, but the existence of those conditions in children is not questioned. If one accepts—as we do—that 1) bipolar disorder is truly a brain disease, and 2) children truly have brains, why would one think children cannot have bipolar disorder?

The authors have a set-up a flawed argument based on inferential leaps: if prevalence estimates are uncertain, therefore the premise of pediatric bipolar disorder is flawed, therefore we can keep telling ourselves it’s an American problem, and a problem that isn’t clearly a problem at that. While it is true that we need more data regarding the international epidemiology of childhood bipolar disorder, we do not need more data to reach the conclusion that children can and do have bipolar disorder and suffer inordinately from it. Slandering pediatric bipolar disorder, and those practitioners who diagnose and treat these children, is unethical, destructive, and does little to help the station of those children and families impacted by one of the most pernicious of all medical conditions.

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