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Isn't the evidence base for pediatric bipolar disorder already sufficient to inform clinical practice?

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In the May 6th Issue of the *Australia and New Zealand Journal of Psychiatry*, Malhi et al published a *Reflection*¹ asserting that the use of the term pediatric bipolar disorder (PBD) should be abandoned. Referencing unreplicated studies and dated citations, the authors incorrectly infer from administrative database studies that rates of bipolar disorder diagnoses are rising among youth, critically missing that the number of *visits* with a bipolar diagnosis increased markedly, not necessarily the number of children with the diagnosis. That visit numbers increased so dramatically more likely reflects that these children were quite ill and needed ongoing treatment, a conclusion supported by multiple prospective follow-ups, and epidemiological studies that report PBD rates as similar across national boundaries, providing no evidence of “shifting sands.”

Dr Malhi and colleagues propose that in lieu of diagnosing bipolar disorder in children, we should “wait and see.” Undoubtedly, our nomenclature should accurately reflect a patient's experience and have clinical utility, taking care to avoid misdiagnosis or added stigma. As PBD clinicians and researchers, we have not observed that youth simply outgrow their symptoms. The long-term result of “wait and see” has been delayed treatment, and increased risks for morbidity, mortality, and illness progression. “Wait and see” trivializes the dysfunction and harm associated with PBD. If one wanted to be ultra-conservative about the

diagnosis and its treatment implications, a clinician could at minimum take a parent's concerns seriously and longitudinally assess symptoms so that progression and need for treatment could be accurately visualized (eg, www.bipolarnews.org, Child Network tab). When parents provide this information to clinicians, the trajectory of symptoms and the inadequacy of current treatment efforts are readily observed.

Dr Malhi and colleagues also argue that adult diagnostic criteria should not be applied to youth with BD since youth are different from adults. This argument contradicts the consensus longitudinal findings in the International Society for Bipolar Disorders Task Force Report that PBD is often recurrent and progressive, and has comorbidity and treatment response patterns that are congruent with adult bipolar disorder.² Indeed, the very observations that PBD often manifests with subtypes, as well as with subthreshold, inter-episodic, and mixed mood states are conceptually aligned with Emil Kraepelin's observations from a century ago that bipolar disorder occurs in juveniles and that these illness features “represent manifestations of a single morbid process.” Malhi et al's argument also disregards some of the pioneering work of the late Dr Barbara Geller, who dedicated her career to validating PBD. Dr Geller addressed developmental context by taking adult criteria and applying them in an age-appropriate way, providing a reliable approach that distinguishes PBD from healthy counterparts. Through the use of a semi-structured clinical interview, she established that youth with PBD have levels of grandiosity, exuberance, and reduced insight that are clearly impairing and distinguishable from healthy agemates,³ and may continue having manic symptoms into adulthood.

Most leading researchers in the field agree on systematized, semi-structured interview-based approaches to a PBD diagnosis. However, due to the time constraints in managed care settings, such approaches are not typically implemented. For clinicians who train in using tools such as the Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia, the semi-structured interview is invaluable for diagnostic confirmation and treatment planning. There also are other readily accessible scales that have been tested extensively, offering large improvements in diagnostic accuracy.

The intensity of mood symptoms in PBD is not just experienced by the child: it is observable by parents and teachers across multiple settings. Behaviors such as hypersexuality, suicidality, grandiosity, and a decreased need for sleep cause significant multi-domain impairment that cannot be mistaken for “age-appropriate expressions and behaviors in children,” regardless of country of origin.² We agree that irritability alone is nonspecific in youth, just as it is in adults, which is why additional symptoms of mania are needed in order to make a diagnosis of PBD (four instead of three) when the index mood is only irritable. When a child receives a systematic diagnosis of PBD using semi-structured interviews, irritability is accompanied by elation in most cases. Dr Malhi and colleagues' concerns about trans-diagnostic symptoms can be equally applied to the other diagnoses they cite (eg, major depressive disorder (MDD) and attention deficit with hyperactivity). Should those diagnoses also be abandoned? In the Diagnostic and Statistical Manual field trials, most childhood disorders showed abysmally low reliabilities (whether based on child, teacher, or parent reports), but PBD was found to be more reliable than MDD and the yet to be validated disruptive mood dysregulation disorder.

Another omission from this article is consideration of the significant role of family history of bipolar disorder, which, when present in a child with subsyndromal manic symptoms, portends an earlier age of onset and increases the likelihood of diagnostic conversion to syndromal bipolar disorder. Indeed, there are now empirically derived risk calculators for the early onset of bipolar disorder that reliably show that early signs and symptoms appear years prior to syndromal onset and are often associated with significant functional impairment, much like adult forms of bipolar disorder. Bipolar disorder frequently runs in families, and although onset of illness occurs commonly during adolescence in familial bipolar disorder, a substantial group of illness onsets also occur during childhood. An early age of onset of bipolar disorder in a child's parent is an independent risk factor for a bipolar spectrum diagnosis converting to syndromal bipolar I or II disorder. Indeed, increased prevalence of the same disorder among family members is one of the five key criteria for validating a disorder proposed by Robins and Guze.

In planning early interventions for youth with these risk phenotypes, we must consider the appropriate balance between the risks and benefits of psychotherapeutic and pharmacological approaches for complex symptom presentations.⁴ The fact that youth with PBD may be at increased risk for such pharmacologically induced adverse effects as weight gain and metabolic syndrome must be balanced against their increased risk for suicide and severe psychosocial impairment when not treated. The worst consequence of abandoning a PBD diagnosis is that it would virtually preclude pursuit of effective new treatments.⁵ Interventions in adults with bipolar disorder are not as well delineated as one would want either.

Diagnostic orphans in psychiatry do not lend themselves to good prognostic outcomes. Dr Malhi and his associates propose alternative formulations of PBD such as “child-parental relationship problem” (blame the parents) or “externalizing disorder” (blame the child), which are perilous in their own right. Debating the prevalence of PBD is reasonable. However, denying the existence of PBD is poor medical practice, poor science, and risks setting the field back 25 years. So, we ask Dr Malhi, if PBD should be abandoned, how should youth who meet criteria for bipolar disorder be categorized and treated?

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