

AT ISSUE:

The Questionable Legitimacy of Pediatric Bipolar Disorder

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Until relatively recently, a diagnosis of bipolar disorder in children under the age of 12 was extremely rare. Before the 1990s, it was generally accepted that bipolar disorder was typically first expressed in the late teens or early 20s. In the past 20 years, there has been a 40-fold increase in the number of children and adolescents diagnosed with bipolar disorder. This diagnosis is varyingly referred to as juvenile bipolar disorder, pediatric bipolar disorder, or childhood bipolar disorder. There are inconsistencies in the age range of children who are included under this diagnosis, as some researchers and clinicians include adolescents in these diagnostic categories, and others include only prepubertal children (up to ages 10–12). In this article, I focus on diagnosing bipolar disorder in prepubertal and very young children, and I use the term *pediatric bipolar disorder* (PBD).

Assigning a diagnosis of bipolar disorder to children has been the subject of great controversy and debate (Carlson et al., 2003). However, consensus exists that the documented rates of PBD have increased exponentially. Harris (2005) reported that 25% of children between the ages of 3–13 who were seen at an inpatient child assessment unit had been diagnosed by their outpatient therapists as having pediatric bipolar disorder, and these children had routinely been prescribed mood stabilizers or antipsychotic drugs, or both. Harris also noted that the parents of another 25% of the children on her unit believed that their children had pediatric bipolar disorder and had asked that their children be medicated for this condition. In my own clinical practice, I have seen children as young as age 3 who entered our clinic with a prior diagnosis of PBD. Again, all of these children had been prescribed antipsychotic or mood stabilizing drugs.

Clinicians agree that we know less about bipolar disorder in children than in adults, and the diagnosis of pediatric bipolar disorder has been referred to as a *high-stakes decision* (Youngstrom, Findling, & Feeny, 2004). If a child actually has bipolar disorder and the diagnosis is missed (a false negative), the developmental consequences for the child are unclear. We do know that in adults, bipolar disorder tends to be progressive, and there is evidence that intervening in the early stages of the disorder can be beneficial. Moreover, giving stimulant or antidepressant medications to adults with bipolar disorder can trigger or exacerbate manic episodes (DelBello et al., 2001). These points suggest that

there might be better outcomes for individuals who develop bipolar disorder if we intervened earlier, even if we are not completely sure of the diagnosis.

However, the consequences of making a false positive diagnosis—that is, diagnosing a child with bipolar disorder and subsequently determining he or she does not meet the criteria for the condition—can have negative consequences. Children diagnosed as having PBD are almost always medicated with drugs such as lithium, Seroquel, Geodon, Risperdal, and Abilify, among others, that have serious side effects. Indeed, the drugs typically used for the treatment of bipolar disorder have far more serious side effects than do medications used for other childhood disorders (Findling, Feeny, Stansbrey, Delpuerto-Bedoya, & Demeter, 2002). Even more concerning is the fact that none of these medications have been well studied in young children. A core question in this debate, then, is How accurately can bipolar disorder be diagnosed in young children? Moreover, if children are given this diagnosis, how confident are we that they will continue to meet the criteria as adults?

Bipolar Disorder in Adults

Bipolar disorder has long been a common diagnosis for adults, and it is often seen in adults who are involved in the child welfare system. It is a debilitating and chronic mental illness that frequently interferes with parents' or caregivers' ability to safely and effectively care for their children. We have well-established and well-researched criteria for the diagnosis of bipolar disorder in adults and adolescents ages 15 and older. Careful adherence to the diagnostic criteria in the DSM-IV-TR, particularly around the presence of manic episodes, allows for an accurate differential diagnosis of bipolar disorder in these populations. Most clinicians can clearly articulate the characteristics of adult bipolar disorder and can confidently identify it.

We also have a good understanding of the etiology of the disorder. Adult bipolar disorder is clearly understood to be a genetic disorder; it is estimated that in 93% of cases, the etiology of bipolar disorder can be identified as inherited (Kieseppa et al., 2004). The mean age when bipolar disorder expresses in adults is the mid-20s. The inherited genes express in a clear pattern of changes in neurotransmitters that lead to cyclical disruptions of mood. Bipolar disorder in adults is a very stable and debilitating condition. Its characteristic mood

instability tends to reoccur over the life span and is best viewed as a chronic and persistent mental illness. It is associated with high rates of hospitalization, unemployment, and suicide (Harrow et al., 1990; Angst et al., 2002). From a child welfare perspective, many parents who meet the criteria for bipolar disorder struggle to provide safe and adequate care for their children.

A primary component of bipolar disorder in adults is the presence of episodic and significant mood changes. The DSM-IV-TR indicates that these mood states must be significantly different from a normal mood state, and they must last from several days to many months. Most, but not all, adults with bipolar disorder exhibit mood shifts between depressive and manic or hypomanic states (Johnson & Leahy, 2004) and display typically neutral mood states in between. The cardinal characteristics of true manic episodes in adults are a decreased need for sleep, pressured speech, racing thoughts, and a high level of distractibility.

There is a robust literature supporting the use of psychotropic medications as a first line of treatment for adults diagnosed with bipolar disorder. As mentioned above, adult bipolar disorder is a strongly genetic disorder that results from an imbalance of neurotransmitters. Most clinicians endorse the use of mood stabilizers as a core component of treatment. Several psychosocial treatments, such as cognitive behavioral therapy or social rhythm therapy, are commonly used in conjunction with appropriate medications.

Broad consensus exists, then, about the existence, diagnostic criteria, and recommended treatment for adult bipolar disorder. When it comes to pediatric bipolar disorder, however, no consensus exists on these points.

Bipolar Disorder in Children—Shifting the Diagnostic Rules

We can trace back the staggering increase in the diagnosis of bipolar disorder in children to the mid-1990s, when Dr. Janet Wozniak joined a research lab at Massachusetts General Hospital. The lab was headed by Dr. Joseph Biederman. Dr. Wozniak became interested in children with attention deficit hyperactivity disorder (ADHD) who were very difficult to treat. She noticed a subgroup of her young clients who had periodic rages. She felt their behaviors, including kicking, biting, and screaming, were extreme. Dr. Wozniak decided these extreme behavioral outbursts were not the result of the impulsive aspects of ADHD. She made a conceptual leap and concluded that the aggressive behaviors she was observing were the result of undiagnosed bipolar disorder. She and Dr. Biederman, along with other colleagues, wrote a series of articles positing that many children who were diagnosed with ADHD actually met the criteria for bipolar disorder. In particular, they argued that the behavioral outbursts seen in some children were actually symptoms of mania (Biederman et al., 2000).

A major diagnostic sticking point accompanied this new diagnosis. As mentioned, the DSM describes bipolar disorder as episodic in nature, specifying that affected individuals display episodes of depression, mania, and intervening neutral mood states that are different from each other and should last a week or more. The children described by Wozniak and Biederman rarely had these long and discrete mood states. Instead they exhibited brief and frequent rages that could occur many times during a single day. To resolve this problem, Biederman's group, along with other researchers, suggested that bipolar disorder had a different presentation in children and that it included rapid or ultradian cycling. Instead of the sustained mood states observed in adults, children could exhibit many mood shifts within a single day and experience quick and extreme bursts of anger or rage. Biederman and colleagues suggested that children with bipolar disorder therefore presented with a different phenotype and labeled this disorder bipolar NOS, or *not otherwise specified*. To treat these mood states, Biederman and colleagues recommended adult mood stabilizers and antipsychotic medications.

Biederman and colleagues' articles had a tremendous impact on how oppositional behavior in children was conceptualized and treated. From that point forward, there was an exponential increase in the diagnosis of bipolar disorder in children and a concurrent increase in the use of mood stabilizers and antipsychotic medications to treat them. These medications were a sharp divergence from the well-researched and well-understood medications for ADHD. A number of researchers subsequently advocated that these medications be used for children as young as age 3 (National Institute of Mental Health [NIMH], 2001).

Opponents to Biederman's research raised a number of objections, many of which had to do with assessment assumptions and with methodology. These concerns will be addressed subsequently in more detail. One less commonly cited criticism is related to money. A 2008 *New York Times* article contended that Dr. Biederman earned at least \$1.6 million dollars in consulting fees from drug companies from 2000 to 2007 and had failed to disclose this income to Harvard University, where he had an academic appointment. He was allegedly paid this money during the years he advocated the expanded use of psychotropic medications in children (Harris & Carey, 2008). Later allegations reported that Biederman told the pharmaceutical company funding his research that a set of future studies would have results that would benefit the company (Harris, 2009). The proposed study was to test the efficacy of Risperdal (risperidone), a powerful, atypical antipsychotic drug, on preschool children. During his presentation to the company, one of his slides read that the proposed trial "...will support the safety and effectiveness of risperidone with this age group" (Harris, 2009, p. A-16). In other words, Dr. Biederman appeared to be promising positive results to the funders of his research before the study was actually conducted. Currently, Biederman is under investigation on several fronts for alleged conflicts of interest.

Certainly, Biederman's group is not alone in accepting research funding from drug companies—an alarming trend in and of itself. But it is important to note that Biederman's work was the cornerstone of both the increased diagnosis of bipolar disorder in children and the greatly increased use of psychotropic and mood stabilizing medications to treat children who supposedly had this disorder. For example, a roundtable discussion sponsored by the National Institute for Mental Health (NIMH) concluded that that prepubertal bipolar disorder existed and could be reliably diagnosed with existing diagnostic instruments (NIMH, 2001). More striking still, the roundtable concluded that bipolar disorder in young children did not have to meet the full diagnosis from the DSM. Children seen in clinics could fall into one of two categories: (1) those who clearly had bipolar disorder because they met DSM-IV criteria for bipolar I or II, and (2) those who *may have* bipolar disorder but did not meet DSM-IV criteria (NIMH, 2001, p. 871).

The work group proposed that a third phenotype for bipolar disorder be developed—bipolar not otherwise specified (NOS). The group suggested that this third diagnostic expression of bipolar disorder did not need to have episodic mood states. Rather, "... the most frequent course is a long-duration episode with rapid cycling (ultradian or continuous cycling as the predominant type) and mixed mania (i.e., co-occurring mania and depression)" (NIMH,

2001, p. 871). The roundtable suggested that screening and diagnosis for bipolar disorder should be done for children as young as age 3 or 4.

The recommendations from this roundtable are frequently cited in textbooks to support the existence of prepubertal bipolar disorder. Of the 19 members of this roundtable, 14 were psychiatrists. Joseph Biederman was a member of the group as were several of his colleagues, including Janet Wozniak. The intent here is simply to suggest that a small group of researchers had a disproportionate influence on the research into pediatric bipolar disorder, and a substantial portion of the research used to justify the broad expansion of the disorder came from Biederman's and colleagues' work.

Frances (2010) has directly argued that a major impetus for the widespread expansion of the use of this diagnosis with children came from researchers such as Biederman, whom he refers to as "thought leading." Frances asserts that these researchers fundamentally changed the way we diagnose bipolar disorder in an overinclusive manner that does not allow for strong fidelity to a diagnostic protocol. Moreover, he has charged that members of the pharmaceutical industry played a major role in this expansion. It allowed them to greatly increase the use of their existing drugs for a large and previously unaccessed population (Frances, 2010).



The Problem of Differential Diagnosis

Funding issues aside, researchers and clinicians have challenged some of the assumptions upon which the diagnosis of pediatric bipolar disorder are based. First is the assumption that children diagnosed with pediatric bipolar disorder will go on to develop the adult-onset type. This is a critical question. If we can identify this often-devastating disorder at a younger age and somehow improve the prognosis, then the use of such powerful drugs may have some justification. However, the few prospective and longitudinal studies that have addressed this question did not support this assumption. For example, Lewinsohn, Klein, and Seeley (2000) completed a longitudinal study of adolescents and reported that about 5% of the sample had what was referred to as subsyndromal bipolar disorder. This group did not meet the full adult characteristics of bipolar disorder, but they had symptoms of the mood elevations suggestive of the disorder. The members of this group were reevaluated at age 24 and were found to have significantly high rates of impaired psychosocial functioning, as well as elevated rates of depression, anxiety, antisocial personality disorder, and borderline personality disorder. However, they did not have increased rates of bipolar disorder. This study suggested that elevated moods in adolescents were transitory. Further, elevated moods were predictive of adult problems but not a specific expression of bipolar disorder.

In another study by Hazell, Carr, Lewin, and Sly (2003), 203 boys aged 9–13 were evaluated for psychological disorders. Of this sample, 124 were diagnosed with ADHD, and 25% of the ADHD

group were said to meet the criteria for mania. However, 6 years later, only one of the children diagnosed with mania continued to meet the criteria. These results suggest that even if children exhibit symptoms consistent with mania, these symptoms are transient. The study did not support a link between early mania and ADHD and subsequent adult bipolar disorder.

In another prospective study by Kim-Cohen et al. (2003), the same subjects were carefully evaluated several times between the ages of 11 and 26. Some were reported to meet the criteria for mania at younger ages. However, none of the individuals who had been diagnosed with mania at a younger age still met the criteria at age 26. The most common precursors of adult problems were oppositional or conduct problems.

Proponents of pediatric bipolar disorder posit that the core symptom of mania is much more common in children than previously thought (Biederman et al., 2000). Yet, high rates of mania in community samples have not been supported. The Great Smokey Mountain study (Costello et al., 1996) evaluated a sample of 4,500 children aged 9 to 13 and found no cases of mania and only .1% of hypomania.

These studies fail to provide clear evidence that older children and adolescents who exhibit symptoms that could be interpreted as mania go on to develop adult bipolar disorder, nor do the studies support a clear path between pediatric bipolar disorder and adult onset bipolar disorder. Further, none of the studies included children younger than age 9. Harris (2005), among others, argues that these findings point to the danger of using a loose definition of *mania* as a core symptom of bipolar disorder in children.

Another challenge to the stability of pediatric bipolar disorder is lack of valid and reliable measures. The most commonly used assessment tools to diagnose PBD are versions of the Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS), and in particular the version developed at Washington University (WASH-U-KSADS). The WASH-U-KSADS has been found to have good inter-rater reliability (Geller, Zimmerman, Williams, Bolhofner, Craney, DelBello, & Soutullo, 2001); however, these instruments rely on a high level of training in their use and a good bit of clinical judgment (Youngstrom, Findling, & Feeny, 2004). Because they rely heavily on clinical judgment, the possibility of assessor bias exists. Moreover, they have not yet been shown to consistently predict adult bipolar disorder (Youngstrom, Findling, & Feeny, 2004).

Another commonly used tool is a profile from the Child Behavior Checklist (CBCL), one of the most commonly used multidimensional assessment tools for children and adolescents (Achenback, 1991). Proponents of the diagnosis of childhood bipolar disorder have developed an algorithm from the CBCL that has been labeled juvenile bipolar disorder phenotype (CBCL-JBD). This profile consists of clinically significant elevations (T scores >70) on the Anxious/Depressed, Aggression, and Attention Problems subscales

(Halperin et al., in press). Some researchers argue that this profile can discriminate PBD from ADHD and can predict adult onset of the disorder (Biederman et al., 2009). However, other research has not supported these conclusions. Halperin et al. (in press) followed a group of children whose parents completed the CBCL when their children were aged 7–11. The same checklist was re-administered 9 years later. Results indicated that while 31% of the children met the criteria for PBD at pretesting, only 4.9% did at posttesting. More important, only two individuals from the study sample actually developed bipolar disorder as adults. Of the two, only one had an elevation on the CBCL-JBD scale. The authors concluded that an elevation on this scale did not predict specific Axis I disorders in late adolescence (Halperin et al., in press). This research, along with other studies (Ayer et al., 2009), suggests that we do not have a clear set of diagnostic tools that identify symptoms in children that lead to adult-onset bipolar disorder. Ayer et al. (2009) concluded that the CBCL-JBD should not be used in the diagnosis of juvenile bipolar disorder.

Some researchers have attempted to identify specific symptoms or behaviors that could be seen as unique or cardinal symptoms of PBD. Biederman et al. (2000) argued that irritability, distractibility, and rages are the core symptoms of pediatric bipolar disorder. However, these symptoms also occur within a number of other more clearly established diagnostic categories for children.

The Issue of Comorbidity

Even the strongest proponents of the existence of PBD acknowledge that it is highly comorbid with other childhood disorders (Youngstrom, Findling, & Feeny, 2004). The most common comorbid diagnoses are attention deficit hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), anxiety disorders, and substance abuse (Biederman et al., 2000). These researchers argue that bipolar disorder is comorbid or co-occurring with these other diagnoses. The proposed comorbidity rates for ADHD are extremely high at 60%–90%. With a comorbidity rate as high as 90%, isn't it reasonable to ask how the symptoms of bipolar disorder can be differentiated from those of ADHD? Proponents of PBD argue that this disorder is often mistakenly diagnosed as ADHD. But the reverse is also quite possible—ADHD is often mistakenly diagnosed as pediatric bipolar disorder. Given that we have clear and agreed upon criteria for ADHD and we do not for pediatric bipolar disorder, it is more credible that pediatric bipolar disorder is the more questionable diagnosis. Many other childhood disorders are reported to have high comorbidity rates with bipolar disorder, including oppositional defiant disorder, conduct disorder, substance abuse, autistic spectrum disorders, and symptoms of trauma (Biederman et al., 2000).

Harris (2005) completed a careful secondary diagnosis of the children coming to her with a prior diagnosis of pediatric bipolar disorder. She found that many of them actually met the criteria for pervasive developmental disorders, reactive attachment disorder

(although this diagnosis is also controversial) (Chaffin et al., 2006), posttraumatic stress disorder (PTSD), fetal alcohol syndrome (FAS), and mild delirium from overmedication. These alternative diagnoses have many symptoms that overlap with the proposed bipolar disorder NOS. These include aggression, oppositional behavior, anxiety, irritability, impulsivity, and mood changes.

From the perspective of child maltreatment, differentiating bipolar disorder from symptoms of trauma is particularly problematic. Traumatized children can be moody, irritable, distractible, aggressive, and sexually inappropriate. It is very difficult to distinguish these symptoms from symptoms purported to be indicative of PBD. Commonly used measures are not successful in differentiating these diagnoses. For example, Ayer et al. (2009) concluded that the CBCL cannot distinguish between PBD and PTSD. They hypothesized that these scales might actually measure an overall pattern of self-regulation.

Issues Specific to Child Welfare

The diagnosis of PBD has other ramifications for professionals involved in the child welfare and child protection field. Our field is inundated with children who are traumatized, distractible, anxious, and depressed and who display acting-out behaviors. We also deal with families under stress and parents who may themselves have psychological difficulties. In this environment, children as young as age 2 are being diagnosed with pediatric bipolar disorder. Since these children cannot accurately self-report their own mood states (imagine asking a 2-year-old if she has been manic lately), the diagnosis is often based upon information received from a parent. Many of the parents involved in child welfare systems have their own difficulties, and they may overpathologize their children and present them in an overly negative manner. Some parents also fail to acknowledge or understand the contribution of poor or inconsistent parenting to their children's difficulties. It is often simpler to request medication for a child than to change their parenting interactions.

Giving any child powerful mood stabilizers or antipsychotic drugs, or both, will certainly calm a child down, and some parents are satisfied with that. Most of these parents are rightfully frustrated and upset by their children's behavior. They often feel they cannot control their children, and in some cases, the children are very aggressive. The prospect of a pill that will calm the child, with no other changes needed, can be most attractive. Especially in child welfare cases, the possibility exists that parents' behaviors are contributing to a child's instability, either through abuse and neglect or by having unrealistic developmental expectations for their children's behavior.

Rebecca Riley presents an extreme example of this concern. She died at the age of 4 from a lethal dose of Clonidine prescribed by a psychiatrist who had diagnosed her at the age of 2 with bipolar

disorder. The psychiatrist had also diagnosed Rebecca with ADHD and had prescribed Seroquel and Depakote in addition to Clonidine, none of which are FDA-approved for use with children. Rebecca's parents, Michael and Carolyn Riley, had a history of involvement in the child protection system. They reportedly had asked repeatedly for more medication to calm Rebecca and their other two children. They were later convicted of her murder. The psychiatrist reached a \$2.5 million settlement with the family. She was reported as saying she relied on the information given to her by the parents as a major part of her diagnosis. She has resumed her practice as a psychiatrist (Wen, 2010).

If It Isn't Bipolar, What Else Could It Be?

Proponents of PBD describe these children as extremely irritable, explosive, distractible, impulsive, and oppositional, and they argue that ADHD alone cannot account for these symptoms. However, the combination of ADHD and oppositional defiant disorder (ODD) or conduct disorder (CD) can easily account for these symptoms. The diagnosis of ADHD explains the impulsivity, distractibility, and hyperactivity, while ODD or CD can account for aggressive and oppositional behaviors. The combination of ADHD and ODD is extremely common in children in the child protection system. Making a distinction between PBD and the combination of ADHD and either ODD or CD has profound implications for both the etiology and treatment of children receiving these diagnoses.

ADHD is a condition which, based on our best understanding of the etiology, has a neurological component. Medication is commonly used to treat this disorder. However, the efficacy and side effects of ADHD medications for children are much better researched and understood than the efficacy and side effects of adult mood stabilizers and antipsychotic drugs when given to children.

As for oppositional behavior, social learning theorists have developed another, well-researched explanation for oppositional behaviors in children. McNeil & Hembree-Kigin (2010) asserted that the core cause is an impaired parent-child relationship. Simply put, parents do not attend to their children when they are exhibiting desired behaviors, do attend to them when they are misbehaving, and thus inadvertently reinforce the acting-out behavior. Patterson, Reid, & Dishion (1994) described a coercive cycle that occurs when children escalate their negative behavior and parents simply give in. If the oppositional behavior we often see is the result of problems in the parent-child relationship, then that is a logical place to intervene. Several well-supported interventions have demonstrated that oppositional behavior can be reduced through behavioral intervention (Eyeberg et al., 2001; Kazdin, 2005). One prominent example is parent-child interaction therapy (PCIT), which has been demonstrated to be effective in reducing acting out behaviors in a wide variety of child populations. Of course, there are no medical side effects to PCIT.

As stated, it is also possible that the children we are seeing in child protective services are exhibiting symptoms of trauma. Here again, we have excellent, evidenced-based psychosocial approaches to address and resolve these symptoms, such as trauma-focused cognitive-behavioral therapy (Cohen, Mannarino, & Deblinger, 2006).

The Importance of Good Assessments

Throughout this article, I have discussed both the challenges and the importance of obtaining an accurate differential diagnosis for the children in our care. In practice, many of the younger children diagnosed with pediatric bipolar disorder were given this diagnosis after only a short interview with the child's parents. One critical component to diagnosing these children effectively is the use of multimodal, multiple-method assessments that rely on several sources of data (parents, teachers, other collaterals, and the children themselves) and a variety of assessment methods (interviews, structured observations, and standardized testing). All diagnoses should be based on a careful assessment protocol, but it is of particular importance for children suspected of having bipolar disorder.

A case example from my clinic will underscore this point. A referral was received for an 8-year-old boy we'll call Matthew. At the age of 3, he was diagnosed by his pediatrician as having bipolar disorder. The initial diagnosis was based upon his mother's report of extreme and sudden rages, oppositional behavior, lack of peer relationships, and difficulties transitioning in school. His pediatrician then referred him to a psychiatrist who prescribed Seroquel. Matthew was subsequently seen by several other mental health professionals, including two psychiatrists, a neurologist, a licensed clinical social worker, and two psychologists. Several gave Matthew the same diagnosis *by history*, meaning the clinicians took the diagnosis from the prior medical records. By the time he came to our clinic, Matthew had been on 14 different medications including Seroquel, Depakote, lithium, Prozac, Abilify, and Strattera. He had been in psychotherapy with four therapists, had been hospitalized twice, and had been involved with crisis and mobile responses four times. At the time of his referral, he was in a partial care program, and he continued to be diagnosed as having bipolar disorder. After all of these services, his mother reported no improvements in his behavior, and she said he was getting worse. She described him as having temper tantrums that lasted for hours. She reported that he had no friends and was refusing to go to school. She was desperate and thinking she might have to send Matthew to a long-term residential program.

Matthew was given a thorough, multimodal, multimethod assessment that included instruments specific to autistic spectrum disorder, based upon his history and his overall presentation at the clinic. He was ultimately diagnosed with Asperger's disorder. With his mother's permission, he was weaned off all his medications. His mother participated in a slightly modified PCIT intervention (McNeil & Hembree-Kigin, 2010), and he was enrolled in a social

skills training program designed for children with Asperger's disorder. Within 16 weeks, his mother reported a decrease in oppositional behavior to within normal limits, and Matthew was functioning well in school. He was not on any medications.

Of course, this is just one example from the million or so children who are being medicated for pediatric bipolar disorder. But it is a cautionary tale about the consequences of misdiagnosis, especially in young children.

Conclusions and Future Directions

Many research and treatment considerations need to be addressed before the controversy surrounding pediatric bipolar disorder is resolved. This article has attempted to illuminate the considerable challenges to the widespread use of this diagnostic category in young children. There is little agreement about the core characteristics of PBD, the ages at which it manifests, and its relationship to adult bipolar disorder (Halperin et al., 2010). For children under age 12 who do not meet the criteria of adult bipolar disorder, there is not even consistent proof that the disorder exists, except as a poorly supported proposed phenotype. Many other well-established and common problems can explain the behaviors attributed to pediatric bipolar disorder. Most, but not all, of the evidence-based treatments for these more typical disorders do not involve the use of powerful psychotropic medications. As indicated, these medications include antipsychotics that have not been well tested in children and adolescents. We have limited understanding of the effects of antipsychotic medications on the developing brain. We do know that even short-term use of antipsychotics can cause significant weight gain in children and adolescents—along with other significant side effects. One group of children placed on antipsychotics had a weight gain of 9–18 lbs in 10 weeks (Olfson, 2010). This type of weight gain can have significant health implications. In the absence of a robust literature that supports the clinical effectiveness of these medications, the side effects may well outweigh any benefits. This is especially true since the antipsychotics are often prescribed for aggressive behaviors, for which we have other, evidenced-based psychosocial alternatives.

One other point of interest is that recent studies have found poor children are more likely to receive antipsychotic drugs. Children who are covered by Medicaid are 4 times more likely to be given antipsychotic medications than are children with parents who have private insurance (Wilson, 2009).

From a child welfare perspective, we should advocate for the use of thorough assessments of children in our care and remain skeptical of the diagnosis of bipolar disorder in young children. Even if such a diagnosis is suspected, the symptoms of oppositional behavior should first be treated with psychosocial treatments. In particular, adult psychotropic or mood stabilizing drugs should be used with extreme caution in young children.

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