

## Juvenile Bipolar Disorder: Overdiagnosis and risk of Iatrogenic Harm

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One of the most contentious topics in psychiatry today is the diagnosis of bipolar disorder in young people. In the early 2000s, the United States had a hospital discharge rate of 95.6 per 100,000 for kids under the age of 20, which was up to 100 times higher than the rates in England and Germany (0.9 and 1.5, respectively) [1]. Additionally, children's and adolescents' outpatient visits almost doubled, and the fastest-growing prescription class was antipsychotics [2]. As defined in epidemiology as diagnosing conditions that would not otherwise cause symptoms or harm [3] and in psychiatry as systemic inflation of diagnostic rates beyond true prevalence due to broader criteria or cultural pressures, these increases have sparked concerns about overdiagnosis [4].

The recurrent mood illness known as bipolar disorder (BD) can be understood by periods of depression and mood elevation that alternate and significantly impede functioning [5]. At least one manic episode is necessary for bipolar I disorder; an episode is characterized by a week or longer of unusually high, expansive, or irritable mood with increased energy, along with symptoms like inflated self-esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, or risky behaviours. These episodes are frequently severe enough to necessitate hospitalization. At least one four-day or longer hypomanic episode and one or more major depressive episodes without a history of mania are characteristics of bipolar II disorder. Mania and hypomania are similar, although hypomania is less severe and usually not incapacitating. The hallmark of both subtypes of BD is its episodic nature, which sets it apart from adolescent attentional issues or persistent irritability.

In accordance with international legislation (United Nations, 1989) and psychiatric research that distinguishes between child (<12 years) and adolescent (12–17 years) presentations [6], juveniles are defined as anyone under the age of eighteen in this article. This group is especially susceptible to both overdiagnosis and underdiagnosis due to developmental heterogeneity. The aim of this article is to understand the trend of overdiagnosis of Bipolar Disorder in juveniles.

### Historical Context

Researchers used the National Ambulatory Medical Care Survey to analyze national changes in outpatient mental health care starting from 1995 to 2010. They discovered that throughout this time, the number of visits that resulted in a diagnosis of a mental illness almost doubled for kids and teenagers, increasing more quickly than for adults. Crucially, youth visits for psychotropic medication rose significantly, with antipsychotics being the prescription class with the greatest rate of growth. However, paediatricians and other non-specialist doctors provided most of this care rather than psychiatrists. The study highlights concerns that the use of medications without enough psychosocial support or diagnostic precision may be encouraged by the growth of diagnostics and the lack of access to child psychiatrists [7].

Clacey and others analysed international hospital discharge data for pediatric bipolar disorder (PBD) from 2000 to 2010, comparing the United States with Australia, New Zealand, Germany, and England. They found striking disparities: for individuals under 20 years old, discharge rates per 100,000 were 95.6 in the U.S., compared with 11.7 in Australia, 6.3 in New Zealand, 1.5 in Germany, and only 0.9 in England. The gap was most dramatic in children aged 5–9, where the U.S. rate was 27 per 100,000, while all other countries were below 1. These findings suggest that the extraordinary prevalence of PBD in the U.S.

cannot be explained by true epidemiological differences but instead reflect divergent diagnostic practices, particularly the broader inclusion of irritability and ADHD-like symptoms within the bipolar spectrum. The authors concluded that such international variation highlights the risk of diagnostic inflation and underscores the need for greater consensus and caution in labeling pediatric mood instability as bipolar disorder [8].

### **Epidemiological Evidence**

In their re-examination of 20 epidemiological surveys on pediatric bipolar disorder (PBD), it was found that statistical meta-analysis was inaccurate due to significant methodological variation among studies. While some adolescents exhibited manic or hypomanic symptoms that frequently resolved or did not predict adult BD, pre-adolescent prevalence rates were negligible or almost zero across cohorts. The authors stressed that there is no correlation between PBD and adult BD as a diagnostic concept and using it could inflate prevalence estimates. According to their research, a large portion of the apparent early-onset BD may actually be temporary developmental events rather than actual disease. Overall, the study cautions that an early diagnosis increases the risk of needless medication and unfavourable iatrogenic outcomes [9].

According to researchers, BD is exceedingly uncommon prior to adolescence, and overestimated prevalence rates lead to a pervasive overdiagnosis in the US. They pointed out that children in the United States have 100–900 times greater rates of BD diagnosis than children in Europe and Australasia, indicating that the disparity is due to overdiagnosis in the United States rather than underdiagnosis in other regions. The authors highlighted that mania usually manifests in mid-to-late adolescence, but hypomanic symptoms in younger children are frequently temporary and do not predict adult BD, based on high-risk offspring research. They also issued a warning about the major iatrogenic effects of overdiagnosis, specifically the needless use of second-generation antipsychotics, which are linked to weight gain, metabolic syndrome, and possible neurodevelopmental hazards. All things considered, the commentary reaffirms worries that the growth of the diagnostic field has resulted in the incorrect classification of children's severe mood instability as BD, which can have negative effects [9].

In a qualitative phenomenological study, researchers used semi-structured interviews with 14 Massachusetts-licensed clinicians to investigate how they make diagnoses of juvenile bipolar disorder (PBD). The study identified several difficulties, such as inconsistent diagnostic methods, doctors' hesitancy to definitively diagnose PBD, and the sparse or irregular use of the assessment instruments at hand. Additionally, participants reported having trouble distinguishing symptoms of PBD from those associated with comorbidities, trauma, or dysfunctional family relationships. The absence of specialized training on child-focused diagnostic criteria was a major contributing cause to these problems. Overall, the results point to the need for more robust diagnostic frameworks, training, and supervision, indicating that inconsistent practices and insufficient clinician preparation may contribute to the overdiagnosis of PBD [10].

### **Diagnostic Challenges**

Sherwood used two sizable datasets of inpatient psychiatric hospitalizations in the US to investigate longitudinal changes in juvenile bipolar disorder (PBD) diagnoses. According to the data, the percentage of children and adolescents diagnosed with PBD increased significantly between 1996 and 2004. Diagnoses decreased in children between 2004 and 2010 but continued to rise in teenagers. Population-adjusted rates per 10,000 increased until the mid-2000s, after which they decreased for all age categories. Similar declines in PBD diagnosis rates were observed in state-level Medicaid data from 2005 to 2015. These results imply that while the later reduction indicates changes in clinical awareness and the correction of overdiagnosis, the sharp increase in PBD diagnoses in the late 1990s and early 2000s may have reflected broader diagnostic methods [11].

A thorough clinical evaluation of juvenile bipolar disorder (PBD) was presented by researchers, who looked at treatment, phenomenology, diagnostic standards, and debates. The authors pointed out that there is currently evidence to support DSM-based criteria that emphasize periodicity, and that previous arguments on the distinction between identifying PBD through acute irritability and aggression and

episodic mood changes have mostly been settled. They stated that the estimated prevalence of juvenile BP-I is around 0.5%, with greater subthreshold rates. They also emphasized the significant role of hereditary susceptibility, which makes family history an important diagnostic factor. Even while many young people recover from episodes, early start is linked to inferior results, and relapse rates are still high. Despite ongoing worries about overtreatment and side effects, treatment possibilities include lithium, atypical antipsychotics, and integrated psychosocial therapies. Overall, the review underscored that while diagnostic clarity has improved, controversies surrounding prevalence and management continue, necessitating further longitudinal research [12].

In their assessment of the literature, Roy and Klein concentrated on the difficulties in diagnosing pediatric bipolar disorder (PBD), the progression of the condition, and treatment strategies. Although real pediatric BD is comparatively rare, they noted that over the previous 20 years, the number of U.S. diagnoses rose significantly. The fact that BD symptoms might be mistaken for those of ADHD, oppositional defiant disorder, and other disruptive disorders is a serious cause for concern. The review also raised concerns regarding the validity of the diagnosis because many children who are first diagnosed with BD do not exhibit continuity into adulthood. Since lithium and atypical antipsychotics have shown promise in treatment but come with serious side effect concerns, psychosocial therapies like family-focused therapy and cognitive-behavioural therapy are crucial supplements. Overall, the authors concluded that overdiagnosis has resulted from the widespread use of diagnostic criteria, highlighting the necessity of thorough and cautious assessments [13].

Concerns over the overdiagnosis of pediatric bipolar disorder were partly addressed by the inclusion of Disruptive Mood Dysregulation Disorder (DMDD) in the DSM-5. Many children who exhibited frequent outbursts of anger and chronic irritability were previously mislabelled as bipolar, despite not meeting the criteria for episodic mania. The DSM-5 gave doctors another way to think about chronic irritability in young people by making DMDD a distinct diagnosis. This decreased the possibility that these individuals would be mistakenly classified as bipolar illness. Though DMDD may reduce false positives, its clinical validity and overlap with other mood and behavioural disorders are still up for debate, raising doubts about how well it will work in the long run to address the issue of juvenile BD overdiagnosis [14].

### **Patient Perspective**

Patient testimonials from online forums offer important insight into the lived experience of diagnostic ambiguity, despite being anecdotal and not subjected to peer review. For instance, one Reddit member talked about having a childhood bipolar illness diagnosis in teens, taking “many medications,” and feeling “violated,” only to have their diagnosis changed to anxiety and OCD. This story demonstrates how diagnostic instability can damage a young person’s sense of self and undermine trust in mental health treatments, while being anonymous and having low generalizability. Additionally, systematic reviews show that kids frequently receive incorrect diagnoses of bipolar illness, ADHD, and depression, which can delay necessary treatment and exacerbate emotional distress [16]. Collectively, these results demonstrate that overdiagnosis is a lived reality that has significant emotional repercussions for kids and their families in addition to being a statistical worry [15].

### **The Indian Context**

In a systematic review and meta-analysis of psychiatric problems in Indian youth, it was found that prevalence rates were 23.33% in school-based groups and 6.46% in community samples. Interestingly, bipolar illness was rarely mentioned in the included research, indicating that the problem in India is more likely to be underdiagnosis than overdiagnosis. The authors explained this discrepancy by pointing to the limited use of standardized techniques, inconsistent approaches, and inadequate diagnostic infrastructure that make it more difficult to accurately diagnose pediatric bipolar illness in clinical and epidemiological contexts [16]. Earlier in a study done by authors, 21 Indian children and adolescents who were diagnosed with mania at NIMHANS, Bangalore, were examined, providing one of the earliest systematic descriptions of pediatric mania in the Indian subcontinent. The study found that while classical manic symptoms such as pressured speech, irritability, elation, distractibility, and grandiose delusions were prominent, psychotic features were also common, and disruptive behaviors often led to diagnostic

confusion. Importantly, none of the cases had comorbid ADHD, although aggressive or hyperactive presentations could easily have been misinterpreted as ADHD or conduct disorder. The authors cautioned that in the Indian context, mania in children is relatively rare but diagnosable, and that misdiagnosis risks arise primarily from conflating manic presentations with disruptive or psychotic disorders. These findings contrast sharply with U.S. trends of overdiagnosis and highlight how diagnostic inflation is not a universal phenomenon but one mediated by cultural and clinical practice differences [17].

### Discussion

Research suggests that there are notable cross-national variations in juvenile bipolar disorder (PBD). Many people point to the dramatic increase in diagnoses in the United States in the late 1990s and early 2000s as an illustration of overdiagnosis, in which the number of diagnostic labels exceeded the actual prevalence. Compared to 0.9 in England and 1.5 in Germany, hospital discharge rates for kids reached 95.6 per 100,000 [8]. Concerns regarding long-term metabolic consequences were raised by the surge in antipsychotic prescriptions that coincided with this increase [7]. Critics contend that rather than being influenced by abrupt biological change, this “false epidemic” was created by diagnostic zeal and pharmacological influence [18]. On the other hand, surveys conducted in Europe and India indicate that BD is still uncommon in young people, with lifetime rates in India being 0.5% and preadolescent prevalence being nearly zero. Manic symptoms are frequently mistaken for conduct disorder, schizophrenia, or ADHD, according to Indian clinical studies, which suggests underdiagnosis rather than overdiagnosis [16].

Differential diagnosis is a significant challenge. While they lack BD’s characteristic episodicity, ADHD, OCD, and disruptive mood dysregulation disorder (DMDD) all exhibit irritability, hyperactivity, and sleep disturbances [15]. This distinction is made more difficult in juveniles due to developmental heterogeneity [3]. These results collectively imply that the fundamental question is not whether BD occurs in children but rather whether it is correctly and consistently recognized in various contexts.

### Suggestions and Recommendations

Clinicians should avoid confusing chronic irritability with mania and stress episodicity when evaluating mood disorders in order to minimize diagnostic errors. Differential diagnosis needs to be strengthened in training programs, especially against DMDD, OCD, and ADHD [15]. Reliability could be improved and subjective impressions could be lessened by using structured diagnostic techniques. Responses that are specific to the context are also necessary. Guidelines and awareness campaigns in the United States should warn against premature pharmacological intervention and diagnostic inflation [18]. One of the article’s limitations is that it mostly uses secondary literature and cross-national comparisons; source data and direct family/clinician viewpoints are not included, which could limit the scope of the analysis.

To avoid misclassifying mania as other diseases, there needs to be more awareness in India. Pharmacological treatment should be saved for specific circumstances and non-pharmacological methods like family therapy and psychoeducation should be incorporated into care in all settings.

The diagnosis of pediatric bipolar disorder is still debatable and influenced by systemic, clinical, and cultural factors. Evidence from India and other areas indicates under recognition is still a concern, even if the U.S. experience highlights the dangers of overdiagnosis and overtreatment. The most accurate diagnostic marker for mania and hypomania is still their episodic nature, but evaluation is still made more difficult by the symptoms’ overlap with those of ADHD, OCD, and DMDD. Accurate recognition is just as difficult as early detection. Clinicians must use strict diagnostic criteria, prescribe sparingly, and strike a balance between being cautious about premature labelling and being alert for real cases. The best course for improving the mental health of young people is to adopt an evidence-based, cross-cultural strategy.

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