

Evidence that bipolar disorder is the poor outcome fraction of a common developmental phenotype: an 8-year cohort study in young people

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Background. Reported rates of bipolar syndromes are highly variable between studies because of age differences, differences in diagnostic criteria, or restriction of sampling to clinical contacts.

Method. In 1395 adolescents aged 14–17 years, DSM-IV (hypo)manic episodes (manic and hypomanic episodes combined), use of mental health care, and five ordinal subcategories representing the underlying continuous score of (hypo)manic symptoms ('mania symptom scale') were measured at baseline and approximately 1.5, 4 and 10 years later using the Munich-Composite International Diagnostic Interview (DIA-X/M-CIDI).

Results. Incidence rates (IRs) of both (hypo)manic episodes and (hypo)manic symptoms (at least one DSM-IV core symptom) were far higher (714/105 person-years and 1720/10⁵ person-years respectively) than traditional estimates. In addition, the risk of developing (hypo)manic episodes was very low after the age of 21 years [hazard ratio (HR) 0.031, 95% confidence interval (CI) 0.0050–0.19], independent of childhood disorders such as attention deficit hyperactivity disorder (ADHD). Most individuals with hypomanic and manic episodes were never in care (87% and 62% respectively) and not presenting co-morbid depressive episodes (69% and 60% respectively). The probability of mental health care increased linearly with the number of symptoms on the mania symptom scale. The incidence of the bipolar categories, in particular at the level of clinical morbidity, was strongly associated with previous childhood disorders and male sex.

Conclusions. This study showed, for the first time, that experiencing (hypo)manic symptoms is a common adolescent phenomenon that infrequently predicts mental health care use. The findings suggest that the onset of bipolar disorder can be elucidated by studying the pathway from non-pathological behavioural expression to dysfunction and need for care.

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Introduction

The World Health Organization (WHO) identified bipolar disorder as the sixth leading cause of disability-adjusted life years in the world among people aged 15–44 years (Murray & Lopez, 1996). The true prevalence and incidence rates (IRs) of (hypo)manic disorder remain unclear. Lifetime prevalence estimates vary from around 1–2% (Regier *et al.* 1988; Kessler *et al.* 1994; Weissman *et al.* 1996) to 5–8% (Carlson &

Kashani, 1988; Lewinsohn *et al.* 1995; Angst, 1998; Szádóczy *et al.* 1998; Judd & Akiskal, 2003) whereas IRs vary between 4 and 33/10⁵ per year (Bebbington & Ramana, 1995).

The reported variability in bipolar population morbidity rates may be caused by several factors. First, nearly all incidence studies on bipolar disorder are based on participants in clinical care, which probably results in a substantial underestimation of rates (Spicer *et al.* 1973; Leff *et al.* 1976; Rasanen *et al.* 1998; Lloyd *et al.* 2005; Kennedy *et al.* 2005b) because many cases either have not sought help or are not diagnosed correctly (Ghaemi *et al.* 2002).

Second, previous work suggests that the age of the study population may be crucial, as there are

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indications that much of the population lifetime risk for bipolar disorder is consumed in adolescence. Thus, Lewinsohn *et al.* (2003) showed that, in a population sample stratified by the age categories <9, 19–23 and 24–29 years, the first lifetime onset of bipolar disorder and subthreshold bipolar disorder almost always occurred in adolescence. Therefore, a young study population as used in the Early Developmental Stages of Psychopathology (EDSP) Study is most appropriate (Wittchen *et al.* 2003). The issue of age is also important in view of the considerable psychopathological, longitudinal and familial/genetic overlap between bipolar disorder and childhood disorders, in particular attention deficit hyperactivity disorder (ADHD), but also oppositional–defiant disorder (ODD) and conduct disorder (CD) (Nierenberg *et al.* 2005; Henin *et al.* 2007). Studying the onset of (hypo)manic symptoms in adolescents allows for quantification of the amount of the bipolar population morbidity rate that can be traced to childhood disorders.

Third, diagnostic criteria used have a major impact on population rates (Akiskal *et al.* 2000; Angst *et al.* 2003). Many people in the general population display subthreshold bipolar disorder (Merikangas *et al.* 2007). Therefore, widening criteria for bipolar disorder will naturally increase the number of cases.

An informative way of describing the bipolar population morbidity rate is to replace dichotomous criteria with dimensional measures; the possible use of dimensional measures in bipolar disorder is currently being examined in DSM-V (First, 2006). Angst & Marneros (2001) suggest that a natural continuum may exist on which all (hypo)manic manifestations of varied length, frequency and severity can be represented. This dimensional approach may be more sensitive and informative in the search for determinants of onset and change, making it easier to monitor onset and progression of psychiatric phenotypes (Cougard *et al.* 2007; van Os *et al.* 2009). Furthermore, it allows for fuller examination of the impact of symptoms on well-being and functioning, severity and distress (Regeer *et al.* 2006), and may facilitate recognition of at-risk states and early intervention (Egeland *et al.* 2000; Hanssen *et al.* 2005; Birmaher & Axelson, 2006). For bipolar disorder, it has the additional advantage of allowing for the separate study of manic and depressive dimensions, the co-occurrence of which in the same mood episode is common in clinical practice and therefore represents an important parameter for study in epidemiological and taxonomic investigations. Finally, it can increase statistical power without loss of clinical utility.

Therefore, the aim of the current study was to investigate dimensional (hypo)manic categories, independent of receipt of mental health care, in a large

representative cohort of adolescents followed over a period of up to 10 years.

Method

Sample

This examination is part of the EDSP study, a prospective longitudinal cohort study. Detailed information about the design, sample, instruments, procedures and statistical methods of the EDSP study is presented elsewhere (Wittchen *et al.* 1998*b*; Lieb *et al.* 2000). Data were collected in a representative population sample of adolescents and young adults living in the Munich area (Germany), aged 14–24 years at baseline. The study sample was drawn randomly from the 1994 government population registers. Fourteen to 15-year-olds were sampled at twice the rate of 16- to 21-year-olds, and 22- to 24-year-olds were sampled at half this rate.

Study design

The present study is based on a subset of EDSP respondents, aged 14–17 years at baseline (T0, $n = 1395$, response rate 75%), thus ensuring a population at risk of developing incident bipolar disorder. Participants completed a baseline survey (T0, $n = 1395$) and three follow-up investigations (T1, T2, T3), covering a time period of approximately 1.6 (T0–T1, $s.d. = 0.2$), 3.4 (T0–T2, $s.d. = 0.3$) and 8.3 years (T0–T3, range 7.4–10.6 years, $s.d. = 0.7$) respectively. Response rates (conditional on T0 completion) were 88% at T1 ($n = 1228$), 83% at T2 ($n = 1169$) and 73% at T3 ($n = 1022$).

Instruments

Interviews were conducted using the computerized version of the Munich-Composite International Diagnostic Interview (DIA-X/M-CIDI; Wittchen & Pfister, 1997), an updated version of the WHO's CIDI version 1.2 (WHO, 1990). The DIA-X/M-CIDI is a comprehensive, fully standardized diagnostic interview and assesses symptoms, syndromes and diagnoses of various mental disorders in accordance with definitions and criteria of the DSM-IV. Its features have been developed and tested in several methodological studies with the CIDI or modifications thereof, including the deletion of many of the CIDI's skipping rules to allow for the study of subthreshold conditions. High inter-rater and test–retest reliability of the CIDI have been established (Wittchen *et al.* 1991; Wittchen, 1994), in addition to validity (Reed *et al.* 1998). Test–retest reliability (κ) of the DIA-X/M-CIDI was reported to be 0.68 ($p < 0.001$) for major depressive disorder and 0.64 ($p < 0.001$) for bipolar disorder

(Wittchen *et al.* 1998a). To ensure reliability of the assessments, fully trained and experienced psychologists who were allowed to probe with follow-up questions conducted the interviews. At baseline, the lifetime version of the DIA-X/M-CIDI was used, and the interval version for subsequent investigations. By using the lifetime version of the DIA-X/M-CIDI at baseline, which includes questions regarding the time period from birth until the interview, it was possible to take into account the possible onset of bipolar disorder before the baseline interview.

Mania categories based on DSM-IV algorithms

Using M-CIDI/DSM-IV diagnostic algorithms (Pfister & Wittchen, 1995), participants were divided into four groups, those experiencing: (1) neither hypomanic nor manic episodes; (2) DSM-IV manic episodes; (3) DSM-IV hypomanic episodes; and (4) either manic or hypomanic episodes [hereafter: (hypo)manic episodes]. The last three groups were subsequently subdivided into participants (*a*) with lifetime co-morbid depressive episodes and (*b*) without lifetime co-morbid depressive episodes.

Mania categories based on symptom score

(Hypo)manic symptoms were assessed using 11 items of the DIA-X/M-CIDI mania section, and concerned items regarding an increase in goal-directed activity, psychomotor agitation, spending sprees, sexual indiscretions, increased talkativeness, flight of ideas, increased self-esteem or grandiosity, decreased need for sleep, and distractibility. These items were rated yes (1) or no (0) and were only rated if: (*a*) at least one of the core symptoms 'unusual happiness or excitement' or 'unusual irritability' was present; (*b*) core symptoms were either noticed by others or caused participants problems; (*c*) symptoms were present for at least four successive days; (*d*) symptoms were not a result of alcohol/drugs use. Guided by previous work (Regeer *et al.* 2006), a sum score of symptom ratings was formed (range 0–11 symptoms). Five progressively stricter and overlapping subcategories of this sum score were created (I, no symptoms; II, ≥ 1 symptom; III, ≥ 4 symptoms; IV, ≥ 7 symptoms; V, ≥ 10 symptoms), which represented the underlying continuous score of (hypo)manic symptoms.

Mania categories based on distress

In participants with ≥ 4 (hypo)manic symptoms, a division was made based on the level of distress, as reported in the DIA-X/M-CIDI mania section. Distress was assessed by asking participants if, at the moment the symptoms were at their worst, they interfered with

life, work or leisure activities, and was coded (1) no interference, (2) some interference, (3) considerable interference and (4) much interference.

Grouping by mental health care

In participants fulfilling criteria for at least one of the above categories, grouping was applied based on whether or not mental health care had been received at the respective assessment. First, participants were asked if they had ever been treated in a hospital or had spoken to a professional because of (hypo)manic symptoms. Second, participants were shown a list on which several types of out-patient, in-patient or day-patient institutions for mental health problems were mentioned, after which they were asked if they had ever sought help at any of these institutions because of mental health problems. All participants who responded positively to either one of these questions were considered to have received mental health care.

Childhood disorders

Between T0 and T1, face-to-face interviews were carried out with respondents' parents to collect information regarding ODD, CD and ADHD (hereafter collectively referred to as 'childhood disorders'). These childhood disorders were assessed with questions covering the criteria defined by the DSM-IV. Information was mostly based on maternal responses (97.4%). The response rate of parents was 86% ($n = 1053$).

Statistical analysis

Cumulative lifetime incidence (CLI) and person-year IRs

Weighting occurred to account for differences in sampling probabilities and also systematic non-response at baseline according to age, gender and geographical location (Lieb *et al.* 2000). Cumulative lifetime incidence up to T3 (CLI) of the (hypo)manic categories was calculated at T3.

Survival analysis was conducted to determine IRs between T0 and T3 using the ST commands in Stata, version 9.2 (StataCorp, 2005). CLI and IR estimates were calculated, grouping by receipt of mental health care. The IR is defined as the number of new cases of disease during a given time period divided by the sum of time that each person remains under observation and is free from disease (the total person-time of observation). After defining appropriate risk sets, IRs were calculated for each category. The risk set is defined as the set of individuals at risk of belonging to a certain category for the first time during the study. Therefore, participants with past or current evidence

Table 1. Cumulative lifetime incidence up to T3 and incidence rates (T0–T3) of (hypo)manic episodes, stratified by care

(Hypo)manic group	Restriction	CLI up to T3 ^a			IR (T0–T3) ^b		
		Total ^c	DEP +	DEP –	Total ^c	DEP +	DEP –
DSM-IV manic episode	None	3.3 (45)	1.3 (18)	2.0 (27)	308.9 (28.7/9277)	103.8 (9.8/9403)	201.9 (18.9/9358)
	MHC +	1.2 (17)	0.6 (9)	0.6 (8)	113.9 (10.7/9419)	50.6 (4.8/9448)	62.9 (5.9/9454)
DSM-IV hypomanic episode	None	4.5 (62)	1.4 (20)	3.1 (43)	409.5 (37.6/9184)	165.9 (15.6/9410)	237.6 (22.0/9258)
	MHC +	0.6 (8)	0.3 (4)	0.3 (4)	27.5 (2.6/9437)	24.5 (2.3/9467)	2.9 (0.3/9453)
DSM-IV (hypo)manic episode ^d	None	7.6 (106)	2.7 (37)	4.9 (69)	713.5 (64.1/8982)	262.3 (24.5/9334)	433.7 (39.6/9131)
	MHC +	1.8 (25)	0.8 (12)	0.9 (13)	132.6 (12.4/9376)	65.8 (6.2/9436)	66.0 (6.2/9424)

CLI, Cumulative lifetime incidence; IR, incidence rate; MHC +, episodes in combination with mental health care; DEP +, with depressive episode; DEP –, without depressive episode.

^a Values are expressed as percentage (number) of cases.

^b Values are expressed as number of cases per 100 000 person-years (denominator is population of person-years).

^c Total group, independent of having lifetime depressive episodes.

^d (Hypo)manic episode: either hypomanic or manic episode.

of this category at baseline were excluded from analysis, in which the strictest possible exclusion criteria were used [e.g. all participants experiencing ≥ 1 symptom were excluded for analyses of incidence of (hypo)manic symptoms]. The total person-times of observation of the individual risk sets thus defined are presented in Table 1.

Childhood morbidity sensitivity analyses

To assess how much of the incidence of bipolar categories could be traced to childhood morbidity, comorbidity with childhood disorders was assessed and childhood morbidity sensitivity analyses (CMSAs) performed. First, lifetime co-morbidity between T0 lifetime (hypo)manic episodes and childhood disorders was assessed using logistic regression. Second, Cox regression was used to calculate associations between childhood disorders and incidence of new (hypo)manic episodes between T0 and T3. Third, CLI and IRs for (hypo)manic episodes were recalculated with exclusion of individuals with these childhood disorders. Similar sensitivity analyses were performed for other (hypo)manic categories.

Demographic risk factors

IRs were calculated stratified by age group as a time-varying variable (15–16, 17–18, 19–21, 22–24 and 25–28 years; age = age during any moment of the study), sex and urbanicity [living in city or rural area at baseline; city area = city of Munich (population density 4061 persons per square mile) and rural area = the Munich surrounding area (population density 553 persons per square mile)] (Spauwen *et al.* 2006). Statistical differences in IRs within age, sex or urbanicity categories

were tested using Cox regression analysis yielding hazard ratios (HRs), using the 15-year age group, male sex, and rural area as reference categories (Table 2). To assess whether any association with demographic factors was independent of the others and unconfounded by co-morbid current or childhood psychopathology, HRs of all categories were adjusted for age, sex, urbanicity, presence of depression (diagnosis of a lifetime DSM-IV depressive episode) and presence of childhood disorders (diagnosis of either ODD, CD or ADHD according to DSM-IV criteria) using the STATA STRATA option for adjustment by stratification in Cox regression. HRs of the distress categories were additionally adjusted for number of (hypo)manic symptoms (as indexed by the continuous sum score of symptom ratings). As part of the CMSA, HRs were calculated similarly after exclusion of participants suffering from childhood disorders.

Results

Analyses are based on 1395 adolescents (51% male). The mean age at baseline was 15.1 years (s.d. = 1.1). Four-hundred and fifteen adolescents (30%) were living in a rural area. Of the 1395 adolescents, 1022 completed T3. Attrition rates were almost equal for sex (28.8% females *v.* 24.8% males), urbanicity (25.3% rural *v.* 27.3% city), and age (22.4% 13-year-olds *v.* 23.8% 14-year-olds *v.* 29.6% 15-year-olds *v.* 25.7% 16-year-olds *v.* 29.5% 17-year-olds).

Incidence of DSM-IV (hypo)manic episodes

CLI rates varied between 1.3% and 7.6% for the different DSM-IV episodic groups, declining after restriction to episodes plus mental health care (Table 1).

Table 2. Predictors of incident (hypo)manic categories

	Risk of incident (hypo)manic category, HR (95% CI) ^b			
	Age (RC: 15-year age group)	Female v. Male (RC: male sex)	City v. Rural (RC: rural)	Childhood disorder (ODD, CD or ADHD)
Manic episode	0.74 (0.50–1.10)	0.07 (0.065–0.79)*	1.55 (0.37–6.57)	3.65 (0.92–14.45)
Hypomanic episode	0.65 (0.50–0.85)**	1.55 (0.62–3.85)	1.08 (0.42–2.77)	7.82 (1.94–31.60)*
(Hypo)manic episode ^a	0.67 (0.54–0.84)**	0.75 (0.36–1.56)	1.21 (0.55–2.66)	5.29 (2.01–13.91)**
≥1 symptom	0.63 (0.55–0.72)**	1.40 (0.94–2.08)	1.15 (0.75–1.77)	0.83 (0.36–1.92)
≥4 symptoms	0.60 (0.51–0.72)**	1.46 (0.88–2.43)	1.10 (0.64–1.89)	1.06 (0.38–2.92)
≥7 symptoms	0.61 (0.45–0.85)*	0.40 (0.13–1.18)	4.51 (0.94–21.72)	2.38 (0.50–11.31)
≥10 symptoms	0.34 (0.11–1.06)	0.60 (0.05–6.79)	5.44 (0.28–107.42)	N.A.
Some distress	0.66 (0.49–0.89)*	0.99 (0.38–2.61)	1.10 (0.43–2.80)	0.95 (0.24–3.71)
Much distress	0.69 (0.43–1.10)	N.A.	0.56 (0.07–4.46)	1.23 (0.19–8.16)
Considerable distress	0.87 (0.34–2.21)	N.A.	0.93 (0.03–26.96)	N.A.
Psychiatric help	0.34 (0.13–0.86)*	2.73 (0.20–36.77)	N.A.	N.A.

HR, Hazard ratio; CI, confidence interval; RC, reference category; ODD, oppositional–defiant disorder; CD, conduct disorder; ADHD, attention deficit hyperactivity disorder; N.A., not applicable.

^a (Hypo)manic episode: either hypomanic or manic episode.

^b Results adjusted for age, sex, urbanicity, depression and childhood disorders. In case of distress/psychiatric help category: results also adjusted for number of (hypo)manic symptoms.

* $p \leq 0.05$, ** $p \leq 0.001$.

Table 3. Cumulative lifetime incidence up to T3 and incidence rates (T0–T3) of (hypo)manic symptoms, stratified by care

(Hypo)manic category	Restriction	CLI up to T3 ^a	IR (T0–T3) ^b
≥1 symptom	None	37.9 (528)	1720.0 (153.2/8909)
	MHC+	6.3 (87)	363.7 (32.9/9054)
≥4 symptoms	None	26.5 (370)	1112.2 (101.0/9080)
	MHC+	4.8 (67)	225.6 (21.0/9145)
≥7 symptoms	None	8.5 (119)	377.9 (35.4/9379)
	MHC+	2.4 (34)	94.7 (8.8/9328)
≥10 symptoms	None	1.0 (13)	77.9 (7.4/9455)
	MHC+	0.5 (7)	27.7 (97.3/9075)

CLI, Cumulative lifetime incidence; IR, incidence rate; MHC+, episodes in combination with mental health care.

^a Values are expressed as percentage (number) of cases.

^b Values are expressed as number of cases per 100 000 person-years (denominator is population of person-years).

Approximately a third of participants had co-morbid depressive episodes. IRs ranged from 104/10⁵ to 714/10⁵ person-years, declining after restriction to episodes plus mental health care (Table 1).

Incidence of (hypo)manic symptoms

The number of participants steadily declined with increasing level of symptoms (Table 3). For participants experiencing ≥1 symptom, the CLI was six times higher before restriction of the group to participants

with symptoms plus mental health care (Table 3). This discrepancy between CLI rates decreased as the number of symptoms increased.

Incidence of distress

CLI and IRs are presented in Table 4. Higher rates of distress were experienced by fewer people. The majority of people with 'some distress' remained outside care, and the majority of people with 'much distress' were in care.

Table 4. Cumulative lifetime incidence up to T3 and incidence rates (T0–T3) of distress, stratified by care^a

(Hypo)manic category	Restriction	CLI up to T3 ^b	IR (T0–T3) ^c
Some distress	None	10.8 (151)	1072.7 (97.3/9075)
	MHC +	1.8 (25)	167.0 (15.6/9358)
Much distress	None	4.1 (58)	267.0 (25.0/9371)
	MHC +	1.0 (14)	96.2 (9.1/9436)
Considerable distress	None	0.8 (12)	51.4 (4.9/9468)
	MHC +	0.2 (3)	18.4 (1.7/9464)

CLI, Cumulative lifetime incidence; IR, incidence rate; MHC +, episodes in combination with mental health care.

^a In participants with ≥4 (hypo)manic symptoms.

^b Values are expressed as percentage (number) of cases.

^c Values are expressed as number of cases per 100 000 person-years (denominator is population of person-years).

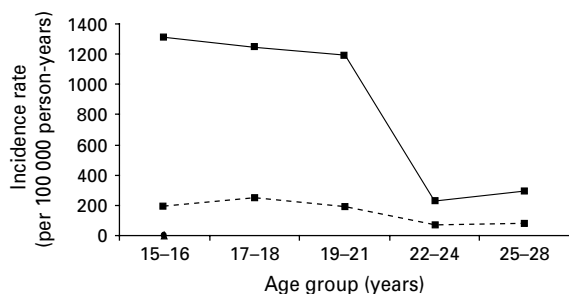


Fig. 1. Incidence of (hypo)manic disorder, stratified by age and care. —■—, (Hypo)manic episode^{a,b}; - - ■ - -, (hypo)manic episode^{a,b}, MHC +. MHC +, episodes in combination with mental health care. ^a (Hypo)manic episode: either hypomanic or manic episode. ^b Independent of having lifetime depressive episodes.

Association with childhood disorders

Seventy-six participants (7.2%) were diagnosed with any childhood disorder, mostly with ADHD (4.1%). Being diagnosed with a childhood disorder did not increase the risk of belonging to any (hypo)manic category at T0 (for detailed results see Tables 1-B, 1-D and 1-E at www.mania.homestead.com). The association between the incident (hypo)manic categories and childhood morbidity was large and significant [HR 5.29, 95% confidence interval (CI) 2.01–13.91, $p=0.001$ for (hypo)manic episode] (Table 2). Thus, CMSAs reduced incidence rates (at most) by a factor of 2 according to the (hypo)manic category (see Table 1-C at www.mania.homestead.com).

Age, sex and urbanicity

A strong association existed between age and IRs for all (hypo)manic categories (Table 2, Figs 1–3), with IRs decreasing as age increased. *Post-hoc* analyses showed

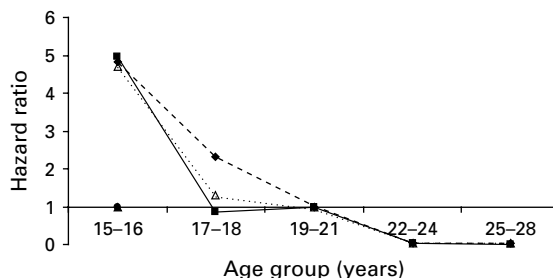


Fig. 2. Hazard ratios of incident (hypo)manic categories, stratified by age group. —■—, (Hypo)manic episode^{a,b,d}; - - ■ - -, (hypo)manic episode^{a,b}, MHC +. MHC +, episodes in combination with mental health care. ^a (Hypo)manic episode: either hypomanic or manic episode. ^b Independent of having lifetime depressive episodes. ^c In participants with ≥4 (hypo)manic symptoms. ^d Results adjusted for sex, urbanicity, depression and childhood disorders [oppositional–defiant disorder (OD), conduct disorder (CD) or attention-deficit/hyperactivity disorder (ADHD)]. ^e Results adjusted for sex, urbanicity, depression, childhood disorders (OD, CD or ADHD) and number of (hypo)manic symptoms.

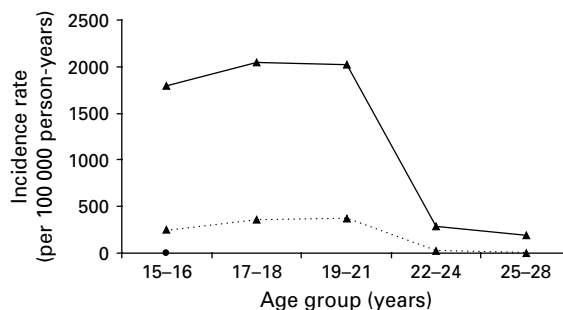


Fig. 3. Incidence of experienced distress in participants with ≥4 (hypo)manic symptoms, stratified by age and care. —▲—, Some distress; ···▲···, some distress, MHC +. MHC +, distress in combination with mental health care.

that the IRs of episodic categories, compared to the age group 15–21 years, decreased very strongly after the age of 21 years [HR 0.021, 95% CI 0.0024–0.18, $p=0.000$ for hypomanic episode; HR 0.031, 95% CI 0.0050–0.19, $p=0.000$ for (hypo)manic episode], with a similar decline (albeit statistically inconclusive) after restriction to episodes plus mental health care. Subsequent CMSAs showed a similar pattern of associations (see Table 1-C, Figs 2-B and 3-B at www.mania.homestead.com).

The incidence of manic episodes was 14 times lower in women compared to men (HR 0.072, 95% CI 0.065–0.79, $p=0.031$). However, no sex differences were present for other (hypo)manic categories and there was no association with urbanicity. In the CMSA, a male preponderance in incidence of manic episodes remained (HR 0.08, 95% CI 0.070–0.86, $p=0.037$), whereas a female preponderance was seen in the category with ≥ 1 symptom (HR 1.51, 95% CI 1.01–2.26, $p=0.045$).

Discussion

Findings

In this large prospective study of over 1000 adolescents and young adults, the results show that IRs of both (hypo)manic episodes and (hypo)manic symptoms are much higher than those reported previously, and that the risk of developing a disorder is very low after the age of 21 years, independent of childhood disorders such as ADHD. In addition, the results demonstrate a continuous distribution of (hypo)manic symptoms and distress, thus supporting the hypothesis that a dimensional representation may usefully describe the (hypo)manic phenotype (Allardyce *et al.* 2007). Only a small fraction of adolescents and young adults experiencing these phenomena were receiving psychiatric care and the co-occurrence of (hypo)manic episodes with depression was low compared to most of the literature. The incidence of the (hypo)manic categories, in particular categories at the level of clinical morbidity, was strongly associated with previous childhood disorders and male sex. In conclusion, this study showed, for the first time, that experiencing (hypo)manic symptoms is a common adolescent phenomenon that infrequently predicts mental health care use. The findings suggest that the onset of bipolar disorder can be elucidated by studying the pathway from non-pathological phenotypic expression to disability.

Limitations

Several limitations need to be considered. First, although a prospective design was used, the study

became partly retrospective by implementing questions regarding time intervals between waves. Therefore, the possibility of recall bias cannot be excluded, although arguably this would be likely to contribute more to false negatives than false positives (Simon & VonKorff, 1995).

Second, exclusion of individuals at T0 and exclusion of the older cohort means that the results are based on a limited age range with an associated decrease in statistical power. This could have caused the incidence to fall after the age of 21 years. However, similar results were found after the oldest two age groups were collapsed, thus increasing statistical power.

Third, the age range of participants was limited as follow-up of participants did not begin until the age of 14 years. Future studies should examine whether adolescent bipolar symptoms, relevant to adult clinical morbidity, are present also in younger samples.

Fourth, the analyses of childhood disorders were all based on retrospective parental report. This may have influenced the reliability of the results. However, Faraone *et al.* (1995) have shown that maternal reports of their children's psychopathology by 1-year recall provided a reliable and accurate means of assessment. In addition, the rates found for the childhood disorders analysed in this study are comparable to the rates found in other studies (Costello *et al.* 2003), which likewise attests to their validity.

Fifth, the predictive validity of the broad category of (hypo)manic symptoms may be enhanced by testing whether (hypo)manic symptoms can also predict depression. Testing this in a *post-hoc* analysis revealed that participants who had at least two (hypo)manic symptoms once at T0, T1 or T2 had a nearly twofold higher risk of ever experiencing a depressive episode compared to participants with less than two (hypo)manic symptoms at T0/T1/T2.

Cumulative incidence and person-year incidence rates

IRs in this study are much higher than those reported previously (Bebbington & Ramana, 1995). A partial explanation for this discrepancy may be the use of clinical samples in previous work. The effect of sample type on observed IRs is clearly shown in the current data, in which grouping for mental health care decreased IRs. However, the elevated IRs cannot be explained entirely by sample type because even for participants receiving mental health care, IRs were still higher than previously reported estimates, whereas CLI estimates did yield estimates comparable to those in previous reports (Lish *et al.* 1994). One reason for the higher IRs may be that the current sample consisted of adolescents, who display the highest risk of developing mental disorders (Kessler *et al.* 2005).

The focus on clinical samples might also explain the low co-occurrence of depressive episodes with (hypo)manic episodes because both types of episodes, independently of each other, increase need for care and help-seeking, resulting in more 'co-morbid' psychopathology at the level of mental health care ('Berkson's bias') (Regeer *et al.*, in press). Accordingly, the co-occurrence of depressive episodes in the current study was higher in participants receiving mental health care.

Bipolar disease as a developmental disorder

The greatest risk of developing (hypo)manic episodes was before age 22 years, after which it decreased to the point of almost disappearing. This finding is supported by other studies in which the most common age of onset for bipolar disorder was reported to be between 15 and 19 years (Szádóczy *et al.* 1998). Findings similarly concur with studies in which substantial numbers of adult patients retrospectively reported first experiencing symptoms in childhood or adolescence (Joyce, 1984). The findings in the current sample show low levels of cross-sectional comorbidity of childhood disorders with (hypo)manic categories at T0, but very high longitudinal comorbidity with new, incident bipolar categories, in particular at the level of clinical morbidity, over time. The CMSA in which childhood disorders were excluded did not change the pattern of association with age. The pattern of findings therefore suggests that the ontogenesis of (hypo)manic symptoms and (hypo)manic disorder may be traced to the adolescent developmental period and that expression of certain childhood disorders may increase the risk for later expression of bipolar morbidity.

Continuity

The current results suggest that (hypo)manic symptoms may represent a common phenomenon in the general population. Symptoms and clinical morbidity showed dose-response relationships, in that more cases of clinical morbidity arose as the number of symptoms increased, supporting continuity between subclinical and clinical categories. Evidence for continuity has been provided by others (Angst *et al.* 2003; Lewinsohn *et al.* 2003; Regeer *et al.* 2006). However, as evidenced by findings in the current study, the vast majority of these individuals with symptomatic expression never develop bipolar disorder. Thus, (hypo)manic symptoms may be conceived partially as pertaining to normal adolescent development. If, however, symptoms persist over time, individuals may be at risk of transition to bipolar disorder

(Cougnaud *et al.* 2007). Thus, future work should investigate whether adolescents with persistent (hypo)manic symptoms are at risk of making the transition to bipolar disorder, and which factors drive such transitions. Possible factors are symptom factors (intrusiveness, frequency and co-morbidity of symptoms), personal and cultural factors (coping, illness behaviour, societal tolerance and the development of functional impairments), and known bipolar risk factors (a positive family history, exposure to life events, or an interaction between these factors) (Lapalme *et al.* 1997; van Os & Verdoux, 2003; Hillegers *et al.* 2004; van Os *et al.* 2009).

Risk factors

Male sex was a risk factor for the onset of manic episodes. This is inconsistent with studies finding equal sex distributions (Lloyd *et al.* 2005). However, the finding does concur with several studies in which it was suggested that male sex is associated with earlier onset of mania (Carlson *et al.* 2000; Kennedy *et al.* 2005a). Male preponderance in incidence was not seen for subclinical bipolar categories, suggesting that male sex specifically increases the risk for clinical morbidity. The link between male sex and poor outcome is well known for other types of psychotic illness, in particular schizophrenia (Castle & Murray, 1991).

Urbanicity generally did not increase the risk for (hypo)manic categories. This concurs with previous findings (Krabbendam & van Os, 2005). A recent study showed any association between (hypo)manic disorder and urbanicity is probably mediated by positive psychotic symptoms (Kaymaz *et al.* 2007).

Clinical implications

Several clinical implications are suggested by this study. First, given the possible wide distribution of low-grade bipolar experiences, the suggested specific developmental phase of expression and evidence that subclinical expression of bipolarity increases the risk for later bipolar disorder in a dose-response fashion (Regeer *et al.* 2006), a public health approach focusing on targeted early identification may merit further investigation. Second, work focusing on psychotic disorder has indicated that subclinical phenotypes may be more likely to make the transition to the fully developed disorder if there is persistence over time (Cougnaud *et al.* 2007; Dominguez *et al.*, in press). Thus, examining patterns and determinants of persistence of subclinical expression of bipolar experiences may be similarly instructive. Third, the findings suggest that greater symptom load and greater levels

of distress are associated with a higher probability of the outcome of mental health care. Understanding the dynamics between symptoms, distress and help-seeking is necessary to develop early interventions. Fourth, the findings suggest that only a minority of those with bipolar experiences are in care, similar to findings in depression and anxiety disorders. Given that, in depression, subsyndromal expression is associated with a substantial amount of disability (Judd *et al.* 2002), individuals with subclinical bipolar experiences not receiving care may similarly have a considerable degree of disability that could be reduced if recognized and treated.

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