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COMMENTARY

Patients' Perspectives on the Consequences of Eliminating Prepubertal-Pediatric Bipolar Disorder as a Valid Diagnosis

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1 | Introduction

Researchers have been so focused on the epidemiology of pediatric bipolar disorder (PBD) that they have forgotten to consider the subjective experience of those who have faced an early onset. PBD is a difficult diagnosis to make, but it should not be limited to adolescents and adults as Malhi et al. [1] just because clinicians are not confident in identifying its presentation in children. Instead of eliminating prepubertal PBD, as Malhi et al. [1] suggest, it would be beneficial to further the research on this phenomenon and bridge the research-to-practice gap so that more children are appropriately diagnosed. We dispute the claims by Malhi et al. [1] and Parry et al. [2] regarding the elimination of prepubertal PBD as valid diagnoses from the perspective of the authors' lived experiences with onsets <12. Despite its diagnostic complexity, prepubertal PBD exists. We present our experiences in adolescence, but we had previous signs of prepubertal PBD. However, our disorders were not diagnosed until later in life. We argue that our symptoms should have been caught prior to adolescence to quell the turmoil ourselves and our families experienced. Our experiences suggest that clinicians become more familiar with prepubertal PBD, rather than ignore the early signs and our lived experiences. We are not the only children to have experienced this phenomenon.

1.1 | Our Story

We both experienced prepubertal PBD symptoms but did not receive an appropriate diagnosis until adulthood. As a result, when we reached adolescence, our early manic and depressive symptoms had turned into full-blown PBD. We engaged in self-harming behaviors such as cutting, burning, and choking. We both ran away from home at an early age and had severe problems with hypersexuality, insomnia, lying, and skipping or dropping out of school.

1.2 | Katrin's Story

Katrin experienced an onset at around 6 years old but was diagnosed with unipolar depression. Although she primarily experienced symptoms of depression, there were clear signs of mania that her family and clinicians missed. At 6 years old, she experienced bouts of energy and decreased need for sleep. Although shy as a child, she went through periods of verbosity that were out of character for her. She remembers a time when she felt especially confident and talkative in a manner that was uncharacteristic, but she could not control her feelings or actions. She proceeded to get up in front of her class and teach her peers alongside the teacher. If the diagnosing clinician had asked her or her family about these abnormal behaviors, she may have been diagnosed and treated properly. Instead, she fluctuated between periods of suicidal ideations, an inability to speak or eat in front of others, and periods of extreme verbosity that led to an inability to function in school. She was finally put on selective serotonin reuptake inhibitors (SSRIs) and experienced mania throughout adolescence until her first hospitalization at the age of 19.

To suppress the symptoms, she was experiencing in her adolescence, she began using marijuana and eventually dropped out of school. Katrin's family finally sent her to a therapeutic wilderness program and a therapeutic boarding school where she was able to talk more freely with other adolescents who shared similar experiences. Even then, her counselors and clinicians failed to recognize the appropriate diagnosis and continued to treat her for unipolar depression.

1.3 | Kathryn's Story

Kathryn never got more than 5 h of sleep after the age of eight. She stayed up all night making up stories, acting them out in bed. She experienced symptoms of hypergraphia as early as six—spending hours writing and generating scores of pages a day. This got worse as she got older, and by the time she was 10, she routinely filled whole journals in 2 day. Her report cards from first and second grade were mixed, and her teachers stated that she ran around the classroom and talked too much, including talking to children and adults she did not know. By the time she was in second grade, she was in therapy, but no clinician identified these early signs of mania, and by the second grade, she had suicidal ideations. At home, she compulsively lied and stole.

By the time she was 16, Kathryn worked two jobs while attending school, rarely slept, and although she was the editor of her senior yearbook, she did not graduate from high school because she skipped class too much. By the time she was 19, she had numerous risky sexual encounters and was married to an abusive man 25 years older than herself. She had her first suicide attempt at the age of 20, after which she was finally diagnosed.

1.4 | Consequences of Not Identifying Prepubertal PBD

The Kindling and Sensitization Model [3] suggests that early life stress leads to subsequent bipolar mood episodes, cognitive impairment, frontal cortical abnormalities, faster and more frequent recurrence of episodes, shortened telomeres, greater risk of dementia, and higher rates of dysfunction and disability. Furthermore, PBD is linked to a more severe course of the disorder than with adult-onset, resulting in higher rates of suicidality, greater treatment-refractoriness, larger rates of substance abuse, and poorer psychosocial effects [4]. Preventing or limiting episodes in childhood may limit future episodes in adolescence and adulthood. Had our episodes been identified and treated psychosocially in childhood, our adolescent and early adult episodes may have been reduced or made less harmful. While researchers debate the epidemiology of PBD, children and adolescents are suffering the consequences of the 5- to 10-year rate of misdiagnosis [5].

1.5 | Conclusion

Malhi et al. [1] and Parry et al. [2] focus on the rate of PBD rather than the phenomenon. For those who have experienced an onset <12, this is quite distressing. Do children in distress have to wait to be diagnosed because researchers are giving up on understanding prepubertal PBD and focusing solely on its epidemiology? For those who have experienced such an early onset, it is as if the field of psychiatry has given up. We could have avoided the adversity we experienced if our symptoms had been recognized, addressed, and treated at the onset. Had we known the cause of our symptoms, we could have had more support during our developmental years rather than using maladaptive coping mechanisms that affected ourselves and our families. We propose that researchers and clinicians become better acquainted with the phenomenon of prepubertal PBD rather than focusing on its epidemiology. Furthermore, we suggest that research be geared toward better diagnostic methods rather than ignoring the phenomenon altogether.

Consent

The authors have provided written consent to the publication of this manuscript having been informed that they are disclosing information that is of a personal and sensitive nature.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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