Your Child Does Not Have Bipolar Disorder

How Bad Science and Good Public Relations Created the Diagnosis

Stuart L. Kaplan, MD

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Childhood in America
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AN IMPRINT OF ABC-CLIO, LLC
Santa Barbara, California • Denver, Colorado • Oxford, England

Library of Congress Cataloging-in-Publication Data

Kaplan, Stuart L.
Your child does not have bipolar disorder : how bad science and good public relations created the diagnosis / Stuart L. Kaplan.
p. cm. — (Childhood in America)
Includes bibliographical references and index.
ISBN 978-0-313-38134-8 (hard copy : alk. paper) — ISBN 978-0-313-38135-5 (ebook)
1. Manic-depressive illness in children—Popular works. I. Title. II. Series.
RJ506.D4K37 2011
618.92'895—dc22 2010047612

ISBN: 978-0-313-38134-8
EISBN: 978-0-313-38135-5

15 14 13 12 11 1 2 3 4 5

This book is also available on the World Wide Web as an eBook.

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Praeger
An Imprint of ABC-CLIO, LLC

ABC-CLIO, LLC
130 Cremona Drive, P.O. Box 1911
Santa Barbara, California 93116-1911

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To Joan Kaplan, my wife and soul mate, and to
Lawrence Kaplan, my son and good friend

In memory of my father, mother, and brother:
Leonard Kaplan, Anne Kaplan, and Philip B. Kaplan

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Acknowledgments

I am grateful to Dr. Joan Kaplan, Sarah Manges, Naomi Busner, and Philip Busner for their editorial assistance and support. I also wish to thank Dr. Sharna Olfman for including this book in her important series, Childhood in America. Finally, I thank Dr. Walter Kaplan and Benita Kaplan for their affectionate support throughout the preparation of the book.

Introduction

In the autumn of 1993 I attended a workshop on bipolar disorder in prepubertal children at the annual meeting of the American Academy of Child and Adolescent Psychiatry. About 10 psychiatrists attended the workshop, which was held in a small, poorly lit room. Only one or two of the doctors present reported actually having seen a prepubertal child with bipolar disorder, but we all agreed to keep our eyes open for other sightings. After the meeting, I returned home to meet with the staff of the large psychiatric inpatient unit I ran for children ages 13 and younger. I asked if anyone on staff had diagnosed a child patient with bipolar disorder. The staff reported that they had never seen such a child.

Approximately three years later, I attended another session about bipolar disorder in prepubertal children at the American Academy of Child and Adolescent Psychiatry annual meeting. This session was held in a huge ballroom beneath a gleaming chandelier, and there were several hundred child psychiatrists in attendance, all of them buzzing with excitement. This was, for me, the first tangible evidence of the tidal wave of unwarranted enthusiasm that was about to engulf the public and the profession for the still relatively new diagnosis of pediatric bipolar disorder.

In less than a decade, from roughly 1994 to 2003, the diagnosis and treatment of bipolar disorder in children and adolescents underwent a dramatic transformation. Before 1995, bipolar disorder was rarely diagnosed in children and adolescents; today nearly one-third of all

children and adolescents discharged from child psychiatric hospitals have been diagnosed with bipolar disorder and are treated accordingly (Blader & Carlson, 2007). The rise of outpatient office visits for children and adolescents with bipolar disorder has increased forty-fold, from 20,000 in 1994–1995 to 800,000 in 2002–2003 (Moreno et al., 2007).

Your Child Does Not *Have Bipolar Disorder* will examine this phenomenon through a variety of lenses. I will draw heavily on my 40 years of experience as a clinician, researcher, and professor of child psychiatry and will make the argument that bipolar disorder in children and many adolescents is incorrectly diagnosed and incorrectly treated. I will discuss the events that precipitated the dramatic increase in the diagnosis, present the evidence against the diagnosis, and describe effective alternative diagnostic and treatment approaches for the serious difficulties these children do exhibit.

Psychiatry, like all branches of medicine, is expected to be based on science. Research is ongoing, and treatment methodology is updated regularly. This, in part, is what makes the dramatic rise in this particular diagnosis so disturbing: It is not based on scientific evidence. It does not reflect any new discovery or insight about the etiology or treatment of the disorder. In fact, the opposite seems to be the case: the scientific evidence *against* the existence of child bipolar disorder is so strong that it is difficult to imagine how it has gained the endorsement of anyone in the scientific community.

Although these children do not have bipolar disorder, they are seriously disturbed. They often have behavior problems at home and at school. They are disrespectful to their teachers, they run around in school hallways, and they are unable to sit still in class or concentrate on schoolwork. Prone to violent outbursts, they may hit other children and get in trouble for fighting. In more serious cases, they may be in and out of child psychiatric units and may end up in juvenile detention centers. Their home lives may be chaotic. Their parents are often exhausted and sometimes feel hopeless. These are children like Victoria, an 11-year-old whose history of violent temper tantrums included breaking her father's ankle with an iron bar, and Shanice, age 10, whose family came to see me after her ninth hospitalization for bipolar disorder.

For children such as these and their families, a misdiagnosis of bipolar disorder can have devastating consequences. Such children are regularly prescribed medications that, although effective in adults with bipolar disorder, are not effective in children, are laden with risk, and have unwelcome side effects.

Because these children are being treated for something they don't have, they often don't get treated for what they do have. It is well established that 60% to 90% of children who have been diagnosed with bipolar disorder also have attention deficit hyperactivity disorder (ADHD) (Singh, DelBello, Kowatch, & Strakowski, 2006). It has also been well chronicled that, dosed correctly, 80% of children with ADHD respond favorably and dramatically to stimulant medication (Greenhill et al., 2002). Unfortunately, those who champion the cause of bipolar disorder in childhood routinely warn against the medication treatment of ADHD. Instead they have insisted, with almost no evidence, that such treatment will lead to a dramatic worsening of the bipolar disorder. Thus, the one class of medication that might be most helpful is frequently withheld.

It is my hope that this book will facilitate the reevaluation of the diagnosis and treatment of many children now misdiagnosed as having bipolar disorder.

Although I can't know without meeting you and your child that your child does not have bipolar disorder, I have interviewed thousands of psychiatrically disturbed children under 13 years of age and have never found a child I believed actually had this diagnosis. Therefore it is highly likely that were I to examine your child, I also would conclude that your child does not have bipolar disorder.

This book is an argument against the diagnosis of bipolar disorder in childhood. It is directed at parents, mental health professionals, and anyone interested in major issues in contemporary child psychiatry. My main argument is simplified by confining it to prepubertal children initially, but the argument is broadened later to include adolescents.

The book is divided into three parts. Part I consists of a critique of the bipolar disorder diagnosis among children and adolescents as well as a critique of the studies that have attempted to support the diagnosis. Some of the social and cultural forces that have influenced the rapid and wide-scale adoption of the pediatric bipolar disorder diagnosis are explored. Part II considers the medications that have been involved in the treatment of children and adolescents misdiagnosed with bipolar disorder. Part III provides direct advice for parents.

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PART I

Critique of Pediatric Bipolar Disorder

1

Adult Bipolar Disorder and the *DSM* System

Beneath all of the controversies surrounding pediatric bipolar disorder is the fact that there is no demonstrable biological basis for any psychiatric disorder, which means that there is no conclusive biological test for any psychiatric diagnosis. There is no laboratory test for a psychiatric disorder, unlike, for example, diabetes, where the presence of high blood sugar confers a degree of solidity to the diagnosis.

Instead of laboratory tests, there is the *Diagnostic and Statistical Manual of Mental Disorders*, commonly referred to as the *DSM*, which is published by the American Psychiatric Association and is widely regarded as the authoritative text on mental illness. The *DSM*, now in its fourth edition, is a compilation of accepted psychiatric diagnoses in the United States, the symptoms of the diagnoses, and the rules for combining the symptoms to establish a diagnosis (American Psychiatric Association, 2000). The *DSM*, which functions with considerable authority, defines mental illness and what conditions will be accepted as constituting mental illness in the United States.

The arguments that will be presented in this book rest, in part, on the fact that what has been called "pediatric bipolar disorder" does not meet the *DSM-IV* criteria for bipolar disorder. The *DSM-IV* criteria describe the symptoms that occur in adults. As will be shown, they do not describe the symptoms that occur in children who have been labeled as having bipolar disorder. To illustrate this most clearly, adults with bipolar disorder will first be described, both to explain bipolar disorder and to contrast it with the lack of these symptoms in children

misdiagnosed as having it. These children will be described in the next chapter.

ADULT BIPOLAR DISORDER

Bipolar disorder, once known as "manic-depressive illness," is characterized by cycles in which a patient rotates between two extremes, or poles, of feeling states: depression and mania. Mania is a necessary component of the diagnosis of bipolar disorder: without a distinct period of mania, the diagnosis cannot be made. In order to appreciate fully what is meant by mania, it may be helpful to understand some of the common behaviors and experiences associated with the condition as it appears to clinicians and patients (Goodwin & Jamison, 2007).

Often, mania begins with a pleasant feeling of happiness. The patients are more pleased than usual with themselves and their capabilities. They begin to talk more loudly and rapidly. They become more active physically and mentally, are able to think more quickly, and accomplish much more than usual with little sense of effort. They have increasingly ambitious ideas about projects at home and work, and everything begins to seem possible. The world may appear fresher and brighter, and the patients' own emotional responses to the world and other people may seem heightened. They become excited about their lives and their activities. Their enjoyment in talking with people increases, and they quickly develop a wider circle of friends. They require less sleep. As the mania develops, they crave more frequent sexual activity and more sexual partners. They believe that they are thinking more quickly and accomplishing more in a reduced amount of time. In the background of these pleasant feelings, irritability may break through as they become less able to wait patiently for the slowness of other people.

This level of mania is known as "hypomania" and is extremely pleasant for patients; they have no desire to give it up. They do not experience themselves as mentally ill; instead, they experience themselves as having a marked increase in productivity, creativity, and happiness.

This is not how they are experienced by others. In the memoir *An Unquiet Mind* by Kay Jamison, PhD—a psychologist who also suffers from bipolar disorder—this was described poignantly (Jamison, 2007). As a female first-year graduate student, Jamison attended a reception for new students given by her dean. At the party she found herself to be charming and witty. She believed that she had managed to interest other faculty members in several of her projects and that she had captivated many senior department members with her affability and charm. Many months after the party, she learned that others regarded her behavior quite differently. She had been seen as having