Your Child Does *Not* Have Bipolar Disorder

How Bad Science and Good Public Relations Created the Diagnosis

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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

worn inappropriate, sexually provocative clothing, having had poorly applied, smeary makeup, and as having talked loudly and fast. Most people at the party, she was told, had had a difficult time understanding her.

Hypomanic patients are recognized by their friends and family as behaving differently from their usual selves, and the difference does not always win social approval. The patients believe that there is nothing wrong with them and shrug off suggestions that they seek help. They refuse to recognize the overexcited, loud, intrusive quality of their behavior. The pleasure they experience in this state leaves most hypomanic patients reluctant to seek or accept treatment.

There is much that is enviable about hypomanic states. Hypomanic patients are active, energetic, tireless, personable, intensely committed to work, ambitious, and sexually active, and they derive great joy from life. Jamison (2004) has argued persuasively that many of mankind's greatest accomplishments in poetry, music, and other areas have been created by individuals in hypomanic or closely related states.

The bliss of the hypomanic state faces many threats. The patient's hypomania may intensify and result in manic symptoms that impair rather than enhance functioning. Shifting from a hypomanic state to a manic state often leads to patients becoming more aggressive, irritable, and intolerant of what they perceive to be others' shortcomings. Becoming less inhibited, they may become loud, rude, and may curse and engage in physical fights. They speak incessantly and become enraged if others try to interrupt or redirect a conversation. They make poor decisions about handling their sex lives that can get them into a variety of difficulties with spouses and acquaintances. Money is spent with increasing recklessness, and extravagant purchases may be made that are not affordable. A typical complaint from a family with a manic breadwinner is the patient bringing home a luxury car such as a Rolls Royce that the family can ill afford. Ambitious business plans become increasingly far-fetched. With great excitement patients may contact a large number of investors to put up money for unrealistic business deals. One of the ironies of patients in this state is that they can organize themselves to be very persuasive and may actually convince others to invest in their projects. The patients think quickly, speak loudly, and are intrusive. They can sleep as little as three hours per night, sometimes less, and still feel rested. The manic patients' self-esteem and self-regard are extremely high.

The patients' mania may continue to evolve until they become psychotic. Psychotic symptoms can include delusions (fixed, false beliefs) and hallucinations (seeing and hearing things that are not present). The delusions developed by many manic patients are often paranoid,

meaning that they sometimes believe that people are out to hurt them or are plotting against them. They may also develop grandiose delusions—believing themselves to be religious or mythological figures or believing that they possess special powers or importance.

Sometimes the behaviors are disruptive to the extent of requiring hospitalization. This was the case with Ms. Jones, a 20-year-old single woman whom I met several days after she was discharged from her first psychiatric hospitalization for bipolar disorder. She had been brought to the emergency room by her supervisor at work, who was concerned about her rapid, incoherent, loud speech, and disheveled appearance. At the hospital she was interviewed by a psychiatrist who immediately recognized her as acutely manic and hospitalized her.

A month earlier, Ms. Jones had begun working in a hospital laboratory after completing a year-long laboratory technician program. Within a week, she began to make complaints to the supervisor about the poor work habits of her colleagues, claiming that they were lazy and indifferent to laboratory procedures. At home her behavior had become quite bizarre. She told her boyfriend that she had been called by God to become a doctor and heal people in faraway lands. She told him that she believed she was destined to make major medical discoveries. She began looking for medical schools on the Internet and told her boyfriend that she felt certain they would accept her. Although she had never been particularly interested in her studies, she began to call for applications to Ivy League colleges for "pre-med" studies in anticipation of applying to medical school. She became enraged frequently and would destroy objects in the house if her boyfriend or others questioned her ability to attend medical school. Along with her medical school plans, she enrolled in a Bible study group and began staying up all night reading sections of the Bible aloud. She believed that it was her calling to become a doctor and do medical missionary work. She slept a total of one or two hours a night without feeling tired. She began calling acquaintances and relatives at odd hours demanding money to pursue her goal of becoming a medical missionary. On the day she was hospitalized, Ms. Jones had spoken to her supervisor at work to announce that she needed a leave of absence so she could pursue her goal of becoming a medical missionary.

While in the hospital, Ms. Jones slept little and read the Bible incessantly. She came to believe that she had the power to help the other patients on the unit by touching them on the back and on the chest, which she described as a biblical prescription for healing the sick. She sang hymns six to seven hours a day and organized several other patients to join her in singing. She continued to believe that she did not have bipolar disorder, though she did not refuse the medication

prescribed during her hospital stay. She was significantly better and ready for discharge within two weeks. Fear of rehospitalization and her fear of losing her boyfriend and job prompted her to continue to take her prescribed medication and to attend therapy appointments regularly. She continued to improve and was able to resume employment at the hospital laboratory.

Patients in severely manic states barely sleep, may barely eat, and as their judgment deteriorates, put others as well as themselves at risk. Typically, manic patients refuse treatment and cannot be controlled. They are overactive and angry, and it is not unusual for severely manic patients to be brought in to an emergency room by the police and then psychiatrically hospitalized against their will. Manic patients are very often enraged at confinement of their activities to an inpatient psychiatric unit and may become violent.

In the less severe stages of mania, patients may be able to fake an absence of mental illness. This is most often seen when families bring manic relatives for evaluation to psychiatric hospitalization and the patients do not wish to be hospitalized. The patients may behave very reasonably during the psychiatric evaluation to avoid hospitalization but then resume their bizarre behaviors immediately following the psychiatric interview.

The opposite is possible as well. A group of women with long-standing bipolar disorder living in a home for the chronically mentally ill lost the heat in the home in the middle of a bitterly cold winter. At their own request, they were brought by the police to a psychiatric emergency room where, seen individually, they seemed agitated and psychotic. They wanted to be admitted to the psychiatric hospital, and they were. Immediately after they were admitted, all calmed considerably and talked rationally among themselves amiably and at great length. The agitation prior to admission may have been feigned to secure admission to the warmth of the heated psychiatric unit.

Both mania and hypomania typically end in a crushing, painful depression. Patients lose their capacity to enjoy life, become despondent, suffer feelings of intense guilt, and often contemplate suicide.

An episode of depression that shortly follows an obvious, recognized manic episode is easily diagnosed as a depressed phase of bipolar disorder. If the bipolar disorder begins as depression, however, without a preceding hypomanic or manic episode, it is not possible to recognize the depression as part of bipolar disorder; the diagnosis of bipolar disorder requires an episode of mania or hypomania. Further complicating the task of diagnosing bipolar disorder, the patient may not recognize having had a hypomanic phase in the past and may seek treatment only after the appearance of the depression. During a first depressive

episode, the patient may deny any previous symptoms of hypomania. It is only the psychological pain of the depression that leads him or her to seek help.

Bipolar disorder patients often cycle from mania to depression and back to mania again; between these manic or depressed episodes are apparently normal periods of functioning. Most of the patients (90%) who have had one episode are likely to have another "mood swing" or episode. These subsequent mood swings are often preventable with medication if the patient agrees to take it; bipolar disorder patients who are early in the course of their illness may find it difficult to believe that they continue to have the illness and continue to require medication.

Although bipolar disorder might present itself in a variety of ways, all cases share a common set of symptoms. In order for a diagnosis to be made certain criteria must be met. These criteria, which are listed in the *DSM-IV,* are not ambiguous: they are described explicitly and with great care.

The argument against the diagnosis of pediatric bipolar disorder is that pediatric bipolar disorder does not meet the *DSM-IV* criteria for bipolar disorder. In fact, the disorder in children looks nothing like the disorder in adults. Before we can attempt a detailed comparison of the two, however, it will be helpful to gain some understanding of the *DSM* system of psychiatric diagnosis and to see how this system works in diagnosing bipolar disorder.

THE *DSM* SYSTEM

The resolution of any dispute about the diagnosis of a psychiatric disorder must begin by consulting the authoritative description of psychiatric diagnoses: the *DSM-IV* of the American Psychiatric Association. "DSM" stands for *Diagnostic Statistical Manual,* and "IV" stands for the fourth edition (American Psychiatric Association, 2000).

There is a new edition of this manual published about every 10 years, and often there are minor revisions every 5 years. The manual is based largely on the recommendations of committees of experts in every diagnostic area who review the available published research studies and any known unpublished data in their areas of expertise. The diagnostic criteria are subject to lengthy critical discussions, and contributions outside the committee structure are also sought from the larger professional and consumer public. As part of the *DSM* process, the criteria are field tested with actual patients to ensure that professionals can use them with relative ease to diagnose patients. In these so-called field trials, the ability of mental health professionals to achieve agreement about the diagnosis is carefully studied.

The *DSM-IV* criteria are easily observable or easily obtained from patient report. These criteria are symptom based and in general do not refer to any causes or theories about illnesses. If a patient has the symptomatic criteria for the illness, he or she has the psychiatric illness. The *DSM-IV* system is based on the humbling truth that the cause of mental illness remains unknown.

The criteria outlined in the *DSM-IV* tend to facilitate a patient receiving the same diagnosis regardless of where he or she is receiving care. Before *DSM-IV* (and its predecessor, *DSM-III*, published in 1980) a patient diagnosed as having schizophrenia at one hospital might receive a different diagnosis at another hospital because of differences in theoretical orientations at the two hospitals. By having observable objective criteria for the diagnosis of mental illness, the *DSM-III* and *DSM-IV* systems minimized these discrepancies between institutions.

Criticisms of *DSM-IV* are plentiful but generally misguided. For example, *DSM-IV* uses specific symptoms to define a psychiatric illness. These symptoms must be asked about and noted to be present or absent. This has led to the complaint that the *DSM-IV* is dehumanizing to patients in that it minimizes or ignores the patients' life stories. John Sadler, MD, a professor and distinguished philosopher of psychiatry, suggested that talking only about symptoms pushes both the professional and the patient to become machine-like, with the professional almost robotically asking *DSM-IV* questions and the patient replying in a similar fashion (Sadler, 2009). Making a related point, David Healy, MD, a distinguished psychiatrist and author, noted that the *DSM* system promotes informational reductionism. By attending only to symptoms and ignoring the patients' history and current problems, he argued, the *DSM* system reduces the amount of information the mental health professional learns about the patient (Healy, 2009).

Although some users of *DSM-IV* may operate in such a fashion, there is nothing in *DSM-IV* that prohibits exploration of the patients' history, current problems, or any other aspect of the patient. And the standards of care of the various professions—such as the American Academy of Child and Adolescent Psychiatry practice parameters for child psychiatric evaluation—demand that professionals take account of these issues. A good psychiatric diagnostician uses the *DSM-IV* symptoms as a portal into important aspects of a patient's life experience.

A third criticism of the *DSM-IV* concerns its major assumption that psychiatric illness is categorical. This means that a patient either has the illness or does not have it, with little in between. If the criteria are met, the patient has the illness; if the criteria are not met, the patient does not have the illness. The categorical approach of *DSM-IV* contrasts with a "spectrum approach" to illness that views most patients

as having parts of many illnesses in different degrees. The benefit of the categorical approach to diagnosis is that it has served as an important barrier to the unwarranted proliferation of labeling people ill who are not.

Finally, and directly related to child mental health, is the criticism that *DSM-IV* lacks a developmental approach. It is claimed that differences between psychiatric illness in children and adults are ignored and differences in psychological development at different ages are treated as if they do not exist. It is true that *DSM-IV* criteria do largely ignore differences between children and adults; *DSM-IV* considers the disorders to be isomorphic (the same criteria apply to children and adults). This may seem to be a simplistic approach to the diagnosis of psychiatric disorders in children and adolescents, but it has been surprisingly effective. For example, prior to *DSM-III,* children and adolescents were not believed to have symptoms of depression. With the application of the *DSM-III* adult symptoms of depression to children and adolescents, however, this population was unexpectedly demonstrated for the first time to have adult symptoms of depressive illness. The opposite has been found as well. Attention deficit hyperactivity disorder (ADHD), long believed to be only a disorder of childhood and adolescence, has been found in adults as well using the *DSM-IV* criteria for the disorder. Adults respond equally well to medications routinely used in children for ADHD.

Regardless of the value of these criticisms, *DSM-IV* criteria serve as the accepted diagnostic criteria of psychiatric illness by clinicians, psychiatric researchers, insurance companies, the American legal system, the Food and Drug Administration, and the vast majority of mental health service providers in the United States.

For all *DSM-IV* diagnoses, there is a list of criteria that must be met in order to have the diagnosis. The "A" criterion is usually considered to be the most important or defining criterion of the syndrome. As can be seen from the list of criteria for a manic episode in Table 1.1, the "A" criterion of one week's duration of expansive or elevated mood can be substituted with irritability and can be shortened to less than one week if the patient is hospitalized. The "B" criterion requires the simultaneous presence of three of the seven listed symptoms—four if the mood is irritable. The "C" criterion reminds the diagnostician that all of the symptoms must be consistent with mania; a manic episode that has all the symptoms of mania plus mixes in symptoms of depression is known as "mixed"—another form of a manic episode. The "D" criterion refers to impairment, which means that the symptoms must interfere with the patient's life. Finally, the "E" criterion reminds the diagnostician that, like most *DSM-IV* diagnoses, a psychiatric diagnosis

TABLE 1.1. DSM-IV Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   (1) inflated self-esteem or grandiosity
   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   (3) more talkative than usual or pressure to keep talking
   (4) flight of ideas or subjective experience that thoughts are racing
   (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a Mixed Episode
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

is not permitted if the condition is due to a medical illness or some other biological cause such as medication or drugs.

Most of these criteria were illustrated in the first portion of this chapter, but there remains one critical point that will be especially relevant going forward: mania, by definition, is not a chronic condition, and the patient cannot have been this way his or her entire life. The "A" criterion specifies "A *distinct* period . . ." (emphasis added). When a patient is in a manic state, a different way of behaving and thinking emerges that is largely unrelated to the patient's previous behavior. Of necessity, the seven listed symptoms of mania (of which three must be present for the diagnosis) must have developed with the onset of the "*distinct* period." They were not present before the onset of the manic episode. Only if the patient first becomes overactive and distracted with the onset of elevated mood (euphoria) do the symptoms count toward a

diagnosis of mania. If the patient has always been overactive and distracted, the symptoms do *not* count toward a diagnosis of mania. *Distinct* refers to "different from the patient's usually functioning."

The "A" criterion of mania demands a period of "*persistently elevated, expansive, or irritable mood*" (emphasis added). Even if the diagnosis of mania is based on irritability rather than euphoria, the irritability must represent a distinct period—clearly different from the person's usual behavior. The elevated or expansive mood is not the happiness of a birthday or of Christmas. Instead, this lasts for at least a week and meets the criteria for the symptoms as described in the "B" criteria. Only after the patient has met the criteria for a manic episode can the *DSM-IV* diagnosis of bipolar disorder be considered.

There are many different forms of *DSM-IV* bipolar disorder, and it is useful to distinguish among some of them. "Bipolar I disorder, single manic episode," is given to a patient who has had a single manic episode but has never had a depressive episode. "Bipolar I disorder, most recent episode manic," requires a present or past manic episode with a past history of at least one other manic episode. If there were depressed or mixed (manic plus depressed) episodes, the most recent past episode must have been manic. "Bipolar I disorder, most recent episode depressed," requires the occurrence of at least one past manic episode, but the most recent episode the patient experienced must have been a depressive episode. The *DSM-IV* also recognizes "bipolar II disorder," which requires at least one "hypomanic" episode and one or more depressive episodes. A hypomanic episode is similar to a manic episode but is less severe.

When a disorder does not meet all the necessary criteria, *DSM-IV* allows for the label "not otherwise specified" (NOS). This means that the patient, by definition, does not meet the full criteria of the disorder, but *DSM-IV* allows the diagnostician to indicate that some of the symptoms of the disorder are present even though the criteria to make the diagnosis have not been met.

Those who have advanced the pediatric bipolar disorder diagnosis have not followed the criteria for the diagnosis outlined in the *DSM-IV.* Instead, many prominent psychiatric researchers have trumpeted to the public a "disorder" that uses the same name that has long been used to define a widely recognized illness but does not meet its *DSM-IV* criteria. About half of all children diagnosed with bipolar disorder are given the diagnosis "bipolar disorder NOS" (Axelson et al., 2006; Galanter et al., 2009). As will be shown in the next chapter, the bipolar disorder NOS diagnosis is a verbal sleight of hand that creates the illusion that a patient without bipolar disorder has the disorder. There is no *DSM* entity for a children's version of bipolar disorder. There is

simply bipolar disorder, and all of its criteria apply irrespective of the age of the patient.

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