

#305 - The Dangers of Diagnosing Children as Bipolar with Stuart Kaplan, MD

David Van Nuys, Ph.D., aka Dr. Dave interviews Dr. Stuart Kaplan

Introduction: My guest today is Stuart L. Kaplan, MD and we'll be discussing his book, *Your Child Does Not Have Bipolar Disorder*.

According to Stuart L. Kaplan, MD, there are six things you should know about him. He's a distinguished Life Fellow of the American Academy of Child and Adolescent Psychiatry. He's a Clinical Professor of Psychiatry at Penn State College of Medicine. He was awarded the Outstanding Mental Health Professional of the Year by the National Alliance of the Mentally Ill, Saint Louis Chapter, in 1998. He's served as the director of Child and Adolescent Psychiatry at three major institutions, two of which were university medical schools. He's Board Certified in Child Psychiatry and Adult Psychiatry and served as an examiner for the American Board of Psychiatry and Neurology 14 times. And finally, Dr. Kaplan has authored over 100 scientific papers, book chapters, abstracts and national and international scientific presentations.

Now here's the interview.

Dr. Dave: Dr. Stuart Kaplan, welcome to Shrink Rap Radio.

Kaplan: It's a pleasure to be here.

Dr. Dave: Well, I'm happy to finally have you on the show. I know you've been waiting in my queue for some time and then I missed one of our appointments because I went away on vacation and forgot that I had lined it up. So I thank you for your patience.

Kaplan: Well, of course, I'm delighted to be on. Not necessary to apologize at all. I'm just happy to be considered.

Dr. Dave: Before we get into your book, let me ask you how did you get into becoming a child and adolescent psychiatrist? I know you -- it's a role that you've been in for quite a while.

Kaplan: Right.

Dr. Dave: Is this something that you always knew you wanted to be or what?

Kaplan: Yes, actually it is. It goes back to my adolescence actually when I was a camp counselor for a couple of years, overnight camp, and I just found myself really so interested in the children I was taking care of and trying to be helpful to them. They would talk to me at times at great length about worries that they had and concerns that they had. I was just quite taken and fascinated by the notion of actually being able to help these kids and to provide them some comfort, solace just by talking to them.

Similarly, I began to read a fair amount about psychology and psychoanalyses as an adolescent. I was just really entranced by various writings about it. I just thought it was fascinating. So the idea that I could -- might one day become an actual psychiatrist was something that just held incredible appeal for me.

Dr. Dave: Well, that's great.

Kaplan: Something that I've stuck with all my life.

Dr. Dave: Yeah, that's great. You know there's something that we have in common is that camp counselor experience when I was --

Kaplan: Great.

Dr. Dave: Yeah, when I was a --

Kaplan: Go ahead. Tell me about it.

Dr. Dave: Yeah, when I was a graduate student at the University of Michigan, they had a camp for emotionally disturbed kids or boys called the Fresh Air Camp. In all places it was located in Hell, Michigan. (chuckles)

Kaplan: Aptly named I'm sure. (chuckles)

Dr. Dave: It was very aptly named. (chuckles)

Kaplan: (chuckles) Right, right.

Dr. Dave: Exactly. Your book is very provocatively titled, *Your Child Does Not Have Bipolar Disorder*, and the subtitle goes on to say, *How*

Bad Science and Good Public Relation Created the Diagnoses. Now that's a pretty strong accusation. Are you saying that children are never bipolar?

Kaplan: Well, I'll tell you I stand by the title. I chose that title very deliberately. A lot of academicians have danced around the idea that bipolar disorder has a dubious sort of existence but very few have come out and baldly stated what is a painful obvious truth as far as I'm concerned and as well as far as many other senior leaders in the field at this time.

I think the disorder -- you know as soon as you say that something in childhood, I think it's largely nonexistent. I hedge a little bit by saying largely because as soon as you say something doesn't exist, it's inevitable that somebody's going to find a case of it and say oh, well, here's a child who has bipolar disorder. Therefore, everything Kaplan said is wrong. So I want to avoid that, you know, I don't want to take a position that is highly improbably. This book, *Black Swan* -- soon as you say there's no black swans it turns out there's flocks of them in Australia and that sort of thing.

I'm sure there's a few cases around but they're extremely rare and --

Dr. Dave: Right.

Kaplan: -- very, very rare and people who say this disorder exists then the burden of proof is on them. Twelve and under in children, prepubertal children, it's largely nonexistent.

Dr. Dave: OK.

Kaplan: It does become a disorder in adolescence. Of course, it does appear during mid- to late adolescence.

Dr. Dave: Yeah, we'll get into adolescence in a bit.

Kaplan: Yeah, sure.

Dr. Dave: But your position is that it's very rare and yet as over a course of a very relatively few years now it's being -- according to your book something like 800,000 cases reported of child bipolar and yet there's no scientific evidence for it you say. Do I have that right?

Kaplan: Well, the people who say that it exists and believe in it and who study it, of course, believe strongly that there is scientific evidence for but when you examine the scientific evidence with a critical eye, the evidence that's put forward is easily countered, easily done away with.

The figure most often quoted, the most solid number in terms of the increase in the disorder is based on an article from Moreno, which is in 1994-95 to 2002, 2003. It was a 4,000 percent increase in the disorder. So it just soared dramatically. There was little or no scientific basis for this and it was largely a cultural phenomena. It was not really that there was some scientific discovery, something seen some place under a microscope or a test tube. There was really little scientific evidence for it. Culturally it was a firestorm and it just took off and managed to be perpetuated and disseminated.

Dr. Dave: You mentioned a name there that I didn't quite catch.

Kaplan: Yeah, I'm sorry. It's Moreno, M-o-r-e-n-o. He wrote an article along with his co-authors from New York, *Arch Gen Psychiatry*. I think that was around 2007.

Dr. Dave: OK.

Kaplan: And that article really was the first major public scientific obstacle or challenge to the diagnosis of bipolar disorder in children. That really was the first blow to the epidemic. I would say the first scientific blow to the epidemic.

Dr. Dave: Now you're not denying that a lot of kids do display some rather severe behavioral disorders, right?

Kaplan: Oh, of course not. Of course, I'm a child psychologist. I see very difficult, challenging kids all day long in a variety of different settings.

Dr. Dave: Yeah.

Kaplan: And kids, of course, children and adolescent can be extremely difficult.

Dr. Dave: Yeah, as a matter of fact, in today's paper I was reading an article about -- people are concerned that the police are being called into schools more and more to deal with what would have

been in the past just considered behavioral problems of one sort or another. Kids are being put into handcuffs. We can't deny that there are some problems out there.

Kaplan: Actually, I didn't see the article but I had a case, myself, this past week where the mother reported that her child, who's my patient -- the police came to the school and they put the kid in handcuffs. I think many disputes in the past would have been settled by more judicious-wise principle, some agreement between parents about how to handle the situation are much too rapidly being turned over to the police. It certainly was the case of my patient. It was ridiculous and now the poor child has to go to court and had to spend a few hours in a prison cell, the police station and everything.

Dr. Dave: Oh, my goodness.

Kaplan: And there really was no reason for it.

Dr. Dave: How old a kid was this?

Kaplan: He's around nine years old.

Dr. Dave: Wow.

Kaplan: Not an evil, malevolent child or even disruptive in particular. He just happened to get into a little -- he got into a fight in front of the school. I don't know whose fault it was but not the sort of thing that ordinarily would lead you to expect a child to be put in handcuffs.

Dr. Dave: Right.

Kaplan: It's a double-edged sword. I'm sure there are some kids who are so difficult to handle that the police have to be called but it should only be done -- should not be the first thing that happens obviously.

Dr. Dave: If it's the case of misdiagnosis that we have all these kids under 12 that are being diagnosed as bipolar and put on meds and so on, what are the diagnoses that would be more appropriate?

Kaplan: Yes, I think that's a very good question. My answer that I put forth in my book and strongly continue to believe in is that most of these children have attention deficit hyperactivity disorder

(ADHD), which I'm sure your listeners are well acquainted with. It's a very common disorder in childhood and also one that's very amenable to treatment. It's very well understood and they have ADHD plus they have a disorder in the DSM4 called oppositional defiant disorder, which is where you tell a child to do something and they refuse to do it. Whatever you ask them to do, they say no and they are very prone to disagree with you about anything and they are irritable, unhappy and easily provoked to anger and aggression. Most of these children, from my perspective, seem to have both ADHD and oppositional defiant disorder.

Dr. Dave: Isn't there some controversy about both of those diagnoses though?

Kaplan: Sure, sure, of course, yeah. There's a lot of controversy about attention deficit hyperactivity disorder in the sense of people feel it's overdiagnosed. They also object to the treatment, which is stimulant medications, most often, although mild cases can be treated psychology.

From my perspective and also from the science, the literature, is that ADHD is not overdiagnosed. There have been several studies, various studies have been done, where it's either diagnosed at a reasonable level or actually an important study by NIMH found that it was often underdiagnosed.

For 20 or 30 years, at least, or longer, there's often alarmist stories in the paper about freight trains trembling through the night with rear end cars loaded up to the top with stimulant medications and so forth. I think a lot of these are just overreaction to scare kind of stories, alarmist sort of stories. The truth is that ADHD and stimulant medications have been studied for decades since the 1930s. It's one of the most effective, safest treatments in medicines. It's another reason I like it because when I see ADHD, I know there's an excellent chance I can be very helpful in a very safe way and change the child and his behavior dramatically, safely, in a brief period of time.

If you have a child who is hyperactive, inattentive, running around, not listening and you give him an adequate dose of stimulant medication, in one hour he's a different kid, which is really dramatic. You don't see that every day in medicine. It's pretty powerful. I'm happy to do that for them.

Dr. Dave: Yeah. My wife is a teacher and I was talking to her about this upcoming interview and she said that she's seen the kind of dramatic changes that you are talking about. She talked about the one child that she has who was just hell on wheels and had such difficulties in the classroom that he asked to be put in the closet. That he just didn't want to have any contact with anybody and as soon as he gets on his medication, he just becomes the sweetest kid --

Kaplan: Exactly.

Dr. Dave: -- and able to interact with others in the classroom and able to engage in learning --

Kaplan: Sure.

Dr. Dave: -- and so on.

Kaplan: Well, that's great. I'm glad you can say that. The other side is among a sizeable portion of the public -- I don't know how large it is but it's pretty big, who hates the diagnosis, who hates the medicine and who's just shrill about denouncing the medicine, overdramatizing any possible side effects. And it makes my job as a doctor trying to persuade parents, most of whom are very reluctant, actually, to try these medications and a lot of them feel really guilty and crestfallen and become tearful when confronted almost with the need of the child for the medication. You know they really become very distraught about it so there's a danger to all the shrill denunciation of the medicine and so forth.

Dr. Dave: Well, I've actually interviewed the -- I'm blocking on his name. The famous Dr. Peter, who -- Dr. Peter something.

Kaplan: Bracken, Brackens or something like that?

Dr. Dave: Breggin, I think.

Kaplan: Yeah. Breggin, Breggin. That's it.

Dr. Dave: Right, who really inveighs against that in particular and against, I guess, psychiatric medication generally.

Kaplan: Yes, he does.

Dr. Dave: Certainly, he's been very influential. That's part of what you're up against, I guess, huh?

Kaplan: Yes. It's very important -- you know I think this antipsychiatry, anti-medication movement is just increasing in numbers, becoming more strident and more influential.

Even *The New York Times* -- they constantly write articles, which suggest that children of ADHD are better off not taking medicine. There are much better ways to handle the problem and so forth. There's a large public venue for complaining about these medicines.

But I also do take the other side. You know the medicine can have side effects. Every time you give a stimulant you don't always hit a home run with it but a good doctor will help with the side effects. If the medicine isn't working they'll switch to a different stimulant medication and so forth and so on. It's not like giving aspirin for a headache. I mean it does require a little finesse and care and so forth to make sure you get the best response from the medicine.

Dr. Dave: ADHD, like bipolar, which we started to talk about and which we will come back to, it seems to be sort of wildly on the increase too in terms of the amount of the diagnoses even though you say studies have shown that it's not overdiagnosed. So if it's not being overdiagnosed, do you have any ideas about why it seems to be on the increase?

Kaplan: Yes, yes, I do as a matter of fact. It used to be thought that ADHD was a diagnosis that was limited to childhood. And around, if you want to say adolescent, around 12 or 13 you sort of lost your ADHD and that was kind of the end of it. Then later on more recently we saw half of the children lose your ADHD and the other half continue on through adolescent.

Now I think it is much better and much more correctly appreciated that ADHD is really found frequently in adolescence and often does not go away with the onset of adolescence. And furthermore, there are a very substantial number of adults who have ADHD --

Dr. Dave: Um-hmm.

Kaplan: -- who can and should and will benefit greatly from getting it treated. I think that's a very correct and important kind of observation and for those of us who treat adults with ADHD. It's

extremely gratifying. These people are -- just being at work is hell for them. They have to fight all day to try sit still and they really have trouble concentrating and they often select a career based on their ADHD. You know they work in construction or something where they can move around a lot because they correctly understand that they can't take a job where they're going to have to sit behind a desk and engage in some fairly tedious kind of work.

Dr. Dave: Do you think there's anything, any kind of environmental cause that's leading to an increase of this kind of problem? By environmental I mean either the social environment or the physical environment.

Kaplan: That's a good question and I don't know the answer. The most wildly understood explanation for ADHD is that it's genetic but there could be other causes for ADHD -- lead poisoning. There are so many toxins in the environment. Who knows what we're exposed to these days in terms of food, air pollution and so forth. So there can be other causes and certainly there are other anxieties associated with short attention span and overactivity. It's very hard to concentrate if you are depressed and so there's a lot of conflict on certain days and so forth in the home environment. Children are going to have trouble concentrating.

Also, the prenatal environment is very important. Fetal alcohol syndrome, people who drink during pregnancy and children often have terrible ADHD as well as a number of other neurological problems. And then children who are neglected and abused during preschool years in infancy and children who are under stimulated during infancy in the preschool years can also present, you know, have a lot of trouble sitting still and run around all the time and so forth. There are a lot of things that can cause the appearance of it but without those obvious insults, it's usually felt to be genetic over time.

Dr. Dave: OK. Well, coming back to childhood bipolar, one of the things that you talk about is the danger of misdiagnosis.

Kaplan: Yes.

Dr. Dave: Tell us a little bit about -- you know what's the downside of labeling a kid as bipolar when, in fact, that's not what's going on?

Kaplan: Well, there are many dangers. One is you allude to in terms of labeling, when a child is given a diagnosis of bipolar disorder, it changes the way everybody looks at the child and it changes the way the child looks at himself. He begins to think of himself differently. He has bipolar disorder. Any diagnosis is a prophecy. It's a prognosis about how you're going to do. So somebody says you have bipolar disorder to a little kid, you're make a prophesy about this kid. You know that oh, he's going to have mood swings and he's going to have (INAUDIBLE). He's going to have depression and maybe he'll be a great poet, a great musician or something like that but he certainly is going to have not an easy life. He has a genetic disorder. His bipolar is clearly a genetic disorder.

The way the child begins to think about himself is very different. People believe in bipolar disorders. There's a whole series of books for parents to read to their young children as they tuck them in at night or something that explains to the young child, three and four years old, about how they have bipolar disorder. I, personally, find these books heartbreaking to read because it's clear to me that the children don't have bipolar disorder and they're being given this false identity.

Dr. Dave: Is it worse? Is it more harmful than telling them they have ADHD?

Kaplan: Oh, I think so. I think so. Definitely, yeah. Bipolar disorder is really a major league psychopathology. You're psychiatrically hospitalized, commonly have to take medicines your whole life, some of which may work, many of which may work, many of which don't work. It's a much more grim prognostic outcome. It follows you your whole life and it often leads to death from suicide during the depressive aspect. Whereas ADHD, it's not such a bad thing. You take your stimulant medication and you do fine and you feel much better immediately.

So, yes, I would say it's very different. And not only that, what the people are telling children is not true. I think one day and the time is not far off, where you're going to have a child who's been told he's bipolar all of his life, who's going to hit his early adulthood and he's going to make a great movie about this or write a great novel or something because it's really an embittering kind of ironic thing to be told by the authorities, intellectual, trusted authorities in your childhood that you have something that you really didn't have and to be treated that way.

Dr. Dave: Yeah.

Kaplan: I think there's a huge difference. When you're told you have ADHD, at least presumably, most of the time that's a correct diagnosis.

Dr. Dave: The other danger that you point out in your book of misdiagnosis of bipolar is that they're given the wrong medications --

Kaplan: Yes.

Dr. Dave: -- and the wrong kind of treatment.

Kaplan: Right, right, right. I'm sort of warming up to that.

Dr. Dave: OK. (chuckles)

Kaplan: (chuckles) I just didn't want to miss the psychological --

Dr. Dave: Right.

Kaplan: -- aspect of getting a long-term diagnosis because I do think that's important but yes, there is at least two aspects to giving the wrong medications.

One, we're often given medications that have been developed and tested and accessed for adults who actually have bipolar disorder and these medications include lithium and also a number of anti-seizure medications, which really have an array of very serious side effects. Actually, in clinical tests or research studies, these medicines really don't work in these children. Period. So they are exposed to terrible risks and they get little benefit and that's not a good thing.

Now there's another side to this as well since anybody who studies bipolar disorder in children or adolescents recognizes and acknowledges that 70 to 90 percent of them have ADHD along with their bipolar disorder. But the people who've advocated for this diagnosis have taken a position that these children should not be given stimulant medications, the one medication that can help them. Therefore, these kids are really doubly disadvantaged. They are getting the wrong medication and they're often forbidden to

have the medication that can help them so they are greatly disadvantaged.

Now there is one medication that is used in bipolar disorder, children and adolescent, one class of medicines that has been shown to be effective and that's anti-psychotic medications like Seroquel, Risperidone, and Abilify. Those are helpful to these kids but they're helpful for any aggressive child -- these medications would be helpful. There's nothing specific about this class of medications for bipolar disorder.

Dr. Dave: Now part of your argument in the book for the fact that kids are misdiagnosed as bipolar is you appeal to the DSM for the *Diagnostic Statistical Manual* --

Kaplan: Right, right.

Dr. Dave: -- of the American Psychiatric Association, version 4 and for adult bipolar mania there has to have been a prior manic episode and you talk in some detail about hypomania and mania very eloquently and colorfully.

Kaplan: Thank you, thank you. It's OK to promote that. Good. (chuckles)

Dr. Dave: Yeah, well, I could identify particularly with the hypomanic part because --

Kaplan: Sure.

Dr. Dave: -- I think I have, interestingly that we are talking about this now, I think I have some bipolar in my genetic history and I was prescribed valium years ago for a stomach ailment of all things and over time I found that valium seemed to do something that relaxed some of my moral considerations --

Kaplan: Um-hmm. Sure.

Dr. Dave: -- and put me into a kind of hypomanic episode that nobody had warned me about.

Kaplan: (chuckles)

Dr. Dave: And that I couldn't see --

Kaplan: Yeah.

Dr. Dave: -- but my wife was concerned about.

Kaplan: Sure.

Dr. Dave: And I was concerned about and so I could really identify with your description of hypomania. Take us through that.

Kaplan: Yeah. Well, stuff like Valium and everything -- it is disinhibiting. It relaxes your inhibitions. You could get in trouble that way.

Dr. Dave: Yeah, and it took -- it happened over -- I don't remember. It's a long time ago but it seems to me that it didn't happen right away. It was over a period of weeks or months.

Kaplan: Sure, sure. Well, a little hypomania is not such a bad thing as far as I'm concerned. I mean a lot of people at times get a little hypomanic like if you're facing writing deadlines. You really have to get busy and do a lot of stuff that might seem overwhelming at times. If you can do that, if you can access a part of your personality -- which can be very productive and very ambitious. I mean, you know, to be able to sit down and write a book that you wouldn't think you'd be able to do that -- it's a little nutty. You have to have some of that ambition available to you. I think what I'm saying is important because in children, in adolescence, you know, a lot of times they're sort of first grappling with ambition or hopes for the future, whatever, can easily be misunderstood as hypomania.

Dr. Dave: Mmm.

Kaplan: I think that's terrible if psychiatrist who believe in bipolar -- they give examples like a child wasn't very good or musical and she's maybe practicing the guitar. He hoped he would be like a famous Segovia or something -- be a great player but he couldn't -- but if you actually listen to him, he really wasn't that good, but so what. All of us who've played musical instruments in childhood, thought we really sounded cool but sooner or later we found out we weren't so good, most of us, and we go onto other things. Finish this part of being a child.

Dr. Dave: Let me just insert something that I just realized which is it might be that not all of our listeners would understand the word the modifier hypo --

Kaplan: OK.

Dr. Dave: -- means sort of less and hyper means more.

Kaplan: Right.

Dr. Dave: So when we say hypomania, we are talking about a slightly manic not a full blown manic attack, which is very extreme and very disruptive and can go into what might be called hypermania, which would be even worse. Hypomania is a mild kind of -- moving in the direction of mania.

Kaplan: Right, right. It's a milder form and it can be very pleasant. If you really have hypomania, you get very busy, friendly, active, although very productive, become very engaging. You find yourself -- the world seems like a brighter place.

Dr. Dave: Mm-hmm.

Kaplan: You find yourself talking to more people. You have more interesting ideas and you start to have more sexual contacts when you're hypomanic and you can feel it's very pleasant. For this reason very few people in a hypomanic state go to see a psychiatrist.

Dr. Dave: In fact, you point out that when you talk about adolescent bipolar and hypomania, you point out that it's a lot like being in love. Adolescence tend to be in love a lot and fall in love quite easily and they have that wonderful high that you get from being in love and the rose-colored glasses that come with it.

Kaplan: Right, right, exactly. There's a wonderful study that I describe in the book. I think it was a Dutch psychiatrist did this study where he found a group of adolescence that was in the early stage of romantic love. They were just really smitten in love with the member of the opposite sex. He gave them this hypomania questionnaire that's usually given to adults. The adolescence that was actually in the early stage of romantic love scored the same as diagnosed adults with hypomania.

Dr. Dave: These were normal kids, right?

Kaplan: Right, absolutely. It's normal. So the point is that it is very important not to misunderstand the hypomania of adolescence like falling in love is psychopathology because it's not. It's just part of normal adolescence.

Dr. Dave: I'm wondering with the overdiagnosis, the misdiagnosis of bipolar among children, I'm suspicious. Where is big pharma in all this? Are they culpable at all?

Kaplan: Oh, yes, of course. They're always culpable. They loved it. They were licking their chops. I don't think they started it but they were very accepting of it. They were happy to promote it and they sold a lot of medication as a result of it. They sold a lot of medication so they were very supportive of it I guess. But to be fair they didn't start it. I think pediatric bipolar disorder is somewhat unusual in mental health circles and I think the National Institute of Mental Health really played a very large part in promoting and disseminating the concept.

Dr. Dave: Why would they do that?

Kaplan: That's a good question. There's a few things I don't know about pediatric bipolar that much but one of them is I really don't know why they did it. I've had several musings about it. Maybe there was an important politician who had a child who seemed to have pediatric bipolar disorder.

Maybe there were several very esteemed influential child psychiatrists who believed strongly in this disorder and maybe they felt well, these eminent child psychiatrists really believe in it. Maybe it would be wise and reasonable to go ahead and promote it. But I don't actually know why.

You know, Jerome Groopman, the columnist, distinguished Harvard guy, who's a columnist for *The New Yorker* wrote a piece about pediatric bipolar disorder around three years ago where he describes a group of parents clutching a book that I absolutely despise called *The Bipolar Child* by the Papoloses. This is a well-known book regrettably. It's probably the best selling book in mental health next to the DSM. It's in its third printing. It's sold a couple hundred thousand copies. Unfortunately, it's devoid of factual information. This book really helped disseminate the diagnosis. I

mean it was a major lever in the public acceptance of the diagnosis because it was on *Oprah* and *20/20*. You know the authors got on all these major TV shows.

So a group of parents were clutching this book and they went to see the director of the National Institute of Mental Health, who at the time was Dr. Steven Hyman. He explained to Dr. Groopman, *The New Yorker* writer, well, all these parents came to see me and they were clutching this book and they were demanding that we do some studies of bipolar disorder. So that's another explanation quote unquote.

Dr. Dave: Yeah.

Kaplan: Who knows. I don't really know. I think there are probably people around who do know but I haven't really heard an explanation yet that I could sign onto, you know.

Dr. Dave: Well, one of the things that you point out which in a way is kind of startling and maybe I knew this at some level but I'd never seen it stated quite so baldly is you say there are really no biological markers for any psychiatric disorder.

Kaplan: That's true. That's true. That's absolutely true. You know psychiatry is always desperately trying to find them and you can't pick up a psychiatry journal every month that isn't reporting some possible marker, you know, a CAT scan of the brain found this, that or the other.

Dr. Dave: Yeah.

Kaplan: But the truth is there's no biological basis for any (INAUDIBLE). No none biological basis.

Dr. Dave: That does open the door for diagnostic fads and we've seen diagnostic fads in what's suppose to be a scientific enterprise but I'm thinking of -- maybe you can think of some examples of diagnostic fads. One that comes to mind to me, I think, is multiple personality.

Kaplan: Exactly. That's a classic. Yeah.

Dr. Dave: When I was in graduate school, I was told I would probably never see one in my life or maybe one or two.

Kaplan: Right.

Dr. Dave: And now I have students coming up to me and almost bragging that they're a multiple.

Kaplan: Yeah. Right, right. That is really -- yeah, that's a classic one and hysteria is another -- you know conversion reaction. World War I, that's what Freud was interested in. Everybody was limping around with (OVERTALK) paralysis of one sort or another and then it just dropped out.

You are right. We are vulnerable to these fads. The media -- this is another point I guess that I try to convey in my book that when the DSM comes out, when a new diagnosis is put forth and people go out -- psychiatrists, mental health psychologists and they see it, they say, "Gosh, I've never seen that before but now that I look at it I see this patient has it." You know like social phobia so forth and so on.

Dr. Dave: Yeah.

Kaplan: And depression. Whenever there's a new diagnosis that comes out, most of us see it and so the explanation is that it's been unrecognized, underappreciated.

Dr. Dave: Mm-hmm.

Kaplan: But another explanation that is equally compelling, if not more compelling, is that we create -- "we" meaning mental health professionals, the various APAs and everything. We create the diagnosis of a culture and certainly by pediatric bipolar disorder is the perfect example. Pre-pubertal pediatric bipolar disorder does not exist but with all the media, all the hype, you know these kids were turning up -- and not only that parents were coming in, the parents would absorb this diagnosis from the media and also from various web sites and from books and everything. They would come in and they would tell you every symptom of bipolar disorder that they had learned and insist that their child had it when in fact the child didn't have it.

Dr. Dave: Yeah.

Kaplan: We created that diagnosis.

Dr. Dave: This makes me think of medical students syndrome where people are in medical school they learn about these various diseases. They start monitoring themselves for it and they become convinced, hey, I've got this. Certainly, those of us who go to graduate school to become psychotherapist, we take abnormal psychology at some point and we begin to fret and experience in ourselves all the signs of all the various diagnostic categories. There's a way in which culturally maybe we all kind of in a way suffer from medical student syndrome.

Kaplan: Right. That's exactly right. This wonderful book -- I think it's called *Crazy Like Us* by a gentleman named Watters. Just a wonderful book. He describes this very vividly. He thinks it's something called the symptom pool and we are all a little unhappy and a little disjointed in certain ways and everything. If things really get bad, walk in the symptom pool for something to attach these feelings to.

Dr. Dave: Yeah.

Kaplan: There are a lot of unruly children running around and pediatric bipolar disorder jumped in the symptom pool and people took it out.

Dr. Dave: Yeah. Now earlier you mentioned parents. We should talk about parents because as you have just pointed out that there are a lot of very concerned parents who've seen this book that you've mentioned and they've heard things about childhood bipolar and you devote the last chapters of your book to, sort of to parents and with advice to parents. What is your advice to parents of a child who has either been diagnosed as bipolar or they're worried that maybe that's what's going on? What would you have them do?

Kaplan: Well, I know this sounds terribly self-serving and I've tried to think of a way of avoiding saying it but I'll just be really blunt and candid, I mean my book, I think, could be very helpful to them. There are about 30 books out there on bipolar disorder on Amazon. Mine is the only one for parents that is critical of this disorder.

Dr. Dave: Um-hmm.

Kaplan: There's one other one for professionals that is also very critical by Sharna Olfman, which is a good book. I think it's called the "Bipolar Children" or something. Sharna Olfman, O-l-f-m-a-n. But

most of the books you're going to read and most of -- 98 percent of the books, 98 percent on the Internet are going to be supportive of the diagnosis.

I think you want to hear the other side. I think you want to know how to discuss the diagnosis with the therapist. What questions to ask. How to evaluate the answers and how to be intelligently critical of what you're hearing. It's not about joining a cult or anything like that. You want to do what's best for your child. I think to inform yourself about the literature and what's been said would be very helpful to parents. It will help you have a better conversation. At the end of the day, you may decide your child's bipolar. At least it would be a well-informed decision.

The other thing is I would say you definitely want to see a good child psychiatrist and you want to see one who believes in DSM (Diagnostic Statistical Manual). In the *Bipolar Child*, the Papoloses strongly suggests you find a psychiatrist who doesn't believe in the DSM, which I think is really terrible advice because the diagnosis must be made -- if it's going to be made correctly on DSM criteria. You want to find yourself a good child psychiatrist, often at a university, but not exclusively there and work with them and come to understand as much as you can about the disorder. But you have to realize that 98 percent of the media stuff you're going to go to or 99.9 is going to be in favor of the disorder.

Dr. Dave: Would part of your advice be to suggest that they also have that professional consider the possibility of ADHD?

Kaplan: Sure, absolutely. And a good professional will because again 70-90 percent of children are diagnosed as bipolar disorder have ADHD. Another thing that's important to appreciate, I think, for parents is often there's a person in the family, might be mother, father, uncle or somebody, who has bipolar disorder.

So even if there is a person in the family who has bipolar disorder, the child has only a one in 20 chance that the child is going to get bipolar disorder and even if they do get bipolar disorder, they're not going to get it during childhood. They get it later on mid- to late adolescence or early adulthood or further on. But just because there's a parent who has bipolar disorder, doesn't mean that the child has bipolar disorder. He can have lots of problems and children of parents with bipolar disorder are vulnerable to difficulties but that doesn't mean they have bipolar disorder.

Dr. Dave: You know it occurs to me that we never did really define bipolar disorder.

Kaplan: Yeah, yeah.

Dr. Dave: It's so well known in the culture. I think we're just assuming that everybody knows what we're talking about. Fundamentally, we're talking about extreme alternating, extreme manic episodes where a person becomes so agitated during the manic phase that it borders on delusions, hallucinations, and just extreme agitation. Then crashes into a crippling kind of depression and that this recycles over and over again. Would you say that's kind of an accurate thumbnail description?

Kaplan: Yes, yes, I would but I have a few caveats.

Dr. Dave: OK, good.

Kaplan: A critical issue is that a person's behavior should be different from what it usually is.

Dr. Dave: OK.

Kaplan: It should be distinctly different. See in children and adolescence who are too aggressive and fighting all the time and irritable all the time, then that's constant. That's just the way they are. They're that way all of the time. It's not just that they cycle into this. They're that way all of the time. So it should be distinct. Something absolutely different than a patient's usual behavior at least at the time of the onset of the disorder.

Dr. Dave: Yes.

Kaplan: It's recognized by other people to be different. Everybody says, "Aw, well, I wonder what's wrong with so and so today. He really seems different than usual." People should recognize it as different and it doesn't have to be extreme. Sometimes it starts off much milder and so forth. Not everybody goes on to become psychotic and require hospitalization. It can often be treated as outpatient. It can also be successfully treated in adults given the right medication, the right diagnosis they can do extremely well and have very productive lives.

Dr. Dave: OK, well, as we wind down here, I'm wondering if there is anything else that you'd like to add. Is there anything you were kind of planning to say or hoping to say that we didn't get to here?

Kaplan: (chuckles) Well, I think it's important when these issues come up that families work together, OK. Seeing the psychiatrist and reading all the material about it and you know that if there are differences of opinion between mother and father, that's understandable but they should at the end of the day they should come together on the way they are going to manage their child.

I often see parents who bitterly disagree. The father waits in the car while the mother brings the child in to see me and so forth. Those are very difficult situations.

Dr. Dave: Yes. Well, Dr. Stuart Kaplan, I want to thank you for being my guest today on Shrink Rap Radio.

Kaplan: It was my great pleasure. Really enjoyed talking with you. Thanks a lot.