CHILDREN'S
TREATMENT CENTER

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IS BIPOLAR DISORDER AN INVECTIVE?

Once upon a day a psychiatrist from a city far away called me. He introduced himself as Doctor M. and asked me to see his adolescent son with "a severe case of ADHD". Dr. M. told me about his unfortunate previous experiences with several local psychiatrists, who were not helpful. His son, Mark, despite all trials with different stimulants continued to do very poorly academically and to misbehave in his boarding school for children with special needs, making noises and being disruptive in class. The last psychiatrist put him on Prozac, which caused severe agitation, so the child had to be restrained and medicated in order to be calmed down. The family fired this doctor and in their search of a new one came across my name.

On the day of our meeting Mark almost barged into my office, constantly repeating: "I am shy, I am shy". He did not look at me; instead he cast glances into every corner of my small and clat-tered office and only having inspected all of them, settled down and sat across me. After this turbulent start Mark turned out to be an interesting and insightive interlocutor. He gave me a perfect description of his inappropriate behavior in class, including weird noises and high dis-tractibility. He also told me, that after he took his first and only dose of Prozac his mood changed dramatically. He felt bold and fearless like a batman. He made a swing using some old rope, which he attached in the stairwell and swayed there at almost 15 ft height laughing and screaming with joy. He was quite surprised to see worried faces of his parents. When I inquired about the reason he could not concentrate, he simply said: "The aliens distract me". What was diagnosed as attention deficit turned out to be the veneer of a long-standing and quite compli-cated psychotic process. The child had been entrenched in his delusional world with auditorial and visual hallucinations and even Schneiderian symptoms for at least a couple of years. No-body has ever paid attention at the mismatch between the standard criteria of ADHD and Marks's bizarre behaviors.

When I presented my clinical findings and treatment suggestions to Marks' parents, his father turned pale and looked insulted. With a carefully suppressed anger he went into a long spiel about the importance of children's fantasies and unforgivable harm, which psychiatric overdiag-nosis could cause. His wife, who clearly was looking up to him fee-bly mentioned that Mark frequently speaks with some invisible people and looks quite odd, but Dr. M. just dismissed her. He still agreed to my treatment suggestions and started Mark on Risperidone, which help miracu-lously. Mark's grades improved dramatically and his behavior was mostly appropriate. He spoke about aliens in a more detached way and was able at times to disavow his impaired reality. He also became more aware of his mood swings and occasional suicidal thoughts. Parents agreed to a Lamictal trial and Mark responded well to it.

One day his father called me quite alarmed and asked if it is possible that Mark was developing tardive dyskinesia: he recently became quite tremulous and restless. Upon questioning Dr. M. reluctantly divulged that he had increased Mark's Dexedrine to almost 60 mg a day without ever letting me know… He explained that from his prospective I did not treat aggressively enough his son's "ADHD" so he decided to take care of that. After I explained again that Marks' psy-chotic and mood disorder take precedence over his so called ADHD, the family stopped seeing me. I hope that Mark gets the treatment he needs.

Let me stop now and try to analyze this case. Treating relatives, especially children, of our colleagues is difficult to begin with. Turning treatment planning into a battlefield is the worst nightmare. In Mark's case, his father refused to see the clinical reality, trying to avoid the pain, which the diagnosis of a psychiatric condition inevitably inflicts on all parties involved. He used his authority to buttress the denial. Is it understandable? Yes! Is it helpful? No! Unfortu-nately a psychiatric diagnosis is still viewed as a pejorative term, an insult, casting blame at the whole family. Several generations of laymen were brought up to think that psychiatric problems stem from faulty families rather than present-

ing a biological condition, requiring a medical approach. Certainly there are shades of gray and sometimes children do reflect dysfunctional family dy-namics and do not carry a psychiatric diagnosis and do not require medical treatment. When parents learn that their child has pneumonia they follow doctor's recommendations and rush to a pharmacy to buy a prescribed medication. When they learn about a psychiatric condition in their child they get angry and refuse to accept it or blame the doctor for misdiagnosing.

Of course, Dr. M.'s case is one of the most dramatic in my practice, but not uncommon. Non-psychiatrists ask similar questions regarding their children: "How do you know that this is a chemical imbalance/bipolar disorder? Why do you call it hallucinations; cannot it be just a fan-tasy? You never ran any tests! Why wouldn't you order some blood work to show the deficit of any chemicals?" And so on and so forth. I try to educate them to the best of my abilities, but it is a Herculecian task to struggle with many years of misconception in psychiatry and media frenzy around ADHD. The truth is, any isolated symptoms cannot be taken out of context of the whole clinical picture and the diagnosis cannot be made on the basis of one symptom only. I came across recently an adult patient who fell a victim to this one-symptom approach. She is a bipolar and mentally retarded person, who has never been able to express herself clearly due to her cognitive limitations. At some point she started to complain that in the middle of the night some monsters fall on her chest from the ceiling and then go away. Her complains were inter-preted as psychotic symptoms and she was put on Haldol. Despite her continuing complaints the dose of Haldol climbed up. One day, in exasperation, she paged her case manager and screamed on the phone that the monster was looking at her through the window. Luckily, the case man-ager was next door and came right away intending to confront the patient with her delusional reality. To the uttermost surprise of the worker she saw a huge possum standing on its hind legs leaning on the glass garden door and scowling at the two ladies. As it turned out a family of possums made it a home in the attic. At night cubs crawled from their mother and fell through the vent duct in the ceiling which opened above this patients' bed. What was taken for delusions turned out to be perfect reality testing: an animal control team was more efficacious than Haldol. In this case nobody paid attention that outside these monster complaints patient continued to function at her usual level, without declines in any areas. Due of the lack of eloquence, her very real complains were grossly misinterpreted. In Mark's case we saw the opposite: his psychotic production was mistaken for a normal fantasy world, despite grossly impaired behavior, aca-demic failures and social ineptness.

My adult patients and parents of my young ones show a wide range of responses to sad and distressing news about their psychiatric diagnosis. Just the name of the condition seems to be more disturbing than it's essence and prognosis. So far, we do not have any reliable sources of information or proper public education to corroborate the opinion that Bipolar disorder is virtu-ally a spectrum disorder with a different degree of impairment and different future. It can fluctuate from a mild and treatable condition to the institutional care level with all intermediate "stops" between these two extremes. In some cases, Bipolar disorder could be more favorable prognos-tically than a severe case of ADHD with concomitant Conduct disorder, which might not suc-cumb at all to any medical treatment and therapy intervention and eventually lead to a personal and social crush.

It seems that psychiatry remains a Cinderella among her more powerful sisters in medicine, operating on a state-of-the-art technological level, translating into the language of numbers and smoky images any pathology hidden in the body. Psychiatric conditions are still considered as strangers (if not shameful secrets), recognition of which strongly depends on the believes of the evaluator, rather than precise clinical assessment. If adult psychiatrists like Dr. M. do not understand the significance of a psychiatric diagnosis in children and it's prognostic implication we should not be surprised to see an incredulous reaction of a "regular" parent in a similar situation. The damage is obvious. The longer the child remains in distress like Mark, the bigger is the gap between him and his peers as he is missing important developmental milestones and falling behind his age group. The later we apply appropriate treatment the less is the possibility that the

child will ever catch up both socially and academically with what he has missed because of his disability.

It took several generations to create a concept of a psychiatric disorder being a curse word. How many generations do we need to learn how to accept a psychiatric diagnosis as one of many medical conditions, which strike humanity and accordingly direct our efforts into helping rather than fighting the reality?