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Differentiating AD/HD from Bipolar Disorder In Children

"The clinical features of children with ADHD and mania that lead to their psychiatric hospitalization indicate the presence of mania, not ADHD. These children are not admitted because of failure to complete homework."

....Dr. Joseph Biederman

Hyperactivity, impulsivity, and inattention are seen in children with AD/HD and Bipolar Disorder, but these two disorders are radically different in terms of the impact that they have on a child's life. Determining what is causing a child's behavior problems is extremely important. AD/HD is far less severe an impairment than Bipolar Disorder. The most important things for an AD/HD child to learn are how to slow down, focus, and organize his life. The most important thing for a child with Bipolar Disorder to learn is how to manage his mood shift from potentially destructive hypomania, to a depression so dark that it can be paralyzing or suicidal.

It may be difficult to distinguish Bipolar Disorder from AD/HD.

Ninety-eight percent of children with the diagnosis of Bipolar Disorder also qualify for the diagnosis of AD/HD because of the presence of inattention, impulsivity, and hyperactivity seen in the attention deficit population (Biederman 2000). Conversely, twenty-two percent of those children diagnosed with AD/HD fit the criteria for Bipolar Disorder (Butler 1995). It is extremely important that this second group of kids with the dual diagnosis be identified so that they may receive proper treatment.

Many children diagnosed with Bipolar Disorder after puberty were diagnosed as AD/HD in the elementary school years. For these kids, the symptoms of impulsivity and craving for stimulation that they experienced before high school now take on the more troubling forms of hypomania and depression as Bipolar Disorder emerges. These children may have been Bipolar all along or they may have developed Bipolar Disorder at age eight or nine but were undetected as suffering from an affective disorder until later.

Some percentage of children and teens with the diagnosis of AD/HD experience challenges that are difficult to distinguish from those seen in Bipolar Disorder. The predilection for dangerous, destructive, and risky behavior; the abuse of substances and other addictive behavior, characterize some teenagers with AD/HD. Or these behaviors may indicate the presence of Bipolar Disorder

in its manic phase. It may be unclear where the simply “disinhibited” behavior of AD/HD leaves off and where the cyclic manic phase of BD picks up.

Seven criteria for differentiating AD/HD from BD

It is important to know if a child is suffering from Bipolar Disorder, AD/HD, or both in a comorbid condition. Different medication, home management, and psychotherapeutic approaches are indicated depending on the condition and harm can be done if, for example, AD/HD medication is used to treat Bipolar Disorder Here are seven criteria for differentiating these two conditions:

1. Are mood shifts or the "aggressive depression" mixed-state present?

If a child has episodes of mania or depression or shows the mixed state aggressive depression typical of early-onset Bipolar Disorder, there is a good chance that the diagnosis of BD may be in order. Though the moods of children with AD/HD may be mercurial, especially when these kids hit their teens, they do not show the severe highs and lows of Bipolar Disorder or the violent expression that can occur in the mixed-state rapid cycling variety which afflicts younger children. AD/HD children may experience discomfort and demonstrate considerable irritability during medication rebound, but they are not chronically irritable as are children with Bipolar Disorder. And they do not usually show the behavioral extremes seen in BD when they are in medication rebound. They do not become over aroused and go screaming off into the darkness as do some kids with the powerful dysphoric hyperarousal of Bipolar Disorder. They do not attack their parents in blind rage. There is a noticeable difference in degree.

2. Does he have first degree family members diagnosed with Bipolar Disorder or other affective disorders?

A meticulous study of his family history is very important for making the AD/HD-Bipolar distinction. Children with Bipolar Disorder often have the condition in their immediate family, siblings, parents, grandparents, especially if they are diagnosed at an early age. This is an indication that affective disorder may exist in the family line. If it does, there is a high probability that it will be passed on (Goodwin and Jamison 1990).

3. Is his speech pressured or hypomanic?

Analyze the quality of a child's verbal output to determine if Bipolar Disorder or AD/HD is on board. Pressured speech seen in BD is known by its outpouring of words on continually shifting topics that may have little relationship to each other. The child's speech is powered by a flight of ideas, a jumble of thoughts, a thought- powered free association in which he will not appear to be listening to others and in fact may interrupt them continually to deliver his monologue. AD/HD's may talk too much and too loudly but they can be redirected and their verbal delivery can be slowed by a request from the listener such as “You're going too fast for me and I'm getting breathless just

listening to you.” This same request to a child with Bipolar Disorder may cause him to pause for about two seconds and then he will resume his monologue where he left off. If pressured speech occurs with other challenges associated with Bipolar Disorder, it is a good idea to assess if it is an aspect of hypomania and thus indicative of the Bipolar presentation. (Wagner, 2000)

4. Is dangerous and risky behavior a result of impulsivity or hypomania?

The dysinhibition of AD/HD is most often seen as a random search for stimulation in any form—be it through danger sports, drugs, gambling, sex, or illegal behavior. Though addictive opportunities are compelling to the AD/HD teen, the quality of hypomania is not present as it is for the BD teenager.

For the BD teen, dysinhibition and stimulus craving can take over the child’s personality, and be directed with a purposeful energy in which he does not seem to need sleep and can power himself energetically toward a goal for several days. He may run away from home in the family car to pursue some wild flight of fancy and stay away for days, only to return exhausted and sleep for 20 hours straight. He may become fascinated by some pet interest and be unable to attend to anything else but that interest day and night for a week or two—dropping everything to go hunting for magic mushrooms, becoming fixated on an interactive game on the Internet with other kids, or steal his parents credit card number and spend hundreds of dollars sampling every kind of porn available on the net or cable TV.

5. Does he rage (Bipolar Disorder) or does he get angry (AD/HD)?

In Bipolar Disorder, rage is present from an early age. It may come up at the drop of a hat. Once it is engaged, it is unstoppable. It will go on for over half an hour. It can be violent, and it often results in exhaustion and rage state specific amnesia. The child may report feeling pleasantly energized by rage. He may hate what happens when he is enraged but he is drawn to the feeling of it (Popper, 1989).

AD/HD children will get enraged because of frustration or simple hot temperedness. AD/HD children do not rage on a consistent basis as do children in the mixed state of aggressive depression seen in BD. And they do not generally get pleasantly energized by it nor do they experience state specific amnesia of what they did when enraged. They lack the expressed malevolence of the Bipolar child who may deliberately attack someone in a fit of rage and try to hurt them. It is important to identify the severity of a child’s rage.

6. Is psychotic activity--hallucinations and severe thought distortion--in evidence?

The child with AD/HD may demonstrate extreme silliness and show a profound lack of common sense because of his inability to focus on things and make good decisions. But AD/HD children generally do not have hallucinations. The child with affective illness, on the other hand, may experience visual hallucinations that are very disturbing to him. Many children with Bipolar

challenges tell me about these hallucinations though they are loathe to discuss these with others for fear of being labeled crazy. Some evaluators now see the presence of visual hallucinations as indicative of Bipolar Disorder and auditory hallucinations as indicative of schizophrenia (Hendren, 2000).

AD/HD children can be extremely oppositional. But most of them are able to eventually see their own involvement in problem situations. The child with Bipolar Disorder is unlikely to admit his part in the issue even when confronted with evidence to the contrary. It is as if a “cognitive hallucination” is present that blocks his perception of reality. Unlike the AD/HD child, who will most likely end up as the underdog in an encounter with parents, defending himself from some accusation of wrongdoing, the child with Bipolar Disorder will take the offensive. He will attempt to impose his will on the family at all costs.

7. Does he show other aspects of Bipolar Disorder such as the nighttime hyperarousal pattern, anempathy, and Conduct Disorder?

There are some additional challenges that Bipolar children typically have that AD/HD's don't.

Nighttime hyperarousal is sometimes seen in AD/HD and is usually a medication side-effect or the inability of the person to calm his sense of AD/HD "driveness." The Bipolar child comes alive at night when his brain levels of serotonin, the “civilizing” neurotransmitter, is at a 24 hour low. He may become a very nasty character and go into full-blown fits of rage or attempt to tyrannize everyone in the family.

Many Bipolar children are anempathetic. They do not understand the feelings of others and may show shallow affect themselves. AD/HD children tend to be supersensitive to the feelings of others when they can stop long enough to pay attention to them. AD/HD kids wear their hearts on their sleeves. This is part of their challenge and charm. Children with Bipolar Disorder may show cruelty and be very circumspect when it comes to their own feelings.

Many children with Bipolar challenges will also qualify for the Conduct Disorder diagnosis (312.82) with its list of law-breaking, crimes against people and animals, and lack of remorse. Though AD/HD's do have a greater chance of being diagnosed with CD than unaffected kids, they do not show the high percentage of comorbidity (69%) that is seen in the pediatric BD population (Kovacs and Pollack 1995)..

Checklist of differences between Bipolar Disorder and AD/HD

1. Presence of mood shift or mixed state of aggressive-depression
2. A family history of affective illness
3. Pressured speech or hypomania are present
4. Dangerous behavior occurs in hypomanic phase
5. Presence of rage (Bipolar Disorder) or anger (AD/HD)?
6. Presence of hallucinations, severe thought distortion, and tyrannical behavior.
7. Other Bipolar challenges are present such as anempathy and Conduct Disorder.

Early correct diagnosis can save a child's life

Dr. Joseph Biederman (Biederman, 2000) maintains that there is a serious lack of knowledge among diagnosticians about how to diagnose the presence of Bipolar Disorder. He points to research on the "kindling" effect of depression to show how misdiagnosis can hurt a child. The kindling effect is seen in the damage the brain incurs as it is weakened by depression over time. The first depression may be bad, but because *it* has happened, the next one is worse.

If a child presents with a mixed-state, rapid cycling early onset Bipolar Disorder and is misdiagnosed "severe AD/HD" and given stimulants, he may be thrown into a manic frenzy. Or the misdiagnosis can result in the child not receiving medical treatment for his depression. Ignoring this problem makes it worse.

If a child is comorbid with both AD/HD and Bipolar Disorder, it may be possible to use stimulant medication or antidepressant medication, but the child's mood disorder must first be stabilized using a mood stabilizer such as lithium carbonate or a newer generation anti-convulsant such as valproic acid (b. Depakote) .

Goodwin and Jamison assert that 15 to 20 percent of those with Bipolar Disorder kill themselves (1990) The misery that these people experience makes AD/HD look comfortably tolerable. Misdiagnosis of the child with Bipolar Disorder can do him great damage because it not only cuts him off from help appropriate to his illness, but sets the stage for his isolation from his community. It is this sense of being alone in an uncaring universe that drives a kid to consider ending his own life. This is a tragedy preventable with the right diagnosis at the right time.

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