

DIAGNOSING BIPOLAR VS. ADHD

By Dr. Charles Popper

Similarities

Both disorders share many characteristics: impulsivity, inattention, hyperactivity, physical energy, behavioral and emotional lability (behavior and emotions change frequently), frequent coexistence of conduct disorder and oppositional-defiant disorder, and learning problems. Motor restlessness during sleep may be seen in both (children who are bipolar are physically restless at night when "high or manic", though they may have little physical motion during sleep when "low or depressed"). Family histories in both conditions often include mood disorder. Psychostimulants or antidepressants can help in both disorders (that is, depending on the phase of the bipolar disorder). In view of the similarities, it is not surprising that the disorders are hard to tell apart.

Differences

So what features can help in distinguishing these two disorders? Some distinctions are obvious.

1. Destructiveness may be seen in both disorders but differs in origin. Children who are ADHD often break things carelessly while playing ("non-angry destructiveness"), whereas the major destructiveness of children who are bipolar is not a result of carelessness, but tends to occur in anger. Children who are bipolar may exhibit severe temper tantrums, during which they release manic quantities of physical and emotional energy, sometimes with violence and property destruction.
2. The duration and intensity of angry outbursts and temper tantrums in the two disorders differs. Children who are ADHD usually calm down within 20-30 minutes, whereas children who are bipolar may continue to feel and act angry for over 30 minutes and even for 2-4 hours. The physical energy that a child with ADHD "puts out" during an outburst of anger could be mimicked by an adult who tries to "enact" the tantrum, whereas the energy generated by angry children who are bipolar could not be imitated by most adults without reaching exhaustion within a few minutes.
3. The degree of "regression" during angry episodes is typically more severe for children who are bipolar. It is rare to see an angry child who is ADHD display disorganized thinking, language, and body position, all of which may be seen in angry bipolar children during a tantrum. Children who are bipolar may also lose memory of the tantrum.
4. The "trigger" for temper tantrums is also different in these disorders. Children who are ADHD are typically triggered by sensory and affective overstimulation (transitions, insults), whereas children who are bipolar typically react to limit-setting (i.e., a parental "NO") and conflict with authority figures. A child who is bipolar will often actively seek this conflict with authority.
5. The moods of children who have ADHD or bipolar disorder may change quickly, but children with ADHD do not generally show dysphoria (depression) as a predominant symptom. Irritability is particularly prominent in children who are bipolar, especially in the morning on arousal. Children with ADHD tend to arouse quickly and attain alertness within minutes, but children with mood disorders may show overly slow arousal (including several hours of irritability or dysphoria, fuzzy thinking or "cobwebs", and somatic complaints such as stomach aches and headaches) upon awakening in the morning.
6. Sleep symptoms in children who are bipolar include severe nightmares (explicit gore, bodily mutilation). Additional information on the specific content of these dreams and why children do not freely reveal these dreams is available in another article by Charles Popper (Diagnostic Gore in Children's Nightmares). Children who are ADHD mainly show difficulty going to sleep, whereas children who are bipolar are more apt to have multiple awakenings each night or have fears of going to sleep (both of which may be related to the dream content described above).
7. The ability to learn in children who are ADHD is often compromised by the coexistence of specific learning disabilities, whereas learning in children who are bipolar is more likely compromised by motivational problems. On the other hand, children who are bipolar are more able to use motivation to overcome inattention; they can stay tuned to an awesome TV show for long periods of time, but children who are ADHD (even if interested) may not stay involved, follow the plot or even stay in the room (especially during commercials).

8. Children who are bipolar often show giftedness in certain cognitive functions, especially verbal and artistic skills (perhaps with verbal precocity and punning evident by age 2 to 3 years).
9. In an interview room, children who are bipolar often demonstrate dysphoric, rejecting, or hostile responses during the first few seconds of meeting. Children who are ADHD, on the other hand, are more likely to be pleasant or at least non-hostile at first meeting, and if they are in a noisy location, they may immediately show symptoms of hyperactivity or impulsivity. Children who are bipolar are also often "interview intolerant". They try to disrupt or get out of the interview, ask repeatedly when the interview will end, or even insult the interviewer. The child who is ADHD, on the other hand, may get frustrated, bored, or more impulsive, but usually without directly challenging the interview or the interviewer.
10. The misbehavior of children who are ADHD is often accidental. If they crash into a wall (or a limit or an authority figure), it is often due to oblivious inattentiveness. The child who is bipolar, in the other hand, is more likely to crash into a wall with intent, for the sake of challenging its presence. Children who are bipolar are highly aware of "the wall" and are sensitive to ways of creating the biggest feeling of impact or challenge to it.
11. The child who is ADHD may stumble into a fight, whereas the child who is bipolar will look for a fight and enjoy the power struggle. While a child who is ADHD may engage in self-endangering behavior without noticing the danger, the child who is bipolar enjoys the danger and seeks it out. The child who is bipolar is intentionally dare-devilish (yet needle phobia is quite prevalent). In general, the danger-seeking is grandiosity ("I'm invincible") in the child who is bipolar and inattentiveness in the child who is ADHD.
12. In the child who is bipolar, danger-seeking grandiosity, energized giggling, and sexual hyperawareness may be seen early in the preschool years, and persist into adolescence and adulthood.
13. The natural course of ADHD is chronic and continuous, but tends toward improvement. There may be periods of worsening, however, during situational or developmental stress, or if a coexisting conduct disorder worsens. Children with bipolar disorder may or may not show clear behavioral episodes or cycles, but they do tend to exhibit increasingly more severe or dramatic symptoms over the course of years, particularly as the child becomes larger and the impulsivity becomes more difficult to contain.
14. Children with ADHD do not exhibit psychotic (thoughts and behavior reveal a loss of contact with reality) symptoms unless they have coexisting psychotic depression, preschizophrenia, a drug-induced psychosis, a psychotic grief reaction. Children with bipolar disorder may, on the other hand, exhibit gross distortions in perceiving reality or in interpreting affective (emotional) events. They may even exhibit paranoid-like thinking or openly sadistic impulses.
15. Lithium treatment generally improves bipolar disorder but has no or little effect on ADHD.

The Coexistence of ADHD and Bipolar Disorder

Children may have ADHD, bipolar disorder, or unipolar disorder (depression), and some children have a combination of ADHD and bipolar disorder or ADHD and unipolar disorder (depression). A child who has either bipolar disorder or unipolar disorder, but not ADHD, may be misdiagnosed ADHD, however, because both the bipolar and unipolar disorders may include symptoms of inattention, impulsivity, and even hyperactivity. There is concern that ADHD is being overdiagnosed and bipolar disorder underdiagnosed in the population of children.