Bipolar Disorder with AD/HD: A Case Study

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The following case study illustrates the complexities of diagnosing and treating children who meet diagnostic criteria for both bipolar disorder and attention-deficit/hyperactivity disorder (AD/HD). It represents an individual case seen in a private medical practice and should not be regarded as the recommended or typical treatment plan for children with both disorders.

A PSYCHOLOGIST called me requesting that I see a 7-year-old who had been in the psychologist's social skills group and was showing indications that he might have AD/HD. The request focused on an assessment for medication for AD/HD. As is my usual way of handling evaluations, I first met with the parents to take a detailed history. This particular history revealed that Michael had been difficult to manage from early infancy. He was a colicky baby, hard to soothe, and did not readily settle into a predictable rhythm of sleep and wake, or hunger and satiation. He was a picky eater and was perpetually irritable. Michael was a very bright child who persistently asked questions about deep and complex topics and had problems with separation, especially from his mother.

He was the parents' first child, and it was not until they had a second who was an easy, well-regulated baby that they began to think that something might be amiss with Michael. The history further revealed that there were diagnosed psychiatric illnesses on both sides of the family. These included anxiety and depressive disorders, with a suicide in a close relative. A teenage cousin had been diagnosed with bipolar disorder and was going through challenging medication trials. To complicate things further, there were thyroid problems in a close relative.

Disturbing Symptoms

At age seven, Michael was disruptive in the home and was physically aggressive towards his younger sibling and mother. He destroyed property, including his own possessions. His father described lengthy car rides to soothe Michael in an attempt to get him back to sleep after abruptly waking in the middle of the night. The family's energies were focused on and absorbed by Michael. His mother ended her professional career to stay at home, and Michael's dad used a home office to be more involved in managing Michael's challenges. Many years of group and family therapy were not reaping much in terms of improvement.

When I met with Michael, he immediately established an almost palpable presence in my office. He was a bright and highly verbal youngster who revealed a morbid preoccupation with death and a precocious existentialism that was startling. He was intense in his intellectual probing of the meaning of life and death, and his drawings were dark and depressing. He was highly anxious, with some obsessive-compulsive traits. He was hyperactive, driven, distractible and impulsive. He slept and ate poorly. His social relationships were impaired. At school, he required intense oversight by the teachers and principal, who worked closely with the parents to provide as supportive an environment as possible. Other children and parents had complained about Michael's aggressive and unpredictable behaviors.

Diagnostic Conundrum

I diagnosed bipolar disorder with mixed states; that is to say one could detect both the depressive and elevated mood states within short periods of time. I discussed my findings and diagnoses with the parents, telling them that while there were enough symptoms to meet criteria of AD/HD, my clinical impression was there was more than AD/HD; that my primary working diagnosis was bipolar disorder, which I would recommend prioritizing for primary intervention. Michael was also an anxious child.

The family was familiar with the bipolar diagnosis and associated treatment challenges because of the teenage cousin who was under treatment, along with the suicide in the family. The parents later told me that they were "devastated" when I made the diagnosis. We agreed that it was appropriate to seek another opinion. The second opinion determined that Michael had both an anxiety disorder and oppositional defiant disorder and recommended treatment of these conditions; however, it is likely that the medication he was

prescribed exacerbated the expression of the hypomanic (mild mania) aspect of his bipolar disorder. Meanwhile, the psychologist was raising the possibility of schizophrenia because of some bizarre thinking that Michael expressed.

A third opinion was sought. That psychiatrist agreed with the diagnoses of bipolar and AD/HD, raised the possibility of learning disabilities and pointed out that because of unfolding brain development, the psychiatric picture would change. It meant that Michael would need ongoing mental health monitoring and interventions.

At that point, I resumed treatment of Michael. My approach was to introduce one medication at a time to better assess its benefits and to watch for emerging side effects. Because of possible cardiac side effects associated with one of the medications I prescribed, medical monitoring of his electrocardiogram, cardiovascular status and therapeutic blood level was an integral part of the treatment. At relatively high doses of the medication, Michael relinquished his persistent morbid thinking and his depression was alleviated. Efforts to decrease the medication to lower therapeutic doses caused him to revert to his preoccupation with death. I also started Michael on a mood stabilizer.

An Evolving Picture

There was cooperation from Michael's pediatrician, who worked with the team of his devoted parents, teachers, the psychologist and me to do everything possible to ensure consistent monitoring. Michael began to stabilize, and school reports were encouraging, though his ability to focus was not as good as it should be. He was participating in sports and social events. And much to his parents' delight, Michael's sleep improved. There were still eruptions within the family, and family therapy was re-instituted by the psychologist.

When spring came, Michael blossomed. During summer he was able to attend camp and have successful overnight stays. In general, he was a nicer child to be around. However, when school resumed in September, Michael began to have difficulties in the classroom, and at home the tantrums and outbursts returned. At that time, we agreed to introduce a stimulant medication to address the symptoms of AD/HD not adequately suppressed by his other medications. The treatment was complicated by adverse effects on his sleep, appetite and weight. Drug holidays were instituted whenever possible, and he was given food supplements to increase his caloric intake. As predicted, Michael continues to have a challenging treatment course, with changes in interventions being required as he and his family encounter new developmental stages.

Putting It All Together

What this case illustrates is the very complex nature of diagnosing and treating children who fit the Diagnostic and Statistical Manual, Fourth Edition (DSM) criteria for both bipolar and AD/HD. It also demonstrates the need for the collaboration of parents, mental health providers, pediatricians and teachers to meet the challenging needs of children whose emotional and behavioral symptoms are not so neatly categorized.

Michael's world was highly unpredictable, frustrating and not often gratifying. His self-esteem was understandably impaired. When bipolar disorder is present, in addition to irritability, one may see grandiosity and expansiveness which alienate children from peers. They may be bossy and even behave in intolerant and contemptuous ways toward others. Mini psychotic episodes, which Michael had in a mild form, may cause perceptual distortions and paranoid inter-

Important Note to Readers: Current data supports treating AD/HD only after a patient's bipolar disorder has been stabilized. In fact, in patients with both disorders, stabilizing mania may require the discontinuation of medications for AD/HD coupled with aggressive treatment to regulate the mood. Similarly, treating bipolar disorder with AD/HD medications (i.e., stimulants, atomoxetine or antidepressants) may actually exacerbate mania and produce "kindling" in those with bipolar disorder. In lay terms, kindling means "adding fuel to the fire." Once the mood has been stabilized, practitioners must cautiously proceed with the treatment of AD/HD.

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pretations of the intentions of peers. This resulted in inappropriate responses to normal events in the environment. At such times it may be necessary to add an antipsychotic medication to the regimen, which was indeed done for Michael.

When AD/HD is the sole disorder present, there is usually better response to stimulant medication, social skills and behavioral interventions; the pronounced mood dysregulation (seen in children with bipolar disorder) is not present. Overlapping areas of dysfunction include ceaseless activity, talkativeness, intrusiveness, difficulty concentrating, impulsivity and impairment of executive functioning related to organizational skills.

Research suggests that there is between 10 and 20 percent overlap of children with AD/HD having bipolar disorder,[1] and some pooling of data sets suggest that between 57 percent and 98 percent of children who have bipolar disorder also have AD/HD.[2] Morbid preoccupations, suicidal thoughts and/or behaviors, decreased need for sleep and/or chronic sleep disruption, elated mood, mood swings, overinvolvement in multiple activities, and bizarre thinking or psychosis should definitely raise the index of suspicion that a youngster diagnosed with AD/HD either really has bipolar disorder instead of or in addition to AD/HD. Parents need to raise questions with their providers and even pursue additional professional opinions if they are concerned about a diagnosis and treatment.

The research on bipolar disorder in children and adolescents is advancing, as is research in developmental psychopathology. Together, these lines of

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research will help us to better understand the early expressions of brain disorders, including AD/HD and bipolar disorder, ultimately informing us about earlier diagnosis, possible prevention strategies and more effective interventions. ■

To learn more about bipolar disorder, please visit: National Institute of Mental Health (**www.nimh.nih.gov/healthinformation bipolarmenu.cfm**); Child and Adolescent Bipolar Foundation (**www.bpkids.org**); and Juvenile Bipolar Research Foundation (**www.jbrf.org**).

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