

A Diagnostic Conundrum by Demitri F. Papolos, M.D. and Janice Papolos

ON A very cold day in February, we met with an editor to discuss our book project, *The Bipolar Child,* and, after listening to us describe early-onset bipolar disorder and its too frequent misdiagnosis as attention-deficit disorder with hyperactivity (AD/HD), he said rather pointedly: "But don't you think parents would prefer that their child be labeled AD/HD and adopt the 'ostrich' syndrome?"

It was a legitimate question, but parents had been expressing just the opposite reaction to us—through our research survey and through our early interviews for the book. These parents knew that something more serious than AD/HD was going on. Many reported that they sat at CHADD meetings and didn't recognize their children in the discussions going on around them. They wanted nothing more than to find a name for the problem and to find a way to help their children.

Indeed, it is often extremely difficult to make the differential diagnosis between AD/HD and a budding bipolar disorder in a young child. At first glance, any child who can't sit still, who is impulsive, inattentive, easily distracted or emotionally labile is more likely to receive a diagnosis of AD/HD than bipolar disorder.

Yet, Drs. Janet Wozniak and Joseph Biederman of Harvard Medical School found that 94 percent of a sample of 43 children with mania met DSM-IIIR criteria for attention-deficit disorder with hyperactivity. In the study we conducted, 93 percent of the 120 children diagnosed with bipolar disorder also met full criteria for AD/HD. In fact, some clinical investigators have remarked that, "bipolar kids seem to meet more criteria for AD/HD than kids who have pure AD/HD."

It is extremely difficult to make the differential diagnosis between AD/HD and bipolar disorder in young children.

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Physicians sometimes overlook the possibility of a bipolar condition because they are focusing narrowly on symptoms such as hyperactivity or depression.

It can be a clinical conundrum. There are no blood tests that spell out a definitive diagnosis, and psychiatry's *Diagnostic and Statistical Manual* makes it extremely difficult for a clinician to make a diagnosis of bipolar disorder in early childhood. It insists that the child present with periods of mania and depression that last for days and weeks.

The clinical truth is that children with bipolar disorder are almost always ultra-rapid cyclers—they can experience mood swings several times a day, and they most often present with great irritability and explosiveness, and brief periods of mania where their behaviors are intensely hyperactive, silly, giddy and goofy.

Because of these difficulties with the diagnostic system, the overlap of symptoms between AD/HD and bipolar disorder, the fact that the two disorders may be co-morbid, and the assumption that bipolar disorder is rare in childhood, it is not uncommon for physicians to focus narrowly on one cluster of symptoms—often the ones that are most recognizable such as the hyperactivity or the depressive symptoms, and to treat with stimulants and/or an antidepressant, hoping to relieve some of the symptoms pharmaceutically.

Yet, data is emerging that is beginning to demonstrate the dangers of treating only the attentional or irritable depressive symptoms, and in the meantime, overlooking the possibility of a bipolar condition. If a child's hyperactive symptoms are treated, and yet he or she is actually onsetting with bipolar disorder, then there is a strong possibility that the stimulants can

exacerbate the bipolar illness. While it's quite possible AD/HD and bipolar disorder are co-existing, parents whose bipolar children were placed on stimulants unopposed by mood stabilizers wrote to us and described some of their children's reactions to stimulant medications. They said things like: "He got sky-high on the stimulant and then violent;" "The stimulant caused physical aggression;" "She got psychotic on stimulants;" "He got suicidal and tried to get run over by a car;" "She went bonkers." Many, many parents described the "rebound" period when the stimulant wore off as the "hours from hell."

The Importance of a Proper Diagnosis

How does a clinician go about making the correct diagnosis? Several years ago, Dr. Charles Popper listed several distinctions between the two diagnostic groups that to this day bring clarity to this issue. In short, they are as follows:

- Destructiveness may be seen in both disorders but differs in origin. Children with AD/HD often break things carelessly while playing, whereas the major destructiveness of children with bipolar disorder tends to occur in anger. Children with bipolar disorder may also exhibit severe temper tantrums during which they release manic quantities of physical and emotional energy, sometimes with violence and physical property destruction. They may even exhibit openly sadistic impulses.
- The duration and intensity of physical outbursts and temper tantrums differs in the two disorders. Children with AD/HD usually calm down in 20–30 minutes, whereas children with bipolar disorder may continue to feel and act angry for up to four hours.
- The degree of "regression" during angry episodes is typically more severe for children with bipolar disorder and they may lose memory of the tantrum.
- The trigger for temper tantrums is also different. Children with AD/HD are typically triggered by sensory and emotional over-stimulation, whereas



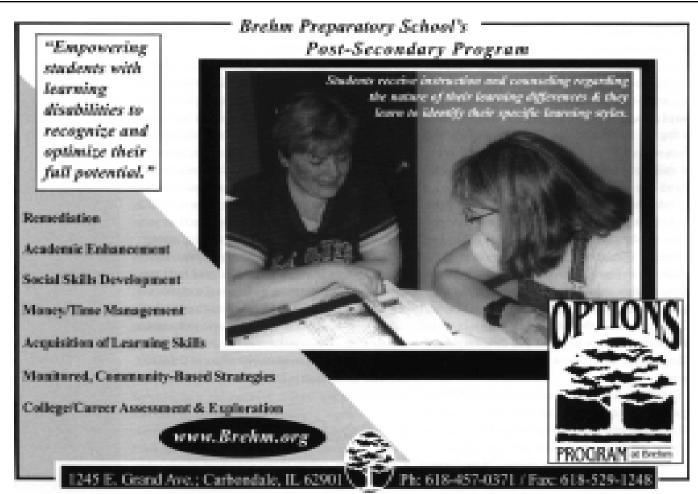
Bipolar Disorder and AD/HD

children who have bipolar disorder typically react to limit setting, such as a parental "no."

- The moods of children with AD/HD or bipolar disorder may change quickly, but children with AD/HD generally do not show depression as a predominant symptom. Irritability is particularly predominant in children with bipolar disorder, especially in the morning on arousal. Children with AD/HD 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 and somatic complaints such as stomach aches and headaches) upon awakening in the morning.
- Disturbances during sleep in children with bipolar disorder include severe nightmares or night terrors, often with themes of explicit gore and bodily mutilation.
- Children with bipolar disorder often show giftedness in certain cognitive functions, especially with verbal and artistic skills (perhaps verbal precocity and punning by age two or three years).



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Bipolar Disorder and AD/HD

thoughts, and all other mania items except

excess energy and distractibility were sig-

nificantly and substantially more frequent

among children with bipolar disorder than

children with AD/HD (i.e., elation: 86.7

percent BP vs. 5.0 percent AD/HD; gran-

diosity: 85 percent BP vs. 6.7 percent AD/

grandiose delusions, 26.7 percent had sui-

cidality with plan/intent and 83 percent

were rapid, ultra-rapid or ultradian (several

One of the great clues in assessing

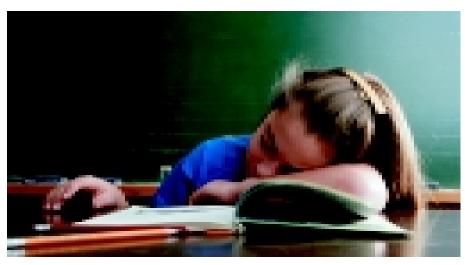
whether a child has bipolar disorder is a

careful examination of the family history.

If mood disorders and/or alcoholism are

coming down both the mother's and the

times a day) cyclers.



Very common traits found in children with bipolar disorder include lethargy, separation anxiety and risktaking behaviors.

- The misbehavior in children with AD/ HD is often accidental and caused by oblivious inattention, whereas children with bipolar disorders intentionally provoke or misbehave. Some children with bipolar disorder are described as "the bully on the playground."
- The child with AD/HD may engage in behavior that can lead to harmful consequences without being aware of the danger, whereas the child with bipolar disorder tends to be a risk seeker.
- Children with bipolar disorder tend to have a strong and early sexual interest and behavior.
- Children with AD/HD usually do not exhibit psychotic symptoms or reveal loss of contact with reality, whereas children with bipolar disorder may exhibit gross distortions in the perception of reality or in the interpretation of emotional events.
- Lithium treatment generally improves bipolar disorder, but has little or no effect on AD/HD.

Barbara Geller of Washington University in St. Louis made more progress toward the clarification between AD/HD and BPD. In 1998, using data she collected from 60 children with bipolar disorder, 60 with AD/ HD, and 90 community controls, she found that elevated mood, grandiosity, hypersexuality, decreased need for sleep, racing be strongly suspected and ruled out first before a child is allowed to idle in the AD/ HD (or the AD/HD/ODD—oppositional defiant disorder) diagnostic categories. It may be that the child has a co-morbid case of AD/HD, but the mood disorder should always be treated first so as not to exacerbate the condition. While the perplexing questions raised

by the frequency of co-morbid diagnoses cannot be resolved at this time, researchers have begun to define a syndrome of bipolar disorder that encompasses symptoms of a number of childhood psychiatric disorders, but also has unique features of its own. Ranging from "very common" to "less common," the symptoms and behavioral traits that have been consistently observed in children with early-onset bipolar disorder may

Very Common

- Separation anxiety
- Rages and explosive temper tantrums lasting up to several hours
- HD). In the bipolar group, 55 percent had

 Marked irritability
 - Oppositional behavior
 - Rapid cycling (frequent mood swings, occurring within an hour, a day, or several days) or mood lability
 - Distractibility
 - Hyperactivity
 - Impulsivity
 - ☐ Restlessness/fidgetiness
 - ☐ Silliness, giddiness, goofiness
 - Racing thoughts



Bipolar Disorder and AD/HD

☐ Grandiosity Carbohydrate cravings ☐ Risk-taking behaviors Depressed mood Lethargy ☐ Low self-esteem ☐ Difficulty getting up in the morning ☐ Social anxiety

☐ Aggressive behavior

Common

☐ Bedwetting (especially in boys)

Over sensitivity to emotional or environmental triggers

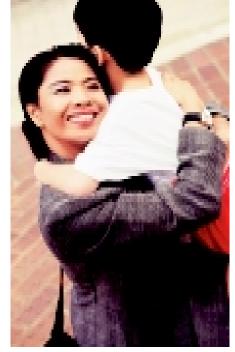
- ☐ Night terrors
- ☐ Rapid or pressured speech
- Excessive daydreaming
- Obsessional behavior
- ☐ Compulsive behavior
- Motor and vocal tics
- Learning disabilities
- ☐ Poor short-term memory
- ☐ Lack of organization
- ☐ Fascination with gore or morbid topics
- Hypersexuality
- ☐ Manipulative behavior
- ☐ Extremely bossy behavior with friends/ bullying
- Lying
- ☐ Suicidal thoughts
- Destruction of property
- Paranoia
- ☐ Hallucinations and delusions

Less Common

- ☐ Migraine headaches
- Bingeing
- ☐ Self-mutilating behaviors
- ☐ Cruelty to animals

How to Treat a Co-Morbid Case of Bipolar Disorder and AD/HD

A common sense treatment plan would be to trial the child on a mood stabilizer (such as carbamazepine, lithium, valproic acid, oxcarbazepine, etc.) at high therapeutic levels, perhaps with the temporary addition of an atypical antipsychotic to control rage and subdue mania. About a month after mood stabilization is achieved and aggressive behaviors have subsided, the child should be



reassessed as to whether attentional problems remain and their level of severity. If AD/HD criteria continue to be met, the current clinical rule of thumb is to start low-dose stimulant medication, gingerly increasing the stimulant—all the while carefully observing the child for signs of activation or mood change.

An 80-item screening questionnaire that might help bring clarity to the proper evaluation of a child's presenting symptoms is available under the heading "research" on our website at www. bipolarchild.com.

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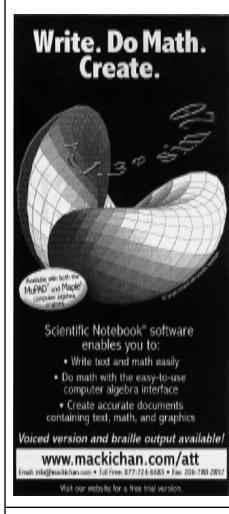
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