BIPOLAR DISORDER AND ADHD IN CHILDREN

BIPOLAR I DISORDER IS BEING DIAGNOSED WITH INCREASING FREQUENCY (INTENSITY) IN PRE-PUBERTAL CHIDREN WITH THE CAVEAT (WARNING / STIPULATION) THAT CLASSIC MANIC EPISODES ARE UNCOMMON IN THIS AGE GROUP (SADOCK & SADOCK). ONE OF THE DIFFICULTIES IN MAKING THE DIAGNOSIS, APART FROM THE RARITY OF THE DISORDER, IS THE CONFUSION/COMORBIDITY WITH ADHD.

The story is told of young Alex, a fifth grader, presenting with discipline problems at school. After an aggressive outburst in which he broke a clock, stormed out of the classroom and right out of the school, he was sent to hospital where numerous tests were conducted, but no diagnosis given. Subsequently, as problems continued for Alex and his parents, he was taken to see a psychiatrist where he was given the diagnosis of ADHD and placed on Ritalin. After a few weeks and no improvement in his behaviour, Alex's dose of Ritalin was increased. Subsequently, Alex was reported to become angry, violent, and totally out of control, resulting in him being hospitalized once again. It was then that Alex was first given the diagnosis of Bipolar disorder, with Ritalin being implicated as triggering his violent outburst (Frank, 2005).

Alex's story is not an isolated case. Indeed the comorbidity as well as the overlapping symptoms of ADHD and Bipolar I disorder, results in a challenge for practitioners distinguishing between the two. Since ADHD is a more common childhood disorder, it is often the first diagnosis given by practitioners (Frank, 2005). Bipolar disorder, in many cases, is misdiagnosed as depression, borderline personality disorder, substance abuse, PTSD, ADHD, or ADHD with depression (Hellander et al., 2007). Complications also arise from the diagnosis of pediatric bipolar disorder as it often presents with a variety of comorbid disorders, including conduct disorder, anxiety disorders, and more generally ADHD. Indeed ADHD has been shown to comorbidly present in 60-90% in children with prepubertal bipolar disorder (Sadock & Sadock, 2007) and ADHD, in some cases, is seen to be the first manifestation of mania in children (Lansford, 2005).
However while the majority of children with bipolar disorder also have ADHD, only approximately one in five children with ADHD meet the criteria for bipolar disorder

(Frank, 2005). Some professionals suggest that ADHD is over diagnosed in children and bipolar disorder, although rare, is under diagnosed. Potentially this is because bipolar disorder usually manifests in adolescence or early adulthood, with its manifestation in children being a much more controversial issue (Frank, 2005). Although prevalence rates for pediatric bipolar are difficult to determine, according to CABF (Child and Adolescent Bipolar Foundation) children have been suffering with bipolar for a long time, but were merely passed as bad or troublesome children or the outcome of poor parenting (Hellander et al., 2007).

The DSM-IV-TR criteria for bipolar disorders are currently the same for children, adolescents, and adults. Criteria for a manic episode include a period of abnormally elevated, expansive, or irritable mood lasting at least a week, or any duration if hospitalization is required, as well as at least 3 (4 if the mood is only irritable) of the following symptoms: inflated self-esteem / grandiosity, reduced need for sleep, being increasingly talkative, flight of ideas or racing thoughts, distractibility, increased goal-directed activity, and excessive involvement in pleasurable activities that has the potential for painful consequences. According to the DSM-IV-TR, some of the criteria required for a diagnosis of ADHD include difficulty sustaining attention, being easily distracted or fidgety, hyperactivity, and talkativeness. In addition many children with atypical hypomanic episodes present with past histories of severe ADHD (Sadock & Sadock, 2007).

The overlapping symptom presentation between pediatric bipolar disorder and ADHD can thus be seen. However diagnosing bipolar disorder in children is difficult as the course of symptoms in children is not the same as in adults (Lansford, 2005). The National Institute of Mental Health acknowledges the difficulty in diagnosing pediatric bipolar as it does not fit the typical symptoms seen in adults (Frank, 2005). Indeed the manic episodes in pediatric Bipolar I disorder are seen to be atypical in that they do not meet the criteria for classic manic episodes. The mood and behavioural characteristics associated with prepubertal children diagnosed with Bipolar disorder include sporadic aggressive outbursts, mood variability, poor attention span, and high distractibility

(Sadock & Sadock, 2007). More specifically pediatric bipolar disorder is characterized by persistent extreme irritability which may involve aggressive or violent outbursts, with angry, irritable or dysphoric feelings remaining between outbursts. Children with this disorder are seen to be highly emotional, and while moods do fluctuate, they are over-ridden by a negative mood. On occasion there may be euphoric mood or grandiose thoughts (Sadock & Sadock, 2007). However euphoric mood is seldom a characteristic of mania in children. Most often the predominant symptom is intense irritability with "affective storms" where the child exhibits aggressive outbursts of temper (Lansford, 2005). This was clearly seen in the story of Alex, and like Alex the main reason for hospitalization of children with mania is due to their aggressive outbursts (Lansford, 2005).

The extreme irritability characteristic of pediatric bipolar is one of the conditions making the task of differentiating between ADHD and childhood mania a difficult one. Irritability is also a common presentation not only in ADHD but in other childhood disorders including oppositional defiant / conduct disorders, autism and major depressive disorder, with in fact only a small number of children with irritability actually presenting with mania (Lansford, 2005).

Symptoms of irritability, distractibility, accelerated speech, and hyperactivity, are thus not useful distinguishing features as they are present in children with both bipolar and ADHD. However some differences are worth noting. Firstly the hyperactivity in bipolar disorder tends to be more episodic than in ADHD. In addition symptoms of mania not overlapping with ADHD include feelings of grandiosity, flight of ideas or racing thoughts, hypersexuality (in the absence of sexual abuse or in the case of a child witnessing the sexual behaviour of adults), feelings of elation, and a reduced need for sleep. Early signs of pediatric bipolar disorder may include bullying – which can be seen as an expression of grandiosity – as well as infants with difficult temperaments (Lansford, 2005).

Other less obvious differences between pediatric bipolar and ADHD are related to the characteristic destructive behaviour and temper tantrums. Destructive behaviour in

ADHD is more the result of carelessness rather than anger as is characteristic in bipolar. The temper tantrums tend to last longer in children with bipolar, and those with bipolar are more prone to forget their tantrums. Children with bipolar tend to seek and enjoy a fight or power struggle, while those with ADHD tend to rather “fall” into such situations. While the moods in children both disorders can change quickly, generally children with ADHD don’t express dysphoria as do children with bipolar. Children with ADHD also tend to arouse quickly in the morning, whereas this is not the case in children with bipolar. While children with ADHD may have trouble going to sleep, those with bipolar awake often during the night and tend to have nightmares. Children with ADHD often have comorbid learning disabilities, while those with bipolar tend to exhibit particular cognitive gifts (e.g. in artistic skills) although their learning may be hindered by motivational problems. While children with bipolar may show distorted or paranoid thinking, this is not seen in children with only ADHD. Finally, although the course of ADHD is chronic, it leans towards improvement over time. Pediatric bipolar, on the other hand, tends to present with more severe symptoms as time passes (Popper, n.d.)

Distinguishing between ADHD, bipolar disorder, and ADHD with comorbid bipolar disorder in children is important with regard to treatment, as bipolar and ADHD benefit from different treatment modalities (Moore et al. 2006). Although stimulants (e.g. Ritalin) are widely used in the treatment of ADHD, in children who have comorbid mania such drugs can potentially trigger affective episodes (Lansford, 2005). In other words the traditional treatments for ADHD can serve to aggravate the mania in children with comorbid ADHD and bipolar disorder. This was seen in the case of Alex, presented in the introduction. Likewise certain medications implicated in the treatment of bipolar (e.g. Lithium / carbamazepine) are not advisable for use in children with ADHD (Moore et al. 2006). In such cases, stimulants need to be administered in conjunction with a mood stabilizer (Lansford, 2005). Risperidone has been shown to improve both symptoms of inattention and hyperactivity of ADHD in children with bipolar disorder (Biederman et al. 2008). However further research in this area is required. It has been shown that the typical presentation of comorbid pediatric bipolar disorder and ADHD is more effectively treated by first stabilizing the mood (Sadock & Sadock, 2007).

The most appropriate diagnosis for prepubertal children exhibiting characteristics such as intense irritability, mood variability, or mood cycling, remains a controversial issue (Sadock & Sadock, 2007). Bipolar disorder is a genetic and highly inheritable illness (Hellander et al. 2007). Family studies have shown that children have a 25% chance of presenting with a mood disorder when one of their parents has bipolar I disorder, and a 50-75% chance when both parents have bipolar disorder (Sadock & Sadock, 2007). This points to the importance of taking clear and detailed histories before coming to the conclusion of a diagnosis. Indeed Lansford (2005) points to the caution of diagnosing pediatric bipolar disorder in the absence of a history of psychiatric illness in the family. Other risk factors for pediatric bipolar include a family history of alcohol or drug abuse, suicide attempts or completions, and even marital conflict or reckless behaviour (Hellander et al., 2007). Thus rather than rushing to a diagnosis, practitioners, need to consider the child as a whole. Misdiagnosing a child can serve to aggravate their problems rather than provide relief.