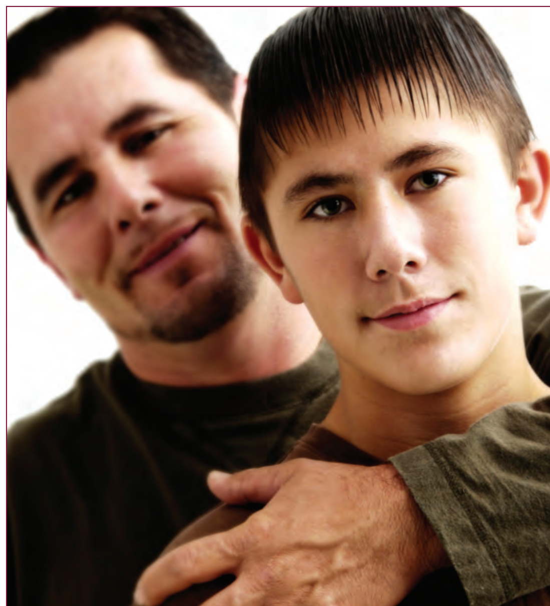
Is It Bipolar *or* ADHD?



From *ADDitude*'s Experts

ADDITUDE
LIVING WELL WITH ATTENTION DEFICIT

Is It Bipolar *or* ADHD?

by Willliam W. Dodson, M.D.

The diagnosis of all mental disorders is largely based on a carefully taken history designed to bring out signs and symptoms that, when grouped together, constitute a recognizable syndrome. The problem of diagnosis in mental health arises from the remarkable overlap of symptoms among conditions.

It can be difficult enough to obtain a diagnosis of attention deficit disorder (ADD ADHD), but to complicate matters further, ADHD is highly comorbid—that is, ADHD commonly coexists with other mental and physical disorders. A recent review of adults at the time they were diagnosed with ADHD demonstrated that 42 percent had another active major psychiatric disorder. Thirty-eight percent had two or more other mental disorders active at the time they were diagnosed with ADHD. Therefore, the diagnostic question is not, "Is it one or the other?" but rather "Is it either or both?"

Perhaps the most difficult differential diagnosis to make is between ADHD and Bipolar Mood Disorder (BMD), since they share many symptoms. It's estimated that as many as 20 percent of those diagnosed with ADHD also suffer from a mood disorder on the bipolar spectrum. A correct diagnosis is critical in treating bipolar disorder and ADHD.

Among the primary symptoms shared by both ADHD and BMD are:

- mood instability
- bursts of energy and restlessness
- talkativeness
- "racing thoughts"
- impulsivity
- impatience
- impaired judgment
- irritability
- a chronic course
- lifelong impairment
- a strong genetic clustering

In adults, the two disorders may occur together. Recent estimates find that 15 to 17 percent of persons with BMD also have ADHD. Conversely, 6 to 7 percent of people with ADHD also have BMD (10 times the prevalence found in the general population). Unless care is taken during the diagnostic assessment, there is a substantial risk of either misdiagnosis or of a missed diagnosis. Nonetheless, a few key pieces of history can guide a doctor to an accurate diagnosis.

Affective or Mood Disorders (BMD)

By definition, an affective or mood disorder is a disorder of the level or intensity of an individual's mood. The quality of mood (happy, sad, irritable, hopeless) is readily recognizable by everyone. What makes it a disorder are two other factors.

First, the moods are intense, either high energy (called mania) or low energy (called depression). Second, the moods take on a life of their own unrelated to the events of the person's life and outside their conscious will and control. Although some environmental triggers have been identified as causing episodes of mood disorders, usually the abnormal moods gradually shift for no apparent reason over a period of days to weeks and persist for weeks to months. Commonly, there are periods of months to years during which the individual is essentially back to normal and experiences no impairment. Although we now are doing a much better job of recognizing that children can and do have all types of mood disorders, the majority of people develop their first episode of affective illness after the age of 18.

Attention Deficit Disorder (ADHD or ADD)

Attention deficit disorder is a highly genetic neuropsychiatric disorder characterized by high levels of inattention/distractibility and/or high impulsivity/physical restlessness that are significantly greater than would be expected in a person of similar age and developmental attainment. To make the diagnosis of ADHD, the triad of distractibility, impulsivity and (sometimes) restlessness must be consistently present and impairing throughout the lifespan. ADHD is about 10 times more common than BMD in the general population.

The two disorders can be distinguished from one another on the basis of six factors:

1. **Age of onset:** ADHD is a lifelong condition, with symptoms apparent (although not necessarily impairing) by age seven. While we now recognize that children can develop BMD, this is still considered rare. The majority of people who develop BMD have their first episode of affective illness after age 18, with mean age of 26 years at diagnosis.

2. **Consistency of impairment and symptoms:** ADHD is always present. BMD comes in episodes that ultimately remit to more or less normal mood levels.

3. **Triggered mood instability:** People with ADHD are passionate and have strong emotional reactions to the events of their lives. However, it is precisely this clear triggering of mood shifts that distinguishes ADHD from bipolar mood shifts, which come and go without any connection to life events. In addition, there is mood congruency in ADHD, that is, the mood reaction is appropriate in kind to the trigger. Happy events in the lives of ADHD individuals result in intensely happy and excited states of mood. Unhappy events, and especially the experience of being rejected, criticized, or teased, elicit intense dysphoric states. This "rejection sensitive dysphoria" is one of the causes for the misdiagnosis of "borderline personality disorder."

4. **Rapidity of mood shift:** Because ADHD mood shifts are almost always triggered, the shifts themselves are often experienced as being instantaneous complete shifts from one state to another. Typically, they are described as "crashes" or "snaps," which emphasize this sudden quality. By contrast, the untriggered mood shifts of BMD take hours or days to move from one state to another.

5. **Duration of mood shifts:** People with ADHD report that their moods shift rapidly according to what is going on in their lives. The response to severe loss and rejection may last weeks, but typically mood shifts are much shorter and are usually measured in hours. The mood shifts of BMD are usually sustained. For instance, to get the designation of "rapid cycling" bipolar disorder, the person need only experience four shifts of mood from high to low or low to high in a 12-month period of time. Many people with ADHD experience that number of mood shifts in a single day.

6. **Family history:** Both disorders run in families, but people with BMD usually have a family history of BMD while individuals with ADHD have a family tree with multiple cases of ADHD.

Note: Always consult with your physician or other qualified health-care professional for questions about the health of you, your child, and family members. The information in this booklet and on ADDitudemag.com do not replace professional medical advice, diagnosis, or treatment.

Willliam W. Dodson, M.D., is a board-certified psychiatrist who has specialized in adults with ADHD for the last 22 years. A former faculty member at Georgetown University and the University of Colorado Health Sciences Center, Dodson is a Life Fellow of the American Psychiatric Association and a member of *ADDitude*'s Medical Advisory Board.