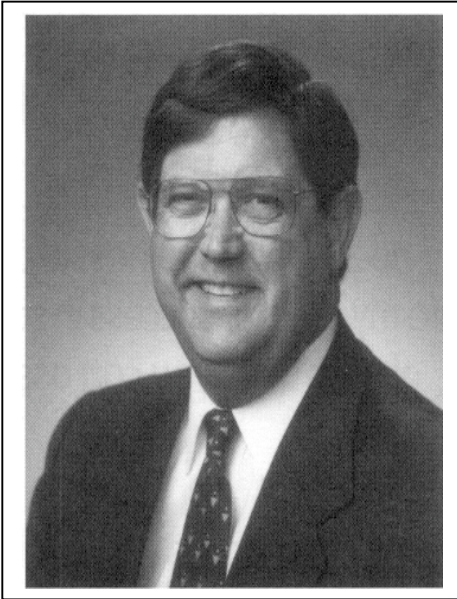


# ADHD and Bipolar Disorder

By William W. Dodson, M.D



*Dr. Bill Dodson is a board-certified psychiatrist in Denver, CO, who specializes in the treatment of adults with ADHD. He is in fulltime private practice but in the past has been on the faculties of Georgetown University and the University of Colorado Health Sciences Center. His research interests are in the sleep disorders associated with ADHD and in how the current theoretical research can be applied to everyday practice situations. This article was first published in the September/October 2000 Issue of ADDvance Magazine.*

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. Our current method of naming mental disorders, the DSM-IV, has 295 separately named disorders but only 167 symptoms. Consequently, overlap and sharing of symptoms among disorders is common. To complicate matters further, ADHD is highly comorbid; that is, it is commonly found co-existing with other mental and physical disorders. A recent review of adults at the time they were diagnosed with ADHD demonstrated that 42% also

had another active major psychiatric disorder. Thirty eight per cent (in other words, virtually all of them) 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 both?"

Perhaps the most difficult differential diagnosis to make is that of ADHD versus Bipolar Mood Disorder (BMD). In adults the two disorders commonly occur together. Recent estimates- also find that 20-25% of persons with BMD have ADHD. Conversely, 6-7% 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 us to an accurate diagnosis.

## **Both ADHD and Bipolar Disorder share primary features of:**

- 1.) mood instability**
- 2) bursts of energy and restlessness**
- 3) talkativeness**
- 4) "racing thoughts"**
- 5) impulsivity**
- 6) impatience -**
- 7) impaired judgment -**
- 8) irritability**
- 9) a chronic course**
- 10) lifelong impairment**
- 11) a strong genetic clustering**

**Affective Disorders.** Affect is a technical term that means the level or intensity of mood. 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. 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.

**ADHD:** This 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, this triad of distractibility, impulsivity and restlessness must be consistently present and impairing throughout the lifespan. ADHD is about ten times more common than bipolar mood disorder in the general population.

## **ADHD and Bipolar Disorder can be distinguished from one another on the basis of six factors**

1) **Age of Onset:** ADHD symptoms are present lifelong. The current nomenclature requires that the symptoms must be present (although not necessarily impairing) by seven years of age. BMD can be present in prepubertal children, but this is so rare that some investigators say it does not occur.

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 people who 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 that 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 losses and rejections 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 many 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.

## **Treatment of Combined ADHD and BMD**

There is a grand total of one published article about the treatment of people who have both ADHD and BMD. That article is about children who have ADHD and "manic-like" symptoms. Despite this lack of published data, the great number of patients involved and the high degree of impairment experienced by people with both disorders has led their physicians to push the envelope of treatment. For the present, however, what follows must be viewed as anecdotal and experimental. Before embarking on any course of treatment, a full exploration of the anticipated risks and benefits of that treatment must be done between the patient and his or her treating clinician.

My own experience with more than 40 patients and the similar experience of other practitioners is that co-existing ADHD and BMD can be treated very well and with extraordinarily good outcomes. The mood disorder **MUST** be stabilized first. This can be done with any of the standard mood stabilizing agents - lithium, valproic acid or carbamazepine. Mood stabilizers are necessary even when the bipolar patient is without symptoms between episodes of illness. Otherwise there is a significant risk of triggering a manic episode. Once the mood has stabilized and any psychotic level symptoms have resolved the first-line stimulant class of medications can be used without significant risk of triggering either a mania or a return of psychotic symptoms.

As with any patient with ADHD, the dose of stimulant class medication must be adjusted carefully. Most adults can clearly tell the difference of just 2 mg of medication. A significant number of adults get optimal results at doses lower than the lowest dose of stimulant class medication manufactured (i.e. less than 5 mg per dose). To avoid over-medication, the initial dose starts at 2.5 mg of medication per dose and is increased by 2.5 mg per dose every day or so until the patient achieves optimal performance and no side effects other than a transient loss of appetite. Because this is still a largely unresearched area of practice, I commonly use a series of computerized performance tests to give some objective confirmation of the response to medication and of the lowest dose that gives optimal performance.

The outcomes for my patients treated for both ADHD and BMD have thus far been good. No one has had to be re-hospitalized and all but 3 have been able to return to work. Perhaps more importantly, they report that they feel more "normal" in their moods and in their ability to fulfill their roles as spouses, parents, employees, and as productive human beings. It is impossible to determine at this early stage whether these significantly improved outcomes are due to enhancement of intrinsic mood stability or whether adequate treatment of the ADHD component makes medication compliance better. The key to these better outcomes, however, lies in the recognition that both diagnoses are present and that they will respond to independent but coordinated treatment.