ADHD Vs Pediatric Bipolar Disorder

Domain	ADHD	Pediatric Bipolar Disorder
General Information	• 3-5% prevalence in childhood • 20% also meet bipolar criteria • frequently comorbid with ODD, CD, SUD, LD, tics, anxiety, depression ADHD is more likely by 15-30% if one parent has ADHD.	• 0.5% prevalence in childhood • 90% of bipolars meet ADHD criteria due to the overlapping symptoms of inattention & distractibility Childhood and adolescent bipolar is more likely [75%] to be rapid cycling. An individual's risk of having full-blown bipolar disorder is 1 percent. Disorders in the bipolar spectrum may affect 4-6%, lifetime. When one parent has bipolar disorder, the risk to each child is l5-30%. When both parents have bipolar disorder, the risk increases to 50-75%. The risk in siblings and fraternal twins of bipolar patients is 15-25%. The risk in identical twins is approximately 70%.
Elements of Criteria	Distractibility Hyperactivity Inattention – difficulty initiating attention when if is called for, difficulty shifting attention, difficulty sustaining attention, daydreaming Disorganization Mood swings	*Mania - elation, high energy, or irritability, grandiosity & self-importance (can achieve delusional quality), impulsive risk-taking, decreased need for sleep, press of speech, talkative, distractible, racing thoughts, impaired. (Note: hyopmania is similar with less severity, no impairment.) *Depression - loss of energy, sadness, hopelessness, decrease interests, suicidal thoughts, loss of pleasure in things the were previously enjoyed, reduced concentration and memory, loss of appetite, disturbed sleep *Mixed episodes contain both manic and depressive symptoms. In adults, states are more likely to alternate, sometimes rapidly, sometimes over periods of weeks or months, often with periods of stable moods
Similarities	• impulsive, hyperactive, mood swings, inattention, high energy • adventuresome in an impulsive way, risk taking, just may not perceive the danger • has a hard time sticking to a goal because of distractibility & impulsivity • inappropriate behavior comes from poor judgment due to immaturity and impulsivity	• impulsive, hyperactive, mood swings [lability], high energy • adventuresome in a grandiose way, seeks the sensation • has a hard time sticking to a goal because of shifts in mood and self-concept • inappropriate behavior comes from poor judgment and can be driven by unlikely goals or fantasies, can be obsessive in pursuit of an interest
Differences	• predominantly a disorder of disruptive behavior and cognitive dysfunctions (working memory, executive functions) • distractibility is the main symptom • the symptoms are always present (may not show intensely in environments which are not distracting),distractibility-impulsivity-inattention is always present	• predominantly a disorder of mood, the dysfunctional behavior follows from the mood disturbance • extremes of sad-depressed-irritable and energized-aggressive-grandiose moods are the main symptoms • the symptoms may not be present at all times, may get progressively worse, with increased impairment

Differences	• hyperarousal comes from the hyperactivity, but child will settle down if focused or tired, • do not generally exhibit *prolonged* dysphoric moods • trigger for more intense symptoms are often over-stimulations, transitions, boredom • grounded in reality, usually keenly observant • ADHD child is more likely to grasp the feelings of others • may have trouble settling down to sleep, but then usually sleeps well, sometimes hard to awaken • often the child is silly, and continues in an activity he or she thinks is silly or fun past the point others are frustrated • can change topics and jump around verbally, but can be re-directed • during interview can be bored, hyperactive, have to get the child's attention before asking a question	• cardinal Symptoms of Bipolar not present in ADHD: grandiosity, elated mood, daredevil acts, flight of ideas, racing thoughts, hyper-sexuality, decreased need for sleep, suicidality with plan or intent • shifts of focus accompanied by shift in mood • aggressiveness is impulsive, arising from frustration, harm is somewhat incidental or careless, usually brief • hyperarousal comes from anger, child imposes his/her will • may show sexual hyper-awareness early • distractibility occurs mainly during extremes of mood • symptoms present in most bipolar children but in 10% or less of ADHD: flight of ideas or racing thoughts, poor judgment, irritable mood • 2 symptoms more likely in bipolar are elated mood (only in 40%) and grandiosity (almost all bipolar, but also in 50% of ADHD, just not as extreme) • 2 symptoms in some bipolars but rarely in ADHD are hyper-sexuality and suicidal thoughts • aggressiveness is hostile, explosive, and often irrational, often comes from others setting limits, harm is usually intentional, and anger can be length • psychosis may be present – mood congruent but unrealistic delusional ideas of grandiose ability or extreme badness • Bipolar child is more driven by own needs, not sensitive to others • energized at night when serotonin level is low and may become raging or tyrannical • sometimes does not need to sleep, more like to have multiple awakenings, to have nightmares • extremes of mood are somewhat independent of environment, may include periods of hopelessness • child is more likely to be aggressive or depressed, not silly • during an interview, can become irritable and annoyed • Determine if the child has a first-degree family member [siblings, parents, or grandparents] with bipolar, check for family members who are alcoholic, drug using, suicide survivors
Treatment	Goal is to keep child on developmental course, to enable learning, to maintain positive self-regard, to improve social skills • stimulants usually make the symptoms better • medications for mood stabilization do not • meds for the co-occurring disorders and symptoms, e.g., aggressiveness, sleep Treatment plan: medications are essential, structuring the environment, limit setting, re-directing to stimulating activities, giving prompts and cues will help functioning, high level of positive reinforcement	Disease Management is the core of treatment, to control symptoms • stimulants and anti-depressants may make symptoms worse • mood stabilizers are more effective Treatment plan: medication, close observation of symptoms, psycho-education about the illness, cognitive behavioral therapy (include family), stress reduction and low *expressed emotionality*, good nutrition, regular sleep and exercise, networking (support)

Treatment	Office assessment may not reveal the whole symptom picture; get data from 2-3 environments Early treatment reduces dysfunction (development lags, self esteem, SA, low achievement). Kids with concommitant CD are at high risk for SUD Family Therapy: psychoeducation, behavioral training. Kids treated well tend to have reduced risk for SUD. Family Therapy: Child Tx is mainly family behavioral therapy, teaching goal setting, getting school reports, mainly using positive reinforcement, work on 2-3 behaviors at a time, appropriate IDEA or 504 or ADA accommodations, supervise homework, assist with organization, know the subjects which are most challenging and provide extra help, avoid escalation, understand how the behaviors are related to the syndrome. Cognitive behavioral also helpful.	If both BP and ADHD are present, treat mood disorder first. Early treatment reduces *kindling effect* of setting the stage for future episodes. Kids not treated are at higher risk for alcohol abuse, drug abuse, and suicide. psychoeducation Family Therapy: Having the entire family involved in the child's treatment plan can usually reduce the frequency, duration, and severity of episodes. It can also help improve the child's ability to function successfully at home, in school, and in the community. Family training and support is second to medication in bipolar recovery: mindfulness , emotional regulation, relaxation, distress tolerance, interpersonal effectiveness, psycho-education about the disorder, appropriate IDEA or 504 or ADA accommodations, and network with other parents, de-escalate ('pick your battles') The response to medications and treatment varies. Factors correlated with better outcome: good medical care, early diagnosis and treatment, adherence to medication and treatment plan, low-stress home and school environments, supportive network of family and friends Factors correlated with poorer treatment outcome: lack of access to competent medical care, time lag from onset of illness to treatment, medications non-adherence, stressful and inflexible home and school environment, co-occurring disorders, use of alcohol and illegal drugs Medication side effects affect schooling [thirst and increased urination, excessive sleepiness or agitation, poor concentration, weight gain, fatigue, easily overheated] Medications can affect school attendance, alertness, concentration, sensitivity (to light, noise and stress), motivation, learning. Convene special education staff, parents, and treatment professionals as a team to work on educational needs.