WHEN ADHD IS NOT ADHD

By Gary R. Spivack, MD

Case A

Johnny is a 10-year-old boy whose parents brought him to my office because he is no longer responding to the stimulants that once helped so much. Increased dosage helped temporarily but his ill temper continued to break through. Now he is too strong to hold when he has tantrums. He has begun to hurt his younger brother and has threatened to hit his mother. Parents say that school is not such a problem, but cries at home are frequent, increasing and intolerable. Their son yells hateful epithets at them and has said that he would kill them or himself.

Case B

Mary, a 12-year-old girl who has been having difficulty paying attention at school, daydreams a lot and "can't concentrate". Her grades are C's and D's despite the intelligence to get A's. Parents say she is well-behaved, well-liked, always in a good mood, talks excessively, has a difficult time waiting her turn, blurts out answers in school and is very distractible. She doesn't get along with her younger sister. She has been on a number of different stimulants but they did not help her grades, poor organization, or inability to finish things that she starts. She feels quite badly about herself, but maintains high expectations. The family is intact with no major changes or difficulties.

Both youngsters had been diagnosed as having an Attention Deficit Hyperactivity Disorder (ADHD) and were treated with a combination of therapy, family work and medication. There was immediate improvement at times but an overall lack of improvement or worsening over time.

Bipolar Disorder or ADHD?

Bipolar Disorder is a well-known and extremely serious psychiatric disorder when it occurs in late adolescence and adulthood, but only in the past decade has its existence in childhood and early adolescence been revealed. Most clinicians are ill-prepared to recognize children with Bipolar Disorder and parents have no information available to them. The disorder most commonly confused with Bipolar Disorder is ADHD. The areas in which the two disorders can overlap and those in which distinctions emerge are noted below. The typical child with ADHD presents with the following:

- Difficulties with attention
- Distractibility
- Impulsivity
- Irritability

Yet mania also interferes with attention, increases irritability and impulsivity, and distractibility is essentially the same as a manic flight of ideas. It is not widely appreciated how similar these symptoms can be. Children with ADHD often experience secondary depression and yet depression is part and parcel of a Bipolar Disorder. It is not by accident that so many children with Bipolar Disorder have not been properly diagnosed.

Differentiation of the two disorders requires a careful medical psychiatric approach to diagnosis. The following areas are clinically useful to differential diagnosis and treatment:

Family History – A helpful distinction between the two disorders is a family history. Since both have a familial inheritance, a detailed family history looking for symptoms or diagnosis of either disorder among blood relatives can be useful. If Bipolar Disorder is revealed, the childhood history of those family members should be explored looking for similarities and differences. Many parents tell me that these possibilities were never considered.

School versus Home – If the behavioral difficulties are worse at home than in school, this may also lead to children with Bipolar Disorder, because they have the most difficulty under conditions of intense affect which is present in the most intimate relationships, (i.e., at home, a boy's disappointment in his mother is much more intense than with his teacher or friends). At school, the focus is on work, not on feelings which are diffused over many different people, lowering the intensity of interactions.

With ADHD, the controlling variables are information overload and excitability. The child with ADHD often does very well in the home under low stimulation and poorly in school, despite being medicated,

Dissociate Symptoms – Children may feel as though they are outside their bodies watching themselves, may feel that they are not themselves or are fragmented. This may be a response to the intensity of manic emotions. Their drawings reflect this – often of robot-like automations or aliens rather than real people.

Racing Thoughts – Children are able to describe this very clearly when asked about it directly. This can present as disorganization and an inability to focus on the subject at hand, severely interfering with school work.

Mood – Adults typically experience shifts from normal mood, to depression and mania episodically, while pre-pubertal children usually experience ongoing continuous mood disturbance that consist of aspects of mania and depression at the same time. This mixed mood is very confusing to the child who can't explain it to his parents, leaving them unaware of his true internal state. The parents view the child through his behavior and are not aware of his subjective distress. Sometimes the depression dominates, resulting in intense suicidal behavior.

Energy and Aggression – Hyperactive children have high levels of energy and aggression but their intensity in mania is unmatched by any other disorder. The aggression typically has a "comic book" or "cartoon" quality to it, in which it is apparent that the child relates to his own aggression as though it and its consequences are somehow unreal.

Grandiosity – Manic adults, who are grandiose, see themselves as being a higher order (i.e., as gods, royalty or other leaders who are above the common man). Grandiose children also see themselves as a higher order – being an "adult". This puts perspective on this defiance and lack of willingness to follow directions such as when parents ask the questions, "Who do you think you are?"

Egocentricity – Manic children expect their inflated desires to be met. Combined with the above grandiosity, one gets an incredibly difficult person to live with and care for.

Hypersexuality – Just as manic geriatric patients can be unusually youthful in their sexual vigor, so can manic children be unusually adult in their sexual interest and behavior. This presents particular problems for parents of early adolescents who pursue sexual behavior as if they were emancipated adults. Provocative postures, gestures, verbalizations and actions are all present.

Loss of Reality Testing - Manic children often say that they hear someone calling their name or have command hallucinations. Other symptoms are worsened when reality does not pose a limit for them. Instead the parents or teachers must impose the limits of reality, i.e., "You can't hit your sister like that because you will hurt her." "You are not in charge here; I am." This bursts their narcissistic bubble and releases rage that is targeted to the bearer of the disappointing news – usually the parent.

Telling Tall Tales – Difficulties with reality testing merge with grandiosity so children exaggerate reality to the point of fantastic unbelievable exploits by themselves or others. This is rather different than the more commonplace lying to get oneself out of trouble.

Resistance to Treatment for ADHD

Lack of response is not proof that the child does not have ADHD, but present with other factors, it may warrant changing the working diagnosis to that of a Bipolar Disorder – and a resultant change in medication from stimulants to mood stabilizers, (Lithium, Carbamazepine, and Valproic Acid) antidepressants and antipsychotics medications.

Proper diagnosis cannot be overemphasized since the results of untreated or improperly treated Bipolar Disorder are devastating. Sadly, there is a tremendous overrepresentation of children with Bipolar Disorder in psychiatric hospitals, residential treatment centers and in the Juvenile Justice system. Development of personality disorders – notably Narcissistic, Antisocial and Borderline Personality Disorders – along with Substance Abuse Disorders – is almost inevitable without proper treatment.

In this era of managed care, it is also important that the child be properly diagnosed so that the appropriate level of services will be authorized. Medication, intensive personal and family therapy along with environmental interventions, special schooling, hospitalization and residential treatment all may be necessary for a child and his family to survive the ravages of this disorder. Parents need to understand this is a biologic, inherited disorder, that they are not at fault by their upbringing of the child, and that with proper treatment, their child can have a productive life.

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