Similarities and Differences: ADHD and Early Onset Bipolar Disorder

Revised from the works of By F. Russell Crites

Some characteristics of ADHD and Bipolar Disorder look the same, but have different motivations.
Others show the same type of behavior, but it is more or less intense in some way.

SYMPTOM	ADHD	BIPOLAR
BREAKS THINGS:	Breaks things carelessly or impulsively while playing (non-angry destructiveness);	Breaks things as a result of anger. He has severe temper tantrums where he releases extreme amounts of physical and emotional energy. Aggression towards others and physical property damage sometimes occurs. May be cruel, destructive, and sadistic.
ANGER:	Usually calms down in twenty to thirty minutes (maybe less).	Anger may be trance-like or have OCD qualities. May continue to feel/act angry for up to four hours or more.
REGRESSION:	Rarely regresses, e.g., displays disorganized thinking, language, and body position.	Regresses and often has disorganized thinking, language and body position during the episode. He may be clinging, display social phobia, and experience bedwetting.
FORGETS THE EVENT:	Does not lose memory of events, except due to inattention.	May lose memory of the tantrum or event.
TRIGGER EVENTS:	Typically triggered by a lack of structure or over-stimulation.	Overreacts to limit-setting, is triggered by anxiety (look for PTSD issues), new social situations, misattribution of motives, or by sensory or emotional over-stimulation.
SLEEP:	May sleep 5-9 hrs. However, he will often be tired due to lack of good REM (rapid eye movement) sleep.	Has a decreased need for sleep (3-6 hrs), e.g., may stay up late and get up early and not seem to have any bad effects.
SLEEPING and WAKING UP:	Usually arouses quickly and attains alertness within minutes. However, they are tired and often do not get a good night sleep…especially hyperactive-impulsive students.	Often stays up late, and is irritable upon early morning arousal. He may have slow arousal and have irritability, fuzzy thinking, or somatic complaints when he gets up (may last for a few hours).
GETTING TIRED:	Seems to wear himself out and get tired during the day (this may be a medication issue).	Not usually tired during the day.
NIGHTMARES:	May destroy the bed covers, but he does not have excessive nightmares or night terrors.	Often has severe nightmares or night terrors. Themes of explicit gore, death, harm, and bodily mutilation are often reported, and may carry forward to wakeful states.

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SYMPTOM	ADHD	BIPOLAR
REALITY and JUDGMENT:	Can see reality for what it is. He can make good judgments, but he just doesn't take the time to do so.	Is grandiose and believes that he can do things that he can't do (impaired judgment). Doesn't think things through, and even if he does, it is often flawed thinking.
MOOD SWINGS:	Will not have significant shifts in mood, e.g., depressed to manic.	Will often have mood shifts during the day, or at the least during the week.
SELF ESTEEM:	Low, resulting from ongoing performance difficulties.	Low, resulting from inherent unpredictability of mood. Grandiose or expansive moods could mask low esteem.
MISBEHAVIOR:	Misbehavior is often accidental and usually caused by inattention, impulsivity, or over-activity.	Will intentionally provoke or misbehave. Often misattributes the intent of others and may attack. Some are seen as the 'bully on the playground'.
CONTROL ISSUES:	Desire more to seek approval. Gets into trouble due to inability to complete tasks.	Intermittent desire to please others, but tends to push limits and relish power struggles. Expert hasslers.
OPPOSIONAL DEFIANCE:	Demonstrates argumentativeness but will relent with show of authority, and are redirectable. Short attention span allows them to "let go" more easily.	Usually overtly and prominently defiant, at times passive aggressive, often not relenting to authority. Tend to insist on getting own way.
LYING and BLAMING:	Self-protective mechanism to avoid immediate adverse consequences.	Enjoys "getting away with it," and to avoid immediate adverse consequences. Grandiosity contributes to disbelief/denial they caused something to go wrong.
ENTITLEMENT:	Overwhelming need for immediate gratification and acts impulsively.	Expansive and grandiose mood creates belief they deserve special treatment. Oriented to "now" or the near future.
CONSCIENCE DEVELOPENT:	Capable of demonstrating remorse when things calm down. Close to developmental age.	Limited conscience development, dependent on mood and caregiver's skills and abilities.
PEER RELATIONSHIPS:	Makes friends easily, but may have problems keeping them due to immaturity.	Can be charismatic or depressed, depending on mood. Conflicts are common due to controlling nature.
MOTIVATION:	Less resourceful - more adult dependent. Okay starters but poor finishers.	Grandiose - believe they are resourceful, gifted, creative. Self-directed, highly variable energy and enthusiasm.
ANXIETY:	Uncommon, unless performance-related.	Emotionally wired. High potentials for anxiety, fears, and phobias. Somatic symptoms common, needle phobia, and some dissociation possible.
DEVELOPMENT and LEARNING	Normal or slow development. Learning disabilities are somewhat common.	Precocious development, especially cognitive and language skills. LD problems are not common, unless comorbid with ADHD or related with disabling mood swings.

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SYMPTOM	ADHD	BIPOLAR
RACING THOUGHTS:	Has racing thoughts that are fragmented; bits and pieces of hundreds of things that distract or draw his attention.	Often has racing thoughts. Usually gives concrete description of thoughts, e.g., “I need a stoplight.” "My thoughts broke the speed limit.” Can tell about a specific ‘topic’ he is racing about. Speech is usually goal directed.
RISK TAKING:	May engage in behavior that can lead to harmful consequences without being aware of the danger. Engages in these behaviors to satisfy a need for increased stimulation, but is oblivious to the dangers/consequences.	Is often a risk or sensation seeker. Engages in risk behaviors to satisfy a need for control. Some intentional dangerous behaviors despite knowledge of potentially harmful consequences.
FIRE SETTING:	Play with matches out of curiosity, nonmalicious.	Intrigued with matches and fire setting, and can have malicious intent.
SEXUAL BEHAVIORS:	Often immature for his age. As a result, sexuality comes along at a slower pace because of psychosocial or developmental delays.	Tends to have strong early sexual interest and precocious behavior. He may be sexually inappropriate for age e.g., use explicit sexual language, sexual pictures
REALITY TESTING:	Usually does not have psychotic symptoms or reveal a loss of contact with reality. Sometimes is clueless about the context due to inattention, but is not delusional.	May exhibit gross distortions in perception of reality or in the interpretation of emotional events. Can be delusional.
ELATION:	Will be elated (Giggle, excited, extremely ‘happy’) when special events occur.	May be elated for no apparent reason, e.g., giggling in the classroom when peers are not, laughing for no reason, etc. At the same time he may be sensitive or easily irritated.
RESTLESSNESS:	May have restless tension as seen in an inability to keep his legs, hands, etc. still. This occurs all day long.	Will have the same problem with restlessness, but it may cycle through the day, often getting worse at night (depends on type of bipolar).
IMPULSIVITY:	Can be impulsive and react to his environment, not so much his inner turmoil.	Will be impulsive due to a swing in moods. If hypomanic, judgment fades. If depressed he may have a need to find a way to reduce his depression or energize himself.
INATTENTION and POOR FOCUS:	Will probably be inattentive or distractible all day long, every day of the week (pending medication).	May be inattentive for a time and then become attentive as he pulls out of his depression. If he goes too far into the manic side he will lose attention again. Attention is often cyclical…may be hour by hour or day by day.

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SELF CENTERED:	May be self-centered, but is usually so because of a sense of frustration at being unable to focus.	Seems to be unable to see other's perspective in a situation. He will do whatever is necessary to justify his position. Very irritable.
SUICIDAL THINKING and SUICIDE:	May talk of suicide as a control issue. Usually there is no intention, plan, etc. for follow through.	May have a morbid fantasy about death, hurting others, etc. Suicide is the leading cause of death of people with Bipolar Disorder.
INJURY TO SELF OR OTHERS:	Would rarely intentionally hurt self or others. If something were to occur it would be more of an accident due to inattention.	Will intentionally hurt self or others with purpose. This purpose will often seem to be malevolent or grandiose in nature, i.e., creative ways to hurt someone who has offended him.
RAGES:	Will have non-directive meltdowns. They are usually short in duration.	Will go into a rage and direct it at a person, or some available target. It is deliberate and intentional in nature. He may attack those in authority.
TALKS A LOT:	May speak out of turn (even have a lot to say), but can be redirected to task.	When manic, may have a verbal outpouring, speaking without stopping even when someone tries to stop him.
SUBSTANCE ABUSE:	Moderate tendencies as coping mechanisms for low self esteem.	Very strong tendencies in attempt to enhance mood or reduce manic/dysphonic moods.
OPTIMAL ENVIRONMENT:	Low stimulation and stress. Support and structure. Identify learning disability components.	Clear and assertive, balance of limits with encouragement and negotiation. Treatment team works together.
PARENTING TECHNIQUES:	Support, encouragement, and redirection are most beneficial.	Most things do not work for the long term until correctly diagnosed and treated with medications and therapy.
MEDICATION RESPONSE:	Responsive to stimulants and other ADHD medications. Not responsive to Lithium or antipsychotic medications.	Responsive to Lithium, anticonvulsives, antipsychotics, anxiolytics. Stimulants may trigger aggression or mania.
PROGNOSIS:	Good to excellent with appropriate medical treatment, ancillary therapies, and educational accommodations.	Fair to good with appropriate treatment. Possible times of regression/relapse even with appropriate treatment.