CHILDREN'S MENTAL HEALTH RESOURCE CENTER

Bipolar vs. ADHD

Understanding the Difference

A clinical overview of how to distinguish pediatric bipolar disorder from ADHD, why accurate diagnosis matters, and what research tells us about the neuropsychological and behavioral differences between these two disorders.

Because bipolar disorder and ADHD share overlapping symptoms, including impulsivity, inattention, hyperactivity, and behavioral lability, distinguishing them requires looking not just at what symptoms are present, but at how and why those symptoms manifest the way they do.

Medications typically used to treat ADHD can have serious detrimental side effects when prescribed for someone living with bipolar disorder.

> ***"All of the features of ADHD can be seen in mood disorders. ADHD is a diagnosis reached only after ruling out a mood disorder."*** Dr. Charles Popper, Harvard Medical School

Children's Mental Health Resource Center provides guidance, education, and diagnostic support for families and providers navigating the complexity of mood disorders in childhood. You are not alone. We are here to help.

FOR FAMILIES AND CLINICIANS

Why Accurate Diagnosis *Matters*

NIMH estimates that as many as 1.2 million children and teens may have juvenile onset bipolar disorder, but be misdiagnosed with something else. One common misdiagnosis is ADHD.

Bipolar and ADHD are distinctly different diagnoses, with different causes, treatments, and courses of illness. But because their observable symptoms can look similar, careful clinical assessment is essential to determine which diagnosis, or combination of diagnoses, is present.

ADHD stimulant medications can activate symptoms of bipolar disorder and trigger manic, hypomanic, or mixed episodes in children who have an undiagnosed mood disorder.

There is no such thing as "extreme ADHD." When a child receiving treatment for ADHD shows increased aggression, decreased need for sleep, heightened hyperactivity, or suicidal or homicidal ideation, this may indicate that bipolar disorder is present and that the stimulant medication is triggering a manic or mixed episode.

Identifying the right diagnosis early protects children from the harms of incorrect treatment and begins the path to the stability and recovery they deserve.

GUIDANCE. COMMUNITY. HOPE.

COMMON QUESTIONS ANSWERED

Can a child have both bipolar disorder and ADHD at the same time?

YES Children can have multiple diagnoses at the same time. Having one does not rule out the other. Research comparing children with bipolar only, ADHD only, and both showed each group had distinct clinical needs.

Can impulsivity determine if it's bipolar or ADHD?

NO Research found that measures of impulsivity did not differ meaningfully among children with bipolar, ADHD, or both diagnoses. Impulsivity alone cannot be used as a differentiating factor between the two diagnoses.

Is slow processing speed a sign of bipolar disorder?

LIKELY Children with bipolar disorder performed significantly worse on all measures of processing speed than children with ADHD only. Slow processing speed may be a core feature or trait of pediatric bipolar disorder.

Can a mood stabilizer help clarify the diagnosis?

YES Mood stabilizers such as lithium improve bipolar symptoms but don't affect ADHD. If a proven mood stabilizer reduces symptoms, this supports a bipolar diagnosis. If it has no effect, it can help rule out bipolar.

Do children with bipolar need special education support even when treated?

YES Even with successful treatment for bipolar symptoms, cognitive disruptions continue for children with the disorder. They need therapy and special education accommodations to succeed at school.

Is hypersexuality in a child always a sign of abuse?

NO Hypersexuality can be a symptom of bipolar disorder unrelated to any history of abuse. Providers should rule out abuse but also recognize that this symptom is part of the disorder, particularly when other bipolar symptoms are present.

My child can't pay attention to anything, even things they like to do. Is this ADHD?

YES Children with bipolar have the ability to attend to things that are of interest to them and can overcome inattention with motivation. But with ADHD, interest alone can't overcome inattention and children will still struggle without support.

FOR CLINICIANS AND CAREGIVERS

THE CLINICAL INTERVIEW REVEALS THE DIFFERENCE

In an interview, children with ADHD tend to be pleasant or at most frustrated and bored. Children with bipolar disorder may appear hostile, reject the interview, insult the interviewer, or leave within seconds. This “interview intolerance” is a meaningful clinical signal.

When a child's challenging symptoms in the interview, at school, or at home feel involuntary to them, when they cannot explain why they did or said things, and are remorseful afterward, this points toward bipolar disorder symptoms.

ABOUT “MISBEHAVIOR”

CMHRC places the word “misbehavior” in quotes when describing bipolar symptoms. What looks like deliberate defiance is often an involuntary symptom. Children frequently cannot stop themselves, and many are remorseful after the fact. Treating this as willful behavior misses the disorder and causes shame and causes low self-esteem in the child.

> *Children with bipolar experience periods of stable mood and pleasant behavior between mood episodes. But if they are experiencing a dysregulated mood, no amount of cajoling can alter that mood state because it is internally driven.*
>
> ON MOOD AND MOTIVATION IN BIPOLAR

UNDERSTANDING THE DIFFERENCES

How the Symptoms *Differ*

Dr. Charles Popper identifies 15 characteristics that can distinguish bipolar disorder from ADHD. Both disorders share symptoms, but the nature, intensity, and origin of those symptoms differ significantly.

TANTRUMS: DURATION AND INTENSITY

Children with ADHD typically calm down within 20 to 30 minutes. In bipolar disorder, tantrums can last up to four hours, with a level of physical energy that most adults could not sustain for more than a few minutes. Children with bipolar may also not remember the tantrum afterward.

Children with ADHD are triggered by sensory overload or unexpected transitions. Children with bipolar disorder react intensely to limit setting, and may engage in active conflict with authority figures when they feel thwarted.

Additional distinguishing features

1. Mood: ADHD does not include depression as a predominant symptom. Bipolar often presents with chronic irritability, a sign of childhood depression.
2. Sleep: In bipolar disruptions include severe nightmares with themes of gore or violence, and multiple awakenings per night. ADHD sleep difficulties are primarily about falling asleep.
3. Morning arousal: Upon waking, children with bipolar experience extended grogginess, fuzzy thinking, and somatic complaints (stomachaches, headaches). ADHD children typically become alert quickly.
4. Course of illness: ADHD tends to improve with treatment over time. Bipolar is cyclical and without treatment is progressive, and may worsen significantly over years.

WHAT TO WATCH FOR

Signals That Warrant *Further Evaluation*

When children with ADHD who are receiving treatment continue to demonstrate cognitive deficiencies, this is a red flag. Further evaluation is needed to determine whether a mood disorder is present or possibly in a prodromal phase.

Possible indicators of bipolar disorder rather than ADHD alone:

- → Tantrums lasting more than 30 minutes, with extreme energy output the child cannot control
- → Child does not remember the tantrum afterward, or parents describe “blank” or “absent” eyes during raging
- → Waking difficulties that last for hours, with physical complaints and profound irritability
- → Nightmares with themes of violence or pursuit, causing fear of sleep
- → Early giftedness in verbal or artistic skills beginning as young as ages two or three
- → Hypersexual awareness or behaviors that appear very early in childhood
- → Danger-seeking behavior that seems to provide a mood boost or sense of invincibility

> *“50% of all mental illnesses begin before age 14. Bipolar affects 3% of all children. Early identification with an accurate diagnosis and effective treatment is the best tool we have to support positive outcomes into adulthood.”* **Elizabeth Errico, CMHRC Executive Director**
>
> ON EARLY INTERVENTION