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# Mood Swings or Mood Disorder? Important Differences in ADHD vs Bipolar Disorder Symptomatology

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### *Key Takeaways*

- *ADHD and bipolar disorder have several overlapping symptoms that can make it difficult to reach an accurate diagnosis.*
- *A major consideration in differentiating between ADHD and bipolar disorder is length of symptom onset/offset.*
- *Dopamine modulators can be useful in patients with comorbid bipolar disorder and ADHD.*

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At first thought, one might presume that differentiating between attention-deficit/hyperactivity disorder (ADHD) and bipolar disorder is a simple task, but the 2 disorders have overlapping symptomatology that can complicate an accurate diagnosis—especially in younger patients. Furthermore, ADHD and bipolar disorder can be present simultaneously; it is estimated that approximately 8% of adults diagnosed with ADHD have comorbid bipolar disorder and approximately 17% of adults diagnosed with bipolar disorder have comorbid ADHD. Both conditions require lifelong management, and accurate diagnosis is imperative to achieving optimal outcomes. Here are some key considerations to help differentiate the overlapping symptoms and begin thinking about management strategies.

### **Symptom Differentiation**

First, the age of onset for ADHD is typically younger than that of bipolar disorder. In fact, the *DSM-5* specifies that symptoms of ADHD must be present before 12 years of age. Bipolar

disorder, on the other hand, typically has an age of onset in the late teens and early 20s. This is not to say that a younger person cannot have bipolar disorder or that an older person cannot have ADHD, but remembering the typical ages of onset can help direct your clinical suspicion and differential diagnosis. I often have children referred to me for diagnosis, and we try not to start with a diagnosis of bipolar disorder in the younger patients. Instead, we look for the more obvious and epidemiologically more likely etiology.

Second—and perhaps most significant—is that ADHD is classified as a neurodevelopmental disorder, whereas bipolar disorder is classified as a mood disorder. Another way I like to think of this is that ADHD follows a top-down model, and bipolar disorder follows a bottom-up model. What does that mean? In other words, ADHD is a problem in the prefrontal cortex of the brain—the part of the brain that helps us with organization, concentration, time management, filtering out distractions, planning, executive functioning, and emotional regulation. In ADHD, a person has trouble regulating and reacting to both cognitive and emotional problems in the environment but does not necessarily have a mood problem—the mood state is correct for the individual. For example, imagine a young girl with pigtails—let’s call her Sally. Perhaps a student sitting behind Sally in the classroom pulls on her pigtails, leading Sally to have the impulse to physically and emotionally react by punching or shouting at them. Someone with ADHD may have trouble stopping that impulse to react, but that doesn’t mean they have a mood problem. Rather, their mood—angry and upset—is appropriate for the situation, but their reaction is not. They likely are not thinking through the consequences and have a reaction with quick onset/offset. In a few minutes to hours, they may feel calmer but also ashamed and defensive about their actions.

By contrast, bipolar disorder is more limbic—more central—so it’s more of a bottom-up model. It involves the older parts of the brain involved in one’s mood state. A person doesn’t need to have an external trigger—such as someone pulling their hair—to influence their mood, although there certainly can be triggers to (hypo)manic or depressive episodes; they may just wake up “on the wrong side of the bed.” So bipolar isn’t a problem of impulse control, but of mood state influenced by brain chemistry. In addition, the onset/offset is much longer in bipolar than ADHD: *DSM-5* criteria for manic/hypomanic episodes in bipolar disorder require that a manic episode be present for a period of at least 7 consecutive days (bipolar I) or that a hypomanic episode be present for a period of at least 4 consecutive days (bipolar II).

Hypomanic symptoms such as high energy and irritability overlap significantly with the presentation of ADHD, but what is key to remember here is the chronicity of the symptoms in bipolar disorder vs ADHD.

Another way to frame this is in the context of *mood swings*. A patient with ADHD may have mood swings, which are related to trouble with mood regulation from the top down in the brain. Again, they have a quick onset/offset—like the QRS complex on an EKG. A patient with bipolar disorder, even if they are classified as rapid cycling, will not have such a quick onset/offset—certainly not within the period of a day. Their mood changes might look more like a big, wide sine wave. Questions I ask to clarify mood swings from bipolar disorder are: “What caused it? What were you responding to? How long did the mood last? How long did it take you to calm down?” If the mood swings are happening over the course of a day, it’s very likely ADHD rather than bipolar disorder.

An important clarifying point here is that the *DSM-5* does specify that ADHD symptomatology be present for at least 6 months. Although this is longer term, the symptoms themselves are still fluctuating much more rapidly than they would in bipolar disorder.

### **Management Focus and Considerations**

I strongly recommend that if someone comes in and truly appears to meet the criteria for bipolar disorder, that should be addressed and treated first, even if you suspect there is comorbid ADHD. This is because ADHD is a diagnosis of exclusion, and the symptoms are just that—symptoms. Difficulty with focus, concentration, and impulsivity can be caused by a range of disorders or lifestyle factors, and their presence warrants investigation into other causative factors before an accurate diagnosis can be made. In a patient who meets the criteria for bipolar disorder but also has symptoms of inattention and concentration, it's only once you have stabilized their mood and they are consistently euthymic that you can evaluate whether they are still struggling with cognition or some impulsive reactivity and inattention; then you can better evaluate whether there truly is comorbid ADHD.

Medication choice can be tricky, because treatment options for both ADHD and bipolar disorder traditionally have focused on either inhibiting or potentiating dopamine. Older antipsychotics that block dopamine can be very useful in bipolar disorder but may negatively impact cognition and/or comorbid ADHD. However, the newer atypical antipsychotics *modulate* dopamine rather than block it. Modulators can either raise or lower levels of neurotransmitters, and they can do that in different parts of the brain: You could be raising dopamine in one area of the brain while lowering it in another. This is applicable when I'm looking to treat someone with bipolar disorder—with or without ADHD. I want to treat the mood symptoms limbically, because usually, the limbic system is too active or “too hot” in bipolar disorder, in which case you want to dial down the amount of dopamine. But—and again, this is regardless of ADHD—I don't want to lower dopamine in the frontal lobe, as that can potentially cause the patient to have problems with cognition. These newer agents that modulate dopamine can treat a mood condition without flattening the frontal lobe and causing a cognitive problem; this is compared with the older agents, which block dopamine across the central nervous system and can make a person feel cognitively “slowed.” Some of the newer agents even have been described as having a “cognitive brightening” effect.

Of course, I'm not saying this is a one-size-fits-all approach with medication—that's never the case. There are times when some of the older antipsychotics and their adverse events can be of benefit to the patient; for example, they may help the patient with sleep or weight gain in addition to treating the mood disorder. I would encourage healthcare professionals to at least know the differences among the available medication options, because the atypical antipsychotics are still such a heterogeneous group of medications and should not be lumped together. In other words, there isn't a typical atypical.