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NEW FINDINGS IN DIAGNOSIS: CORRELATION BETWEEN BIPOLAR DISORDER AND REACTIVE ATTACHMENT DISORDER

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Historically, mental health professionals have long associated attention deficit disorder (ADD) with reactive attachment disorder (RAD). It is true that children who have been abused and/or neglected do have attentional problems secondary to their abusive circumstances or brain maturational problems. Experts have put this correlation of ADD and RAD at between 40% and 70% for either abuse/neglected children and/or adopted children.

In my experience as psychiatric consultant to the Institute for Attachment and Child Development since 1977, as well as within my own private practice and consultations with other attachment programs and adoption agencies in which I supervise psychotherapists who work with attachment disorders, I have come to realize that attention deficit disorder is vastly over diagnosed in this clinical population leading to inadequate even contraindicated treatment. I have concluded that correlations between bipolar disorder and reactive attachment disorder are indeed much more common. This conclusion has led to different, and in my experience, much more effective medical treatment plans for these children.

I have reached the above conclusion gradually over the last several years. In the past twenty-five years, since my graduation from medical school, I have diagnosed and treated approximately 3,500 cases of ADD and approximately 1,000 cases of bipolar disorder. Particularly in my role as a consultant to the Institute for Attachment and Child Development program, it has been my professional privilege and pleasure to assess and treat children from all over the United States and at least a few foreign countries. In my experience, this miscorrelation between ADD and RAD is international.

Regrettably, mental health professionals, parents and adoption agencies, have had poor, even misleading histories of birth parents of abused/neglected adopted children. In our attempt to understand their psychological and/or physiological predispositions to various mental illnesses, family histories of mental illness are extremely important. Abused and neglected children, as we are all aware, develop attachment or bonding difficulties that lead to oppositional and defiant conduct problems.



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Despite this inadequacy of data regarding birth parents, enough information has emerged so that I can say with some degree of professional certainty that, in essence, there are four diagnoses of parents who are capable of abusing or neglecting their children. One of these is considered of psychological origin, one is alcohol and substance abuse, and two are well-known genetic biochemical disorders. ADD is not among them.

1-ANTISOCIAL (SOCIOPATHIC) PERSONALITY DISORDER

Many of the diagnostic characteristics of children with severe reactive attachment disorder also fit adult characteristics of antisocial personality disorder. These include substantial conduct disorders including cruelty to people or animals, lying, stealing, fire setting, failure to conform to social norms, irritability, aggressivity and impulsivity. Such people have little regard for the truth and lack empathy and remorse. Many of these adults were themselves abused or neglected in early childhood.

2-DISORDERS OF COGNITIVE PERCEPTION, MOSTLY BORDERLINE PERSONALITY DISORDER AND PARANOID SCHIZOPHRENIA

The etiology of borderline personality disorder is not well understood, but there is evidence of both genetic and psychological influences, to some degree attributable to poor parenting (neglect or over-protection) between birth and three years of age.

Borderline personality disorder manifests as long-term patterns of unstable mood, interpersonal relationships and self-image.

Paranoid schizophrenia is a complex disorder, usually strong genetically influenced and is characterized by thought disturbances such as delusions and hallucinations. They may be apathetic or have inappropriate affect (feeling tone). They tend to function at low levels of self-care and have frequent hallucinations or delusions related to circumscribed themes of distrust. They relate poorly to others and others have a difficult time getting close to them. As such, they do not frequent cohabit, form lasting relationships or have children. In a delusional or hallucinatory state, they are capable of abuse or neglect, though uncommonly.

3-ALCOHOL OR SUBSTANCE ABUSE

In my experience working with abused children, this is the single most common characteristic of abusing parents. However, in my experience, it is also most commonly a coexistent factor of abuse. In other words, while alcohol and substance abusing parents may abuse their children, it is usually of less severity and is usually not in an ongoing manner. Purely alcohol or substance abusing parents who over-indulge and neglect or abuse their children are ordinarily regretful and remorseful of their actions.

On the other hand, if alcohol or substance abusing parents also have a coexisting antisocial personality disorder, borderline personality disorder, paranoid schizophrenia or bipolar disorder, the intensity of the abuse is more severe, and the extent of the abuse is far more lasting. Also, given the above coexistence factors, little remorse or regret is felt, leading to a cycle of continuing abusive situations.



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4-BIPOLAR DISORDER

This is a common psychiatric mood disorder representing 2 to 3 percent of the general population. It is a genetic, inherited, familial disorder that ultimately results in biochemical imbalances within one's central nervous system. It manifests in manic (or hypomanic, a lesser form of manic) and/or depressive mood disturbances. In my professional experience, this is by far the disorder that has the greatest coincidence with abuse or neglect of children and as such is the genetic disorder that these children with coexistent reactive attachment disorder can inherit. The degree of self-centeredness, irritability and intensity of rage reactions while in a manic state is frequently sufficient to create severe abusive conditions. Correspondingly, the degree of profound depression is likewise severe and prolonged enough to create long standing neglectful circumstances.

Parents of children with ADD, in my professional opinion, uncommonly, even rarely, manifest sufficient self-centeredness, irritability or intensity and frequency of rage reactions. Such parents are reality based, generally have a high regard for their children and even if they were to uncommonly abuse their children, are in almost all sets of circumstances ordinarily filled with enough regret and remorse as to learn from their own experiences and not repeat such actions. In other words, the abuse that they might render is ordinarily of a mild transient nature and not of the severe or prolonged degrees that we experience with children with emotional attachment or bonding problems.

While there are some characteristics in common between ADD and bipolar disorder in children, hopefully an experienced clinician can differentiate between the two. What I have just written, however, is indeed easier said than done. Probably all experienced clinicians, myself included, have made errors in clinical judgement, confusing these two disorders.

In somewhat of an over simplified manner, most children with ADD manifest inattention (difficulty with focusing or sustaining concentration) and impulsivity. Approximately 50 percent of children with attention deficit disorder are hyperactive. There usually are multiple subtle differences between ADD and bipolar disorder so as to hopefully differentiate between the two.

While some children with ADD have difficulty getting to sleep, many children with bipolar disorder also manifest this symptom. Their mind can race, or they may have some subjective experience that their thoughts are in some way accelerated. Children with bipolar disorder can commonly have more nightmares, including "gory" nightmares, where most children with ADD, once they get asleep, are frequently able to remain asleep.



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While some children with ADD are capable of having temper outbursts, these outbursts usually subside within a matter of several minutes. The rages for children with bipolar disorder can be of extremely intense degrees and may be prolonged over periods of a half hour to a few hours duration. During that time, children with bipolar disorder are capable of putting out an enormous amount of energy that is difficult for even an adult, while trying, to simulate. Children with ADD who have temper outbursts commonly manifest them as a result of some form of overstimulation or overexcitation, whereas children with bipolar disorder most commonly react to some form of limit setting.

While children with ADD can be moody, most would not be considered so. Children with bipolar disorder, on the other hand, commonly would be described as both moody and exhibiting tendencies toward mood swings. These mood swings can have a great deal of dysphoria (a mood of general dissatisfaction) as well as oversensitivity and irritability leading to the above-mentioned rage reactions.

Motivational factors also tend to differ between children with bipolar disorder and those with ADD. Children with ADD are truly inattentive and lack the capacity to sustain concentration. They tend to remain motivated and willing to please, though their follow through and resultant productivity can be poor. The concentration of children with bipolar disorder depends much more on motivation and frequently manifests a similar but different symptom known as distractibility.

Children with bipolar disorder are much more “intense” by nature, whereas children with ADD are much more “laid back”. Children with bipolar disorder can accomplish a great deal within a relatively short period of time. At times, they may appear especially motivated, enthused and interested in certain activities, and at other times their productivity will be practically nonexistent as they show almost no motivation, interests or enthusiasm, even for things they have historically enjoyed doing.

Children with bipolar disorder may even show certain giftedness or creativity, particularly along verbally articulate lines, whereas children with ADD usually are less inclined to the above characteristics. Children with ADD “see the forest and not the trees”, i.e., getting a general feel for the “vibes” of a situation, while misunderstanding detail. Children with bipolar disorder, on the other hand, “see the trees and not the forest”, sometimes obsessing on detail, while missing the global picture.

The misbehavior of children with ADD is often accidental, due to inattentiveness or obliviousness of circumstances. Children with bipolar disorder tend to be much more destructive. Children with bipolar disorder look as if their destructiveness has far more innate thoughtfulness, consciousness, deliberateness and purposefulness.

ADD tends to be chronic and continual, but tends toward gradual improvement with age and experience. While there may be no clear episodic or cyclic patterns within children with bipolar disorder, their behavior tends to worsen over the years.



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Obviously, all of the above attempt at differentiating between symptoms of ADD and bipolar disorder is made enormously more complex by the coexistent element of bonding and attachment disturbances. A further complicating factor is that stimulant medications may help specific symptoms of inattention and distractibility within children with bipolar disorder, while they may also make tendencies toward irritability and rage reactions worse, particularly over extended periods of time. Mood stabilizing medications (Lamotrigine, Oxcarbazepine, Lithium and Valproic Acid) etc. tend to produce at least moderate improvement within children with bipolar disorder but tend to have minimal effect on children with ADD.

Over the last few years, several books have been authored concerning ADD, but, to my knowledge, no such books exist regarding bipolar disorder, particularly in children.

Many of these authors and experts have emphasized sleep problems, motivational problems, irritability, oppositional/defiant behavior, including rage reactions, as occurring fairly often within ADD. In my experience, all of these above symptoms are vastly overrated in most children with ADD and underemphasized, both to the general population and to the mental health community in regard to bipolar disorder.

In my strong professional opinion, all of the above symptom complex, particularly in children with coexistent histories of abuse, neglect and emotional bonding problems with corresponding oppositional and defiant behavior, should be considered to be of bipolar disorder etiology, not ADD, unless the previous ADD diagnosis and treatment has produced moderate to substantial benefits.

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