24-7 SHALOM PSYCHIATRY PLLC

ADHD vs. Bipolar Disorder Comprehensive Differential Diagnosis and Treatment Program

Clinical scope: Children, adolescents, and adults. This proposed evidence-informed program describes assessment and treatment pathways; specialized services should be represented as available only when appropriately staffed and implemented. DSM-5-TR criteria below are clinical paraphrases, not a reproduction of the manual.

1. Core distinction: lifelong traits versus mood episodes

ADHD is a neurodevelopmental condition marked by persistent inattention and/or hyperactivity-impulsivity, typically traceable to childhood and expressed across settings. Bipolar disorders involve distinct episodes of mood and energy/activity change that depart from the person's usual baseline. Both conditions can cause distractibility, agitation, rapid speech, impulsive decisions, irritability, and impaired judgment. They can also coexist.

Clinical feature	ADHD pattern	Bipolar pattern
Time course	Chronic, developmentally persistent; varies with demands	Discrete manic/hypomanic/depressive episodes with change from baseline
Impulsivity	Often habitual, context-sensitive; poor inhibition	May intensify sharply during elevated/irritable mood episodes
Sleep	Delayed sleep, inconsistent routines; fatigue after insufficient sleep	Mania/hypomania may cause decreased need for sleep without expected fatigue
Mood	Brief frustration/reactivity often triggered by events	Sustained mood and energy/activity change meeting episode duration criteria
Attention	Persistent across multiple settings	May worsen prominently during mood episodes
Grandiosity/psychosis	Not core ADHD features	Can occur in mania; psychosis implies mania rather than hypomania

2. DSM-5-TR: ADHD diagnostic criteria (paraphrased)

A persistent pattern of inattention and/or hyperactivity-impulsivity interferes with functioning or development. For each domain, at least six symptoms are required through age 16, or five symptoms at age 17 and older; symptoms persist at least six months, are developmentally inappropriate, and negatively affect functioning. Several symptoms must have existed before age 12, occur in at least two settings, and clearly interfere with or reduce functioning. Symptoms must not occur exclusively during a psychotic disorder and must not be better explained by another mental disorder.

Inattention symptoms: careless errors; difficulty sustaining attention; seeming not to listen; failure to follow through; disorganization; avoiding sustained mental effort; losing items; distractibility; forgetfulness.

Hyperactivity/impulsivity symptoms: fidgeting; leaving seat; excessive running/climbing or internal restlessness; difficulty with quiet activities; acting "on the go"; excessive talking; blurting answers; difficulty waiting; interrupting/intruding.

Presentations: predominantly inattentive (F90.0), predominantly hyperactive/impulsive (F90.1), combined (F90.2); other specified (F90.8) or unspecified (F90.9) when appropriate. Document severity (mild/moderate/severe) and partial remission when applicable. Presentations may change over time.

3. DSM-5-TR: bipolar spectrum and related diagnoses (paraphrased)

Manic episode: A distinct period of abnormally elevated, expansive, or irritable mood and increased activity or energy lasting at least one week, most of the day nearly every day (or any duration if hospitalization is necessary). At least three additional symptoms are present (four if mood is only irritable): inflated self-esteem/grandiosity; decreased need for sleep; pressured/increased speech; racing thoughts/flight of ideas; distractibility; increased goal-directed activity or psychomotor agitation; excessive involvement in risky pleasurable activities. Marked impairment, hospitalization, or psychosis is required; exclude substance/medical causes.

Hypomanic episode: Similar symptom cluster and change in energy/mood, lasting at least four consecutive days, observable by others and distinctly different from baseline; not severe enough for marked impairment or hospitalization and no psychosis. Symptoms attributable to substances are not counted without sufficient evidence of an independent episode.

Major depressive episode: At least five symptoms during the same two-week period, including depressed mood or loss of interest/pleasure: appetite/weight change, sleep change, psychomotor change, fatigue, worthlessness/guilt, concentration difficulty, or recurrent thoughts of death/suicide. Symptoms cause distress or impairment and are not attributable to substances/medical illness. In youth, mood may be irritable.

Diagnosis	Distinguishing DSM-5-TR framework
Bipolar I disorder (F31.x)	At least one manic episode; depressive or hypomanic episodes may occur but are not required. Code depends on current/most recent episode and features.
Bipolar II disorder (F31.81)	At least one hypomanic episode and one major depressive episode; never a manic episode; clinically significant distress/impairment.
Cyclothymic disorder (F34.0)	Numerous subthreshold hypomanic and depressive symptoms for ≥2 years (≥1 year in youth), present at least half the time and not absent >2 months at a time; no full qualifying episodes during initial period.
Other specified bipolar and related disorder (F31.89)	Clinically significant bipolar-spectrum symptoms that fall short of full criteria, with reason specified.
Unspecified bipolar and related disorder (F31.9)	Bipolar-spectrum symptoms without sufficient information or without specifying why full criteria are not met.
Substance/medication-induced bipolar disorder	Mood symptoms temporally linked to an implicated substance or medication, after clinical causal assessment.
Bipolar disorder due to another medical condition	Prominent mood disturbance judged directly attributable to a medical condition.

Additional considerations: Mixed features, rapid cycling (at least four mood episodes in 12 months), psychotic features, seasonal pattern, and peripartum onset are specifiers or clinical features—not separate “types” of ADHD. Chronic irritability in children without distinct episodes may suggest disruptive mood dysregulation disorder rather than pediatric bipolar disorder.

4. Structured diagnostic evaluation and screening

• Obtain a longitudinal timeline: onset before age 12, baseline functioning, distinct changes in mood/energy, episode duration, recovery periods, school/work history, and sleep need versus sleep opportunity.

• Interview patient and, with consent, caregivers/partners or teachers; review school records, prior hospitalizations, pharmacy history, and previous diagnoses.

• ADHD measures: ASRS-5 or ASRS-v1.1, DIVA-5, CAARS 2, BAARS-IV, Vanderbilt/Conners 4 for youth, BRIEF-2 or BRIEF-A for functional executive skills. These support but do not establish diagnosis.

• Mood measures: MDQ (screen only; variable specificity), Hypomania Checklist-32, Young Mania Rating Scale (YMRS), PHQ-9, and clinician-rated depression measures. Positive screens require diagnostic interview.

• Assess psychosis, suicidality, self-harm, substance use, trauma, anxiety, sleep disorders, medication-induced activation, family history of bipolar disorder, and functional consequences.

• Consider structured interviews such as SCID-5 or MINI where available and appropriate. Neuropsychological testing is reserved for complex cognitive or learning questions, not routinely required.

5. Medical assessment: what tests are and are not required

No laboratory, genetic, EEG, MRI, or computerized performance test independently diagnoses ADHD or bipolar disorder. History, examination, and longitudinal psychiatric assessment remain central. Tests are selected to evaluate mimics, comorbidities, and medication safety.

Test/assessment	When indicated and purpose
Vitals, BMI, sleep and cardiovascular review	Baseline for stimulant/atomoxetine/antipsychotic/lithium planning; monitor pulse, BP, weight, and growth in children.
CBC, CMP, TSH (± free T4)	Evaluate anemia/metabolic or thyroid contributors when suspected; baseline monitoring for selected mood stabilizers.
Renal function/eGFR, electrolytes, calcium, TSH; pregnancy assessment when relevant	Before lithium and periodically thereafter; pregnancy testing based on clinical context and shared decision-making.
Liver function, CBC/platelets; pregnancy assessment when relevant	Before valproate/carbamazepine and for indicated monitoring; substantial reproductive safety concerns.
A1c or fasting glucose, lipids, weight/BMI	Baseline and follow-up for second-generation antipsychotics.
ECG/cardiology review	When cardiovascular symptoms, personal/family cardiac risk, or medication-specific risks warrant; not universally required for ADHD.
Urine toxicology	When substance exposure or controlled-substance safety questions warrant; not a universal diagnostic requirement.
Sleep study, iron/B12/ferritin, other investigations	Only if suggested by history or examination.
CPT/QbTest/TOVA, neuropsychological testing	Optional adjuncts for specific clinical questions; cannot reliably separate ADHD from bipolar disorder alone.

6. Treatment sequencing when ADHD and bipolar disorder coexist

If an individual has active mania, hypomania, psychosis, or severe mood instability, prioritize stabilization and urgent safety assessment before initiating or escalating ADHD-directed activating medication. Once mood is adequately stabilized, reassess persistent childhood-onset ADHD symptoms and functional impairment. Consider

cautious ADHD pharmacotherapy with close monitoring for emerging insomnia, activation, hypomania, or mania. Never presume that stimulants are categorically contraindicated for all individuals with bipolar disorder; risk depends on current mood state, co-treatment, history, and monitoring.

7. ADHD medication management: implementation, goals, adverse effects

Option	How used and treatment goal	Key risks/monitoring
Methylphenidate/dexmethylphenidate (e.g., Concerta, Ritalin, Focalin)	Select immediate or extended-release formulation; start low, titrate to attention/task-completion response; monitor rating scales and real-world functioning.	Appetite/weight loss, insomnia, headache, irritability, tachycardia/BP increase; misuse risk; rare psychotic/manic symptoms.
Amphetamine formulations (e.g., Adderall XR, lisdexamfetamine)	Individualized daily regimen and titration after evaluating bipolar stability; goal: improved inhibition, task completion and organization.	Similar stimulant adverse effects; anxiety, agitation, insomnia, appetite suppression; possible mood switching.
Atomoxetine	Daily nonstimulant; gradual response over weeks; goal: sustained symptom reduction where stimulants are unsuitable.	GI upset, decreased appetite, insomnia or somnolence, pulse/BP increase, rare liver injury; boxed warning for suicidal ideation in children/adolescents; possible mania.
Viloxazine ER	Daily nonstimulant with gradual titration per age/label; goal: improved attention and impulsivity.	Somnolence, appetite reduction, fatigue, insomnia, BP/HR changes; boxed warning for suicidal thoughts/behaviors; interactions and mania screening.
Guanfacine ER / clonidine ER	Alpha-2 agonists, especially for pediatric ADHD; adjust gradually and taper rather than stop abruptly.	Sedation, dizziness, hypotension, bradycardia; rebound hypertension on abrupt discontinuation. Adult ADHD use is off-label in US.

Clinical workflow: document baseline symptom targets, BP/pulse/weight, sleep, appetite, substance and cardiac risk, mood history, informed consent, and prescribing safeguards. Review response and adverse effects during titration; obtain collateral observations where appropriate. If activation or emerging mania occurs, promptly reassess medication and mood safety. No medication is prescribed solely from a positive screening score.

8. Bipolar disorder medication management: implementation, goals, adverse effects

Treatment	Clinical role and goal	Common/important adverse effects and monitoring
Lithium	Mood stabilization and relapse prevention; may be used for acute mania and maintenance. Adjust based on clinical response, serum levels, renal function, and interactions.	Tremor, thirst/polyuria, GI symptoms, weight change, hypothyroidism, kidney effects; toxicity risk with dehydration, NSAIDs, ACE inhibitors/ARBs and some diuretics. Check levels and renal/thyroid status.
Lamotrigine	Maintenance, especially prevention of depressive recurrence; not an acute antimanic treatment. Titrate slowly.	Rash, dizziness, headache, nausea; rare serious rash/SJS/TEN. Valproate interactions require dose adjustments.

Treatment	Clinical role and goal	Common/important adverse effects and monitoring
Valproate/divalproex	Acute mania and selected maintenance situations; monitor labs and levels when indicated.	Sedation, tremor, weight gain, thrombocytopenia, liver/pancreatic toxicity; major fetal and reproductive risks; avoid when alternatives suitable.
Quetiapine	Evidence-based option for bipolar depression, mania, and maintenance depending on regimen.	Sedation, orthostasis, metabolic changes, weight gain, dyslipidemia/glucose changes; monitor metabolic parameters.
Lurasidone	Bipolar I depression, including certain adjunctive regimens; take with food per labeling.	Akathisia, nausea, somnolence, EPS; monitor movement and metabolic effects.
Cariprazine	Option for bipolar mania/mixed episodes and bipolar I depression per labeling.	Akathisia, EPS, insomnia, nausea; long half-life complicates rapid dose assessment.
Aripiprazole / risperidone / olanzapine and other indicated antipsychotics	Used for acute mania or maintenance according to drug-specific indications; select based on episode polarity and tolerability.	Akathisia/EPS, sedation, weight/metabolic changes, prolactin effects (especially risperidone), movement disorders; agent-specific monitoring.

Important: Treatment choice depends on whether the current episode is mania, bipolar depression, mixed features, or maintenance. Antidepressant monotherapy is generally avoided in bipolar I disorder because of potential mood switching; if used in bipolar depression, decisions require careful selection and monitoring. Medication dosing and contraindications must follow current labeling and individualized risk assessment. Valproate has particularly serious reproductive risks, including teratogenicity and neurodevelopmental harms.

9. Psychotherapy: how sessions are delivered and therapeutic goals

ADHD-focused CBT: Usually structured weekly sessions. Identify one recurring impairment (e.g., missed deadlines); establish calendar/task capture, break work into short steps, use time estimates and implementation intentions, rehearse skills in session, assign between-session practice, and review objective completion data. Goal: improved executive functioning and reduced avoidance.

Bipolar-focused psychoeducation: Review personal early warning signs (reduced sleep need, increased energy/spending, accelerated speech, emerging depression), medication adherence, substance triggers, and relapse response plans. Create a written mood/sleep chart and crisis escalation plan. Goal: early detection and relapse prevention.

Interpersonal and Social Rhythm Therapy (IPSRT): Track sleep/wake times, meals, social contact and daily routines; stabilize rhythms and address role transitions or interpersonal stress. Goal: reduce circadian disruption and mood recurrence.

Family-Focused Therapy (FFT): With consent, provide family psychoeducation, communication training (active listening, constructive requests) and structured problem-solving around warning signs, school/work needs and support. Goal: reduce conflict and support treatment adherence.

DBT-informed emotion-regulation skills: Teach trigger tracking, paced breathing, distress tolerance, pause-and-plan routines and interpersonal effectiveness; rehearse during sessions. Goal: reduce impulsive reactions and improve coping. DBT is adjunctive rather than a replacement for evidence-based bipolar pharmacotherapy.

CBT for bipolar disorder: Identify unhelpful beliefs about sleep, medication, stress and mood symptoms; use behavioral activation carefully during depression, monitor for activation, and develop relapse-prevention routines. Goal: reduce residual symptoms and strengthen self-management.

Parent/family interventions for youth: Use behavior plans, positive reinforcement, predictable routines and coordinated school communication for ADHD; distinguish episodic mood changes from chronic behavioral dysregulation. Goal: improved home/school function and earlier recognition of mood episodes.

10. Safety and longitudinal follow-up

• At each relevant visit, evaluate current mania/hypomania, depression, psychosis, suicidal or homicidal thoughts, impulsive high-risk behavior, substance use, sleep, and ability to maintain safety. Document only findings actually assessed.

• Use mood and sleep tracking alongside ADHD symptom scales and functional targets. Separate sustained mood episodes from moment-to-moment emotional reactions.

• During acute mania, severe psychosis, dangerous impulsivity, or suicidal crisis, arrange urgent/emergency assessment based on severity; routine outpatient follow-up may be insufficient.

• Follow medication-specific laboratory and metabolic schedules; review interactions, reproductive considerations, adherence and side effects.

• Coordinate with therapists, primary care, school supports and family/collateral sources with appropriate consent.

11. Practical 24-7 Shalom Psychiatry workflow

Visit 1: symptom chronology, DSM-5-TR interviews, risk assessment, medication/substance review, collateral plan and targeted screening. Visit 2: review records and scales, clarify episodicity and diagnostic alternatives, complete indicated medical assessment, and discuss shared treatment priorities. Follow-up: treat active bipolar symptoms first when present; use structured monitoring to reassess residual ADHD; introduce or adjust interventions cautiously and document measurable goals, tolerability and safety. Actual visits may be consolidated or expanded depending on clinical complexity.

12. Selected clinical references

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Disclaimer: Educational clinical-program framework, not a standing order or substitute for individualized assessment. Confirm current medication labeling, guidelines, state law, and service availability before implementation.