SYMPTOM COMPARISON ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD					
Symptom	**ADHD**	**Bipolar I Disorder**	**RAD**	**ODD**	**PTSD**
Age of Onset	Birth. Technically present before age 7.	2-3, 7, 13-35	Birth to 3.	Usually evident before 8 y/o. Gradual.	Following exposure to extreme trauma.
Family History	ADHD, academic difficulties, alcohol & sustance abuse	Mood disorders, academic difficulties, alcohol & substance abuse, adoption, ADHD	Abuse and neglect, severe emotional & behavioral disorders, alcohol & substance abuse, abuse and neglect in parents early life	History of Mood D/O, ODD, Conduct D/O, ADHD, Substance Abuse, Serious marital discord	Family history, childhood experiences, personal variables and preexisting mental disorders
Incidence	Approx. 6-9% of pop.	2-3% of gen. pop.	3-6% of gen.pop.	2-16% depending on pop. Measured	1-14% over a lifetime
Cause	Genetic, worse with stress,	Genetic, worse with stress and hormones	Secondary to neglect, abuse, abandonment	May be tied to ADHD, Anx., Dep., BPD, LD's, and Communication disorders	Exposure to a perceived or real life threatening event
Duration	Chronic and unremitting, tends toward improvement	May or may not show clear episodes and cycles; can worsen over the years with increased severe and dramatic symptoms	Depends on life circumstances, including treatment and innate temperament; can worsen over the years resulting in antisocial character disorders	1/2 of all preschoolers outgrow by age eight; older kids less likely to do so	Symptoms must be present one month after traumatic event; may be long lasting, especially if stressor is of human design

Adapted from: Attachment, Trauma, and Healing. p. 263-265; DSM IV TR

SYMPTOM COMPARISON

ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD

Symptom	ADHD	Bipolar I Disorder	RAD	ODD	PTSD
Attention Span	Short, leading to lack of productivity	Dependent on interest & motivation, distractible	Usually prolonged secondary to hyper-vigilance, under stress can shorten	Not noted as a problem in ODD unless D/O is co-occurring	Problems with concentration or task completion; can include intrusive recollections or dissociation
Impulsivity	Acts before thinking, has remorse	Driven, grandiose, thrill-seeking, little regret	Usually deliberate actions; poor cause and effect thinking; no remorse with severe cases	Misbehavior seen as possible problem with impulse control	Can see self-destructive impulsive behavior
Hyperactivity	50% are hyperactive, disorganized, boys diagnosed hyperactive more than girls	Wide ranges, with hyperactivity common in children	Common	Seen as high motor activity in preschoolers, can be common with co-morbid disorders	Possible due to hyper vigilance, anxiety
Self-esteem	Low, rooted in ongoing performance difficulties	Low due to inherent unpredictability of mood	Low, rooted in abandonment, feeling worthless, unlovable and bad, masked by anger	May be low in school years,	May have severe guilt, shame, hopelessness and seeing self as damaged
Attitude	Generally friendly in a genuine manner	Highly unpredictable, dysphoric, moody, negativistic	Superficially charming, distrusting, emotionally distant, non-intimate	Argumentative, justify behavior as a response to unreasonable demands	Reduced ability to feel emotions, sense of foreshortened future

Adapted from: Attachment, Trauma, and Healing. p. 263-265; DSM IV TR

SYMPTOM COMPARISON

ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD

Symptom	ADHD	Bipolar I Disorder	RAD	ODD	PTSD
Control issues	Tend to desire to seek approval; get into trouble with inability to complete tasks, poor impulse control and cause and effect thinking	Intermittent desire to please (based on mood), tend to push limits and relish power struggles.	Controlled and controlling, only for self- gain, manipulative, covert and punitive	Deliberate testing of limits	Stimuli avoidant, feeling constant threat, increased startle response
Oppositional and Defiant	Argumentative, but usually redirectable	Usually overtly and prominently defiant, often not relenting to authority, moods impact	Covertly or overtly defiant, passive aggressive	Argue, ignore, intentionally annoy, verbally aggressive, property destruction	May avoid or refuse exposure to stimuli
Blaming	Self-protective mechanism to avoid adverse consequences	Disbelief/denial that they caused something to go wrong	Rejecting of responsibility, lack of empathy	Typical, often blames others for mistakes or misbehaviors	Tendency to blame self
Lying	To avoid consequences	To get away with things	To remain in control or due to distorted perceptions or poor ego strength	To avoid consequences	Not noted
Fire setting	Out of curiosity, impulsivity non-malicious	Can play with matches and set fires	Revenge seeking, malicious, danger seeking secondary to despair	Possible, but can signal progression to conduct disorder of antisocial traits	Not noted as a generic PTSD symptom

Adapted from: Attachment, Trauma, and Healing. p. 263-265; DSM IV TR

SYMPTOM COMPARISON
ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD

Symptom	ADHD	Bipolar I Disorder	RAD	ODD	PTSD
Anger, irrationality, temper, rage	Response to overstimulation, low frustration tolerance, need for immediate gratification; rage reaction is usually short lived	Secondary to limit setting or attempts to control their excessive behavior, can last for extended periods of time; overt, can be assaultive	Chronic, revenge oriented; eternal victim position, rationalization for destructive retaliation; can be hurtful to innocent others and pets	Chronic irritability, verbal aggression, property destruction, frequent outbursts , impaired ability to regulate moods	Jumpy, irritable, anger outbursts, impaired ability to regulate moods
Entitlement	Overwhelming need for immediate gratification	Grandiose, feeling entitled to get what they want.	Compensating for abandonment and deprivation	May feel that they are above the rules or that the rules don't make sense	Not noted
Conscience development	Capable of demonstrating remorse when calm	Limited conscience development, less cruel than RAD	"Street smart," survival skills, can be manipulative, limited remorse	more interested in meeting own needs, less in the needs of others, especially when agitated	Developed per individual, access to feelings and thinking may be numbed or heightened
Sensitivity	Inattentive to circumstances can be seen as insensitive	Acutely aware of circumstances and are 'hot reactors'	Hyper vigilant, compensating for past helplessness; limited emotional repertoire, insensitive	Often touchy, easily annoyed by others	Jumpy, irritable, responses out of sync to current circumstances
Perception	Flooded by sensory overstimulation, hyperactive, distractible, shuts down	Self-absorbed, preoccupied with internal need fulfillment, narcissistic	Self-centered, primary process, primitive distortions	Out to win, difficulty seeing the views of others	Can be impacted or colored by remnants of traumatic events

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SYMPTOM COMPARISON ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD					
Symptom	**ADHD**	**Bipolar I Disorder**	**RAD**	**ODD**	**PTSD**
Peer relationships	Makes friends easily, but not able to keep them	Can be charismatic or depressed, depending on mood; conflicts are the rule	Very poor, controlling and manipulative; not able to maintain relationships	Can be hostile, usually more verbal than aggressive	Detached, with decreased enjoyment, social withdrawal, impaired relations
Sleep disturbances	Common, especially problems with falling asleep, tend to "sleep hard,' once asleep	Problems with relaxation due to racing mind, nightmares common	Hyper-vigilance lightens sleep; tends to need little sleep, arise early in the AM	Not noted as a problem in ODD unless D/O is co-occurring	Intrusive thoughts, recurring dreams, difficulty falling and staying asleep
Motivation	Problems with motivation if perceived as "painful," poor finishers	Grandiose, believe they are resourceful, gifted, creative; self-directed, variable energy and enthusiasm	consistently poor initiative, limited industriousness, intentional inefficiency	Motivated to win arguments, avoid rules, limits and dictates	Can be impacted by lingering effects of trauma
Learning difficulties	Common, frequent auditory perceptual difficulties, lack of fine motor coordination	Non-sequential, nonlinear learners, verbally articulate	Brain maturational delays secondary to adverse early life experiences from conception forward. As for all, genetics impact	Learning and Communication Disorders tend to be associated	Levels of hyper vigilance or dissociation can impact learning

Adapted from: Attachment, Trauma, and Healing. p. 263-265; DSM IV TR

SYMPTOM COMPARISON
ADHD, BIPOLAR DISORDER, RAD, ODD, AND PTSD

Symptom	ADHD	Bipolar I Disorder	RAD	ODD	PTSD
Anxiety	34% with ADHD also diagnosed with Anxiety	Emotionally wired, and have high potential for anxiety, fears, & phobias. Somatic symptoms common. Needle phobic	Can live in a state of hyper-vigilance, poor emotional awareness or admission of fears	Not noted as a problem in ODD unless D/O is co-occurring	Present
Sexuality	Tend to be emotionally immature and sexually naïve. At risk as they grow	Sexual hyper-awareness, pseudo-maturity, high activity level	Can use sex as a means for power, control	Not noted as a problem in ODD unless D/O is co-occurring	Lingering effects can impact interest
Substance abuse	At risk due to impulsivity and immaturity	Strong tendencies, often in attempt to self-medicate	At risk, genetic factors can influence, need to remain in control can be a deterrent	Precocious use of drugs and alcohol a noted potential	At risk as attempt to cope with intrusive feelings and memories
Optimal environment	Low stimulation and stress, support and structure	Clear and assertive, limits and encouragement	Balance of security and stability, S.P.A.C.E.	Clear and consistent rules, limits and consequences. Do not argue	Safe and supportive allowing for exposure and desensitization
Psychopharmacology	Stimulant medications, Strattera, Wellbutrin, Clonidine, Intuniv	Mood Stabilizers: Lithium, Carbazamine, Valproic Acid, Verapamil, Risperdal	Antidepressants, Clonidine may help with hyper vigilance	SSRI's, Zoloft, Paxil	SSRI's, Zoloft, Paxil
	Adapted from Attachment, Trauma and Healing. P. 263-265; DSM IV TR				