Differential Diagnostics

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1 PRESENTER

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2 Assumptions and Clarifications

- This training is an advanced training, aimed at licensed mental health providers. This information is not to be used by those who do not have the educational background to legally and ethically diagnose.
- This presentation does utilize the DSM 5 criteria as the main guiding diagnostic criteria.
- This presentation is based on a combination of the DSM 5 criteria, current research on these disorders as well as clinical experience and expertise. What is presented here is not meant to in any way replace in depth training on differential diagnostics.

3 Reflection

How comfortable are you diagnosing ADHD in your practice? (0-5)

How comfortable are you diagnosing mood disorders in your practice? (0-5)

Do you feel confident in your diagnostic interviewing skills? If not, why not?

How important is it to you to provide accurate diagnoses to your clients?

4 Main Point

Providing accurate diagnoses to our clients is a vitally important part of our work.

Why?

Human dignity

Social Justice

Unconditional Positive Regard

Access to treatment and services

Hope and perspective

5 Guiding Principles

#1: Ockham's Razor for Diagnostics

Ockham chooses a razor

Make a diagnosis(es) that is the least intrusive and simplest explanation for the client's symptoms.

"Least intrusive": the level of intervention necessary, reasonable, and humanely appropriate to the client's needs, which is provided in the least disruptive and invasive manner possible

#2 "When you hear hoof beats think…"

Horses not zebras

6 Differential Diagnostic Process

What is important to have from clients in the differential diagnostic process?

7 Differential Diagnostic Process

MUST Haves:

- Family Mental Health History
- Individual Mental and Physical Health History
- Presenting Symptoms
- History of Symptoms
- Information on Sleep
- Information on Substance Use
- Trauma History
- Completed Screening Tools
- Current Medications

HELPFUL TO HAVE:

- Observer Report(s)*
- Report Cards from K through 12 schooling
- Family Physical Health History
- QBCheck/Test
- Previous Medication History/ Reactions

8 Differential Diagnostic Process: In Depth Diagnostic Interview

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HANDOUT PAGE 2

1 Prevalence Rates

1.1 Bipolar Disorder

- An estimated 2.8% of U.S. adults had bipolar disorder in the past year.
- An estimated 4.4% of U.S. adults experience bipolar disorder at some time in their lives (Bipolar Disorder, 2017).

1.2 Borderline Personality Disorder

- An estimated 1.4% of adults experience borderline personality disorder (Personality Disorders, 2017)

1.3 Attention Deficit Hyperactivity Disorder

- The overall prevalence of current adult ADHD is 4.4%.
- The estimated lifetime prevalence of ADHD in U.S. adults aged 18 to 44 years was 8.1% (Attention-Deficit/Hyperactivity Disorder (ADHD), 2017)

1.4 Bipolar Disorder

Mood fluctuations are trackable, non-situational, dependent cycles of manic/hypomanic behaviors which then transition to a deeply depressive episode.

Impulsivity demonstrated by reckless and impulsive behaviors are most commonly found during the manic/hypomanic phase of bipolar cycles. Impulsive behaviors observed in bipolar disorder are often highly intense, risky actions which may not be demonstrative of the client's values. Reviewing the history of impulsive behaviors before the bipolar break will be important in the differential process.

Symptom Onset is most commonly noticed in late adolescence/early adulthood due to a traumatic event in the client's life which precipitates a bipolar "break". Bipolar can be diagnosed in younger children and older adults, as well. It is crucial to fully assess the manic/hypomanic experiences of the client to ensure that these experiences meet the criteria of abnormal, significantly heightened states which last for a specific amount of time and include inappropriate and uncharacteristic behaviors.

Self-Harm, marked by suicidal ideations and self-harming behaviors are, at times, found in those with bipolar disorder. The greatest risk for suicide is when a client is descending from a manic or hypomanic episode and is aware that the next phase of the cycle is deep depression. Suicidal ideations and self-

harming behaviors are generally found to be a response to the intense lived experience and internal distress. It is important to note that self-harm and suicidal ideations are not core features of bipolar disorder.

1.5 BORDERLINE PERSONALITY DISORDER

Mood fluctuations are most often connected with efforts to avoid real or imagined abandonment; these fluctuations are extremely reactive responses to interpersonal stressors. Mood fluctuations can also be attributed to a chronic need to relieve an internal feeling of emptiness (American Psychological Association, 2013, p. 664).

Impulsivity in borderline personality disorder must have the potential for self-damaging effects and can generally be described as dangerous and/or destructive behaviors. Impulsive, self-damaging acts are usually "precipitated by threats of separation or rejection or by expectations that the individual assumes increased responsibility" (APA, 2013, p. 664).

Symptom Onset is most commonly found in early adulthood. It is often recommended that personality disorders not be diagnosed until early adulthood, as teenagers are prone to emotional liability, unstable interpersonal relationships and affect, as well as issues with self-image. It is essential that developmental, stage-of-life challenges not be interpreted as symptoms of borderline personality disorder (APA, 2013, p.667).

Self-Harm and suicidal ideations and behaviors are listed as one of the *diagnostic criteria* for borderline personality disorder. These behaviors can be considered one of the key features of this disorder, as an exemplification of the tendency towards extreme responses to stress. Self-harm and suicidal ideations are often utilized as a manipulative tool within interpersonal relationships as a way to keep others from abandoning them (APA, 2013, p.664)

1.6 ATTENTION DEFICIT HYPERACTIVITY DISORDER

Mood fluctuations are primarily situationally dependent, which are disproportionate responses to stimuli. ADHD mood fluctuations are often described by clients as being on a "rollercoaster".

Impulsivity in ADHD can be seen in a wide range of behaviors in a client's life ranging from blurting speech, staying up too late, and driving distracted, to over-spending, impulsive eating, or reckless behavior (most commonly for the thrill of the experience, not to harm themselves). Impulsivity is generally understood as a "hasty action that occurs in the moment without forethought…" (APA, 2013, p.61). Impulsive behavior in ADHD is often due to a desire for immediate reward and a struggle with delayed gratification.

Symptom Onset can begin at any time between birth and 12 years old. While symptoms may become more pronounced as responsibilities increase with age, behaviors and symptoms of ADHD must be present before the age of 12 for the diagnosis to be made (APA, 2013, p.60).

Self-Harm and suicidal ideations are not a core diagnostic feature of ADHD. ADHD is a disorder which is experienced across the life span. As such, it has been found to have a positive correlation with increased risk of suicide and self-harming behaviors in adolescence. These increased risks are generally associated with impulsivity and the lack of prefrontal cortex activation in those with ADHD. The literature does not support the idea that those with ADHD utilize self-harming and suicidal ideations to manipulate those around them. Self-harm and suicidal ideations are most commonly found in the literature to be more pronounced in those who have ADHD as well as another diagnosable mental health issue such as major depressive disorder.

2 DIFFERENTIAL DIAGNOSTIC CHALLENGES

2.1 Emotional Dysregulation

- Emotional dysregulation in all three diagnoses is commonly a source of distress for both the client and those around them. It is, in all three of these diagnoses, often unable to easily be controlled or regulated by the client.

- **Differential Considerations**
  - Activating Event(s)
    - BPD: Fear of abandonment, being left alone, or not being special/significant in another's life; fear of feelings of emptiness
    - Bipolar: While there may be an activating event to start the bipolar cycle, it is important to consider if the emotions being expressed are in line with the situation; laughing at a funeral, crying on a birthday
    - ADHD: (Exaggerated) response to often unexpected stimuli
  - Intensity, duration, and recovery from dysregulation
    - BPD: Intensity = danger, duration = situationally dependent, recovery = goal is achieved
    - Bipolar: Intensity = if cycling, expect intensity duration= predictable, recovery = short if towards mania, long if towards depression

- ADHD: Intensity = disproportionate to stimuli, duration = usually short lived recovery = often quick

Tip for Differential Diagnosis:

If, after a full evaluation, you are still unable to understand the mood fluctuations and emotional dysregulation of the client, prescribe them to use a mood and event tracking app. Have the client indicate what their mood is at least 3 points during the day and require them to indicate what was happening in the time leading up to the notation of the mood. If a diagnostic code is needed before this can be done, utilize the least severe code and make note of the need to "rule out" a more serious diagnosis.

2.2 Executive Functioning **CHALLENGES**

- Bipolar Disorder, Borderline Personality Disorder and ADHD all significantly impact the executive functioning of clients.

- Clients with any of these disorders will, at times, struggle with personal organization, distractibility, lack of consistency, impulsivity, forgetfulness and other executive functioning skills.

- Executive functioning challenges is where these three disorders tend to look the most alike. This is because when these three disorders are undiagnosed and go untreated, they tend to create patterns of **instability** in the client's life. However, it is important to remember that not all instability and executive functioning issues have the same causes and impacts on the client.

2.3 **ASSESSING EXECUTIVE FUNCTIONING CHALLENGES**

- Borderline Personality Disorder: Executive Functioning impairments may be most present when in a state of emotional or interpersonal distress. The client is often capable of these functions, but may choose not the utilize this ability in order to avoid being seen as competent which could lead to abandonment by others.

- Bipolar Disorder: Before the onset of bipolar disorder, consider if the client had notable executive functioning issues. Executive functioning issues may be part of the presenting

concern, but depending on where the client is in their cycle, may seem unimportant or irrelevant to them. It is more likely that if the client is manic, hypomanic, or deeply depressed, a caregiver or loved one will focus on the deficits in executive functioning, not the client themselves.

- ADHD: Executive Functioning issues are pervasive across many areas of the client's life. Often, issues surrounding executive functioning are the core complaint of the client and their loved ones and are causing notable distress. ADHD is often seen as a challenge with performing to the level of ability. If executive functioning challenges across the client's lifespan is leading to underperformance, this may be an indication of ADHD.

- **Differential Diagnosis**: Assess for the onset, consistency, level of impairment, and impact of executive functioning impairments on the client's life.

2.4 INTERPERSONAL RELATIONSHIPS

- Consider the **causes** of relational distress (be mindful of language)

- Assess for the client's **insights and concerns** about the interpersonal relationships issue(s):

    - Is the client concerned for themselves or the other person/people?
    - Who or what is the client blaming?
    - Is the client aware of the emotional pain of the other person, and if yes, how does that impact them?

- **Be Cautious:** Resist the temptation to rely too heavily on interpersonal relationship issues in the diagnostic process; all three of these disorders, as well as other mental health issues, can present with a pattern of behavior in interpersonal relationships that may appear to the diagnosing professional to be maladaptive. It is important to asses, as fully as possible, other aspects of the client's lived experience before making a diagnosis.

2.5 COMORBIDITIES

- **Verify** that the client meets the diagnostic criteria for all mental health diagnoses given. If a diagnosis is uncertain or unclear, make a "rule out" note, instead of officially diagnosing the client.

- **Examine Carefully** to fully determine that a client's symptomology **cannot** be explained by any other, less severe, mental or physical health issues, substance use, or response to trauma.

- **Consider the implications** of these diagnoses on the client's life. Aim to give hope throughout the diagnostic process.

3 DIAGNOSTIC CONSIDERATIONS

3.1 Trauma History

- What is Trauma? A normal response to an abnormal experience.
- Traumatic experiences have a significant impact on the human person's body and brain. Both acute and chronic exposure to trauma can cause behaviors and impairments which may present very similarly to all three disorders discussed here.
- Consider using V/Z codes to code the experiences the person has had and point towards the need for trauma treatment.
- Consider recommending intensive trauma therapy to clients to process trauma if you are unclear on the diagnosis.

3.2 Gender

- 75% of those diagnosed with borderline personality disorder are Women.
- One girl for every three boys is diagnosed with ADHD in childhood, yet that gap does not persist into adulthood.
- Considering the overlap in symptoms, could a lack of ADHD diagnosis in childhood contribute to the over representation of women diagnosed with borderline personality disorder?

3.3 Least Intrusive

- Consider the prevalence rates in your practice.
- Consider treatment options, outcomes and accessibility.
- Consider reassessment after trauma treatment.

Ockham chooses a razor

Could an ADHD diagnosis be seen as "Least Intrusive"?