Greet your neighbors!

Differential Diagnosis: ADHD, Autism, Mood Disorders, and Borderline Personality Disorder

This is a three hour training

(yes, there will be breaks)

Introduction

Presenter: Noelle Lynn, LMSW, ADHD-CCPS

Yes, I am pregnant.

Because of this, and my own neurodivergence, I am going to use accommodations throughout my presentation.

Objectives

- ➔ Analyze symptom presentations to determine which DSM 5 diagnostic criteria are fully met by the client's experience.

- ➔ Describe, in detail, the diagnostic criteria for ADHD, Autism, Mood Disorders and Borderline Personality Disorder (and the differences between seemingly overlapping symptoms)

- ➔ Accurately assess for and diagnose clients with ADHD, Autism, Mood Disorders and Borderline Personality Disorder.

Disclaimers

- ➔ This information is designed to be used only by licensed clinical professionals who hold a master's or PhD in a mental health field and are currently in good standing with their licensing board. Use of this information in other settings is strictly prohibited as the information taught here is only meant to be used in a differential diagnostic setting.

- ➔ Any misuse of this information is not the responsibility of Noelle Lynn. She cannot be held liable for any misuse of the information presented here.

- ➔ The content of this presentation (handout, PowerPoint, and audio) is for conference participants ONLY. DO NOT COPY or SHARE this handout without direct written permission from Noelle Lynn. You can contact Noelle directly at noelle@dobetteradhd.com.

- ➔ Participants **do not have permission** to reproduce or share this presentation, or any part of it.

Notes on Language…

- When speaking, it is difficult for me to repeat exactly what I just said (verbatim) because I am often in a flow state. The recording of this talk will likely be available through the conference, and I am happy to do my best to repeat the content, I just will likely not be able to exactly recall the way I phrased it.

- Neurodivergent Affirming language is very important to me. However, in the community there is still a lot of discuss about the use of person vs. identity first language. Because of this, I may switch back and forth between this language throughout the presentation. My language may not always be perfect, and I ask you provide me feedback on that after the talk through email, as I am always open to learning.

Notes on Language…

- Autism Spectrum Disorder, also known as ASD, will be called “Autism” throughout this presentation. Dr. Devon Price in “Unmasking Autism” does an excellent job explaining language preferences for this population. “Autism” is currently the preferred language, and I will do my best to use it throughout the presentation.

- I will try NOT be using acronyms for Borderline Personality Disorder or Bipolar Disorders. This is because they can very easily get confused between each other with the use of the acronyms. If you are confused at any point about which one I am talking about, please ask for clarification.

Request for a neurodivergent affirming space:

Request for a neurodivergent affirming space: One of the core values, to me, of a neurodivergent affirming space is to not assume you know someone's intention behind an action. If I say something which is confusing, hurtful, and angering to you, please consider if you think that was intentional on my behalf. Before rushing to judgement, please seek clarification with me. You are welcome to do this in the moment (if needed, esp. If you are triggered), after this talk in person, or in an email after the fact. I want to make sure that if anything is upsetting or unclear that we are able to go through a repair process which is safe for both of us.

Also, I am neurodivergent! This means I may express myself in non-neurotypical ways.

What we won’t be covering today

- ➔ The physical, environmental, and other factors which can significantly impact a person’s mental health
- ➔ The parts, process, and tools used for diagnosing in clinical practice
- ➔ How to do administer a diagnostic interview and other aspects of a diagnostic process

What we won't be covering today

- ➔ How to write a diagnostic report which can be used by your clients throughout their lives for support and access to help and accommodations for their diagnoses
- ➔ Recommendations for these clients for next steps and how to direct them to the right services for their particular needs
- ➔ Disorders other than the four listed in the title

These, and more, are all important to learn how to do. Noelle Lynn and other clinical professionals do provide trainings on these topics. However, this presentation is designed to be a deep dive into the more challenging aspects of these diagnoses.

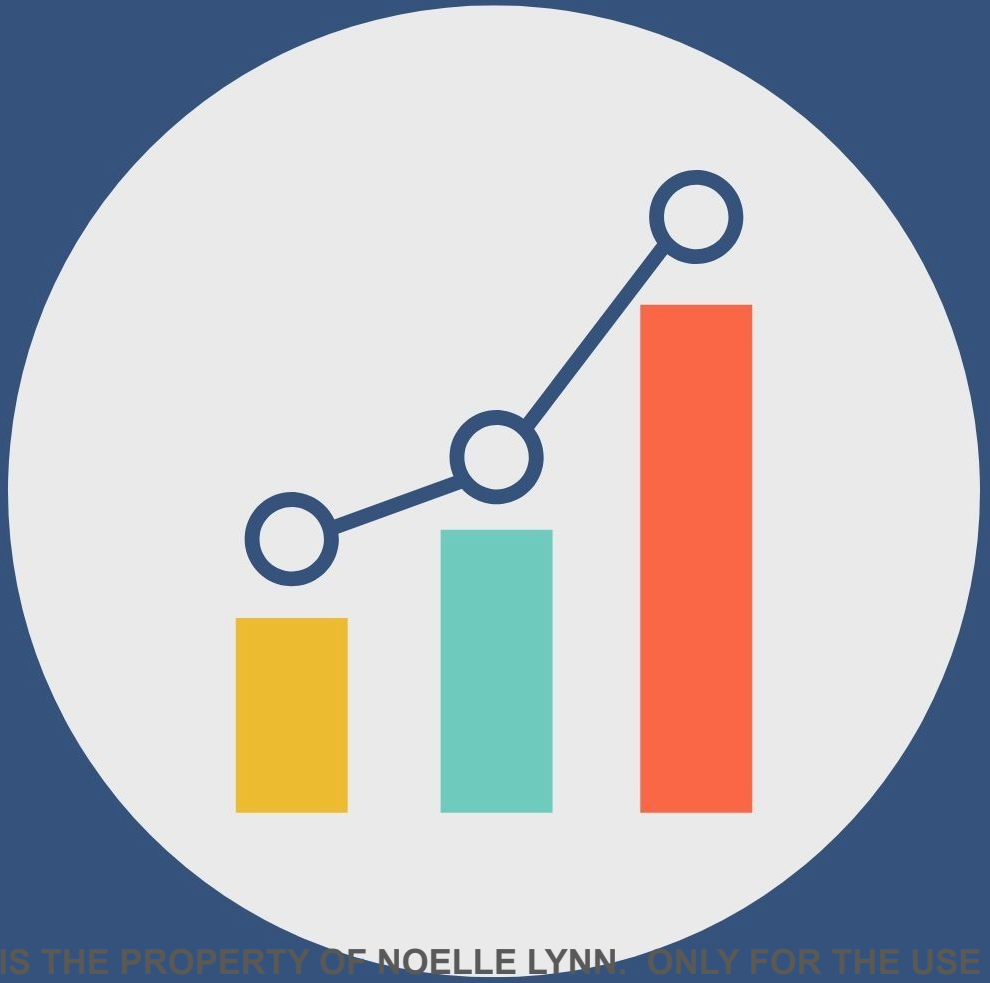
Why are YOU here today?
Why do you do this work?

(Share with a neighbor who you don't already know)

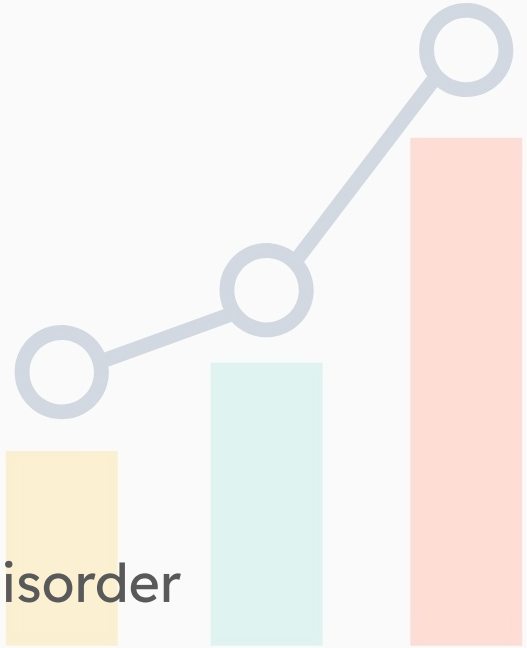
Self Check: Why do we do this?

- To significantly reduce or eliminate the distress the person in front of me is experiencing.
- To provide language, explanation and insight into an experience which previously has gone unexplained.
- To provide a different answer to clients for the question: “What is wrong? It must just be **me**”

START WITH STATISTICS



Start with Statistics



Generalized Anxiety Disorder	2.9% of population 9% life time morbid risk
Major Depressive Disorder	7% of population 12 month prevalence
Post Traumatic Stress Disorder (PTSD)	3.5% of population 12 month prevalence

Start with Statistics: Mood Disorders

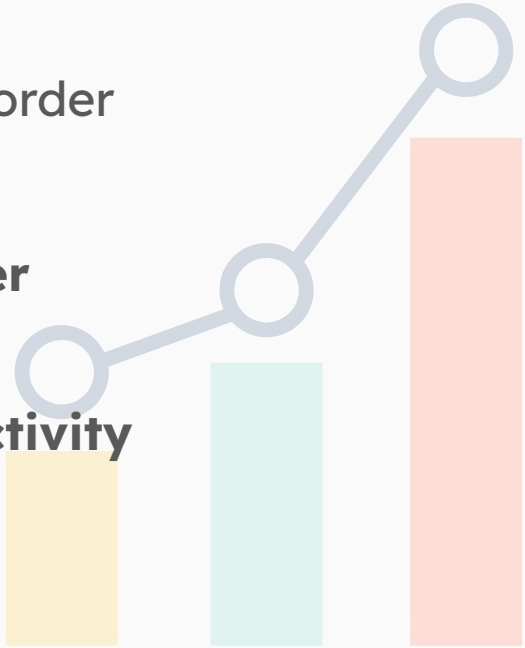
Bipolar One, Bipolar Two, Cyclothymia

2.8 % of population in the past year

Bipolar One, Bipolar Two, Cyclothymia

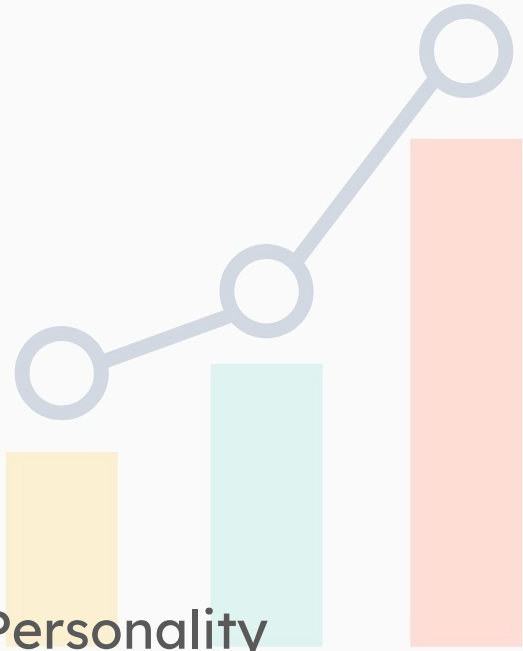
4.4 % of US Adults experience bipolar in their life time

Start with Statistics



Obsessive Compulsive Disorder (OCD)	1.2% of population 12 month prevalence rates
Autism Spectrum Disorder (Autism)	2.3% of population of 8 year old children
Attention Deficit Hyperactivity Disorder	4.4% of population 12 month prevalence rate
	8.1% of population life time prevalence

Start with Statistics: Personality Disorders



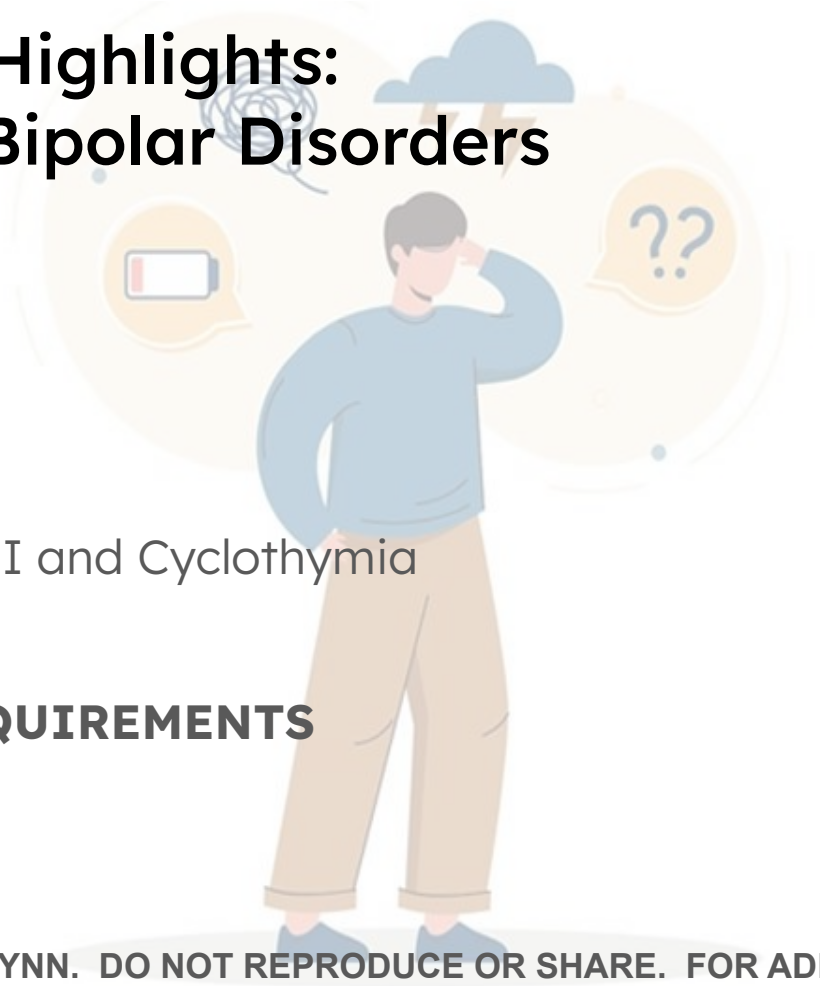
Borderline Personality Disorder	1.6% of median population
Histrionic Personality Disorder	1.84% of population
Obsessive Compulsive Personality Disorder	2.1% of population (low end)

READ THE DSM 5 CRITERIA

Read, and then re-read multiple times, the diagnostic criteria in the DSM 5. Always start with the DSM 5 description of the diagnosis. Read the whole section, not just the criteria lists. Read it multiple times. If you don't understand something, seek clarification.

Yes, the DSM 5 is highly imperfect, with many, many known issues and flaws. However, it is the starting point we have to work from. Many clinicians do not have a strong foundation in **what is actually written in the DSM 5,** and thus make diagnoses which the client does not meet the actual criteria for. There are situations where an argument can be made to make a diagnosis without FULL DSM 5 criteria met, but these decision must then be based in up to date research and extensive clinical practice and supervision experience.

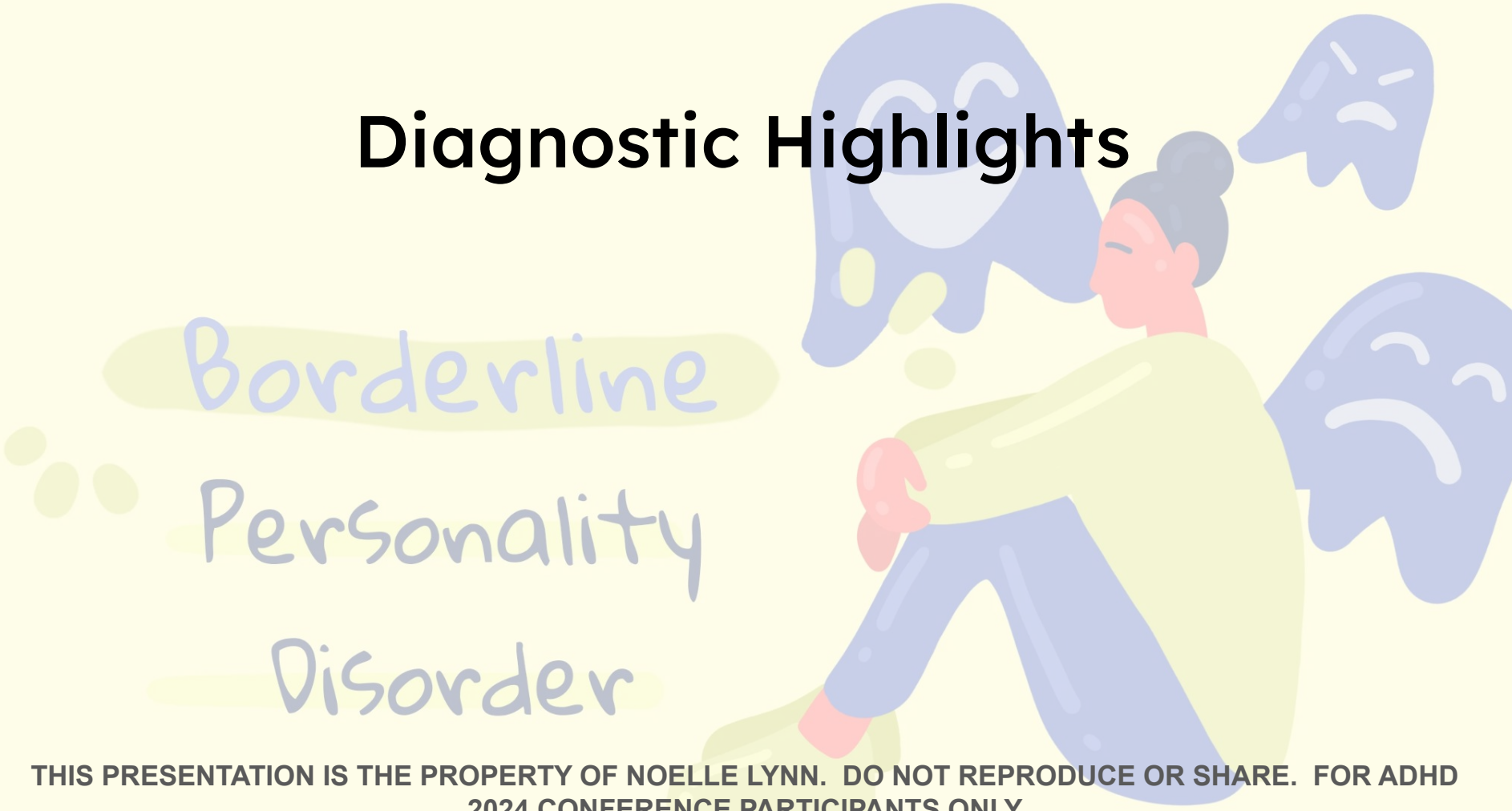
Diagnostic Highlights:
Mood Disorders/ Bipolar Disorders



= Bipolar I, Bipolar II and Cyclothymia

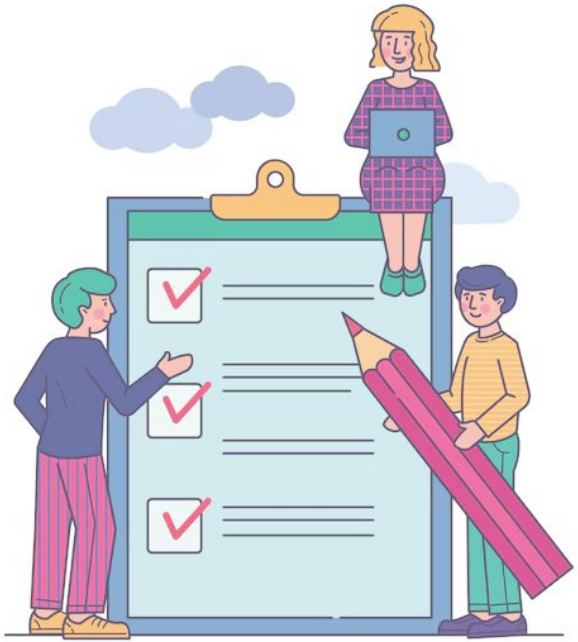
Diagnostic REQUIREMENTS

Diagnostic Highlights

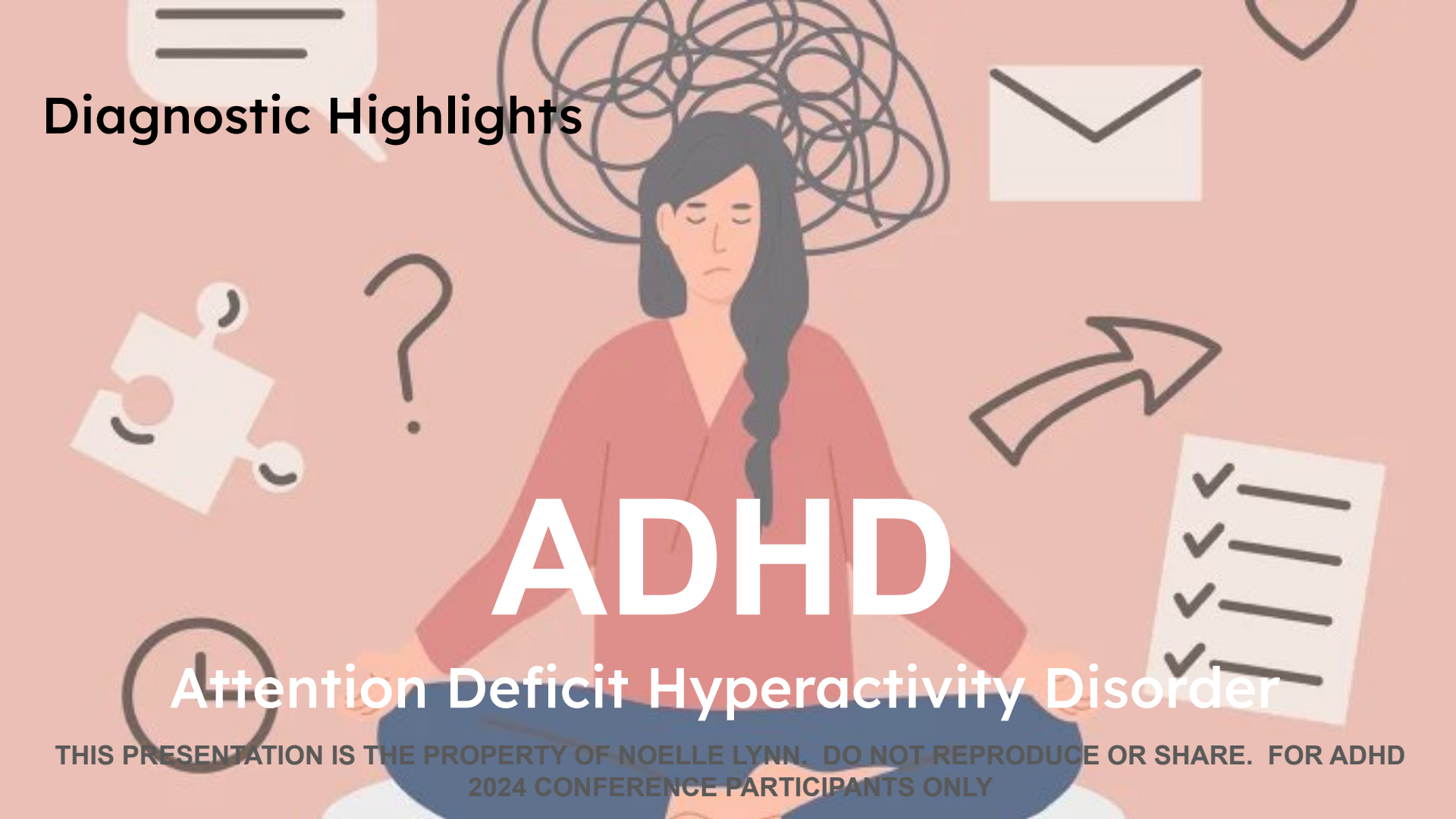


Diagnostic Process:
Bipolar Disorders and Borderline Personality Disorder

- ➔ No recommended screening tools for these disorders.
- ➔ If possible, multiple diagnostic interviews as well as a mood trackers, sleep diaries, observer reports, and more can be helpful in this process.



Diagnostic Highlights



ADHD

Attention Deficit Hyperactivity Disorder

Diagnostic Highlights:
Autism Spectrum Disorder (Autism)

Screening Tools for ADHD and Autism

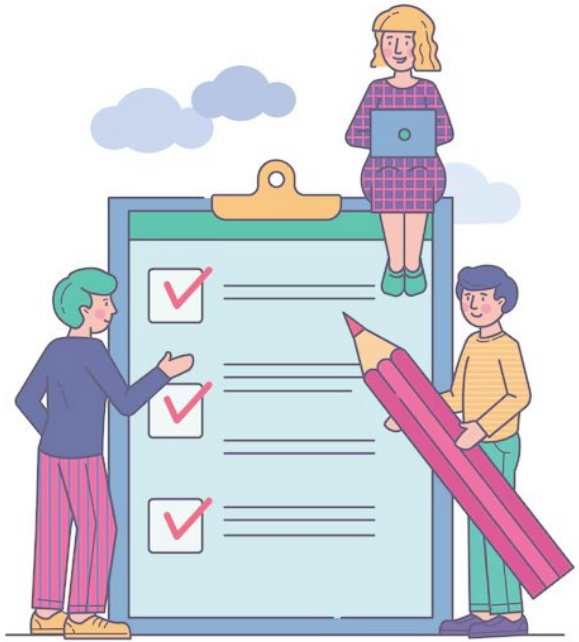
Noelle's preferences**:

ADHD

- ➔ ASRS 1.1 Adult ADHD screener and observer report
- ➔ If you need a semi structured interview: DIVA 5
- ➔ QBTest/Check (as a part of the process, does not determine diagnosis)

Autism:

- ➔ Embracing Autism Screening Tools



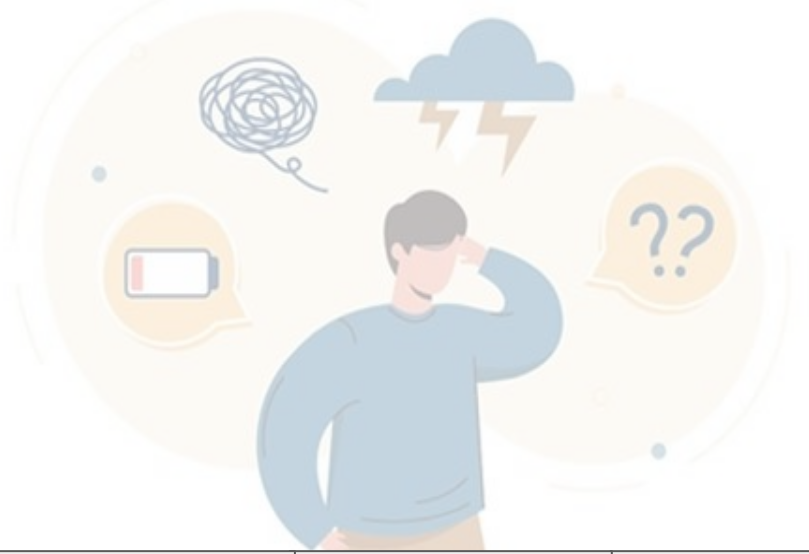
Screening tools DO NOT diagnose!

Diagnoses MUST be made based on an in depth diagnostic interview

SIX KEY DISTINGUISHING SYMPTOMS

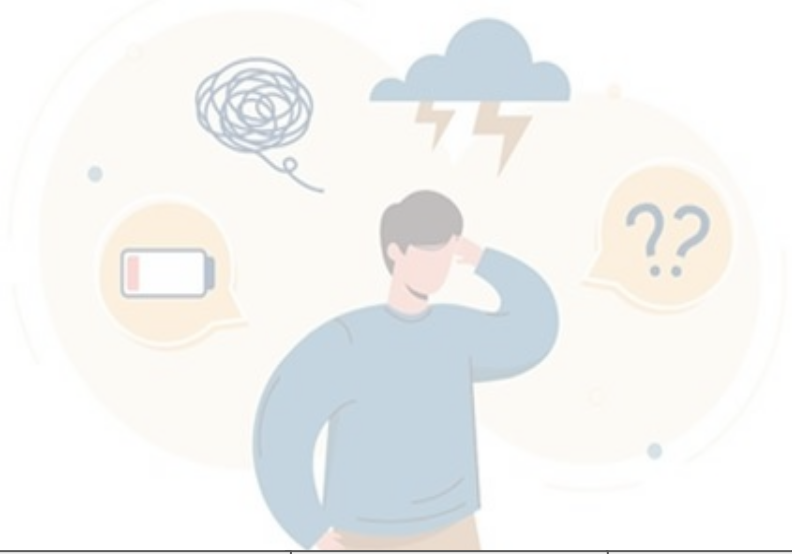
Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbances	Social Functioning and Impairment

MOOD DISORDER



Mood Fluctuations					

MOOD DISORDER

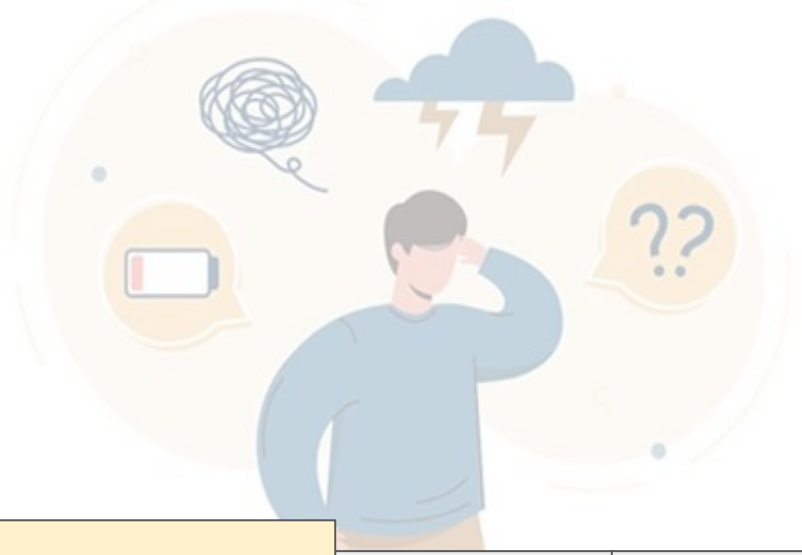


Mood Fluctuation	Impulsivity			

MOOD DISORDER

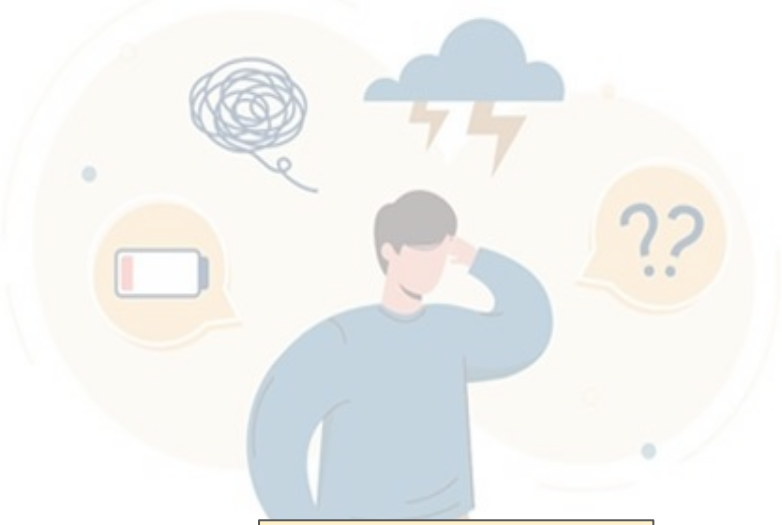
Mood Fluctuations	Impulsivity	Symptom Onset			

MOOD DISORDER



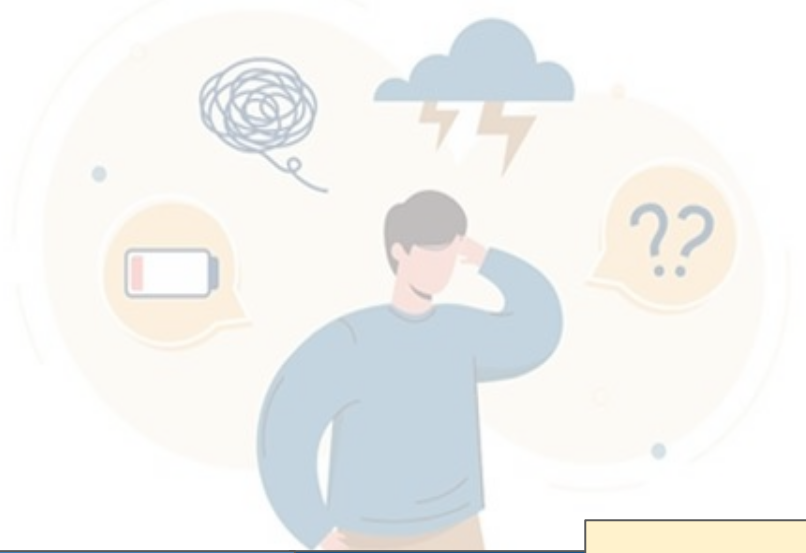
Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm		

MOOD DISORDER



Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbances	

MOOD DISORDER

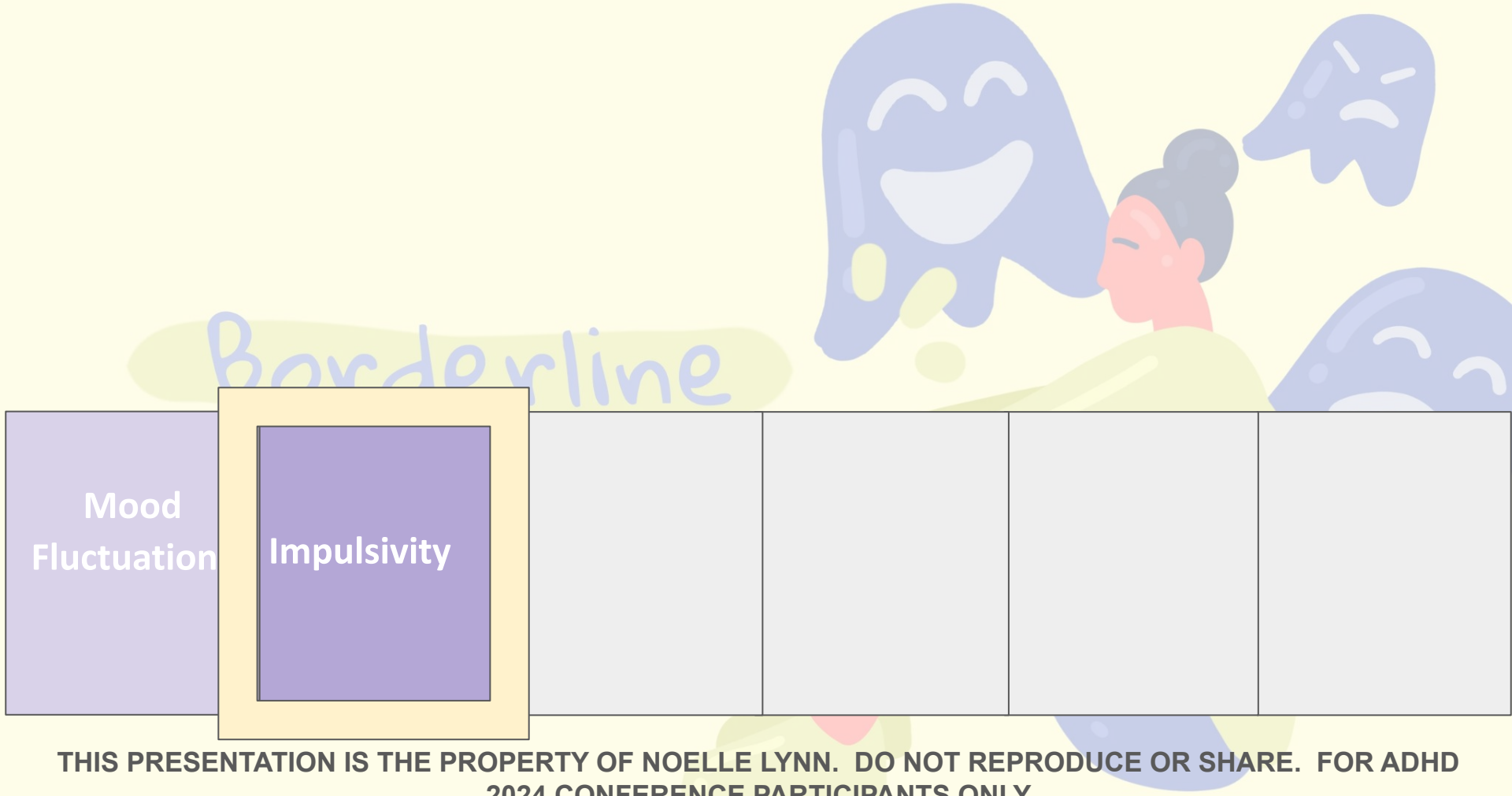


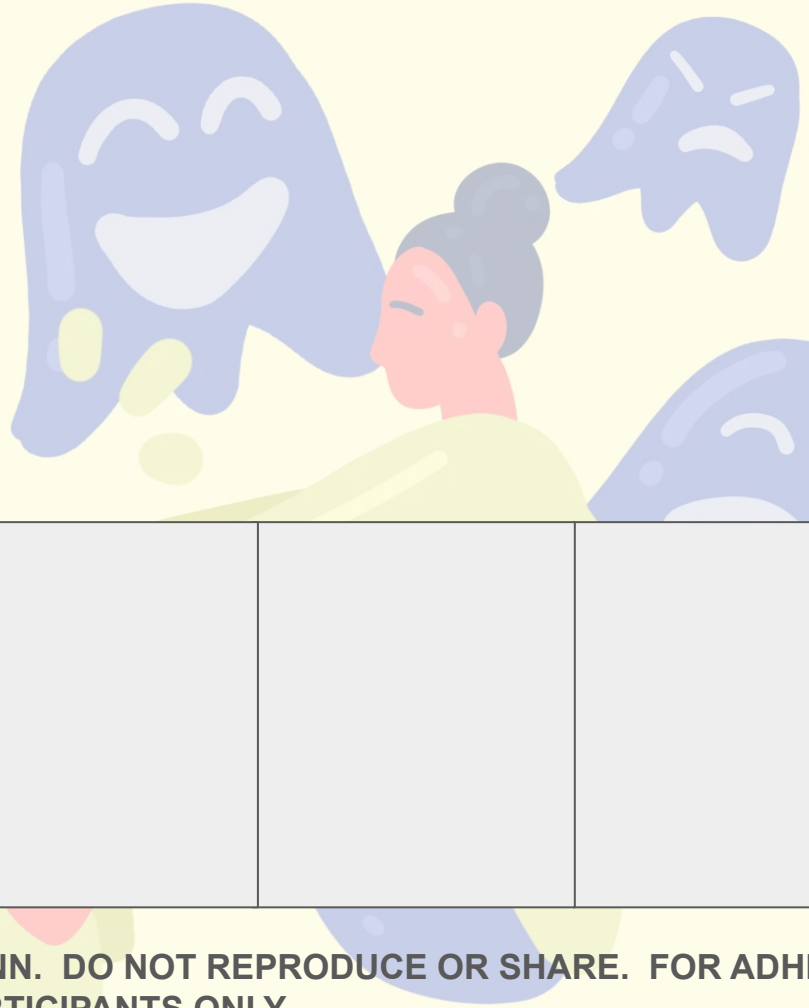
Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbance	Social Functioning and Impairment

Questions so far?

Borderline

Mood Fluctuations					





Borderline

Mood Fluctuations	Impulsivity	Symptom Onset			

Borderline

Mood Fluctuations	Impulsivity	Symptom Onset	**Self Harm**		

Borderline

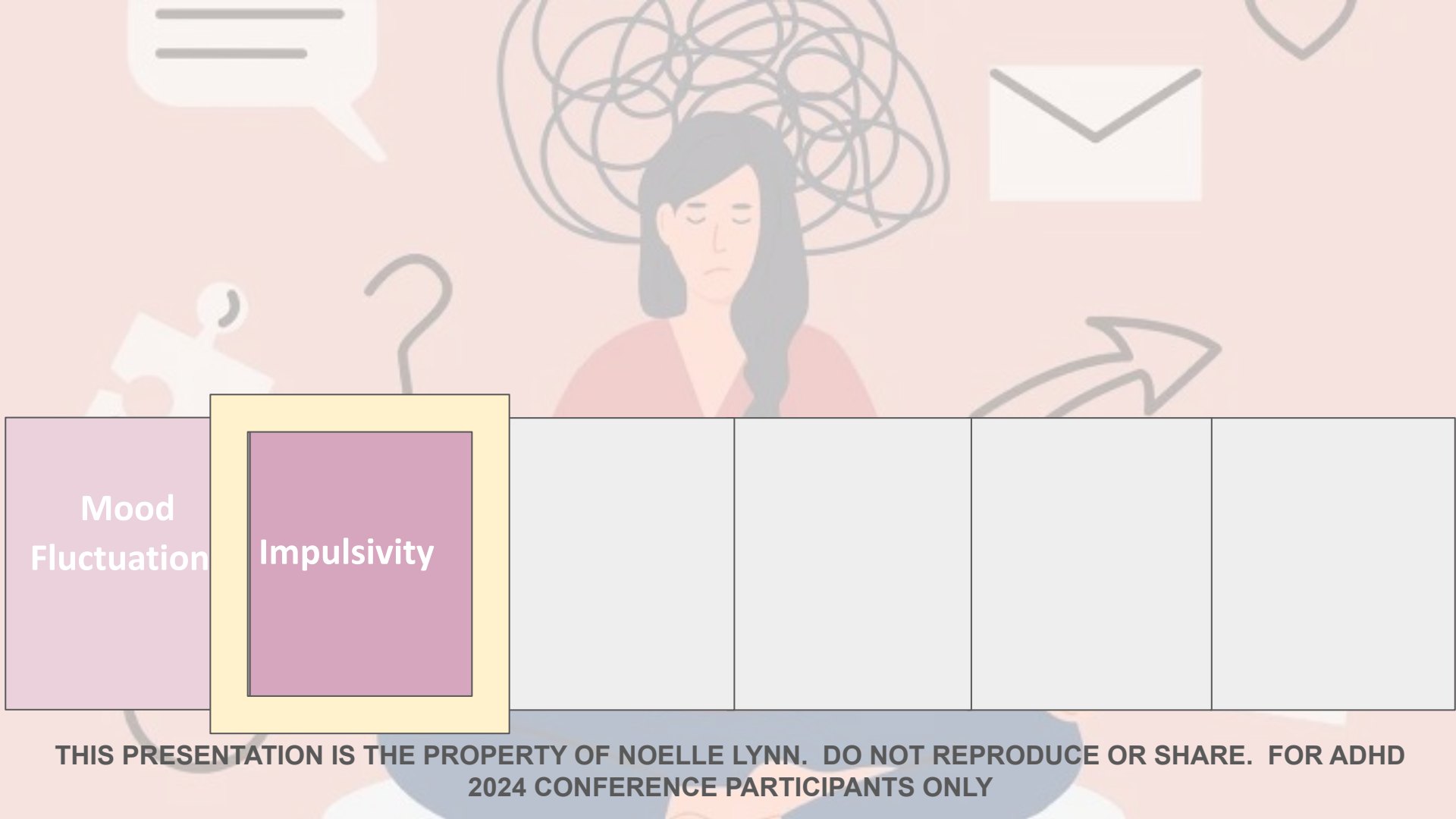
Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbances	

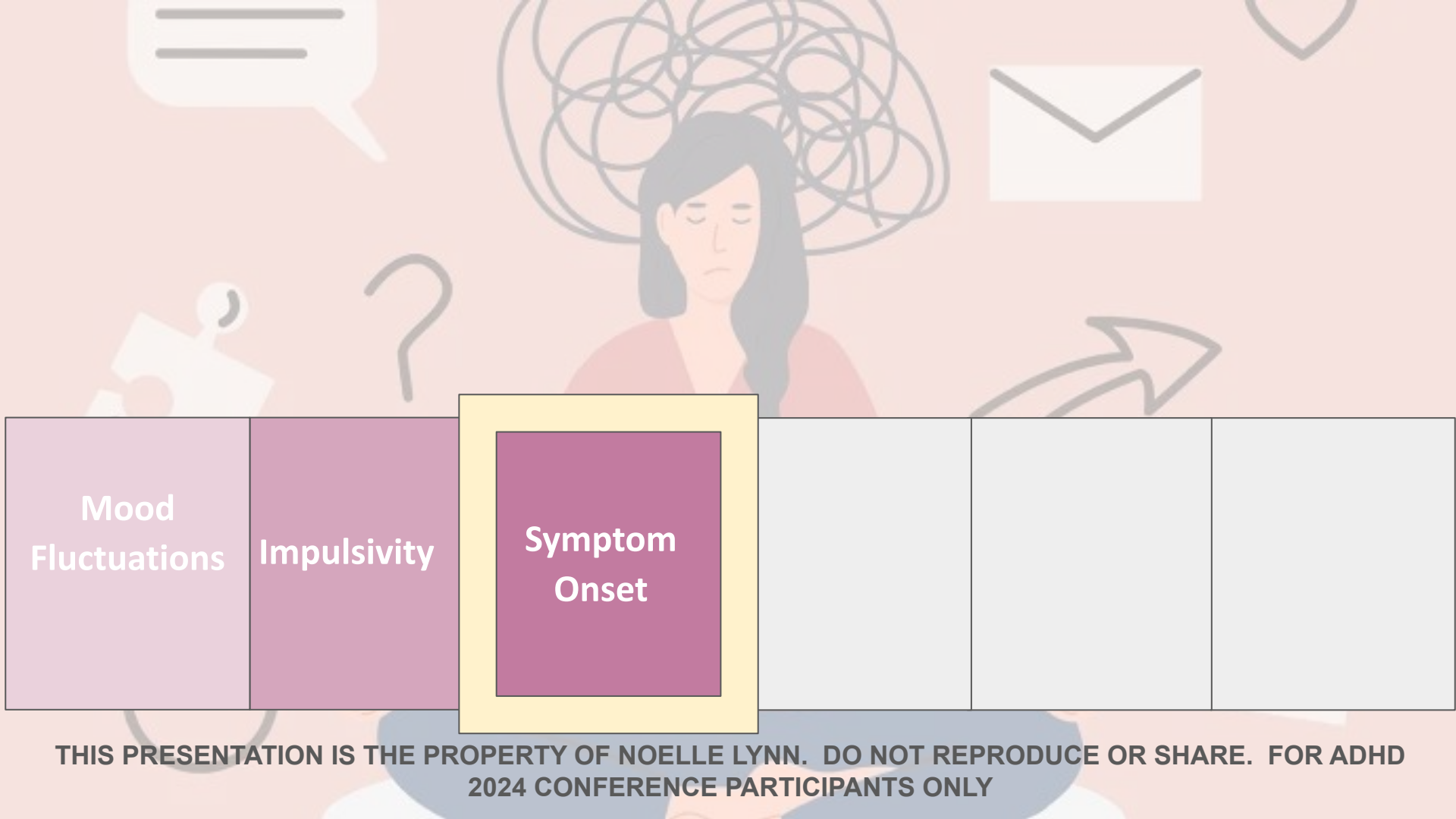
Borderline

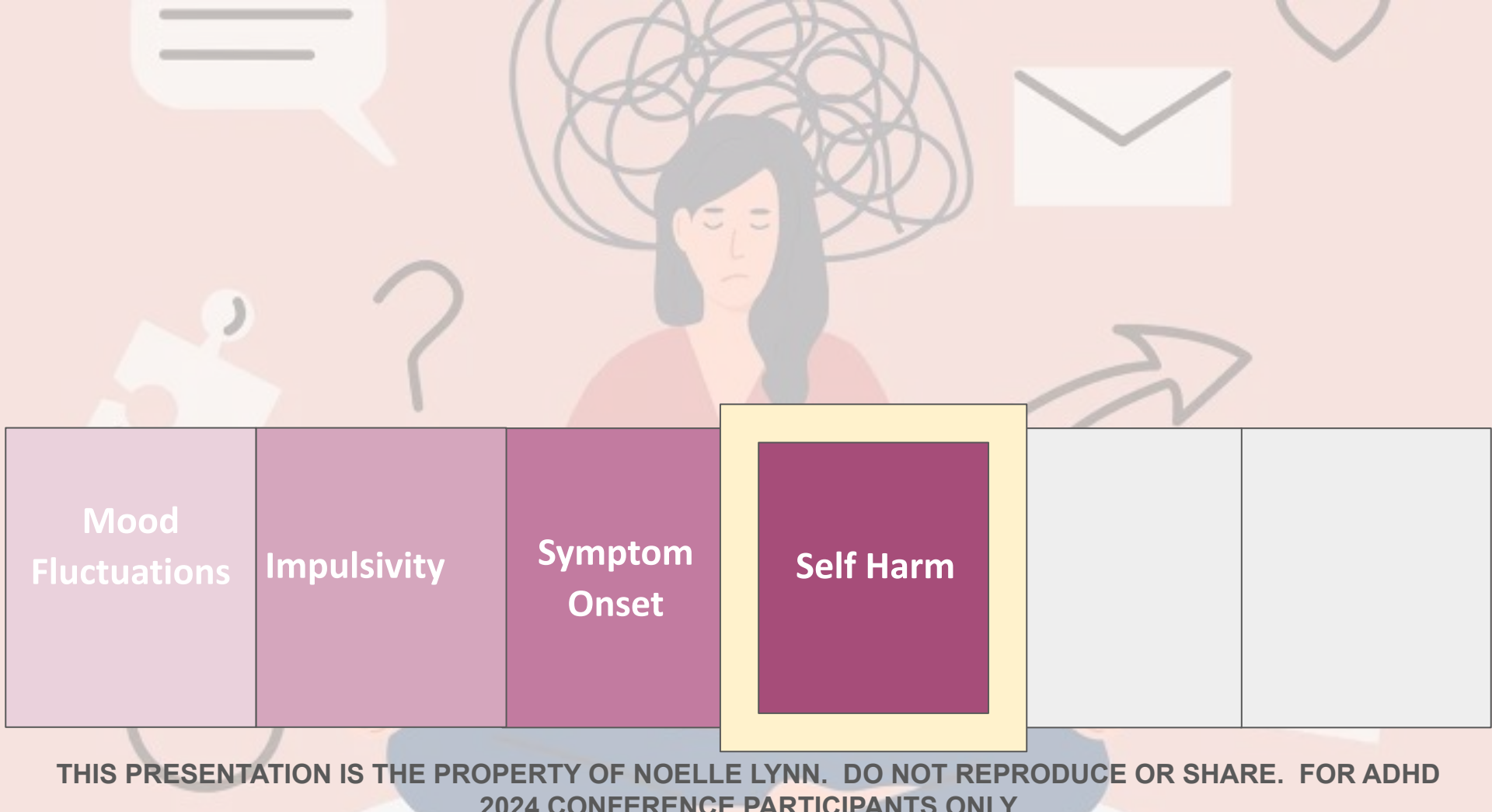
Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbance	Social Functioning and Impairment

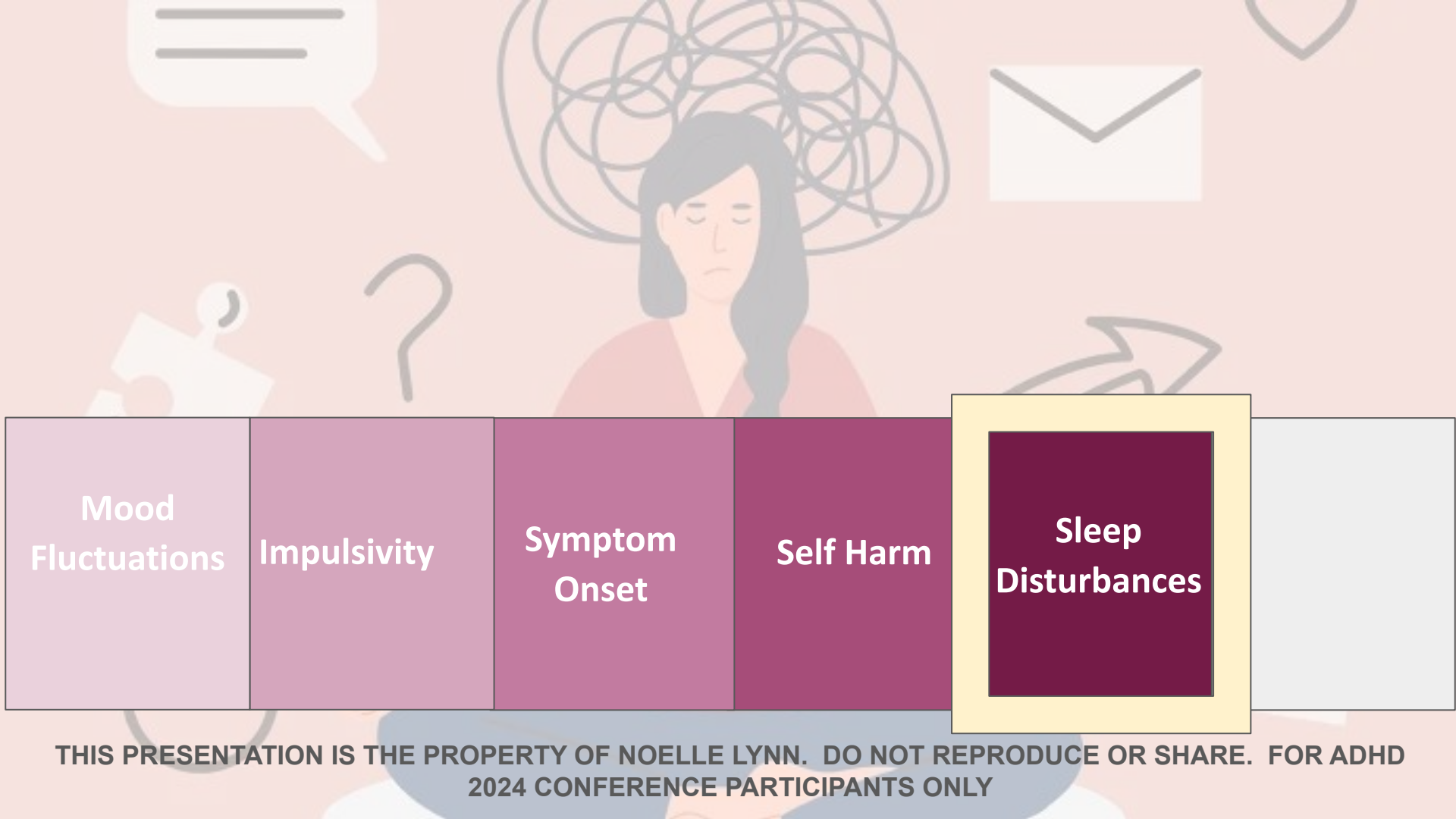
Questions so far?

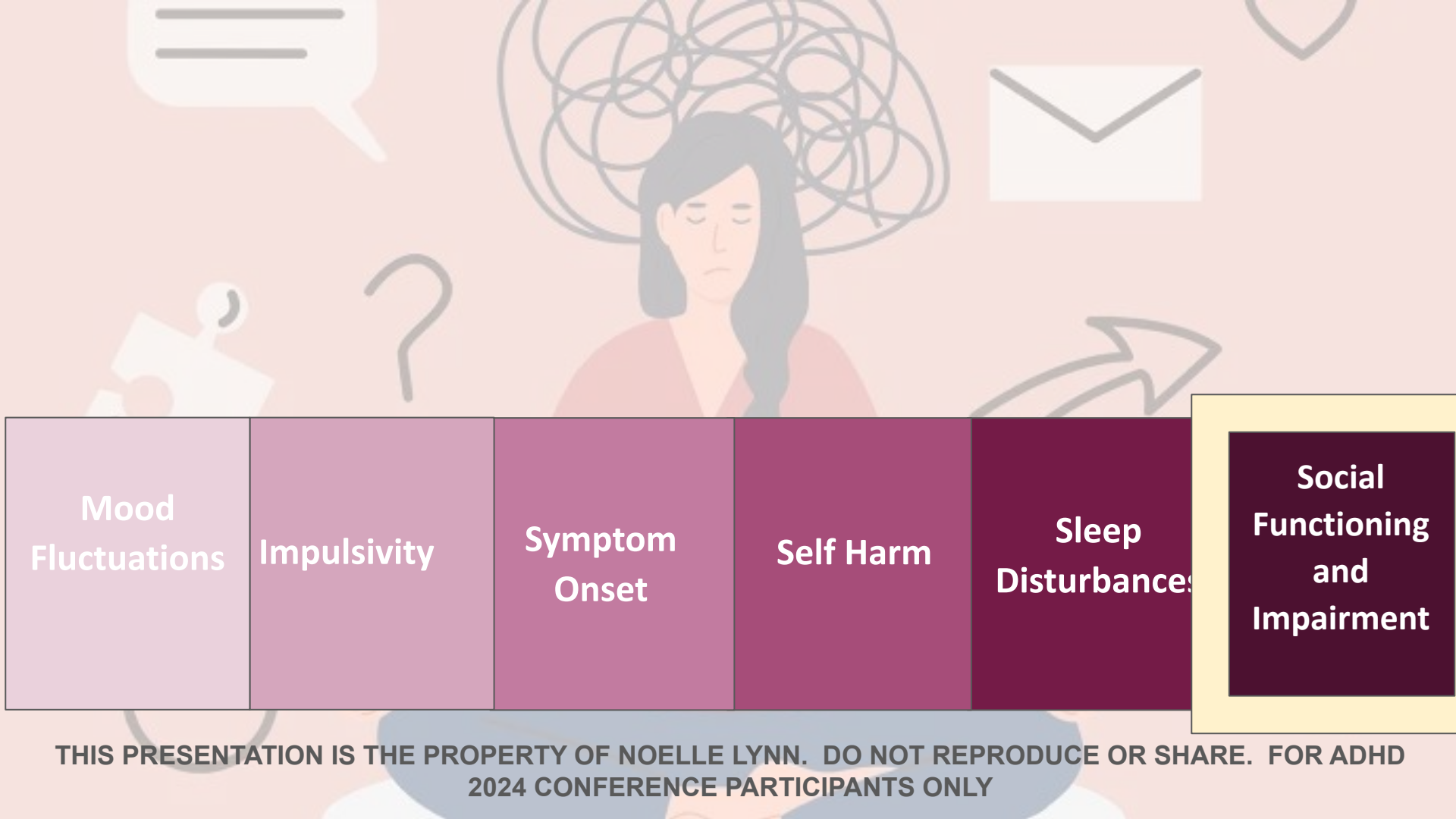
Mood Fluctuations					











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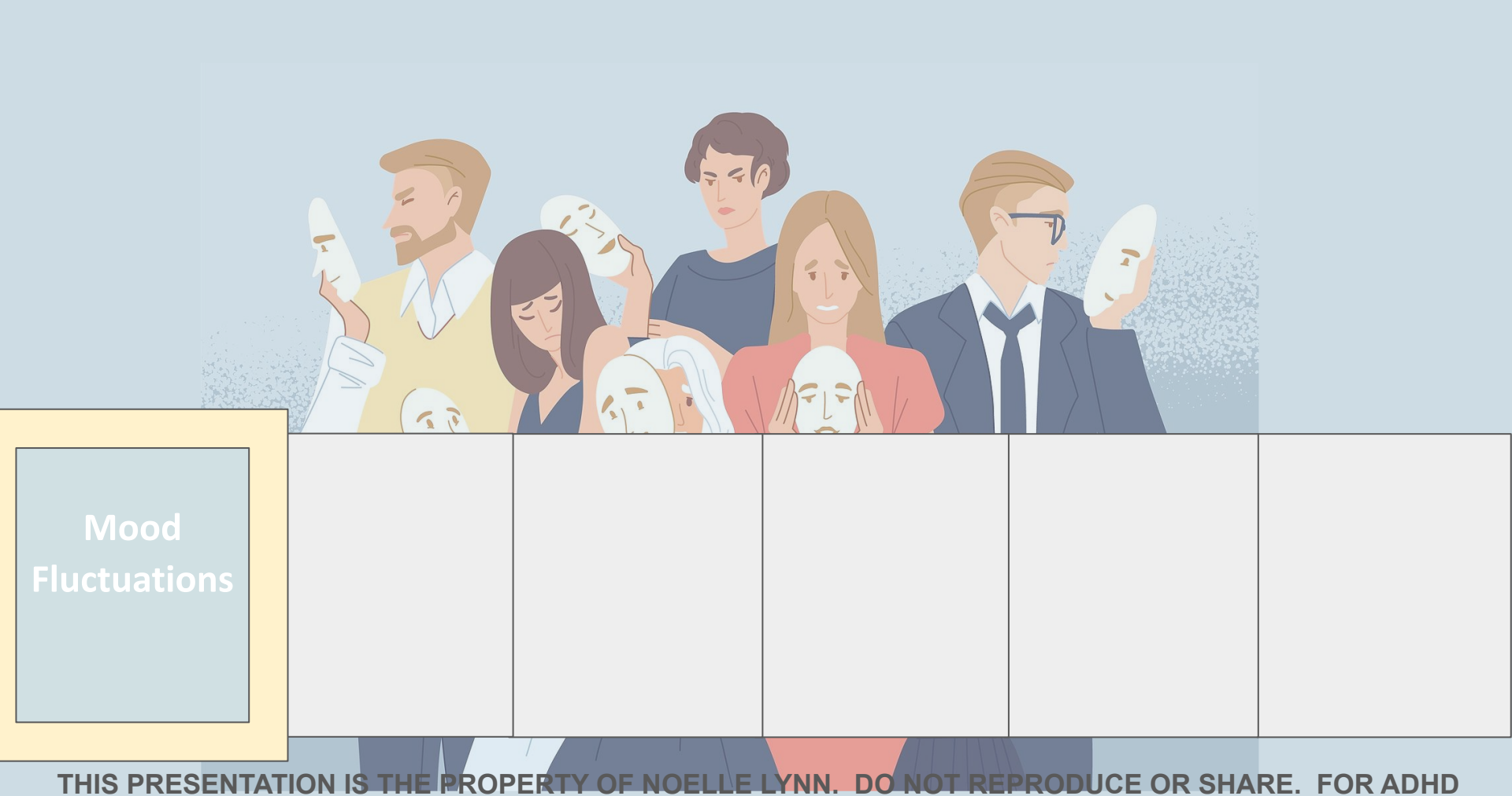

Mood Fluctuations

Mood Fluctuation

Impulsivity

Mood Fluctuations

Impulsivity

Symptom Onset

Mood Fluctuations	Impulsivity	Symptom Onset	**Self Harm**		

Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbances	

Mood Fluctuations	Impulsivity	Symptom Onset	Self Harm	Sleep Disturbance	Social Functioning and Impairment

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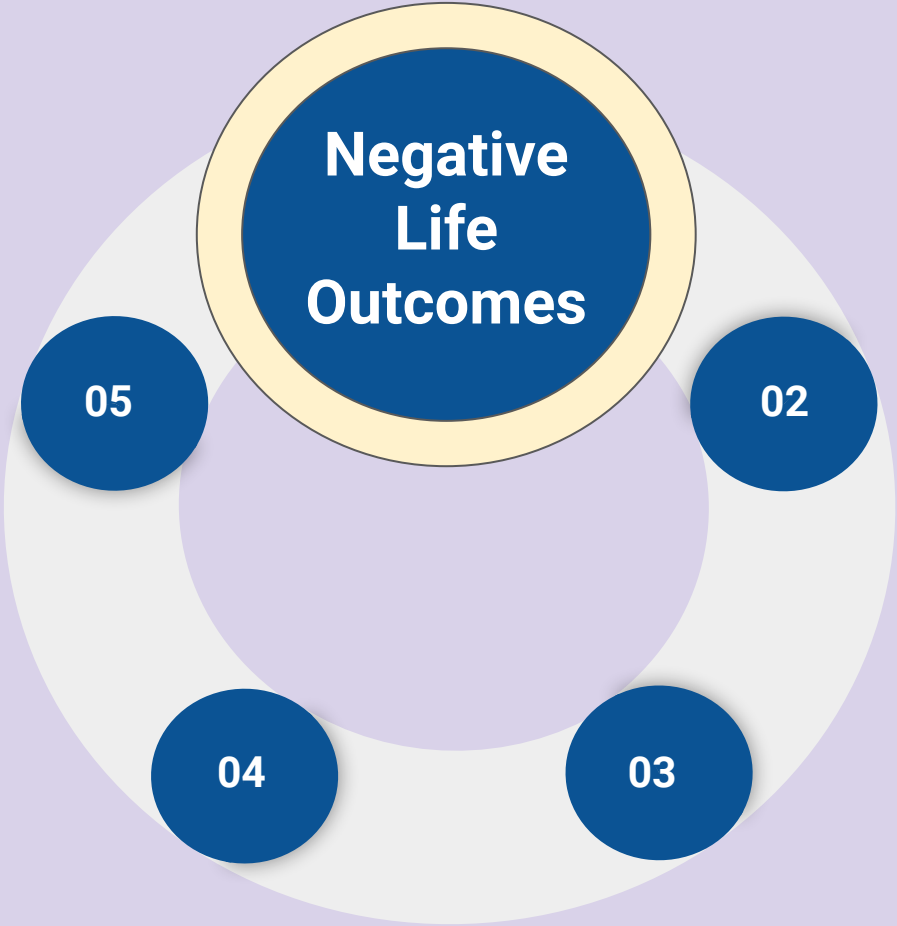

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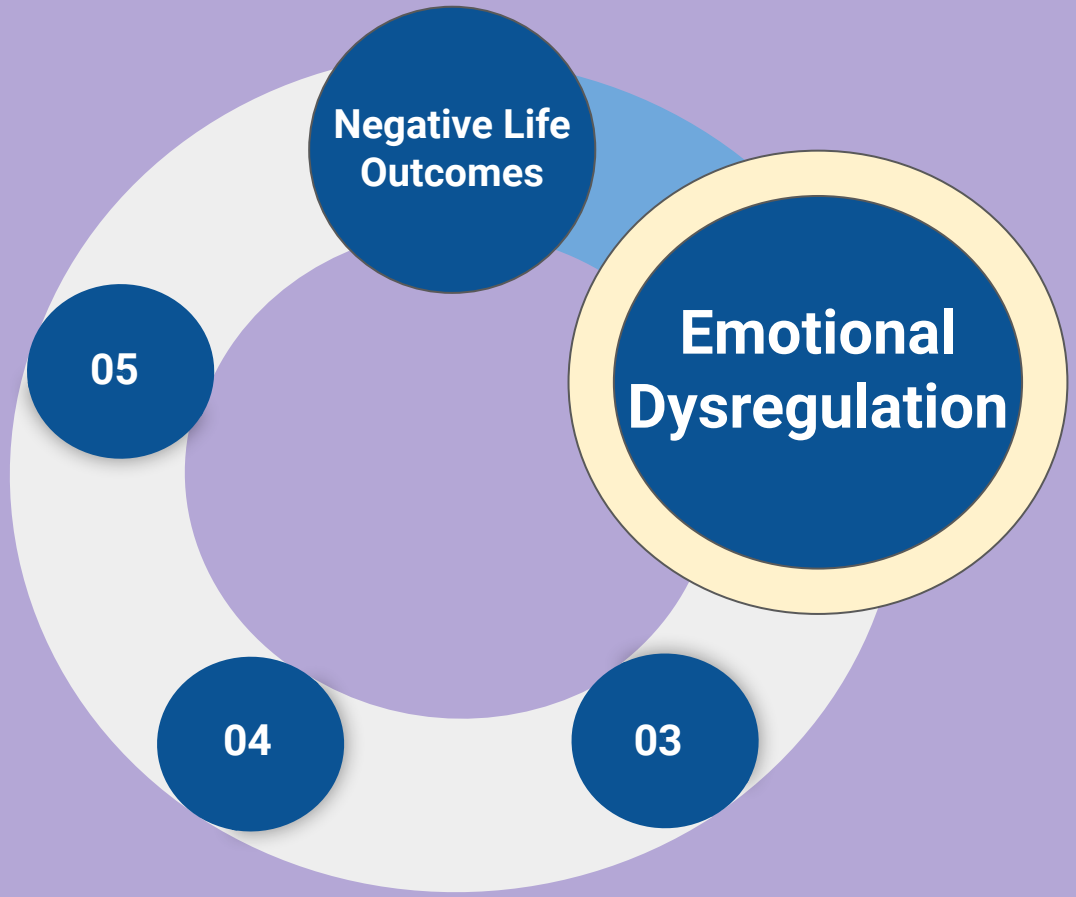

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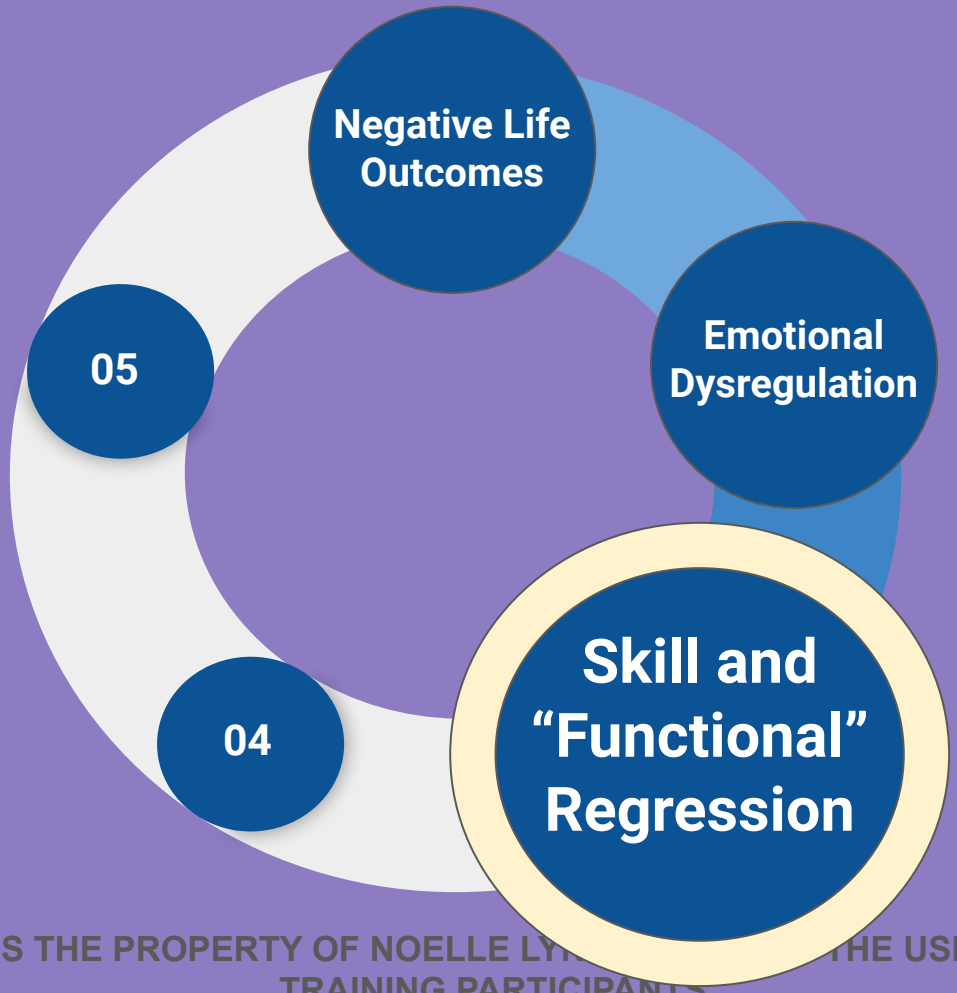

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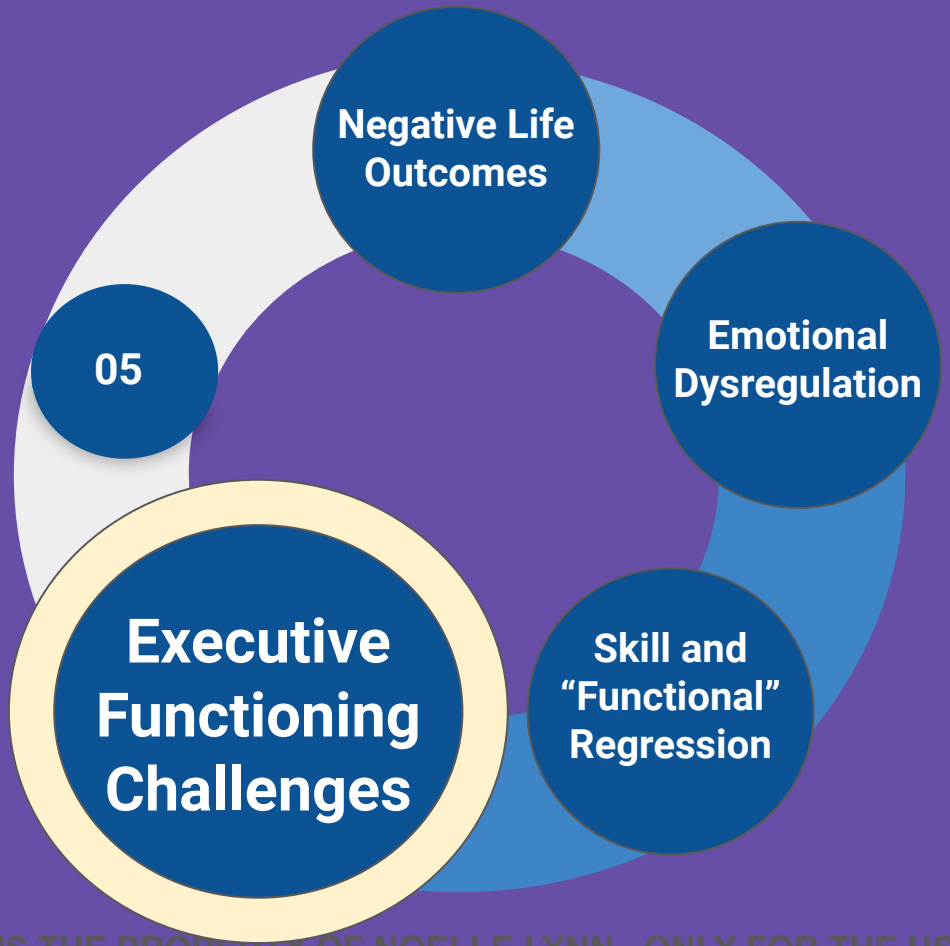

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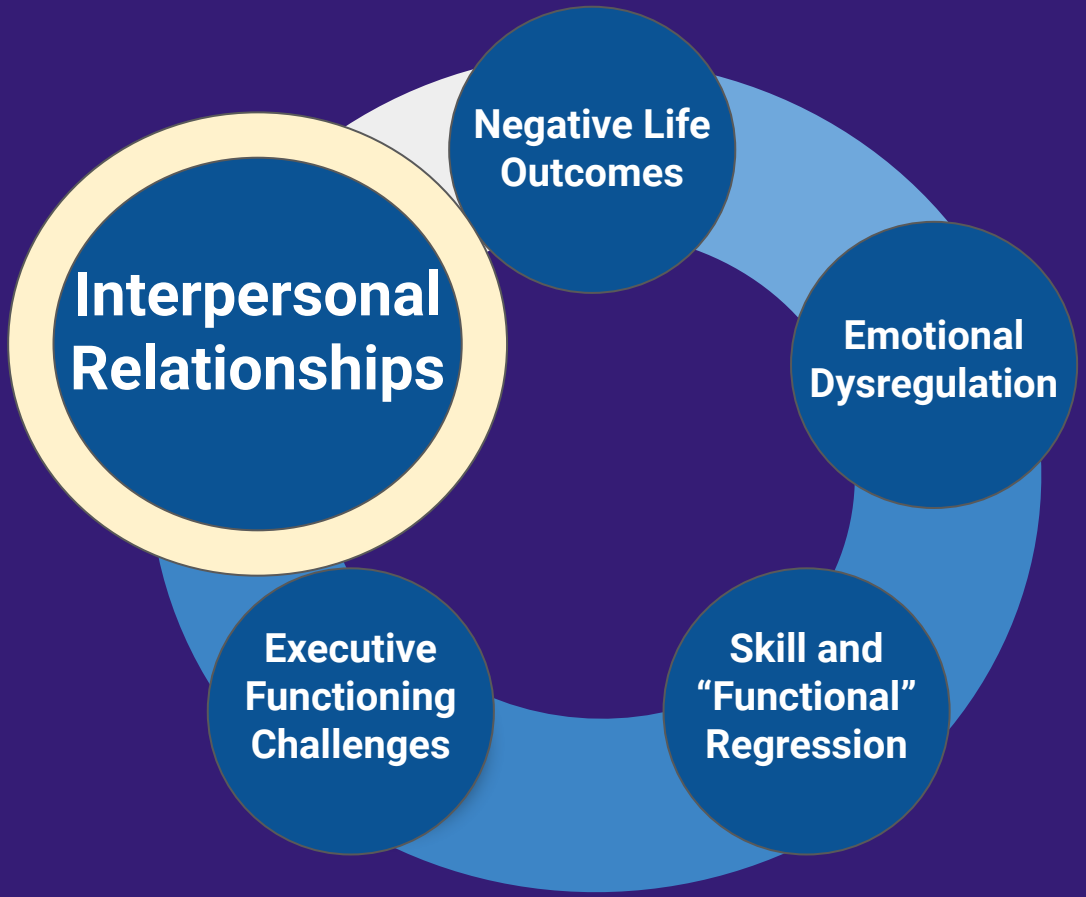

Questions so far?

Questions so far?

Co-occurring disorders

What about Premenstrual Dysphoric Disorder (PMDD?)

Thoughts on borderline personality disorder

BPD	Autism
Desiring to recruit help/using charm to form relationships	May mask autistic traits to fit in and form relationships
Hypersensitive to social cues	Difficulty reading social cues
Hypervigilant about the opinions of others	Lacks social understanding
Has emotional outburts as a results of experiencing intense emotional pain	Has meltdowns as a result of sensory overstimulation and experiencing intense emotional/physical pain
Strong response towards others when needs are not met (e.g., confrontation, anger)	Withdrawal from others when needs are not met (e.g., social isolation)
Uses external validation to regulate self-esteem	Disturbed sense of self based on social outcasting
May engage in idolization & devaluation of others	May treat others as special interests

From Embracing Autism; https://embrace-autism.com/its-not-bpd-its-autism/