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

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About Me section (already have)

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What won't be covered here:

- ➔ The physical, environmental, and other factors which can significantly impact a person's mental health
- ➔ The exact parts and processes used for diagnosing in clinical practice.
- ➔ How to administer a diagnostic interview and other aspects of a diagnostic process.
- ➔ How to write a diagnostic report that 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.

Objectives

1. Analyze symptom presentations to determine which DSM 5 diagnostic criteria are fully met by the client's experience.
2. Describe, in detail, the diagnostic criteria for ADHD, Autism, Mood Disorders and Borderline Personality Disorder (and the differences between seemingly overlapping symptoms)
3. 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.

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What is your why?

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

01. Prevalence Rates

a. 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).

b. Borderline Personality Disorder

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

c. Attention Deficit Hyperactivity Disorder (ADHD)

- 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)

D. Autism Spectrum Disorder (Autism)

- An estimated 1-2% of the U.S population has reported Autism. (DSM-5)
- In May 2024, the CDC reported that about 1 in 36 children have been identified with ASD. Autism is 4 times more common in boys than girls. (CDC)
    - Data and Statistics on Autism Spectrum Disorder
- "About 1 in 6 (17%) children aged 3–17 years were diagnosed with a developmental disability, as reported by parents, during a study period of 2009–2017. These included autism, attention-deficit/hyperactivity disorder, blindness, and cerebral palsy, among others". (CDC)

02. Diagnostic Criteria Overview

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 I, Bipolar II and Cyclothymia

Diagnostic REQUIREMENTS:

- ➔ Sleep disturbances
- ➔ Trackable patterns of mood fluctuations that are NOT situationally dependent
- ➔ Mania: MUST meet the full criteria for at least ONE true manic episode.
- ➔ Hypomania: While not as distinct of a state of mania, hypomania does have its own set of features which can be clearly and consistently documented and which are unique to the disorder.

Borderline Personality Disorder

- ➔ **Excessive Fear of Abandonment**

- ➔ Recurrent suicidal behaviors, gestures, or threats or self-mutilating behavior. These behaviors most commonly coincide with a desire to prevent someone from "abandoning" them, or to avoid chronic feelings of emptiness.

- ➔ **Chronic feelings of emptiness**

- ➔ Transient, stress-related paranoid ideation or severe dissociative symptoms which are triggered when there is the perceived threat of possible abandonment

- ➔ Unstable sense of self or self image

Note on Screening Tools for Bipolar Disorders and Borderline Personality Disorder

- ➔ There are no screening tools which Noelle recommends. The MDQ for Bipolar Disorder will often score as a false positive for those with ADHD, not because they have a mood disorder, but because of how the questions are written.

- ➔ Both of these disorders need to be diagnosed through an indepth diagnostic interview, and if at all possible, over the course of several meetings over a period of time. Both of these disorders are difficult to determine if the client meets criteria in a one off meeting. Mood trackers, sleep diaries, observer reports, and more can be helpful in this process.

Diagnostic Highlights for ADHD

- ➔ Symptoms are present before the age of 12 years old*

- ➔ Adults need to meet at least 5, children need to meet at least 6 of the diagnostic criteria for one or both subtypes.

- ➔ There are three subtypes of ADHD: Inattention, Hyperactive/Impulsive, and Combined. These three subtypes can look very different in their presentations but are, in fact, the same disorder.

- ➔ Two tips for assessing for ADHD and executive functioning challenges:
  - ◆ Clarify that your questions are specifically about when the client is doing uninteresting tasks, which they find boring or mundane.

  - ◆ If a client who is being assessed for ADHD reports not struggling with a symptom, make sure to take the time to ask how they manage that particular issue.

- ➔ **Emotional dysregulation** is not currently listed as part of the DSM 5 criteria for ADHD. However, a significant amount of research as well as information from clinical practice settings show that

emotional dysregulation is often a core feature of ADHD which often increases the distress caused by the disorder.

Diagnostic Highlights: Autism Spectrum Disorder (Autism)

- ➔ Social and communication deficits **must** be persistent and across multiple domains
- ➔ Restricted patterns of behaviors and movements may not be something the person is fully aware of, as they may have found ways to incorporate these into their lives so they are not disruptive or obvious to others
- ➔ Special interests are topics on which the person knows an incredible amount of information. It can often be described as an "encyclopedic" level of knowledge. However, the Autistic person will often say they actually don't know everything on the topic (because, technically, they don't). Special interests are interests this person has been involved in and interested in for many years and which they love to talk about. They can change over time and with age and growth, but often a person will have several they have had throughout their lives. It's important to remember that special interests can be "socially acceptable" and thus less obvious as a special interest. It is also fairly common for Autistic people to have a special interest in other people.
- ➔ The DSM 5 clearly states that while there should be some evidence of Autism in early development, a person may not experience the full impact of being Autistic until later in life. This is very important to keep in mind when assessing adults.

Screening Tools:

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
- ➔ If you would like training in a semi-structured diagnostic interview for Autism, the MIGDAS is recommended.

03. Six Key Distinguishing Symptoms

Bipolar Disorders

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. Suicide is actually MORE likely in bipolar II than bipolar I because the depression has been found to often be deeper in bpII than I.

Sleep Disturbances: A consistent history of sleep disturbances are required for a bipolar diagnosis. Sleep disturbances in bipolar are defined as:

Remember: The client is REQUIRED to meet the bipolar-specific definition of sleep disturbances for the diagnosis to be made.

Social Functioning and Impairment: Social functioning is significantly impacted by where the person with bipolar is in their cycle. If the person is manic/hypomanic, they will often be highly social, engaging in a lot of interactions, talking as though everyone is their closest friend, and, possibly, using up a lot of relational capital. When someone with bipolar is in a mixed state, they are often irritable and may be fairly difficult to be around. Finally, when in a depressed episode, the person with bipolar will socially withdraw and isolate as much as possible. They will lose touch with people, not follow through on obligations, and have little to no interest in work, family obligations, or social engagements. These fluctuations often cause the person to experience social impairment because the people around them don't understand why they are so inconsistent in their behaviors, energy and actions.

A. 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)

Sleep Disturbances: check

- ➢ Sleep disorders:
  - Insomnia
  - Nightmares
  - Delayed sleep onset due to being in a hypervigilant state
- ➢ Sleep disturbances:
  - Hyperarousal: struggle with heightened arousal and negative emotional states that affect their sleep onset and sleep quality

Social Functioning and Impairment

- ➔ Borderline personality disorder is marked by a desperate fear of abandonment. This can play out in social settings by the person having a sudden and intense flare of anger or fear because they are afraid of being abandoned or left alone.
- ➔ Challenges with an unstable self-image contribute to social challenges for those with borderline personality disorder. They can have significant fluctuations in how they act and engage with others which can be very distinct and confusing to those around them (example: quiet, withdrawn and conservatively dressed at a party one week, outgoing, loud, flirty and flashy dressed the next week)

B. 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 lifespan. 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.

Sleep Disturbances and disorders are common among those who have ADHD. One of the most commonly reported sleep issues for those with ADHD is delayed sleep phase onset syndrome. Many people see this challenge of a lack of will power, however it is anything but. Those with delayed sleep phase experience their naturally occurring melatonin being delivered an average of 105 minutes later than those without (APSARD, 2024). This means that the natural signals to get tired are significantly delayed. Delayed sleep phase onset syndrome IS a DSM 5 diagnosis and can be included as a diagnosis in an assessment if it is deemed helpful to the client.

Other common sleep disorders in ADHD are:

- ➔ Restless leg syndrome
- ➔ Obstructive Sleep Apnea
- ➔ Narcolepsy: If you suspect a client may have narcolepsy, make sure they get a sleep study as the symptoms of narcolepsy mimic ADHD symptoms almost exactly.

Social Functioning and Impairment: Because ADHD has several different subtypes and a wide variety of expressions, challenges with social functioning can be fairly wide-reaching. However, when looked at closely, all of these challenges are, at the core, caused by issues with executive dysfunction.

Impulsive/Hyperactivity:

- Blurting and interrupting when others are speaking
- Speaking quickly and passionately and over others

- Jumping into the middle of a conversation in a way that, externally, may seem off-topic
- Being physically restless in social settings, constantly getting up and down or fidgeting
- Moving too quickly and missing important information or details needed for whatever social interaction they are engaged in
- Seeming self-centered by telling related stories about their own experiences

Inattentive:

- Becoming distracted or bored and thus zoning out in conversations and thus missing important and/or needed information
- Highly distractible (both internally and externally) and thus can miss social cues because they weren't paying attention
- Becoming easily overwhelmed by and then distracted from communication needed for relationship and social maintenance
- Forgetfulness and inattention to important details needed for events
-

Both:

- Not consistent about responding to emails, texts and voicemails
- Missing events because they weren't on the calendar or where on the wrong day/time
- Forgetting birthdays, anniversaries, and other major life events
- Getting overwhelmed or distracted in social environment which can come off as rude to the people they are interacting with
- Struggling to be on time for events, meetings, etc.
- Can become easily offended and/or emotionally dysregulated when they **feel** the possibility of rejection or misunderstanding, a response which is often disproportionate and caused by a lack of clear communication and clarification.

AUTISM

Mood Fluctuations in Autism are often linked to sensory sensitivities and the impacts of demands on the nervous system. Those with Autism will, at times, experience "Autistic meltdowns" which are times of prolonged distress where caregivers and loved ones struggle to be able to intervene and bring relief. When explored in more detail, mood fluctuations in Autism can usually be connected to an external experience of sensory overwhelm and/or higher demands than they can currently tolerate.

Impulsivity: Most people do not think of impulsivity when considering Autism. It is not a core feature of the disorder, and if it is present in a significant way should be considered as indication of a co-occuring ADHD diagnosis. Impulsivity, however, can be seen in motor-based movements, repetitive behaviors, and outbursts/meltdowns from overstimulation or unmet needs. Impulsivity can also occur in social situations where an Autistic person may blurt out something inappropriate, miss social cues, or is does not comprehend the social impact of a behavior and engages in it impulsively because of peer pressure or wanting to fit in. Those with Autism can also struggle to wait their turn, at times not understanding the "why" behind needing to wait.

Symptom Onset: Symptoms of Autism can often be seen, retrospectively, in childhood. However, especailly for females, symptoms may be significantly masked or they may be taught how to do the desired behavior (example: eye contact). The DSM 5 say **"Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life)."** This is an important consideration when assessing a client because many people have gone undiagnosed with Autism for many, many years. However, if the clinician can get curious about the lived experience of the person in front of them, they will be able to hear whether or not this person experiences symptoms of Autism throughout their lives.

Self Harm: Those who are Autistic have been found to be at notably higher risk for self-harming behaviors than allistic (CITATION). However, self-harm is not a core feature of Autism. Examples of self-harm and self-injury in Autism often include head banging (against hard objects), hitting, biting or scratching ones self, skin picking, hair pulling and head shaking. These behaviors have been found to be fairly specific to those with Autism and are seen in both adults and children. Self-harm and self injury in Autism is used, most often, as a regulation tool. The Autistic person who engages in self harm or self-injury is most often in some kind of emotional distress and is seeking relief. It is not commonly used as a manipulative tool but instead for emotional regulation.

Sleep Disturbances:

- ➔ Insomnia
  - ◆ Those with autism take an average of 11 minutes longer than others to fall asleep at night (Furfaro, 2020)
  - ◆ Those with autism experience less restorative sleep than others. They spend 15% in REM as compared to 23% for neurotypical people (Furfaro, 2020)
  - ◆ "80 percent of autistic preschoolers have disrupted sleep" (Furfaro, 2020)

- ➔ Sleep Difficulties and Disorders in Autism Spectrum Disorder
  - ◆ "Problems with sleep quality related to ASD symptoms also may be experienced including sensitivity to stimuli in sleeping environment, parasomnias, insomnia or difficulty falling asleep, night waking and screaming, sleep-disordered breathing, restless sleep, sleep talking and walking and early morning waking" (Richdale & Johnson, 2020)

- ➔ Autistic people have been found to produce a decreased levels of melatonin which is essential for restful sleep (Yenen & Cak, 2020)

(Issues with) Social Functioning and Impairment is a core feature of Autism. The first diagnostic criteria states "persistent deficits in social communication, and social interactions across multiple contexts (current and/or historical). The DSM 5 then proceeds to outline how these deficits and impairments appear in daily life for the Autistic person. Even if the person has masked their social challenges, they will still be able to report on the internal experience of the distress and discomfort which can be caused by social interactions.

04. DIFFERENTIAL DIAGNOSTIC CHALLENGES

A. NEGATIVE LIFE OUTCOMES

1. All four of these disorders can have a significantly negative impact on the quality and length of a person's life. These impacts include, but are not limited to:
    - ➢ School interruption and non-completion
    - ➢ Recurrent job loss
    - ➢ Separation or divorce
    - ➢ Substance use/abuse
    - ➢ Addictions
    - ➢ Significant relational issues with family, friends and co-workers
    - ➢ Money challenges
    - ➢ Legal issues

2. When assessing a client for these, and other, disorders, it is essential to take the time to determine the cause(s) of these negative outcomes. This takes patience, time, and insightful questioning. It is important **not** to assume the cause of these outcomes are only based on a person's background or environment.

3. Poverty, systemic racism and injustice, epigenetics, intergenerational trauma, abuse, neglect, and more can contribute to many of the challenges clients face. However, it is important to dig into the client's lived experience to determine, as much as possible, if there are mental health challenges which are also contributing to the life outcomes the client is experiencing.

4. Remember! All four of these discussed disorders are genetically passed down from parents to children.

B. EMOTIONAL DYSREGULATION

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

- ➔ **Differential Considerations**
    - ◆ Activating Event(s)
        - 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
        - Borderline Personality Disorder: Fear of abandonment, being left alone, or not being special/significant in another's life; fear of feelings of emptiness

- ADHD: (Exaggerated) response to often unexpected stimuli, perceived or actual rejection and/or misunderstandings, or overwhelm.
- Autism: Sensory overload/overwhelm, too much social interaction, demands placed on them (or their nervous system) which feel like it is too much for them to handle.

◆ Intensity, duration, and recovery from emotional dysregulation

- Bipolar: Intensity = if cycling, expect disproportionate intensity when manic or hypomanic, and hypoarousal when depressed duration = predictable when cycles are tracked recovery = often fairly short if towards mania, longer if towards depression
- Borderline Personality Disorder: Intensity = excessive and can be dangerous, duration = situationally dependent, it will last until the goal is achieved recovery = only once the threat of "abandonment" is no longer present.
- ADHD: Intensity = disproportionate to stimuli, duration = usually short lived recovery = often quick
- Autism: Intensity = can range from mildly to very intense, depending on a variety of factors duration = as long as it takes for the person to be able to re-regulate. Autistic meltdowns can last for some time and are often unresponsive to interventions and supports recovery = can be slow and requires rest and activities which are rejuvenating to the person.

c. Skill and "Functional" Regression

Each of these four disorders can, at times, present with skill and/or "functional" regression. When looked at closely, these regressions often have distinct characteristics. Yet, this aspect of these diagnoses can regularly lead to misdiagnoses because of the complexities of the overlap and a limited understanding of these experiences in each disorder.

Bipolar Disorders: When manic/hypomanic, those with Bipolar often are capable of significant executive functioning. However, they are unable to maintain this level of executive functioning when in a mixed or depressive state. This is significant skill and functional regression, which is cyclically dependent and happens consistently throughout the course of a bipolar cycle.

Borderline Personality Disorder: Skill and functional regression in borderline personality disorder is utilized intentionally to prevent abandonment and to help them avoid feelings of emptiness. The person with borderline will become unable to do basic skills and life functions without significant help because it requires the people or person in their lives to be more needed and thus more likely to stay. These skill and functional regressions, which are often episodic, do not come with the level of shut down and other symptoms which we see in a bipolar disorder depressive cycle or in Autistic burn out.

ADHD: Skill and functional regression can, at times, be seen in ADHD. However, it is more often an actual skill deficit than a regression. It is most often described as a frustration others have with the

person who has ADHD that they seem to be able to do certain skils and executive functions in one setting (example: work or a hobby) but not another (such as home or at school). This skill inconsistency can, from the outside, appear willful and manipulative. However, it is actually caused by the fact a person with ADHD is interest driven. Their ability to focus and engage is at a significantly higher level when they are interested in what they are doing. Sadly, this is not something a person with ADHD can directly control, and is often a frustration to both themselves and others. Another time when skil and functional regression can be seen in ADHD is when the responsibilities and demands of life exceed the person's capacity to cope. This is often seen in new moms who are coming in to be assessed for the first time, or students who are transitioning to college and really struggle with new found freedom and lack of structure.

Autism: Skill and functional regression is seen in Autism quite often, especially when someone is coming in to be assessed. Skill and functional regression is a key part of autistic burnout, which many Autistic people experience at various points throughout their lives. When this happens, the Autistic person may be unable to do daily life tasks they were able to do before, struggle with communication, work responsibilities, and interpersonal relating, they may even become selectively mute at times. Skill and functional regression can bring on significantly more physically based behaviors, such as head banging, rocking, arm flapping, stimming, and echolalia. More repetitive and rigid behaviors are often engaged in when someone is in Autistic burnout and the "regression" can often include to safe foods, environments, and life patterns. From a lay prospective, people may say that the person is "becoming more Autistic" but this is an inaccurate why of describing what is happening.

D. Executive Functioning Challenges

- Bipolar Disorder, Borderline Personality Disorder, ADHD, and Autism 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 four 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.

E. Assessing Executive Functioning Challenges

- **Bipolar Disorder:** Before the onset of bipolar disorder, consider if the client had any 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.

- **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. Their executive dysfunction is inconsistent, and cannot be documented as a consistent and ongoing issue in the client's life.

- **ADHD:** Executive dysfunction is the core diagnostic feature of 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. . All of the diagnostic criteria are linked to a chronic, persistent, and life-disrupting inability to consistently executively function. Those with ADHD do not use their executive dysfunction as a way to manipulate people, though they can, at times, experience learned helplessness because of the lifelong nature of these challenges.

- **Autism:** Autistic people experience a range of challenges with executive dysfunction. Each person's presentation of executive functioning challenges in Autism will be unique to the person. However, there are some which are more common in this diagnosis: communication challenges, rigid thinking, planning and organizing tasks/activities, consistency in daily tasks, and sustaining attention when uninterested. Executive functioning difficulties in Autism are seen across the life span. When an Autistic person is passionate about or highly motivated to do something, they often can overcome their executive functioning challenges. It is important to note that this not something they do to manipulate or try to control people to stay in their lives.

F. 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 assess, as fully as possible, other aspects of the client's lived experience before making a diagnosis.

G. 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.

H. Let's talk about Borderline Personality Disorder

J. What about PMDD?