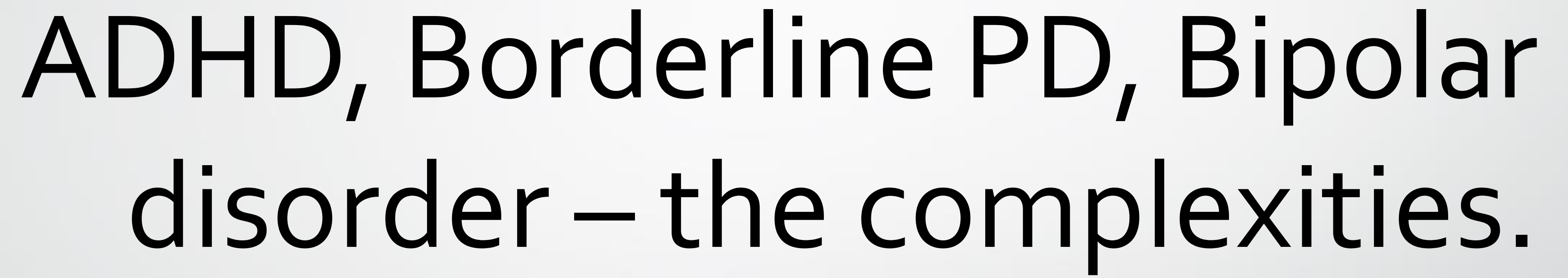

ADHD, Borderline PD, Bipolar disorder – the complexities.

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Objectives

- To go through the criteria of individual disorders.
- To gain an understanding of overlapping symptoms.
- Potential strategies for diagnostic pointers.

Scenario

- 30 year old female presenting with stress, low mood after the break up of a relationship. Previous history of self harm and overdoses. Gives history of mood swings and hyperactivity. Currently, informing you during the consultation about her thoughts of harming herself. What more can you explore in the 10min consultation.
- Differential diagnosis ??

ADHD – criteria

- Persistent pattern of instability and/or hyperactivity-impulsivity that interferes with functioning or development as characterized by
- **Inattention** and /or **hyperactivity and impulsivity**
- **For adults – 5 out of the 9 symptoms from the above domains.**
- persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities :

ADHD- criteria

- Several symptoms present prior to the age of 12 years.
- **Two or more settings** (e.g. at home, school or work, with friends/relatives; in other activities).
- Evidence of **interference in social, academic and occupational functioning.**
- Symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder – not better explained by another mental disorder.
- **Combined / Predominantly inattentive/ Predominantly hyperactive/impulsive presentation.**
- **Mild, Moderate and Severe.**

ADHD – behavioural manifestations

- **Inattention** – wandering off the task, lacking persistence, having difficulty sustaining focus, being disorganized – not due to defiance or lack of comprehensions.
- **Hyperactivity** – excessive fidgeting, tapping, or talkativeness, extreme restlessness and wearing others out with their activity.
- **Impulsivity –** hasty actions that occur in the moment without forethought and that have high potential of harm to the individual, social intrusiveness, making important decisions without consideration of long term consequences.
- **Symptoms vary depending on the settings** – may be minimal in novel setting – interesting activities, external stimulation, one to one interaction

ADHD – associated features

- Low frustration tolerance, irritability or mood lability
- Increased risk of suicide when comorbid with mood, conduct or substance use disorders.
- 5% children and about 2.5% adults. (males > females 1.6:1 – adults).
- Substantial proportion of children with ADHD remain relatively impaired into adulthood.
- Adulthood – inattention and restlessness + impulsivity remain problematic even when hyperactivity has diminished.
- Substantial heritability.

ADHD – functional consequences

- **Functional consequences :**
- Poorer occupational performance, attainment, attendance and higher probability of unemployment, elevated interpersonal conflict.
- Antisocial PD, substance use disorder, incarceration
- Traffic accidents, violations.
- Laziness, irresponsibility, or failure to cooperate, family discord, Peer neglect/rejection, negative interactions.

ADHD – Differential diagnosis/ Comorbidity

- Autism Spectrum Disorder - (indifference to communication cues).
- Anxiety disorder - (inattention due to worry and rumination).
- Depressive disorder – (poor concentration due to mood).
- Bipolar disorder – (episodic, and other specific bipolar features).
- Substance use disorders – clear evidence of what came first may be reqd.
- Personality disorders – disorganization, emotional/cognitive dysregulation.

ADHD – Rx strategies.

- Stimulant medications.
- Non-pharmacological interventions – support groups, skills training, coaching, CBT based interventions and counselling, self help for self management.

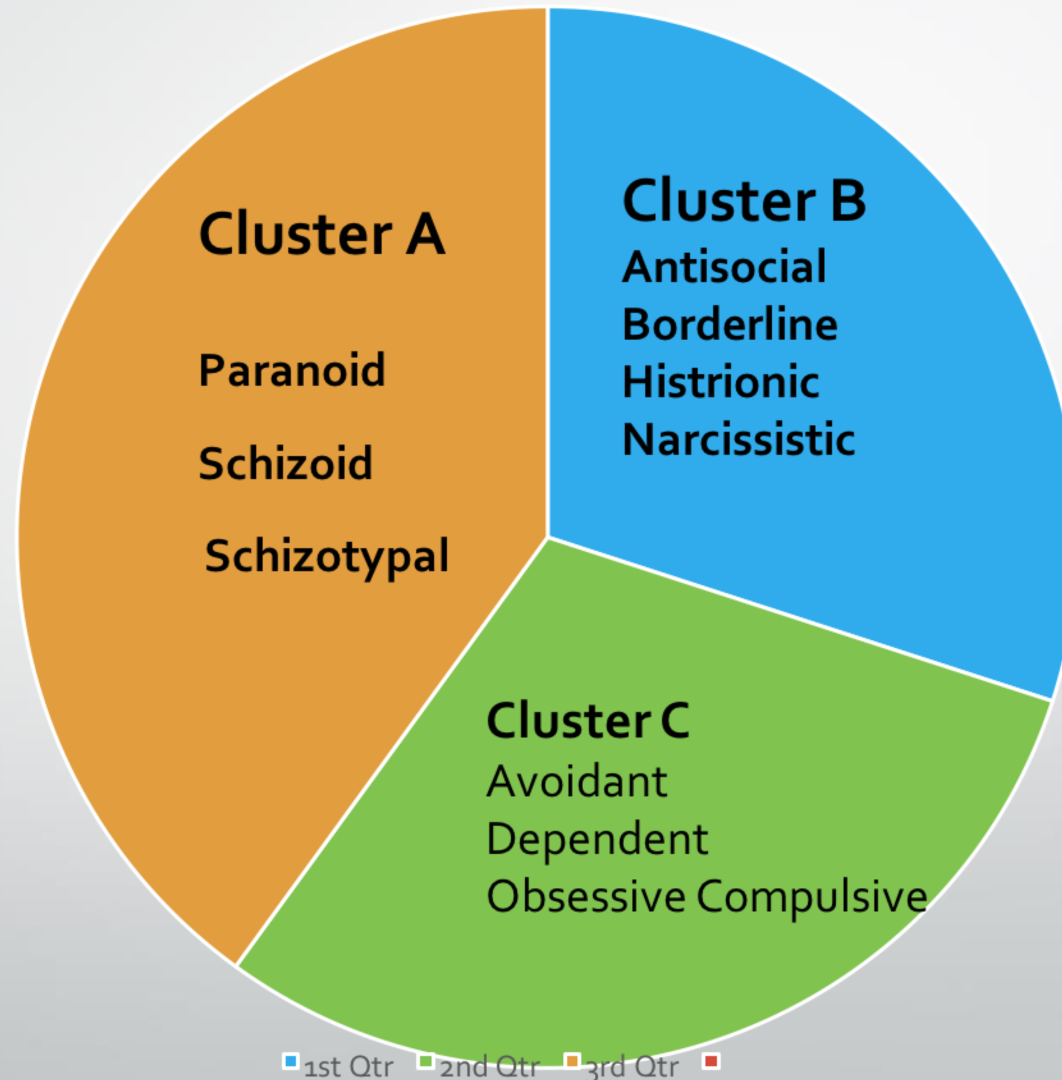
General Personality disorder

- Manifested in two (or more) areas :
- **Cognition (i.e. way of perceiving and interpreting self, others, & events)**
- **Affectivity (i.e. range, intensity, lability, appropriateness of emotional response).**
- **Interpersonal functioning.**
- **Impulse control**
- **Not explained by another mental disorder, substance effects, another medical condition.**

Personality Disorders – why bother ?

- High prevalence
- Community samples - up to 10.3%
- Psychiatric outpatients - from 39% to 67%
- Up to 40% of patients under CMHTs have at least one personality disorder
- Inpatients 25%- up to 50%.

Clusters



Borderline Personality disorder

- Frantic efforts to avoid real or imagined abandonment.
- Unstable and intense interpersonal relationships
- Markedly and persistently unstable self image or sense of self.
- Impulsivity
- Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour
- Affective instability due to a marked reactivity of mood.
- Inappropriate, intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociative sx.

Borderline PD – relevant issues.

- Intense abandonment fears and inappropriate anger.
- Abandonment implies they are "bad"
- Abandonment fears related to intolerance of being alone
- Efforts to avoid abandonment include impulsive actions – self mutilating or suicidal behaviours.
- Idealization and Devaluation – sudden and dramatic shifts in their views of others.
- Impulsivity – gamble, spend money irresponsibly, binge eat, abuse substances, unsafe sex, drive recklessly, recurrent suicidality.

Borderline PD – relevant issues

- Marked reactivity of mood – extreme reactivity to interpersonal stresses
- Extreme sarcasm, enduring bitterness, verbal outbursts.
- Recurrent job losses, interrupted education, separation/divorce
- Physical and sexual abuse.
- Co-morbid – depressive and bipolar disorders, substance use disorders, eating disorders, ADHD, plus other personality disorder.
- Significant heritability
- Early onset and long standing course.

The last thing a psychiatrist wants to hear when treating someone with a multiple-personality disorder:

Gee, Doc! I feel like a brand new person!

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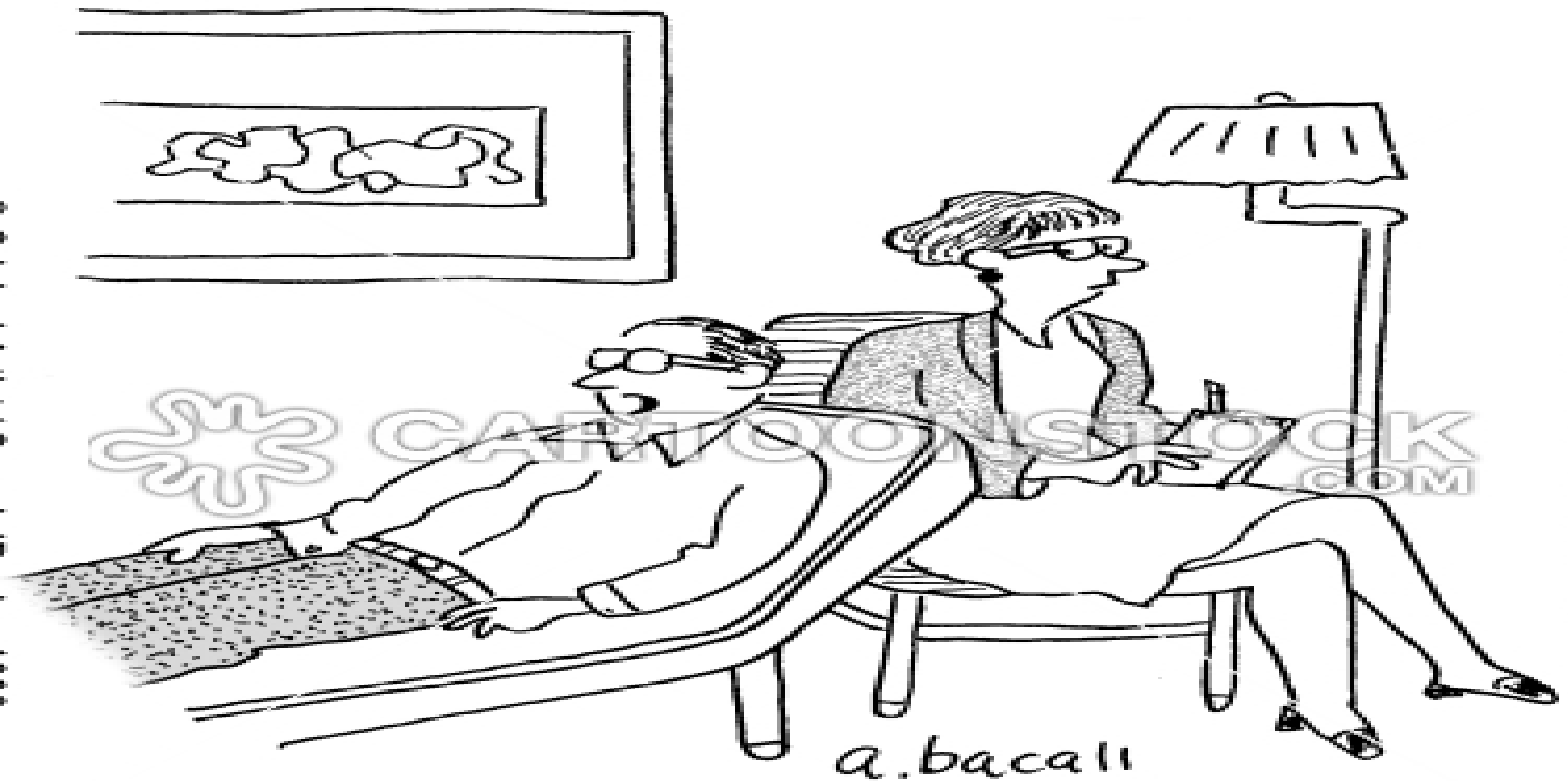
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a.bacall
"I have multiple personalities and they are all following me on Twitter."

Usual questions about Borderline PD

- Have you often become frantic when you thought that someone you really cared about was going to leave you ?
- Do your relationships with people you really care about have lots of extreme ups and downs ?
- Have you all of a sudden changed your sense of who you are and where you are headed ?
- Have you done often done things impulsively (spending, sex, subs abuse, reckless driving, binge eating) ?

Usual questions about Borderline PD

- Have you tried to hurt or kill yourself or threatened to do so ?
- Do you have a lot of sudden mood changes ?
- Do you often feel empty inside ?
- Do you often have temper outbursts or get so angry that you lose control

Quality statement (NICE GUIDELINES)

People with borderline or antisocial personality disorders are prescribed antipsychotic or sedative medication only for short-term crisis management or treatment of comorbid conditions.

RATIONALE

No drugs have established efficacy in treating or managing borderline or antisocial personality disorder. However, antipsychotic and sedative medication can sometimes be helpful in short-term management of crisis (the duration of treatment should be no longer than 1 week) or treatment of comorbid conditions.

The NICE guideline on borderline personality disorder recommends:

Psychological therapies for managing and treating the disorder. Because of the variety of symptoms and the variation in needs, flexible approaches that are responsive to the needs of each person with personality disorder are important. Involving people with borderline personality disorder in decisions regarding their own care is key for their engagement with treatment.

When a person with an established diagnosis of borderline personality disorder presents to primary care in a crisis: (NICE Guidelines)

Assess the current level of risk to self or others

Ask about previous episodes and effective management strategies used in the past

Help to manage their anxiety by enhancing coping skills and helping them to focus on the current problems

Encourage them to identify manageable changes that will enable them to deal with the current problems

Offer a follow-up appointment at an agreed time.

Bipolar Disorders

- Bipolar I Disorder – manic episode – a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week.

- Bipolar II Disorder - current or past hypomanic episode – as above but for at least 4 days – not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation.

- A common associated feature – Impulsivity – suicide attempts and substance use disorders.

Summary of Overlapping symptoms

- Impulsivity
- Affective instability
- Inattention and lack of concentration
- Hyperactivity, restlessness, agitation
- Impairment in various domains

Strategies for diagnosis/ Take Home Message

- Careful and systematic assessment of developmental psychiatric history
- Current mental state examination
- Adult psychiatric history
- Supporting evidence from informants
- Chronic emotional instability and affect storms of personality disordered patients vs. truly hypomanic or manic behaviour

Strategies for diagnosis/ Take home message

- General nature of patient's relationships with significant others
- Capacity to assess others in depth
- Chronic interpersonal conflicts
- Difficulties in maintaining stable commitments to work and profession as well as to intimate relationships
- Shifts of symptomatology according to difficult social circumstances
- Analysis of environmental triggers
- Information about ADHD symptoms predating symptoms of pd
- ADHD vs. Bipolar – Episodic nature

Psychiatric and Psychological interventions at Spire

- Detailed Psychiatric Diagnostic assessment and treatment plan
- Psychopharmacological interventions – medication monitoring
- **Counselling, Stress Management, Solution focused therapy, CBT/DBT based interventions , Individual and Couple therapies – via – Mrs. Sukhjit Sambhi – Individually tailored interventions**
- **Psychiatric Assessments offered via GP referrals to me – via Secretary at Spire Yale Hospital.**
- **Psychological interventions either by direct patient contact or GP referrals addressed to Mrs. Sukhjit Sambhi – via Spire Yale Administration Team.**

You know I charge extra
for bipolars and people
who are borderline.
Their moods change too
much to keep up with.
Also, for multiple
personality disorder,
I charge for each
personality.

ROTTENeCARDS USER CARD

Please ask questions.
Thank you for your kind attention