
SAQ

Don’t panic! Distinguishing between borderline, bipolar, and ADHD patients

Fiore Lalla, MDCM, FRCP

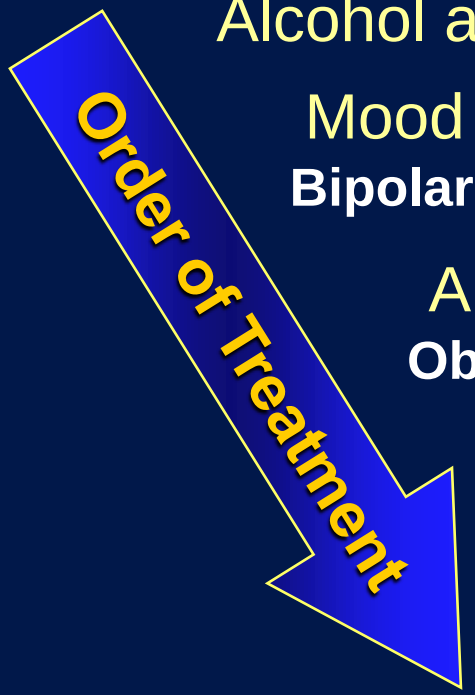
Divulgation des conflits d'intérêts

Conseil consultatif ou comité analogue	
Essais cliniques ou études	
Honoraires ou autres revenus	Valeant, BMS, Otsuka, Eli Lilly, Lundbeck, Janssen, Shire
Subventions de recherche	

Riddle me this….

- Rapid cycling bipolar disorder is a stable subtype of the illness: T/F
- 15 years into borderline history, a patient has what probability of remission:20, 40, 65, 75%?
- Up to how many adhd patients are borderline: 15,30,35 %
- What is the most frequent presentation of a borderline in family practice: suicidality, depression, somatization, or anxiety?
- Which class of drugs appears to cover the most symptom types in borderline? Antidepessants, mood stabilizers, or antipsychotics?
- *In the community,* what is the F:M ratio of borderlines: 5:1, 3:1, 1:1?

Case Presentation: Diagnostic Prioritization for Pharmacotherapy



Alcohol and substance abuse

Mood disorders and active Borderline pathology

Bipolar and MDD

Anxiety disorders

Obsessive-compulsive disorder, generalized anxiety disorder, panic

ADHD

Order of treatment also considers the severity of the concurrent disorders.

Goodman D. Treatment and assessment of ADHD in adults. In: Biederman J, ed. *ADHD Across the Life Span: From Research to Clinical Practice—An Evidence-Based Understanding.* Hasbrouck Heights, NJ: Veritas Institute for Medical Education, Inc.2005.

Borderline ⇄ Bipolar

Borderline personality disorder: Commonly reported features

Impulsivity
Unstable relationships
Unstable self-image
Affective instability
Fear of abandonment
Recurrent self-injurious or suicidal behavior
Feelings of emptiness
Intense anger or hostility
Transient paranoia or dissociative symptoms

Over 50% of consultation requests reaching psychiatrists (second line) For evaluation at Lakeshore Hospital site, CIUSSS West Island Montreal Suffer from BPD, undiagnosed for the most part at least a decade.

Clinician biases that may favor a bipolar disorder diagnosis, rather than BPD

Bipolar disorder is supported by decades of research
Patients with bipolar disorder are often considered more “likeable” than those with BPD
Bipolar disorder is more treatable and has a better long-term outcome than BPD (although BPD is generally characterized by clinical improvement, whereas bipolar disorder is more stable with perhaps some increase in depressive symptom burden)
Widely thought to have a biologic basis, the bipolar diagnosis conveys less stigma than BPD, which often is less empathically attributed to the patient’s own failings
A bipolar diagnosis is easier to explain to patients than BPD; many psychiatrists have difficulty explaining personality disorders in terms patients understand

BPD: borderline personality disorder

Borderline Personality in the Medical Setting

Randy A. Sansone, MD, and Lori A. Sansone, MD

- Patients with borderline personality disorder tend to present with different symptoms **as a function of treatment setting.**

- **Mental health settings: present with relationship difficulties, mood lability/dysphoria, and graphic self-harm behavior**.

- ***In primary care settings, patients with this disorder tend to present with pain sensitivity and somatic preoccupation***.

- The characteristic symptoms observed in patients with borderline personality in primary care settings (ie, pain sensitivity/syndromes, somatic preoccupation) have been described in the literature by a number of clinicians and verified by a number of investigators, including the authors.

EPIDEMIOLOGY

- The point prevalence of BPD is 1.4 percent and the **lifetime prevalence is 5.9 percent**. (vs 1-2.5% Bipolar I and ll)
- Studies in clinical settings found BPD was present in **6.4 percent of urban primary care patients**, 9.3 percent of psychiatric outpatients, and approximately 20 percent of psychiatric inpatients
- The ratio of females to males with the disorder is greater in clinical populations than it is in the general population. **The ratio is 3:1 in clinical settings**.
- Multiple epidemiologic surveys of the United States general population have found the lifetime prevalence of BPD **does not differ significantly between men and women.**
- This discrepancy suggests that **women with BPD** are more likely to seek treatment than men.
- In a study of patients with BPD, men and women were found to have **similar rates of childhood-trauma** history and levels of current psychosocial functioning.

Manifestations of Primitive Ego Defenses: The Difficult Patient in the Medical Setting

- **Splitting**: Keeping completely apart two opposite ideas and their associated feelings. Staff are divided into “good ones” and “bad ones,

- **Projective identification**: The tendency to see some staff as “bad” as the patient feels.

- **Primitive idealization**: The tendency to see some staff as totally “good” to protect the patient from “bad” staff or from the patient's medical condition.

- **Omnipotence and devaluation**: A shift (splitting) between the need to establish a relationship with a magical, powerful staff (primitive idealization) versus the conviction of omnipotence in the self that makes all others impotent by comparison

Distinguishing bipolar, borderline (BPD), and adhd

- Probably the most important distinguishing characteristic is that the borderline displays symptoms and behaviors in response to a perceived environment that is rejecting or invalidating.
- The other patient types display their symptoms across environments, often without provocation and independent of stimulus or stress.
- Overlap of borderline and bipolar diagnoses not frequent (less than 10% in each).
- The borderline wants a bipolar diagnosis, and 40% of BPD get that diagnosis!

Key distinguishing features

Quality of mood episodes

Types of impulsivity

Longitudinal course

Prognosis

The natural history of bipolar disorder often includes periods of remission, but recurrence is normal, particularly if adherence to treatment is poor. The polarity of the index episode can predict the polarity of subsequent episodes.[58] Patients with a depressive predominant polarity are most likely to attempt suicide, have a depressive onset, and be diagnosed with bipolar II disorder that follows a seasonal pattern.[59] Conversely, with a manic predominant polarity, drug misuse is common and patients usually present at a young age with a manic episode and have bipolar I disorder.[60] In a 15-year follow-up study, patients with bipolar I[61] and bipolar II[62] disorder had euthymia for about half the study period, with depression being the most prevalent mood state, reported during 31% and 52% of the study, respectively. Mixed episodes, hypomania, or mania were recorded for 1·6% and 10% of the study, respectively. Subsyndromal states were three times more common than full syndromal episodes.[61,62]

Mood differences

- In BPD, mood swings, usually of negative affect, are triggered by interpersonal stressors or perceived stressors, are transient, last from minutes to hours, and are highly dependent on the environment.
- In bipolar disorder, mood swings are more spontaneous and of longer duration (weeks/months not hours/days), especially for bipolar I disorder, and there are *extended periods of elation.*
- In addition, in bipolar disorder, acute episodes and symptom-free intervals occur, while in BPD, the affective instability is part of a characteristic pattern of emotional responding
- Rapid cycling mood states are rarer and ***transitory***

REVIEW ARTICLE

Rapid Cycling in Bipolar Disorder: A Systematic Review

André F. Carvalho, MD, PhD; Dimos Dimellis, MD, PhD; Xenia Gonda, MA, PharmD, PhD; Eduard Vieta, MD, PhD; Roger S. McIntyre, MD, FRCPC; and Konstantinos N. Fountoulakis, MD, PhD

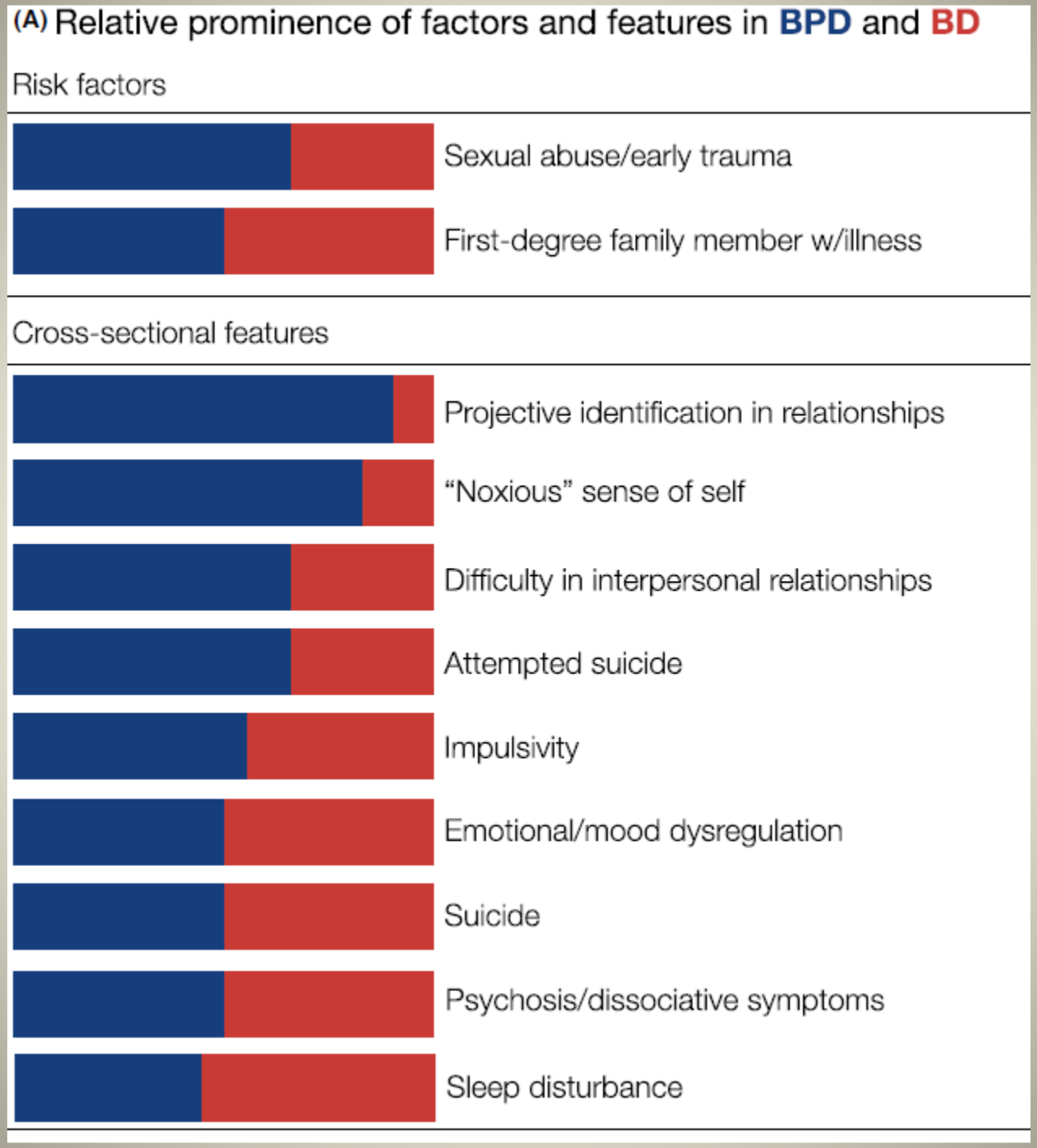
The only confirmed close relationship of rapid cycling is that to female gender, while connections to specific bipolar subtype, depressive predominant polarity, treatment with antidepressants, and several biological factors are not universally accepted or documented beyond doubt.

Impulsivity

- Clinically, impulsivity is believed to be more episodic in bipolar disorder than in BPD, although inter-episode impulsivity is seen in bipolar disorder when comorbid substance abuse complicates the clinical picture.
- Impulsive acts such as suicidal behavior occur in both disorders, but in bipolar disorder these are predominantly found in the *depressive phase and they are related to hopelessness while in BPD, they are often a function of the inability to tolerate acute distress and made out of anger*

Course

- Many cases of bipolar disorder assume a chronic depressive course, with long-term morbidity and substantial inter-episode symptomatology, whereas multiyear follow-up studies of patients with BPD have found that most people eventually stop meeting threshold criteria for the disorder


(A) Relative prominence of factors and features in BPD and BD
Risk factors
Sexual abuse/early trauma
First-degree family member w/illness
Cross-sectional features
Projective identification in relationships
"Noxious" sense of self
Difficulty in interpersonal relationships
Attempted suicide
Impulsivity
Emotional/mood dysregulation
Suicide
Psychosis/dissociative symptoms
Sleep disturbance

Diagnosing borderline personality disorder

Robert S. Biskin MD, Joel Paris MD

Retrospective studies have shown that symptoms resolve over time, with 75% of patients at 15-year follow-up and 92% of patients at 27-year follow-up no longer having the disorder.[8,9] One large, well-conducted 10-year prospective study found that 93% of those with borderline personality disorder had at least a 2-year period of remission, but only 50% also attained good psychosocial functioning.[10]

‘DARE’ to spot borderline personality disorder

Lorraine S. Roth, MD

- Depression, destruction, denial, denigration
- Anger, abandonment, abuse
- Relationships, regrets, repetition
- Extremes, emergencies, ennui, emptiness
- (BPD is an illness of self, identity, and stress related reactions)

McLean Screening Instrument for Borderline Personality Disorder

1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?	1 = yes 0 = no
2. Have you deliberately hurt yourself physically (e.g., (punched yourself, cut yourself, burned yourself)? How about made a suicide attempt?	1 = yes 0 = no
3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)?	1 = yes 0 = no
4. Have you been extremely moody?	1 = yes 0 = no
5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?	1 = yes 0 = no
6. Have you often been distrustful of other people?	1 = yes 0 = no
7. Have you frequently felt unreal or as if things around you were unreal?	1 = yes 0 = no
8. Have you chronically felt empty?	1 = yes 0 = no
9. Have you often felt that you had no idea of who you are or that you have no identity?	1 = yes 0 = no
10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?	1 = yes 0 = no

Zanarini BPD screening instrument: Francais

1) Est-ce qu'il vous est déjà arrivé que vos relations les plus proches aient été perturbées par beaucoup d'arguments ou des ruptures répétées ?

2) Est-ce que vous vous êtes déjà automutilé(e)s (ex. en vous coupant, en vous brûlant, en vous donnant des coups) ? Avez-vous déjà fait une tentative de suicide ?

3) Avez-vous déjà eu au moins 2 autres problèmes d'impulsivité ? (ex. surconsommation de nourriture, d'argent ou d'alcool, des emportements ou des crises verbales, etc.)

4) Avez-vous déjà été d'humeur changeante ?

5) Est-ce que vous avez déjà ressenti beaucoup de colère et ce de façon fréquente ? Avez-vous déjà souvent réagi de façon sarcastique ou colérique ?

6) Est-ce que vous vous êtes déjà méfié(e)s d'autres personnes et ce de façon fréquente ?

7) Est-ce que vous vous êtes déjà senti(e)s surréel(le) ou comme si tout ce qui vous entourait était surréel ?

8) Est-ce que vous vous êtes déjà senti(e)s chroniquement vide ?

9) Est-ce que vous avez déjà senti que vous ne vous connaissiez pas ou que vous n'aviez pas d'identité ?

10) Avez vous déjà fait des efforts désespérés pour éviter de vous sentir abandonné(e) et/ou pour éviter d'être abandonné (ex. appeler quelqu'un de façon répétitive pour vous assurer que vous êtes importants pour eux, leur prier de rester avec vous, leur tenir physiquement)?

IDESPAIRR: A Mnemonic for Diagnosing BPD	
DSM-5 Criteria	**Suggested Diagnostic Questions**
Identity disturbance	"Do you have a sense of where you're going in life?"
Disordered mood	"Do you find that your mood changes a lot in the course of the day?"
Emptiness	"Do you feel empty inside, as if there's nothing there?"
Suicidality	"Have you ever thought of suicide, and have you made an attempt?"
Paranoia	"Do you feel when you're outside that strangers are looking at you, commenting on you, and probably criticizing you?"
Abandonment intolerance	"When you start a relationship, do you feel that you're going to be dumped from day one?"
Impulsivity	"Have you engaged in reckless behavior involving money, sex, driving, drugs or alcohol, or eating?"
Rage	"Would people describe you as having a short temper?" "Do you lose control when you get mad?"
Relationship problems	"What happens to you in a close relationship?"

Screening for Bipolar Disorder and Finding Borderline Personality Disorder

Mark Zimmerman, MD; Janine N. Galione, BS; Camilo J. Ruggero, PhD; Iwona Chelminski, PhD; Diane Young, PhD; Kristy Dalrymple, PhD; and Joseph B. McGlinchey, PhD

Conclusions: Positive results on the MDQ were as likely to indicate that a patient has borderline personality disorder as bipolar disorder. The clinical utility of the MDQ in routine clinical practice is uncertain.

Determining if Borderline Personality Disorder and Bipolar Disorder Are Alternative Expressions of the Same Disorder: *Results From the National Epidemiologic Survey on Alcohol and Related Conditions*

Iris de la Rosa, MD; et al.

J Clin Psychiatry 2017;78(8)

- A model with 3 positively correlated factors provided an excellent fit for the latent structure of borderline personality disorder and bipolar disorder symptoms
- Correlations between the 3 factors are consistent with the clinical presentation of 2 syndromes (depression and mania) that can be characterized as a unitary psychiatric entity (bipolar disorder) and a third syndrome (borderline personality disorder)
- The findings converge in suggesting that bipolar disorder and borderline personality disorder are overlapping but ***different pathologies***.

J Psychiatr Res. 2017 Aug;91:90-97

Unblending Borderline Personality and Bipolar Disorders.

di Giacomo E, Aspesi F

"Borderline Personality and Bipolar Disorders can be distinguished with high precision using common and time-sparing tests. The importance of discriminating these clinical features may benefit from this evidence."

ham-a, ham-d, ymrs, borderline personality severity index used in patients having received mental health care, diagnoses confirmed previously with scid 1 and 2

All the tests statistically discriminated the disorders ($p < 0.0001$).

Comorbidity proved to be extremely small (3.6%)

"Some key symptoms were essential in differentiating the disorders. A sense of guilt, depersonalization, irritability, lack of insight, and paranoid ideation were able to separate even bipolar patients and borderline personality patients with a comorbid manic episode (YMRS score > 20)"

(B) Efficacy of treatments across **BPD** and **BD**

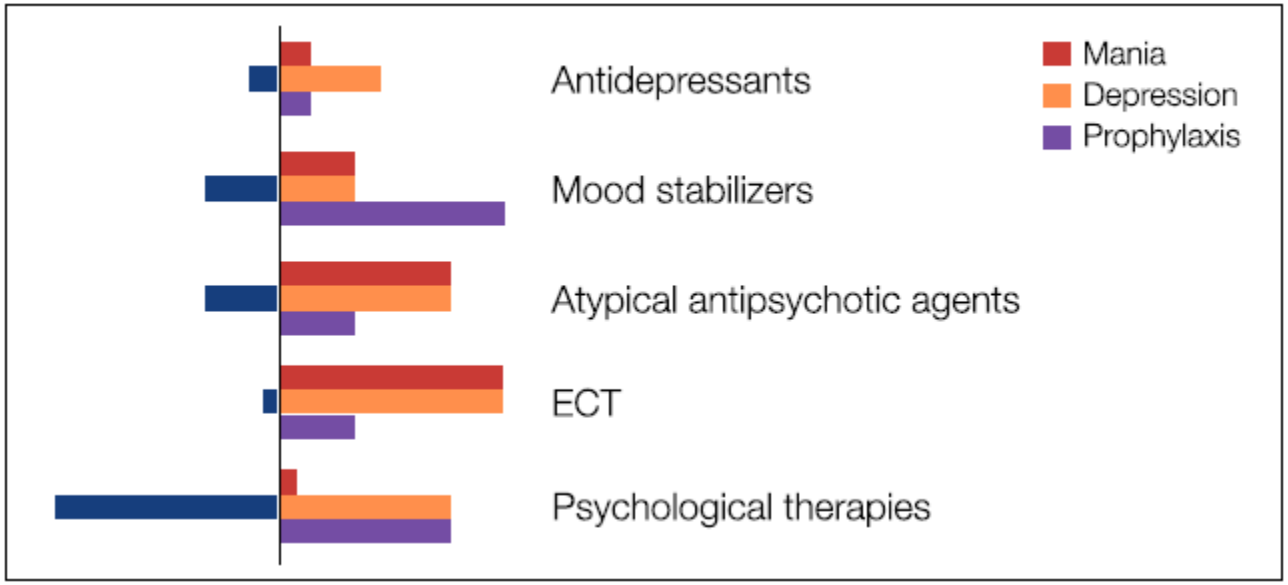


TABLE 6–1. Current status of pharmacotherapy for borderline personality disorder (BPD)

- About 30 randomized controlled trials have been conducted (antipsychotics > antidepressants > mood stabilizers > others), usually with small samples (average size about 40), variable outcome measures, and limited duration.
- No medication is uniformly or dramatically helpful.
- No drug has been licensed by the FDA as an effective treatment for BPD.
- Pharmaceutical company–sponsored research has been limited by disproportionate fears of violent or suicidal acts in patients who receive or do not receive medications—both incurring possible liability.
- Polypharmacy is associated with multiple side effects, and the effects of augmentation are unknown.
- The number of medications taken is inversely related to improvement.
- Minimal attention has been given to medication effects on interpersonal relationships.

Proof of concept study proposal

- 7 recent patients referred to me by first line mental health services at LGH
- Referred for mood disorder resistance or suspicion of borderline pd, I confirm bpd.
- Diagnosed by myself and treated an average of 6-8 months before DBT started
- 5f, 2m; interview and scales show mild comorbid depression.
- All have tried antidepressants and atypical AP for months in the past: completely ineffective.
- All showed significant and measureable differences in all bpd symptom spheres within weeks at doses of latuda add-on 20-40 milligrams daily
- Only one stopped, because of improvement
- All patients state this has been the most useful medication taken in last years
- Stimulus for further research?

Effectiveness of dialectic behavioral therapy in routine outpatient care: the Berlin Borderline Study

Christian Stiglmayr[1*], Julia Stecher-Mohr[2], Till Wagner[2], Jeannette Meißner[2], Doreen Spretz[3], Christiane Steffens[3], Stefan Roepke[4], Thomas Fydrich[2], Harriet Salbach-Andrae[5], Julian Schulze[3] and Babette Renneberg[3]

Results: Patients significantly improved regarding self-injurious behaviors, number of inpatient hospital stays, severity of borderline symptoms and psychopathology. At the end of the first treatment year, 77% of the patients no longer met criteria for BPD diagnosis. Fewer therapy discontinuations by patients were observed when therapists participated in consultation teams.

Conclusions: Under routine mental health care conditions in Germany, outpatient DBT leads to positive results comparable to those reported in other effectiveness studies and in randomized controlled trials.

Dialectical Behavior Therapy Life Enhancement Skills At A Glance

Skills Training AAA Model

Awareness
Acceptance
Action

Core Mindfulness Skills

What Skills	How Skills
Observe	One-mindfully
Describe	Effectively
Participate	Non-judgmentally

Reality Acceptance Skills

Pain + Non-acceptance = Suffering

- Radical Acceptance
- Turn the Mind
- Practice Willingness
- Notice Willfulness
- Loving Kindness

Distress Tolerance Skills

Temperature
Intense physical sensations
Paced breathing
Paired Muscle Relaxation

Stop what you are doing
Take some deep breaths
Observe the situation
Proceed effectively

Activities
Contributing
Comparisons
Emotion opposites
Pushing away
Thoughts
Self-soothe with the senses

Imagery
Meaning
Prayer
Relaxation
One thing at a time
Vacation
Encouragement

Create SMART Goals

Specific
Meaningful
Achievable
Recordable
Timeline plan

VITALS to Success

Validate
Imagine
Take small steps
Applaud yourself
Lighten your load
Sweeten the pot

Emotion Regulation Goals

- Identify, label, understand emotions
- Decrease unwanted emotion responses
- Decrease emotional vulnerability

Emotion Regulation Skills

- Identify, label, functions of emotions
- Mindful to emotions
- Check the facts of emotion responses
- Behavior chain analysis
- Problem solving
- Pros and cons
- Opposite action to emotion urges
- Respecting emotions
- Managing extreme emotions

Accumulate positive emotions
Build skills mastery
Cope ahead for emotional events

treat
Physical
i**L**lness
Eat balanced meals
Avoid drug use
Sleep balanced
Exercise regularly

4 options 4 problems

1. Tolerate the problem
2. Change your beliefs
3. Solve the problem
4. Stay miserable

Behavior Analysis

1. Name the behavior
2. Prompting event
3. Rate intensity Level
4. Note duration
5. List vulnerabilities
6. Behavior links: actions, body sensations, thoughts, events, feelings
7. Short term positive effects
8. Long term negative effects
9. Replace problematic links with skills
10. Apply skills until you find what works for you

Interpersonal Effectiveness Skills

Describe
Express
Assert
Reinforce

Mindful
Appear confident
Negotiate

Gentle
Interested
Validate
Easy manner

Fair
Apology free
Stick to values
Truthfulness

Randomized Controlled Trial of Web-Based Psychoeducation for Women With Borderline Personality Disorder

Mary C. Zanarini, EdD et al., J Clin Psychiatry 2018;79(3)

Those in the treatment group reported a significantly greater decline in all 5 studied areas of borderline psychopathology: affective symptoms (P = .021), cognitive symptoms (P = .001), impulsivity (P = .015), interpersonal difficulties (P = .032), and overall borderline personality disorder symptoms (P = .035).

Conclusions: Taken together, these results suggest that internet-based psychoeducation is an effective form of early treatment for reducing the symptom severity of borderline personality disorder for periods up to 1 year.

If the diagnosis is borderline pd

- Tell the patient, even if there are just strong traits
- Reassure that prognosis is good! Better than bipolar or chronic depression…
- Use “good practice management” paradigm
  - Be yourself: honest and authentic: don’t be afraid!
  - Psychoeducation: a biopsychosocial condition responsive to DBT and meds***: One session can make all the difference***
  - Link the reactions and symptoms to stress and preach relieving the stress quickly and practically

Box 3: Resources for patients and clinicians

For patients

- National Institute of Mental Health: www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
- Borderline Personality Disorder Resource Center: http://bpdresourcecenter.org/
- National Education Alliance for Borderline Personality Disorder: www.borderlinepersonalitydisorder.com/index.html
- Chapman AL, Gratz KL. *The borderline personality disorder survival guide: everything you need to know about living with BPD*. Oakland (CA): New Harbinger Publications; 2007.

For clinicians

- National Education Alliance for Borderline Personality Disorder: www.borderlinepersonalitydisorder.com/index.html
- Behavioural Tech, LLC (for clinicians interested in dialectical behaviour therapy): www.behavioraltech.org/index.cfm
- Paris J. *Treatment of borderline personality disorder: a guide to evidence-based practice*. New York (NY): Guilford Press; 2008.
- Gunderson JG, Links PS. *Borderline personality disorder: a clinical guide*. Washington (DC): American Psychiatric Publishing; 2008.

Borderline⇄Adhd

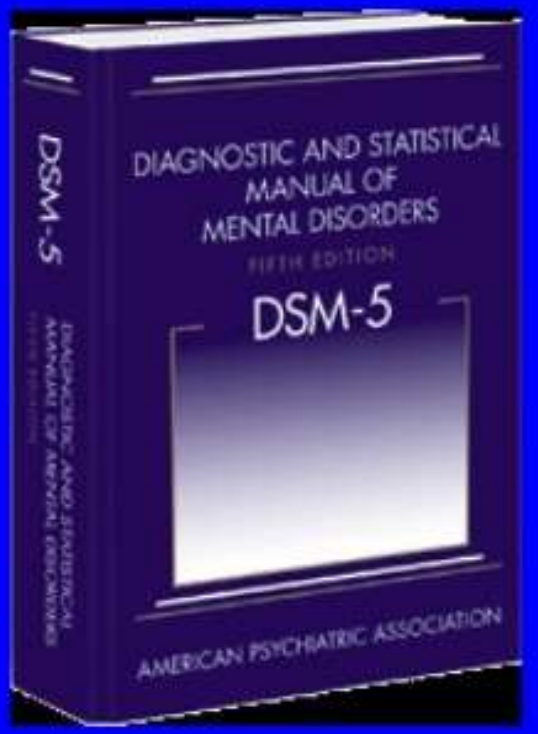
ADHD QUIZ!!!!

- The average genetic contribution to adhd is:
- 80%, 60%, 40%, or 20%
- If your child is adhd, the probability you have it is:
- 70%, 50%, or 20%
- The first accurate description of the adhd syndrome was in: 1798, 1842, 1913. 1974
- What is the sex ratio (M:F) of borderline personalit in the general population?
- In any given patient, all stimulants (dextroamphetamine or ritalin) are all about equally effective: true or false?
- Who refills their adhd med prescriptions the least? Kids, adolescents, college kids, or elderly?
- Psychostimulants help non-adhd individuals drive better? True or false?
- It is proven that psychostimulants are effective boosters to antidepressants. True or false?

Fidgety Phil (Heinrich Hoffmann 1809–1894)

DSM-V Revisions to ADHD

- Same criteria as DSM-IV
- Onset before age 12 (age 7 in DSM-IV)
- 5 symptom criteria in adults (6 in DSM-IV)
- Removed autism-spectrum d/o from excluders
- Elaborated ADHD criteria descriptions (more examples for adults)



Adult adhd introduction

- The symptom clusters of inattention, impulsivity, and hyperactivity in the adult are very non-specific and occur in many conditions
- Many adults seek the diagnosis to escape responsibility, or to get stimulants

(?) DSM-5 makes the mistake of allowing adhd to have an onset at age 12; it should be age 7 or less, and this is a seminal part of the diagnosis (?)

TABLE 3.

Differential Diagnosis of Attention-Deficit/ Hyperactivity Disorder

Psychiatric Disorders

Oppositional defiant disorder
Disruptive mood dysregulation disorder
Intermittent explosive disorder
Bipolar disorder
Autism spectrum disorder
Anxiety disorders
Intellectual developmental disorder
Substance use disorders
Personality disorders

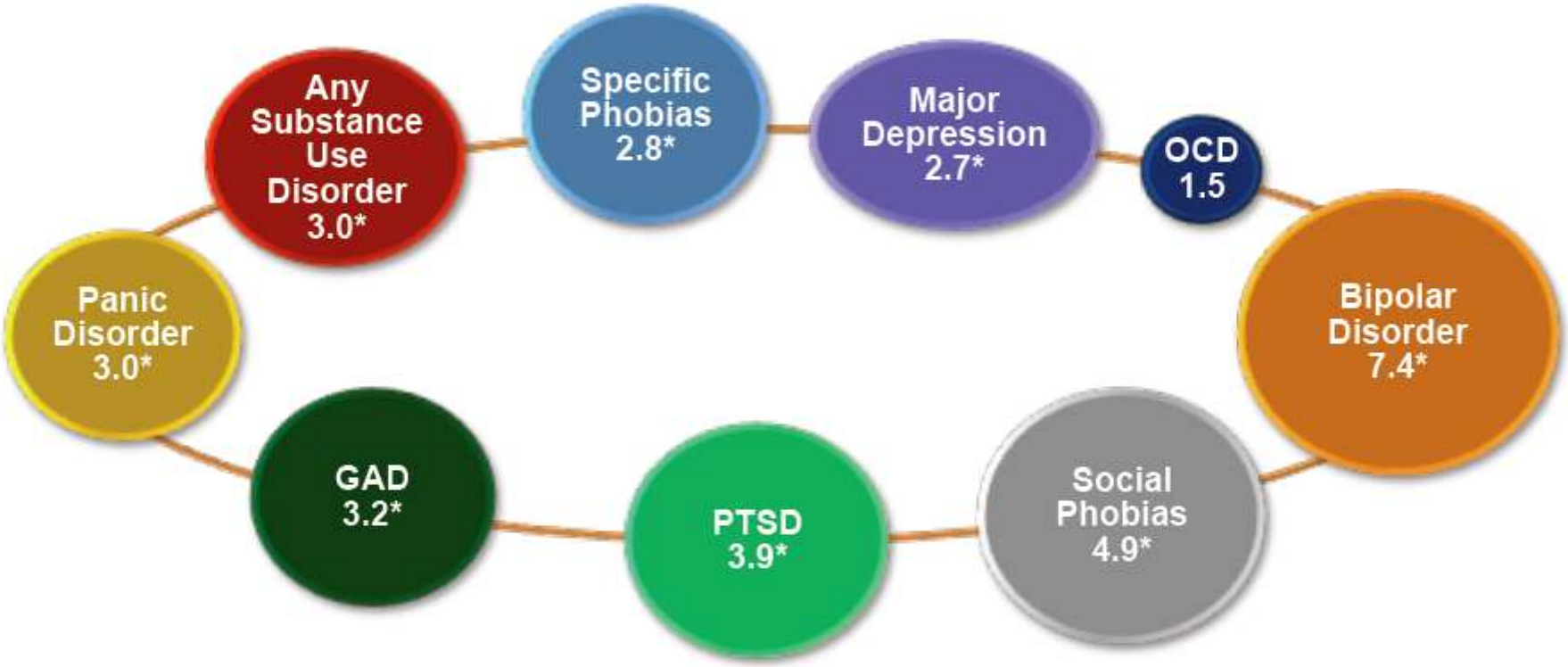
Psychosocial Conditions

Abuse and/or neglect
Poor nutrition
Neighborhood violence
Chaotic family situation
Being bullied

Medical Disorders

Medication-induced symptoms (eg, asthma medications)
Sensory impairments (poor eyesight or hearing)
Seizure disorder
Thyroid abnormality
Heavy metal poisoning
Head trauma
Apnea or other sleep disorders

Adult ADHD "Ring of Fire"
NCS-R: Psychiatric Comorbidities



Odds Ratio (95% CI). *$P < .05$.
GAD = generalized anxiety disorder; NCS-R = National Comorbidity Survey Replication; OCD = obsessive-compulsive disorder; PTSD = posttraumatic stress disorder.
Kessler RC, et al. *Am J Psychiatry.* 2006;163(4):716-723.

ASRS Screener v1.1

1. Inattention	Never	Rarely	Some-times	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2*	3*	4*
How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2*	3*	4*
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3*	4*
How often do you have problems remembering appointments or obligations?	0	1	2*	3*	4*
1. HyperactivityImpulsivity					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3*	4*
How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3*	4*

Significant items in Red (*p=0.5); Likely to have ADHD with ≥ 4 significant items

World Health Organization http://www.med.nyu.edu/psych/assets/adhdscreen18.pdf

QUESTIONNAIRE SUR LA SANTÉ DU PATIENT – 9 (PHQ-9)

Au cours des 2 dernières semaines, selon quelle fréquence avez-vous été gêné(e) par les problèmes suivants ? *(Veuillez cocher (✔) votre réponse)*	**Jamais**	**Plusieurs jours**	**Plus de la moitié du temps**	**Presque tous les jours**
1. Peu d'intérêt ou de plaisir à faire les choses	0	1	2	3
2. Être triste, déprimé(e) ou désespéré(e)	0	1	2	3
3. Difficultés à s'endormir ou à rester endormi(e), ou dormir trop	0	1	2	3
4. Se sentir fatigué(e) ou manquer d'énergie	0	1	2	3
5. Avoir peu d'appétit ou manger trop	0	1	2	3
6. Avoir une mauvaise opinion de soi-même, ou avoir le sentiment d'être nul(le), ou d'avoir déçu sa famille ou s'être déçu(e) soi-même	0	1	2	3
7. Avoir du mal à se concentrer, par exemple, pour lire le journal ou regarder la télévision	0	1	2	3
8. Bouger ou parler si lentement que les autres auraient pu le remarquer. Ou au contraire, être si agité(e) que vous avez eu du mal à tenir en place par rapport à d'habitude	0	1	2	3
9. Penser qu'il vaudrait mieux mourir ou envisager de vous faire du mal d'une manière ou d'une autre	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Si vous avez coché au moins un des problèmes évoqués, à quel point ce(s) problème(s) a-t-il (ont-ils) rendu votre travail, vos tâches à la maison ou votre capacité à vous entendre avec les autres difficile(s) ?

Pas du tout difficile(s)	**Assez difficile(s)**	**Très difficile(s)**	**Extrêmement difficile(s)**
☐	☐	☐	☐

Table 1. Questions in the Optimal RiskSLIM *DSM-5* ASRS Screening Scale[a]

1. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly? (*DSM-5* A1c)
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? (*DSM-5* A2b)
3. How often do you have difficulty unwinding and relaxing when you have time to yourself? (*DSM-5* A2d)
4. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves? (*DSM-5* A2g)
5. How often do you put things off until the last minute? (Non-*DSM*)
6. How often do you depend on others to keep your life in order and attend to details? (Non-*DSM*)

Abbreviations: ADHD, attention-deficit/hyperactivity; ASRS, Adult ADHD Clinical Diagnostic Scale; RiskSLIM, Risk-Calibrated Supersparse Linear Integer Model.

[a] Response categories are never, rarely, sometimes, often, and very often. The never response option is scored 0 for all questions; the highest scores are 5 for questions 1 and 2, 4 for question 5, 3 for question 6, and 2 for question 4, resulting in a scale with scores in the range 0 of 24.

Pearls

Is he DISTRACTED? Considerations when diagnosing ADHD in an adult

Richard C. Christensen, MD, MA

Adult attention-deficit/hyperactivity disorder (ADHD) can be challenging to assess accurately. Adult ADHD differs significantly from childhood ADHD, in that hyperactivity often is absent or greatly diminished, comorbid disorders (depression or substance use) are common, and previously compensated attention deficits in school can manifest in the patient's personal and professional life.[1]

The mnemonic **DISTRACTED** can help when recalling key components in assessing adult ADHD.[2] Because ADHD is a developmental disorder—there are signs of onset in childhood—it is important to maintain a longitudinal view when asking about patterns of behavior or thinking.

Distractibility. Is there a pattern of getting "off track" in conversations or in school or work situations because of straying thoughts or daydreams? Is there a tendency to overrespond to extraneous stimuli (eg, cell phones, computers, television) that impedes the patient's ability to converse, receive information, or follow directions?

Impulsivity. Does the patient have a history of saying things "off the cuff," interrupting others, or "walking on" someone else's words in a conversation? Is impulsivity evident in the person's substance use or spending patterns?

School history. This domain is important in diagnosing ADHD in adults because there needs to be evidence that the disorder was present from an early age. How did the patient perform in school (ie, grades, organization, completion of homework assignments)? Was there a behavioral pattern that reflected hyperactivity (could not stay seated) or emotional dysregulation (frequent outbursts)?

Task completion. Does the patient have trouble finishing assignments at work, staying focused on a project that is considered boring, or completing a home project (eg, fixing a leaky faucet) in a timely fashion?

Rating scales. Rating scales should be used to help support the diagnosis, based on the patient's history and life story. There are >12 scales that can be utilized in a clinical setting[3]; the ADHD/Hyperactivity Disorder Self-Report Scale is a brief and easy measure of core ADHD symptoms.

Accidents. Adults with ADHD often are accident-prone because of inattention, hyperactivity, or impulsivity. Does the patient have a history of unintentionally hurting himself because he "wasn't paying attention" (falls, burns), or was too impatient (traffic accidents or citations)?

Commitments. Does the patient fail to fulfill verbal obligations (by arriving late, forgetting to run errands)? Has this difficulty to commit created problems in relationships over time?

Time management. How difficult is it for the patient to stay organized while balancing work expectations, social obligations, and family needs? Is there a pattern of chaotic scheduling with regard to meals, work, or sleeping?

Employment. Has the patient changed jobs because the work becomes "too boring" or "uninteresting"? Is there a pattern of being terminated because of poor work quality based on time management or job performance?

Decisions. Adults with ADHD often make hasty, ill-informed choices or procrastinate so that they do not have to make a decision. Does the patient's decision-making reveal a pattern of being too distracted to hear the information needed, or too impatient to consider all the details?

Remember: No single component of this mnemonic alone suffices to make a diagnosis of adult ADHD. However, these considerations will help clarify what lies behind your **DISTRACTED** patient's search for self-understanding and appropriate medical care.

References

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Table 2. Differential Diagnosis of Attention-Deficit/ Hyperactivity Disorder (ADHD) and Borderline Personality Disorder

ADHD	Borderline personality disorder
Early onset	Adolescent onset
Charming, naïve	Angry and negative
Stable relationships	Intense, stormy relationships
Adventurous	Fear abandonment
Unpredictable	Manipulative
Insensitive	Oversensitive, distort
Poor judgment	Mini-psychosis
Random impulsivity	Driven intent to harm

The relationship between childhood history of ADHD symptoms and *DSM-IV* borderline personality disorder features among personality disordered outpatients: The moderating role of gender and the mediating roles of emotion dysregulation and impulsivity

Andrea Fossati[a,b], Kim L. Gratz[c], Serena Borroni[b,d], Cesare Maffei[b,d], Antonella Somma[a,b], Davide Carlotta[b,*]

"Moreover, ADHD and BPD frequently co-occur, with rates of BPD among adults with ADHD ranging from 19% to 37%. Finally, there is evidence to suggest that childhood ADHD may be a risk factor "

The Canadian ADHD association's view:

ADHD and Borderline Personality Disorder (BPD)43

BPD may occur in either gender. It is advised that the individual should be over 16 before a formal diagnosis of BPD is applied due to prevailing biases associated with this disorder. While patients with BPD are often impulsive, labile and have difficulties with executive function, the presence of rage, emptiness, planned manipulative behaviours, primitive defence mechanisms, deliberate self-destructive actions, abandonment anxiety and suicide attempts differentiate the two disorders. While patients with BPD may have ADHD, the BPD is the more severe disorder and more likely to impact outcome. Treatment of ADHD in the context of BPD, especially with short-duration stimulants, should be undertaken with caution. However, effective treatment of underlying ADHD can improve active participation in psychosocial treatments. Patients with BPD who have clear evidence of ADHD in childhood often expect that treatment of the ADHD in adulthood will resolve the personality issues. In these cases, it is important to explain the treatment limitations of ADHD medications. This wll reduce the risk that patients will react with feelings of abandonment, rage, disappointment, devaluation or feel that they have been rejected.

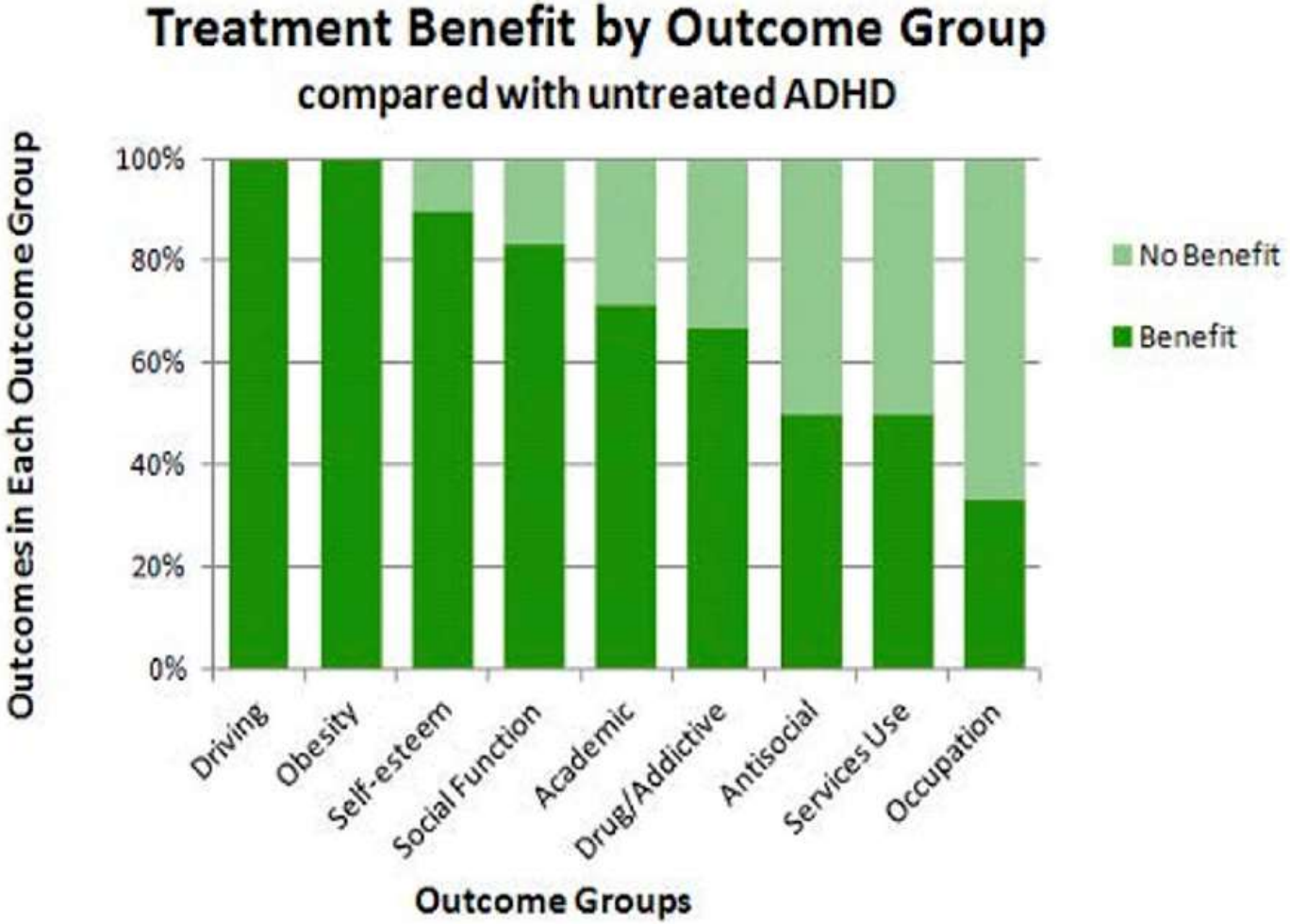

Figure 6 Benefit and no benefit with treatment by outcome group. This graph shows benefit (dark green bars) or no benefit (light green bars) by outcome group in treated participants with attention deficit hyperactivity disorder (ADHD) versus untreated ADHD. Improvement was reported most often in studies of driving and obesity outcomes (left side), with a greater proportion of outcomes reported to exhibit no benefit following treatment compared with no treatment in studies of occupation (right side). An intermediate proportion of studies of self-esteem, social function, academic, drug use/addictive behavior, antisocial behavior, and services use outcomes reported benefit with treatment.

ADHD⇆Bipolar

Nonoverlapping symptoms

ADHD
Forgetful in daily activities
Difficulty awaiting turn
Difficulty organizing self
Loses things
Avoids sustained mental effort
Does not seem to listen
Difficulty following through on instructions/fails to finish work
Difficulty sustaining attention
Fails to give close attention to details/makes careless mistakes
Bipolar mania
Inflated self-esteem/grandiosity
Increase in goal-directed activity
Flight of ideas
Decreased need for sleep
Excessive involvement in pleasurable activities with disregard for potential adverse consequences
Marked sexual energy or sexual indiscretions

ADHD: attention-deficit/hyperactivity disorder

Disorder	Borderline	Bipolar	ADHD
Type of illness	Character	Mood	Neurological
Baseline state	Unhappy, mood swings	Normal	Disorganized
Relationships	Unstable, idealize then denigrate	Normal, unless in a severe episode	Stable
Impulsivity	Response to environment, intent to harm, “act out”	Normal, unless in a severe episode	Unpredictable and often independent of triggers
Chronic emptiness	Yes	No	No
Response of treator	Frustrated, angry, rejected (due to primitive defenses)	Helpless in depression or elated in mania	No particular response, often quite likeable
Presence of weeks/months of mania, depression	Chronic downs, no sustained elation	Yes, use these in diagnosis	No, use ASRS scale to initiate assessment
Epidemiology	6%, Onset in early adulthood.	1-2%, Onset in late teens, early adulthood	5-8%, Onset in early childhood (?); GENETIC
Hierarchy of treatment	Treat first	Treat first	Treat last

Summary:

- There is a growing recognition of bipolar and ADHD conditions amongst clients seeking medical or psychological consultation
- Clinicians must resist the urge to give these diagnoses given the prevalence and presentation of the borderline personality
- We now have a better understanding of the presentations of these conditions and better evaluation tools to distinguish them.
- Simple scales, short structured interviews, and response to past treatment are vital in directing to the right treatment modalities.

Case Vignette

- John is a 50-year-old, white, never-married man who initially presented with irritability and depression.
- He had been given a diagnosis of bipolar II disorder 10 years earlier. John described his moods as never vacillating to periods of elation but rather as centered on feelings of hostility and anger. He had a 20-year history of heavy alcohol use
- Over the next few sessions, his preoccupation with his partner's fidelity and whereabouts, his dependency on others, identity confusion, and impulsivity manifested themselves.
- He had rapid mood shifts in session, particularly when the discussion centered on his current romantic relationship of 5 months.
- Given the quality of his mood swings and associated symptoms, BPD was diagnosed and John was referred for medication management and dialectical behavior therapy.
- As noted by Gunderson and colleagues,[9] and as exemplified by this case, persons with BPD often receive a diagnosis of bipolar spectrum disorder.