sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION
Michael Kennedy, MFT – Division Director

RCHC Case Presentation

Starring Melissa Ladrech as Susan and Michael Kozart as Dr. Keigh

Case Presentation

- The following case is presented in three video installments.
- After each installment, we will have a break-out discussion on the case. Questions for discussion include:
  - Differential Diagnosis
  - Next steps for work-up
  - Treatment Considerations

Installment 1

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Case Presentation

Installment 1: "The patient with ADHD."

- Diagnostic Considerations:
  - Attention-Deficit/Hyperactivity Disorder: Neurodevelopmental Disorder: at least several symptoms required to have occurred prior to age 12.
    - Inattentive type: six or the following, for greater than six months duration
      - Overlooks details/makes careless mistakes
      - Difficulty sustaining attention in work or play
      - Does not seem to listen when directly spoken to
      - Does not follow through on instructions
      - Difficulty organizing tasks
      - Avoids tasks that require mental effort
      - Misplaces objects necessary for tasks (e.g. notebook)
      - Easily distracted
      - Forgets to do everyday activities of chores
    - Hyperactive type: six or more of the following, for greater than six months duration
      - Fidgets
      - Leaves seat when remaining in seat is expected
      - Runs about or climbs in situations where this is inappropriate
      - Unable to play or engage in leisure situations quietly
      - Always on the go—as if 'driven by a motor.'
      - Talks excessively
      - Blurts out an answer before the question has been completed
      - Difficulty waiting turn
      - Often interrupts conversations.

Case Presentation

Installment 1: "The patient with ADHD."

- Diagnostic Considerations: continued.
  - Differential Diagnosis:
    - Intellectual developmental disorder
    - Anxiety Disorder
    - Depressive Disorder
    - Bipolar Disorder
    - Substance Use Disorder
    - Personality Disorder
    - Psychotic (Thought) Disorder
    - Neurocognitive Disorder (Dementia)
  - Work-up
    - Additional History/CURES
    - Labs/Tox Screen/Pregnancy Status
    - To test or not to test
  - To Treat or not to Treat?
    - Threshold for using stimulants

Installment 2

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Case Presentation

Installment 2: "ADHD becomes Bipolar."

- Diagnostic Considerations:
  - Bipolar I Disorder: Must meet criteria for Mania—a distinct period (>1 week) of abnormally elevated, expansive or irritable mood plus abnormally increased goal oriented activity. During this period, three or more of the following symptoms are present (four if the presenting complaint is mainly irritability). These symptoms cause marked impairment in social or occupational functioning.
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep
    - More talkative than usual
    - Flight of ideas
    - Distractibility
    - Increase in goal directed activity
    - Excessive involvement in activities that have a high risk of danger or painful consequence (hyper-sexuality, excessive spending, foolish business deals).
  - Bipolar II Disorder: Must meet criteria for hypomania—at least four days of any of the above symptoms, though below the threshold of marked impairment in social or occupational functioning.
  - Clyclothymia: 2 years of numerous episodes of hypomania or sub-syndromal depression. These symptoms are persistent, and the individual has not been without symptoms for more than 2 months out of the 24.

Case Presentation

Installment 2: "ADHD becomes Bipolar."

- Diagnostic Considerations continued:
  - Rapid Cycling Specifier: presence of at least four distinct mood episodes within a 12 month period that meet the criteria for manic, hypomanic or major depressive episode. Episodes need to be demarcated by full or partial remissions of at least 2 months duration.
  - Short Duration Specifier: hypomanic symptoms of no more than 2-3 days duration, with history of major depressive episodes.
- Differential Diagnosis:
  - ADHD
  - Anxiety
  - PTSD
  - Disruptive mood dysregulation disorder
  - Personality Disorder

Case Presentation

Installment 2: "ADHD becomes Bipolar."

- Work-Up
  - History
  - Labs/Pregnancy Status
- Treatment:
  - Meds:
    - When to use mood stabilizers—and if so, which ones?
    - Should Adderall be stopped?
  - Psychotherapy

Installment 3

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Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- What do we mean by emotional dysregulation: recurrent 'out of control emotion' and impulsivity. The defining quality is reactivity rather than persistence. Most commonly, there is an important psychological story-line to be fleshed out—a trigger.
  - Unlike ADHD and the bipolar disorders, the mood swings are triggered by circumstances in the environment or internal thoughts/associations.
  - The mood swings are jagged, and highly spontaneous
  - They can be associated with intense secondary demoralization, anxiety, and preoccupation.
- The diagnoses most associated with emotional dysregulation are the Cluster B Personality Disorders, of which Borderline Personality is the most prevalent.

Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: a pervasive patter of instability of interpersonal relationships, self-image, and affects, associated with marked impulsivity. Includes at least 5 of the following:
  - Frantic efforts to avoid real or imagined abandonment
  - A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
  - Identity disturbance: markedly and persistently unstable self-image or sense of self.
  - Impulsivity in at least two areas that are potentially self-damaging. (e.g., spending, sex, substance abuse).
  - Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
  - Affective instability due to a marked reactivity of mood
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger
  - Transient, stress-related paranoid ideation or severe dissociative symptoms

Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: psychodynamic perspective
  - Distrust/general suspiciousness represents a key starting point: from an evolutionary standpoint, this pushes patients into a state of heightened stress (fight or flight), with a corresponding tendency to view the world in 'black and white' terms.
  - Mood swings are the result.
  - Cutting can represent multiple psychological processes
    - Displaced rage
    - Self-hatred
    - Dissociation into an experiential space of complete control
    - Release of stress
    - Common identity with others in pain/Means of acceptance
    - Means of expressing state of helplessness/pain
  - Childhood trauma can contribute to the development of Borderline Personality, though it is by no means a necessary pre-condition. Much evidence also points to a biological vulnerability to emotional dysregulation.

Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: challenges
  - Stigma: some patients unwilling or incapable of accepting the label (for understandable reasons).
  - Many such patients utilize more tolerable diagnostic labels to express their distress
  - Many of the symptoms truly cross-over into other diagnoses
    - ADHD, PTSD, BPAD, Anxiety/Panic Disorder, Major Depression
  - Due to the intensity of the symptoms, many patients understandably seek the 'medication solution'.
    - Stimulants provide some degree of 'insulation' from stressful people or situations.
    - Benzos may diminish anxiety
  - Self-medication is highly prevalent
  - Legal problems/Unemployment/Homelessness are major sequelae
    - Arguably the number one cause of homelessness in Sonoma County.
  - Addressing the symptoms requires a psychological perspective; meds can be utilized, but usually as a tool to enable the patient to achieve greater control over symptoms.

Case Presentation

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Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: Treatment
  - Medications
    - Mood stabilizers: safety considerations
      - Lamictal, Depakote, Topamx, Tegretol, Lithium
      - Antipsychotic mood stabilizers
    - Small role for antidepressants
      - Don't forget the placebo effect
    - Stimulants need to be used with caution, but may have a role in helping highly motivated patients achieve greater success and self-validation.
    - Be very careful with benzos
    - Safe sleep meds: trazodone, low-dose Seroquel, Benadryl.

Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: Treatment
  - Psychotherapy
    - DBT (next session)
    - CBT
      - Mindfulness Perspective: knowing how one's mind works enables one to bracket 'perceptions' of reality.
        - These perceptions are merely thoughts—not truths
          - In BPD, thoughts are heavily influenced by pervasive distrust/suspiciousness/paranoia
          - They lead to certain reactions
            - Affective instability vis-à-vis others and to oneself
            - Self-harm

Case Presentation

Installment 3: "Bipolar becomes Emotional Dysregulation or Instability."

- Borderline Personality: Provider Considerations
  - Maintenance of a non-judgement stance
  - Avoidance of term 'manipulation'
    - Borderline patients are not trying to manipulate. They are truly reacting to perceived fears, with a heightened vulnerability to extreme thinking.
    - They find it profoundly difficult to sustain 'collegial' relationships
  - Openness to consider medication 'solutions', though with a corresponding acknowledgement of the role of counseling psychology
  - Be prepared to deal with splits, directed anger, hopelessness, despair
  - Work closely with BH specialists if available.

The End

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