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**Case Study Module 7**

**Section 1**

***Client #1***

The first client was seeing the doctor because he wanted a new prescription of ADD medication. He did not appear to have difficulty focusing while meeting with the therapist. He is a college student and says he was on the medication for most of his life. He says he was diagnosed and placed on medication around the age of 5. He claims he has difficulty focusing and his grades are failing due to being off of the medication. He was resistant to the doctor contacting his parents or prior medical professionals. According to the client he meets the following criteria: fails to pay close attention, has difficulty sustaining attention, fails to follow through on instructions, has difficulty organizing tasks, and has difficulty in engaging with tasks that require extended mental effort. The therapist should consider that the client is reluctant to share previous medical records and claims the onset of symptoms were very early on. The therapist should seek further information from other people in the client’s life such as medical professional or family before committing to the diagnosis. The therapist should also rule out any substance abuse disorders.

***Client #2***

This client had great difficulty holding still and focusing on the therapist. Her eyes wandered around the room and she regularly had to be prompted to rejoin the conversation. Her mother said her symptoms started in kindergarten. She struggles to remember things and often loses objects that are important to her. She struggles to sit still and fidgets often with her hands. Her mother said she can focus on a video game and will sit still playing for extended periods of time. The client meets the following criteria for inattention: fails to give attention to details, has difficulty sustaining attention, does not listen when spoken to directly, does not follow through on instructions, has difficulty organizing tasks, often loses things, is easily distracted by stimuli, and is forgetful with daily activities. She meets the following criteria for hyperactivity: she often fidgets, she leaves her seat when expected to sit still, has difficulty waiting for her turn, blurts out answers, and is on the go. She is African-American and there is less clinical identification for people in her racial group. Diagnosis is also less common in females than in males.

***Client #3***

This client is an adult male who is struggling with work. He was referred by his employer because he has made several recent mistakes. He says he is easily distracted at work and finds his mind wandering in meetings. He struggles to sit still and is often squirmy. He loses things regularly, is messy, and struggles to remember to pay his bills. He remembers being easily distracted as a child and receiving poor marks for behaviors such as speaking out of turn. He says caffeine calms him down, and he avoids sugar. He meets the following criteria for inattention: fails to pay attention, difficulty sustaining attention, difficulty listening does not follow directions, difficulty organizing tasks, avoids tasks with sustained mental effort, loses things, easily distracted, and forgetful. He meets the following criteria for hyperactivity: fidgets, leaves seat, restless feeling, on the go, blurts out an answer, has difficulty waiting his turn, and interrupts others. He expressed that several of his symptoms were present before the age of twelve and his symptoms exist at home and work. His symptoms strongly impair his daily life.

***Clients #4***

This client has a severe case of autism. He showed extensive stimming behaviors such as rocking and waving his arms in the air. He made no eye contact and struggled to communicate. He repeated the doctor’s phrases back to him with a singular tone. He struggled to answer any open ended questions and disconnected from what was happening. He eventually expressed that he had reacted to a classmate moving his desk close to him which was a breach of classroom rules. He became distracted and told the therapist about trains. He met the following criteria: deficits in socio-emotional reciprocity, non-verbal communicative behaviors, and understanding relationships. He exhibited repetitive patterns such as repeated motor movements, inflexibility with routines, fixated interests, and hyperactivity to sensory input. He does not show other disabilities, and his symptoms started in childhood. The therapist was able to observe him and communicate with his mother which allows for a deeper understanding of symptoms. He did not appear to have an intellectual impairment.

***Client #5***

The last client had a milder case of autism. He had many of the same issues as the previous client, but he was able to remain calm. He had a more natural communication pattern and participation in the conversation. He still did not make eye contact and fidgeted with his hands. He was able to describe the event at school and explain that his reaction was because of the other child’s behavior. He provided detail and had some awareness of social cues. He also was able to understand that he had to come to the therapist’s office because of his mother’s feelings. He met the following criteria: abnormal social approaches, deficits in non-verbal communicative behaviors, and understanding relationships. He exhibited repetitive patterns such as stereotyped motor movements, insistence on sameness, fixated interests, and hyperactivity to sensory input.

**Section 2**

ADHD and Autism Spectrum Disorder share many similarities and fundamental differences. The disorders have social components that make the individuals stand out from others. ADHD is characterized by persistent inattention and/or hyperactivity that interferes with daily functioning. Deficits in social communication and interaction characterize Autism Spectrum Disorder (American Psychiatric Association, 2022). Both disorders can include criteria such as fidgeting, fixated interests, and hyperactivity.

These disorders often appear similar in the real world. ADHD is often an undiagnosed label placed on any child that is somewhat hyperactive, and ASD is ascribed to anyone who is a little odd. My husband’s family has a lot of people who meet the minimum criteria for ASD but were never diagnosed. My sister-in-law and brother-in-law have exhibited ASD symptoms since infancy and have struggled tremendously in social situations. They are incredibly rigid and fixated on their areas of interest. They are both married, hold doctorates, and have genius-level IQs, but they are unable to integrate into social situations or pick up on any non-verbal cues. Autism can be a very lonely disorder. Even though someone shows little interest in social interaction, or a lack of understanding does not mean that they do not wish they could more naturally develop social bonds. I have spent a lot of time reading about autism to help me learn how to love my family in ways that are meaningful to them.

I have also spent a lot of time with children who have ADHD. In my personal experience, I have noticed that girls tend to be diagnosed later in life and receive less support than the boys. These girls often struggle socially and have difficulty feeling “normal.” I have also seen ADHD symptoms manifest as a trauma response. The hyperactivity, inability to focus, and forgetfulness can be brought on by difficult family environments or as a response to natural disasters. With foster children, there seems to be a quickness to diagnose ADHD without asking about the onset of symptoms. Several foster children that we had were diagnosed in their late teens. Due to abuse and neglect, the doctors who diagnosed would have not been able to ask about the onset of symptoms. These children often had severe reactions to the medication and were on dozens of other medicines to offset the side effects. ADHD is a very real and difficult disorder that can be over diagnosed without taking proper diagnostic measures.

**References**

American Psychiatric Association. (2022). Desk reference to the diagnostic criteria from DSM-5-TR(tm). American Psychiatric Publishing.