Attention Deficit Hyperactivity Disorder (ADHD), Bipolar Disorder, and Borderline Personality Disorder (BPD) often overlap, making them hard to tell apart. All three feature severe **mood swings**, **impulsivity**, and **trouble focusing**. While they share symptoms, they have different causes, timelines, and treatments.

Symptoms They Share

- **Moodiness:** Quick shifts from feeling great to feeling down.
- **Impulsivity:** Doing things quickly without thinking.
- **Focus Issues:** Trouble paying attention or staying organized.

Key Differences at a Glance

[	Core Feature	Onset & Duration	How to Tell the Difference
ADHD	Brain development that affects focus	Starts in **childhood** and is **constant**	No "vacation" from symptoms; struggles happen every day.
Bipolar	Brain chemical changes causing mood cycles	Starts in **teens or adulthood**; comes in **episodes**	Moods change in long cycles (weeks or months) with normal periods in between.
BPD	Emotional pain linked to relationships	Starts in **teens/early adulthood** and is **ongoing**	Moods change very fast (within hours) and are triggered by people.

Why Overlap Happens

- **The "Switching" Effect:** The ADHD brain gets bored fast. This craving for brain stimulation can look like bipolar mania (a very high, active mood).

- **High Comorbidity:** These conditions often happen together. Up to 40% of people with BPD also have ADHD, and about 20% of people with ADHD also have bipolar disorder.

Diagnosis is not simplistic. Every Individual is different and should be treated as such.

ADHD and BPD: The Evolution of Conjoined Diagnoses

How our conceptualizations of ADHD and BPD have changed and intertwined.

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KEY POINTS

- ADHD and BPD share many symptoms that often are expressed together.
- We have developed understanding of disorders that were not conceived of four decades ago.
- When either ADHD or BPD is recognized, it may be prudent to look for possible evidence of the other.

Before 1980 and the publication of the DSM-III, neither the diagnosis of attention-deficit/hyperactivity disorder (ADHD) nor the conceptualization of borderline personality disorder (BPD) existed.

What would now be considered ADHD was then defined as “hyperkinetic reaction” (sometimes referred to as “minimal brain dysfunction” or other similar terms). It was estimated to exist in around 3 percent of children and adolescents and then magically vanished; adults could not qualify for the diagnosis. At that time, there was no formal psychiatric equivalent to what we describe as BPD, although other personality disorders were defined.

Over the ensuing decades, our understanding of these behaviors has undergone significant reassessment. Defining characteristics of ADHD are now more refined and descriptive in the DSM-5. Prevalence is now estimated to be closer to 10 percent of children and adolescents and the condition is now diagnosed in adults at increasing rates.

Similarly, in 1980, many clinicians did not “believe in” the diagnosis of BPD, considering it to be an offshoot of bipolar disorder or an aberrance that did not exist as a separate illness. Although the formal defining characteristics of BPD have changed little in the last forty years, biological and genetic observations have reified the distinctiveness of the diagnosis.

These two orphan diagnoses have now been adopted into a tribe in which they share a kind of kinship. ADHD and BPD can exhibit many common symptoms, including moodiness, impulsivity, anger outbursts, disorganization, vulnerability to substance abuse, attention-drawing behavior, impaired social functioning, and a tendency to be easily bored. Comorbidity is common. Although research data vary significantly,[1] one national epidemiological study determined that the lifetime comorbidity of BPD in the ADHD population was 33.7 percent.[2]

ADHD and BPD each have significant hereditary features. Studies indicate that 40 to 50 percent of children with ADHD have at least one parent with the disorder. There is also strong hereditary penetration among family members of BPD patients, though it is not as large as that seen in ADHD. Environmental factors play a stronger role in the emergence of BPD symptoms.

Children with ADHD behavior may be more likely to be bullied or traumatized in many ways. Other children may ridicule them and parents may be frustrated with them. Abuse is often detected in the history of BPD patients. Some researchers hypothesize that children with ADHD may therefore be more vulnerable to developing BPD.

An individual is not a diagnosis. We are all a combination of genetic potentials and happenstance, emotions, and behavioral reactions. As our understanding of the human condition continues to be refined, prejudices against those whose struggles in our world are more overt will diminish.

References

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