Understanding Dual Diagnosis

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Resources and Supports for Individuals with IDD and Mental Illness – 11/14/2024

Kim Shontz, LCSW

Illinois Crisis Prevention Network

Building a community of support that enables people with disabilities to flourish

Overview of Training

- Introduction
- History of Dual Diagnosis
- Primary Care Fact Sheet
- Specific Disorders
- Considerations
- Questions

The "*Other*" Dual Diagnosis

- Dual diagnosis = Being diagnosed with more than one disorder

  Commonly refers to a person diagnosed with a psychiatric disorder and substance abuse issue

  Dual Diagnosis refers to being diagnosed with ID/D and a psychiatric disorder = The ***Other*** Dual Diagnosis

  INTELLECTUAL/DEVELOPMENTAL DISORDER DOES NOT = MENTAL ILLNESS

History of Dual Diagnosis

- 1876 – American Association on Mental Deficiency – "schooling"
- 1908 – Introduction of psychoanalysis in U.S.; people with ID/DD did not fit in this model and could not participate in tx
- 1900-1960 – "Tragic Interlude" (Menolascino)
  - Treatment teams no longer include psychiatrists
  - First generation antipsychotics not available to people with ID/DD

The "*Other*" Dual Diagnosis

- 1960-1970 – concept of Dual Diagnosis introduced by Dr. Frank Menolascino
  - Psychotherapy proved useful – Slivkin
- 1981 – Psychiatric Aspects of Mental Retardation Newsletter published by Sovner – now Habilitative Mental Health Care Newsletter
- 1982 – National Association for Dual Diagnosis founded

Diagnostic Overshadowing

Reiss, Levitan, and Szyszko

Symptoms or behaviors that may be due to a specific mental illness are attributed to an intellectual/developmental disability

Ex: Psychotic symptoms may be attributed to an intellectual disability; assumption that people with ID/D cannot experience depression

- Comorbid conditions are undiagnosed and untreated

Lennox & Chaplin (1995,1996)

- 67% of consulting psychiatrists agreed that antipsychotics are overused to control aggression
- 86% supported the proposition that people with ID/DD receive a relatively poor standard of psychiatric care
- 90% agreed that specialized units provide higher level of services
- ***30+% prefer not to work with people with ID/DD***

Edwards *et al.* (2007)

- 75% agreed that antipsychotics are overused to control aggression
- 68% agreed that people with DD receive a relatively poor standard of psychiatric care
- 85% agreed that specialized services provide a higher standard of care
- ***58% reported they prefer not to treat adults with ID/DD***

Primary Care Fact Sheet on Dual Diagnosis of Adults with Mental Retardation and Developmental Disabilities

(Richard E. Powers, MD (2005) – Bureau of Geriatric Psychiatry DDMED 42)

- Intellectual disability is common in the general population (1%); however, most are mildly intellectually disabled (85%)
- Serious mental illness (SMI) is common in persons with ID/DD regardless of the cause of intellectual disability (30-60%)
- Anxiety, depression, and psychosis are common in people with ID/DD

Primary Care Fact Sheet (cont)

- Substance abuse is as common in young persons with mild ID as in other people
- Environmental stressors can produce new psychiatric symptoms
- Accurate assessment of psychiatric problems requires a comprehensive medical, psychiatric, and behavioral evaluation

Primary Care Fact Sheet (cont)

- Behavioral management is always preferable to psychotropic medications
- Antipsychotic medications have limited benefit for behavioral problems
- Antihistamines can produce significant confusion and this class of medication is not indicated for sedation

Primary Care Fact Sheet (cont)

- Many medical problems (19%) are missed in people with ID/DD that may produce behavioral symptoms
- Chronic pain is common (over 25%) and often under-recognized in the person with ID/DD (61%)

Importance of Accurate Dx

- Appropriate medication regime
- Helps us know what to "expect"
- Fosters empathy from care givers
- Informs clinical and behavioral intervention planning and implementation
- Guides training for families and staff

A Note About Hospitalization

"It's all behavioral. There's nothing we can do."

Things To Consider…

- Medication side effects
- Life circumstances
- Physical development vs. emotional development
- Lack of ability to communicate symptoms
- Inability to tact emotions
- Impaired knowledge of social norms
- Lack of education and understanding of symptoms

Things To Consider…

It is often difficult for the person to express their wants and needs

- Unable to "put into words" what they need or want
- Lack of assertiveness
- Impulsivity
- Fear of others not responding to their wants or needs

Things To Consider…

- History is important!
  - Many people lost skills over the years by being placed with others who do not have the same skill sets
  - Special Education Services were not available to many of the older adults
  - Institutional behaviors are learned behaviors
  - Abandonment issues – May try to "test" new relationships

Diagnostic Manual – Intellectual Disability (DM-ID and DM-ID2)

- DM-ID 2 was released as an adaptation of the DSM-5
- Evidence-based methods and supported by the expert-consensus model
- Focuses on issues related to diagnosis in people with ID, limitations in applying DSM-5 criteria to people with ID, and adaptation of the diagnostic criteria

Chapter Guidelines

- Chapter Summary
- Review of diagnostic criteria
- Application of diagnostic criteria to people with ID
- Etiology and pathogenesis
- Adaption of diagnostic criteria

Table of Adapted Criteria

DSM-5 CRITERIA	ADAPTED CRITERIA FOR MILD TO MODERATE ID	ADAPTED CRITERIA FOR SEVERE TO PROFOUND ID

Common Co-Occurring Diagnoses

- Major Depression
- Schizophrenia
- Post Traumatic Stress Disorder
- Intermittent Explosive Disorder

Major Depression

- Five or more of the following symptoms in two week period with at least one of the symptoms being depressed mood or loss of interest or pleasure
  - Depressed mood most of the day nearly everyday
  - Diminished interest or pleasure in preferred activities
  - Changes in weight (weight loss or gain)

Criteria Continued

- Changes in Sleep (insomnia or hypersomnia)
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to concentrate or make decisions
- Recurrent thoughts of death or suicide

Major Depression with ID

- A Major Depression Diagnosis requires only ***four*** criteria and includes ***irritability*** as a diagnostic feature.
  - Depressed mood may be described as:
    - Sad Facial Expression
    - Flat Affect or Absence of Normal Expression
    - Rarely Smiles or Laughs
    - Cries or is tearful

Major Depression with ID

- Irritable mood may be described as:
  - Grouchy or having an angry facial expression
  - Having an onset or increase of agitated behaviors (physical and verbal aggression, self injury)
  - Angry affect
- Stereotypies, ritualistic, and or repetitive behaviors may increase during irritability.

Major Depression with ID

- Diminished interest or loss of pleasure
  - Refuses preferred activities
  - Withdrawn and spends excessive time alone
  - Becomes aggressive when prompted to participate in activities they used to enjoy
  - Avoids social interactions
  - Previously motivating objects or activities have lost their reinforcement power

Major Depression with ID

- Changes in Weight
  - Eating in excess
  - Obsessing about food
  - Stealing food
  - Agitated behaviors emerge around meal times
- Changes in Sleep
  - No adaptation

Major Depression and ID

- Changes in psychomotor behavior
  - Rarely sits down, paces, walks rapidly, and fidgets
  - Slower movements, decreased or stopped talking, less active
- Fatigue or loss of energy
  - Appears tired and becomes agitated when prompted to engage in physical activities
  - Spends excessive amounts of times sitting or laying

Major Depression in ID

- Feelings of worthlessness or inappropriate guilt
  - Identifies self as bad
  - Expects punishment
  - Blames self for problems
  - Unrealistic fear that caregivers will be angry or reject them
  - Excessively seek reassurance
  - *People in the severe to profound range might not have the cognitive ability to experience this*

Major Depression with ID

- Diminished ability to concentrate or make decisions
  - Reduced productivity at workshop/ day program
  - Diminished self care skills
  - Cannot complete tasks that they previously could
  - Increased agitation when prompted to do tasks that they have done previously
  - Has apparent memory problems that "come and go"
  - Unexplained skill loss

Major Depression with ID

- Recurrent thoughts of death or suicide
  - Talks about death
  - Frequent unrealistic physical complaints and fears of illness or death

Mood Disorder Considerations

- Mood disorders may be missed in the ID population due to differences in phenomenology
- Developmental effects may account for the presenting clinical picture and thus historical information is important when making a diagnosis

Considerations

- Aside from Depression and Bipolar other mood disorders have rarely been studied with this population
- Agitation and aggression may be behavioral manifestations not symptoms of a clinical diagnosis. There is a high frequency of people with ID/D diagnosed with a mood disorder.
- The ID population may present with symptoms of mood disorders when they are experiencing an undiagnosed underlying medical condition.

Anxiety Disorders and IDD

- Adaptation for people with Severe to Profound ID:
  - Fear or anxiety can be observed rather than subjectively described
  - "Individual finds it difficult to control the worry" is not required
  - Only 1 or 6 symptoms is required for dx

Schizophrenia

- Two or more of the following present for a significant portion of time during a one month period
  - Delusions
  - Hallucinations
  - Disorganized Speech

Schizophrenia

- Grossly Disorganized or Catatonic Behavior
- Negative Symptoms
  - Avolition
  - Alogia
  - Affective Flattening

Schizophrenia and IDD

- No adaptation however a multidisciplinary approach is highly emphasized.
- Self talk is common for the ID population and should not be interpreted necessarily as an extension of a psychotic disorder
- A significant change in behavior should alert a clinician to the possibility of psychosis
- Assessment may be extremely difficult for people in the severe to profound range of ID

Psychotic Disorder Considerations

- Expressive communication is essential for a diagnosis to be reached
- Diagnosis becomes increasingly more difficult to make with increasing degrees of ID
- Literature does not reveal a significant change in presenting symptomology however emphasizes lengthy observation and assessment when significant behavior changes occur, particularly bizarre behavior
- There are no biological symptoms that can be objectively observed, tested, and recorded

Post Traumatic Stress Disorder

- The person has been exposed to a traumatic event in which both were present:
  - An event that involved actual or threatened death or serious injury or threat of physical integrity of others
  - The person's response involved intense fear, helplessness, or horror. In children this may be expressed through disorganized or agitated behavior

PTSD

- The traumatic event is persistently re-experienced
- Avoidance and numbing symptoms
- Physiological hyper-arousal

PTSD and ID

- There is considerable evidence that there is an increased likelihood of disorganized or agitated behavior with greater levels of impairment
- Recurrent and intrusive thoughts
  - Behavioral acting out is common
    - Self Injury may be a symptom of traumatic exposure

PTSD and ID

- Recurrent dreams
  - Frightening dreams without specific content are more likely with individuals with lower developmental ages
- Feeling as though the event is recurring
  - Trauma specific enactments have been observed in individuals with moderate to severe ID

PTSD and ID Cont.

- Efforts to avoid thoughts, feelings and conversation
  - No adaptation but may be difficult in individuals with verbal limitations
- Efforts to avoid activities, places or people
  - Many caregivers will report this as non-compliance
- Inability to recall aspects of trauma
  - Problems with recall may appear to be a function of a person's disability however careful assessment is required

PTSD and ID

- Diminished interest or participation in activities
  - May be seen as non-compliance
- Feeling detached or estranged
  - For severe to profound ID, more isolative behavior may be reported
- Sense of foreshortened future
  - Many people with ID do not have normative expectations regarding their future
- Increased Arousal Responses
  - No adaptation

Clinical Considerations

- The developmental level at which trauma occurs is significant because it has a major impact on the persons ability to adapt.
- Trauma disrupts the maturing person's development
- The younger the person is when they experience the trauma, the more likely it is for them to engage in self injury.

Clinical Considerations

- People that are traumatized in childhood are more likely to engage in compulsive re-enactments of the event
- ID is associated with a greater probability of distress following stressful events
- ID is associated with high rates of PTSD
- People with ID may experience PTSD for events that are not typically seen as traumatic

Intermittent Explosive Disorder

- Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property
- The degree of aggressiveness expressed during the episode is grossly out of proportion to any precipitating stressor.
- The aggressive episodes are not better accounted for by another mental disorder

IED and ID

- ***Episodes that last at least two months*** and involve a failure to resist aggressive impulses.
- The degree of aggressiveness is grossly out of proportion to any stressor ***and to the degree of the level of ID***
- The aggressive episodes are not better accounted for by any other mental disorder ***except if the other disorder is mild compared to the aggression, or is temporarily unrelated to the aggression***