

Clinical Excellence *in* Dual Diagnosis:

- **Trauma, Intellectual Disability,
& Treatment**

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Intellectual Disability in DSM-5

***A disorder with onset during the developmental period
that includes both intellectual and adaptive
functioning deficits in 3 domains:***

Conceptual

Social

Practical

Intellectual Disability (ID) in DSM-5

Key changes in DSM-5

No more “axis 2”

Emphasis on Adaptive Functioning as opposed to IQ score

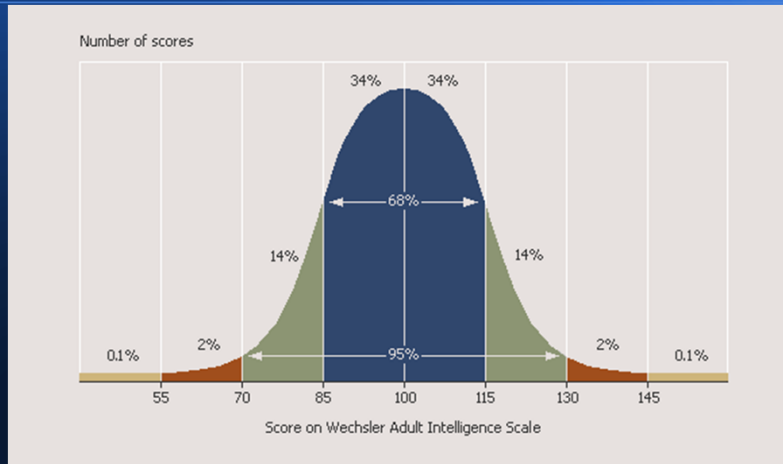
ID: 3 domains in DSM-5

The ***conceptual*** domain includes skills in language, reading, writing, math, reasoning, knowledge, and memory.

*The ***social*** domain refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities.

*The ***practical*** domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.

Distribution of IQ Scores



Does IQ Predict Well-Being?

- The DM-ID reports:
“Individuals with ID have been estimated to be 2 to 4 times more likely than those in the general population to experience psychiatric disorders.”

Sternberg et al (2001) state:

“Lower IQ has been suggested as perhaps the most significant factor associated with psychiatric disturbances in children.”

Chen et al (2006) : The Johns Hopkins Collaborative Perinatal Study

- Followed 4025 live births (born 1959-1965) tracking
- Physical, neurological, cognitive and socioemotional development and health; assessed at:
 - Birth,
 - 4 mo. THEN AGAIN, BETWEEN 1992 AND 1994
 - 8 mo. WHEN Ss WERE ADULTS
 - 12 mo.
 - 3 yrs.
 - 4 yrs.
 - 7 yrs.
 - 8 yrs.

Findings from Chen et al.

- Children with IQs below 70 at age 4 had a 3-fold incidence of treatment for emotional disorders in their early 30's
- Individuals with borderline intellectual functioning were at 150% increased incidence of treatment for emotional disorders

Chen et al. continued

- Children with borderline intellectual functioning and with MR who grew up in disadvantaged family environments were even more likely to experience unfavorable mental health outcomes in young adulthood.
- Note: Family-related influences were assessed via 3 constructs: family structure; family stability, and family interactions.

Factors Contributing to the Increased Prevalence of Psychological Disorders in People with Developmental Disabilities

- Low levels of social support
- Poorly developed social skills
- Learned helplessness
- Lower socioeconomic level
- Increased presence of physical disabilities (e.g., epilepsy)
- Increased likelihood of CNS damage / Increased presence of language dysfunction

Contributing Factors (con't.)

- Decreased opportunities to learn adaptive coping styles
- Increased likelihood of chromosomal abnormalities, metabolic diseases, and infections
- Decreased inhibition in response to stressful events
- Higher rates of sexual abuse

Nezu, C.M., Nezu, A.M., & Gill-Weiss, M.J. (1992). *Psychopathology in persons with mental retardation: Clinical guidelines for assessment and treatment*. Champaign, IL: Research Press.

IT and Mental Health Outcome

IT in Childhood has been documented to lead to:

Mood Disorders

Anxiety Disorders

Personality Disorders

Dissociative Disorders

Substance Abuse

And, most recently, Psychotic Disorders, including
Schizophrenia

IT and Psychosis

Children exposed to Intentional Harm (abuse)

Vs

Children exposed to Unintentional Harm (accidents)

Showed significantly higher rates of psychotic symptoms at age 12,

Even when genetic factors were controlled for.

Children who grew up with abuse by adults and also experienced abuse by peers had even higher rates of psychotic symptoms.

IT and Psychosis, continued

Rates of PTSD:

In General Pop: 3 – 5%

In Schizophrenics: 17 – 46%

In Bipolar Disorder: 11 – 24%

Patients with Psychosis were *2.72 times* more likely to have experienced childhood trauma than those without psychosis.

(Trauma: physical or emotional or sexual abuse; neglect, parental death, bullying)

2013 Boston Children's Hospital Research

Analyzed data from 6,483 teens aged 13 – 17. Found 61% had been exposed to at least 1 type of trauma: IT; Injuries; Natural Disaster; Death of Close Friend or Family Member.

Of the 61%, 4.7% experienced PTSD.

But,

For those whose trauma was rape: 39% experienced PTSD;

For those whose trauma was physical abuse by caregiver: 25% PTSD

Effects of IT

1. Dysregulation of Affect and Behavior
2. Disturbances of Attention and Consciousness
3. Interpersonal Difficulties
4. Distortions in Attributions
5. Cognitive Difficulties
6. Physiological Complications
7. Poorer Overall Physical Health

Dysregulation of Affect and Behavior

Common Affective Symptoms:

- Lability
- Anhedonia
- Flat or numbed affect
- Sudden or explosive anger
- Incongruous or inappropriate affect

Dysregulation of Affect and Behavior, Continued

Behavioral symptoms may include:

- Withdrawal
- Self-injury
- Aggression
- Oppositional behavior
- Compulsions

Note: Traumatized adolescents demonstrate an increased reliance on action, as opposed to symbolic representation

continued

Additional related research findings:

Abused children were found to be acutely sensitive to perceiving facial cues as conveying anger; and are more likely to interpret positive emotions as ambiguous.

2. Disturbances of Attention and Consciousness

Common symptoms include:

Dissociation

Depersonalization

Memory disturbance

Inability or reduced ability to concentrate (Note: many children with PTSD meet criteria for ADHD, but reverse is not true. ADHD and PTSD appear to be distinct. Exposure to IT does not appear to be a risk factor for ADHD.)

3. Interpersonal Difficulties

Common Problems Include:

Difficulties with trust

Low interpersonal effectiveness

Diminished social skills

Poor understanding of social interactions

Poor perspective-taking abilities

Expectation of harm

Poor boundaries

4. Distortions in Attributions

Abused children were found to be acutely sensitive to perceiving facial cues as conveying anger; and are more likely to interpret positive emotions as ambiguous.

Also, more likely to distort personal responsibility in both directions (externalizing blame or assuming personal responsibility)

5. Cognitive Difficulties

Common Problems Include:

Disrupted executive functioning, such as poor planning ability, and poor problem-solving ability, even in emotionally neutral contexts. Executive functioning declined even further in research depicting aggressive situations.

6. Physiological Complications

In children with PTSD vs Controls, brain research has found:

Decreased volume in the corpus callosum, prefrontal cortices, and temporal lobe; and

Increased volume in the superior temporal gyrus.

Both age of onset and duration of abuse correlated significantly with brain volume aberrations.

Physiological Complications, continued

A study with women who had experienced abuse as children found decreased volume in particular areas of the corpus callosum, although not as widely as that found in children, suggesting that CNS alterations may persist into adulthood, but in modified form because of maturation or adaptation.

Extensive research documentation of brain aberrations due to physical and sexual abuse, corporal punishment, and even parental verbal abuse (often the result of cortisol elevations.)

7. Poorer Overall Physical Health

A recent epidemiologic study confirmed the link between childhood abuse and long-term changes in immune response. In this longitudinal study, childhood abuse was associated with elevated CRP levels, white blood cell counts, and other markers of inflammation 20 years later. (Note: **C-reactive protein (CRP)** is a [protein](#) found in the blood, the levels of which rise in response to [inflammation](#).)

Research has found an increased risk of autoimmune diseases, gastrointestinal disorders, headache, and numerous other disorders.

Worldwide
approximately 1/3 of all Children
experience physical abuse



IT & ID: 2000 Study: Omaha, Nebraska

40,000 Children:

Those with ID had:

- * 3.7 X the rate of Neglect;
- * 3.8 X the rate of Emotional Abuse;
- * 3.8 X the rate of Physical Abuse;
- * 4.0 X the rate of Sexual Abuse.

2005 Study in the UK

119,000 Children .

Those with ID had:

- * 2.9 X the rate of Emotional Abuse
- * 3.4 X the rate of Physical Abuse
- * 5.3 X the rate of Neglect
- * 6.4 X the rate of Sexual Abuse.

Note: Overall, children with ID were 6.5 X as likely to have at least 1 type of maltreatment, --But, this rate dropped to 4.7 X as likely when adjusted for SES.

IT & Adults with ID

A study done in N. Carolina (2006) with over 5,000 women found

Women with ID 2.6 times more likely than women without disabilities to have been sexually assaulted in the past year.

Diagnostic Considerations: PTSD and ID

- Van der Kolk et al summarize the following re: PTSD alone:
 - “the developmental level at which trauma occurs has a major impact on the capacity of the victim to adapt.”
 - Trauma has an impact on the maturation of biological as well as psychological processes. It has been found repeatedly that traumatic exposure disrupts the maturing organism's development of self-regulatory processes, leading to chronic affect dysregulation, destructive behavior toward self and others, learning disabilities, dissociative problems, somatization, and distortions in concepts of self and others.

Van der Kolk et al

Traumatized adolescents (from the general population) demonstrate an increased reliance on action, as opposed to symbolic representation

People who developed PTSD secondary to child abuse have more profound physiological dysregulation in response to non-traumatic stimuli than do people who developed PTSD as adults

ID & Socioeconomic Inequalities in Health

- Hillary Graham (2005)
J. of Applied Research in ID
- People with ID are more exposed to the social conditions associated w/ poor health, and have poorer health than the wider population;
- Children born into poorer circumstances are at increased risk of the forms of dev delay assoc w/ ID: speech impairments, cognitive difficulties, & behavior problems

Graham (2005)

- For children and adults, the prevalence of ID is higher among those in poorer SES;
- Women w/ mild ID are further disadvantaged by hi rates of adolescent motherhood;
- For children and adults, co-morbidity disproportionately affects people w/ ID

Prevalence of Psych Disorders in Children & Adol w/ & w/out ID

- E. Emerson (2003). *J. of ID Research*
- Sampled data collected on 10,438 Ss, aged 5- 15 yrs, in England, Scotland, & Wales;
- Children with ID were over 7 times more likely to have a diagnosed psych disorder than their non-ID peers;
- “Data presented in the present paper also provide very strong evidence to suggest that the presence of ID must be considered a highly significant risk factor for the dev of some specific forms of psych disorder.” (p. 6).

Emerson (2003), cont.

- Conduct disorders, anxiety disorders, ADHD, & PDD were sig. higher in children w. ID;
- No sig difs re: rates of depressive disorders, eating disorders, or psychosis;
- Overall prevalence of ID: 2.6% (boys: 3.7%; girls: 1.4%)
- Sig difs in prevalence also by SES (profession of H of H)
I & II Professional: 1.9%
III Skilled Occupations: 2.4%
IV & V Partly Skilled & Un: 3.8%

Assessment Considerations

- Diagnostic Overshadowing (Reiss, Levitan, & Szyszko, 1982)
- Lack of resources, awareness, and financial means to secure treatment; tend to be other-referred, with overrepresentation of externalizing problems
- Clinicians report feeling ill-prepared to treat people with DD

Advances in Assessment

- *The DM-ID: Diagnostic Manual-Intellectual Disabilities:*
 - *A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability*
- A publication of NADD in association with the American Psychiatric Association

Intake Overview

- **ASSESSMENT: INDIVIDUAL & SUPPORT SYSTEM**
- **INDIVIDUAL CLINICAL INTERVIEW**
- **COLLATERAL INTERVIEW; RECORDS REVIEW**
- **(COLLATERAL FIRST/RATIONALE)**
- **TRIAGE**
- **THERAPEUTIC NEED? TYPE?**
- **OTHER NEEDS/REFERRALS?**
- **MEDS? REC? VOC? RES?**
- **POST H.S. VULNERABILITY**

CLINICAL INTERVIEW

- **ESTABLISH SAFETY**
- **ESTABLISH RESPECT**
- **GUARDIANSHIP, INFORMED CONSENT**
- **CLARIFY NATURE OF THERAPY**
- **ESTABLISH PATIENT'S TAKE ON THE PROBLEM**
- **ASSES COPING/DEFENSE MECHANISMS**
- **INVESTIGATE SYMPTOMS**
- **ASSESS SELF-CONCEPT**
- **PROPOSE INITIAL TREATMENT PLAN**

SIDEBAR: CONSTRUCTING A WORKING MODEL OF OUR NEW CLIENT

- **ATTACHMENT STYLE**
- **CHARACTER STYLE**
- **FAMILY OF ORIGIN CONTRIBUTIONS**
- **CURRENT SUPPORT SYSTEM
CONTRIBUTIONS**
- **STAGE OF LIFE**
- **ENVIRONMENTAL CONTRIBUTIONS**
- **PATTERNS OF
REINFORCEMENT/MAINTENANCE OF Sx
OR PROBLEM BEHAVIOR**

“ . . .attachment experiences early in life directly shape the cortical processes involved in bodily regulation, capacity for communication with others, emotional balance, flexibility, empathy, self-understanding, and the capacity to self-soothe states of fear.”

Daniel Siegel, MD



Interactive-Behavioral Therapy

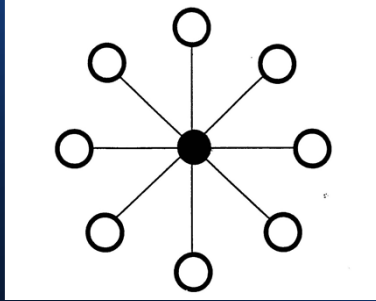
- Draws on Moreno's model, incorporating stages and techniques from Psychodrama
- Is informed by recommendations from Yalom's extensive research on group psychotherapy and is designed so as to maximize the therapeutic factors he (and others) identified
- Has been investigated via a number of research studies; references available.

Stages of a Session

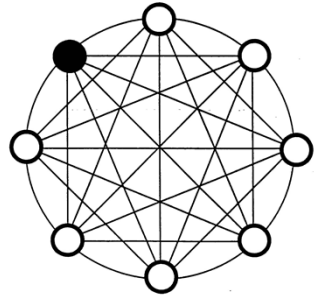
<i>IBT</i>	<i>Traditional</i>
•	
1) Orientation	
2) Warm-up & Sharing	1) Warm-up&Interview
3) Enactment	2)Enactment
4) Affirmation	3)Sharing/Closure

Teaching Vs. Facilitation

Social Skill Training Model



IBT Model



Therapeutic Factors (Yalom)

- Acceptance/Cohesion
- Altruism
- Guidance
- Modeling
- Interpersonal Learning
- Corrective Recapitulation
- Imparting of Information
- (Moreno: Role Development)
- Universality
- Installation of Hope
- Catharsis
- Self-Understanding
- Self-Disclosure
- Existential Factors
- Social Skill Development

Hope Research; Shane Lopez, 2013

Maltby (J. of Research in Personality, 2010) study at Leicester U., tracked college students over 3 years. Found hope was better predictor of academic achievement than: Intelligence, Personality, or Prior Academic Achievement.

Hope Research, Continued

Lopez (J. of Positive Psychology, 2013) compared relationship between Hope & Employee Productivity; meta analysis of 45 studies; over 11,000 employees and a wide range of work settings.

Found **Hope accounts for 14% of work productivity**; This was more than that accounted for by: Intelligence; Optimism, or Self-Efficacy. *“Basically a hopeful person does one day a week more work than a less hopeful person in a 7-day week.”*

Additional Findings from van der Kolk et al:

- Maltreated toddlers use fewer words to describe how they feel;
- And have more problems attributing causality than do secure, non-traumatized children of the same age.

PSTD and IQ Research

- Research with combat vets found lower IQ associated with higher rates of PTSD (Macklin et al, 1998). Precombat IQ was used, and amount of combat exposure was controlled for. Conclusion: For a given amount of combat exposure, those with lower precombat IQs were more likely to develop PTSD following combat exposure.
- Possible protective value of:
 - 1) subjective appraisal of danger vs. of one's own coping abilities/resources;
 - Therapeutic values of:
 - 2) putting event into words;
 - 3) ascribing meaning)?

Sexually Abused individuals with developmental disabilities

- Experienced higher rates of depression, anxiety, and sexual maladjustment

And

- Were more likely to be prescribed psychotropic medications than abused individuals in the general population

Research by Matrich-Maroney (2003)

Key Factors that Increase Risk of Sexual Behavior Problems

- Sexual victimization/ trauma
- Neurological impairment:
 - *77% of sexual offenders have ADHD (vs 18% in general population)
 - *65% of adult males with FASD have inappropriate sexual behavior
(note: 60% of people with FASD also have ADHD!)

Interviewing Adult with ID

Speak directly to the individual; resist the pull to interact exclusively with the caregiver;

Keep your statements/questions short; ask the individual to repeat back to you what he's heard you say;

And vice versa: repeat back to the individual what you've heard them say; check for clarity;

Observe individual's reaction to caregiver's report; interrupt their process (after some observation time) to direct them to each other: pause; repeat; clarify.

Caregivers/Support Staff

1. Avoid punishing OR reinforcing symptoms.

2. Elicit; clarify; normalize feelings.

* put into words unspoken (but demonstrated) feelings

* affirm verbalization of feelings

3. Offer support; brainstorm or review coping options.

4. Review and affirm coping/self-care efforts.

Caregiver Support Plan: Sari

1. Symptoms: “hearing” scary noises; “seeing” abuser.
2. Verbalize/ show understanding of feelings, “Sounds like you feel scared; is that right?”
“I'm glad you can tell me”
3. “Let's go over what you can do to feel better”
4. “Good for you. You did something to try to help yourself feel better.”

Caregiver Support Plan: Mia

Symptoms: impulsive acting out upon feeling threatened (runs away; cuts self; drinks or drugs).

Clarify, put into words, and normalize feelings: “I'm scared and I'm angry” in therapy session; then in session with caregiver present; demonstrate acceptance; then at home.

Review strategies to release intolerable feelings safely (go out for smoke; send text; walk to 7-11, buy coffee, return)

Review and affirm efforts.

PTSD changes in DSM 5

PTSD is no longer categorized as an Anxiety Disorder;
It is in the newly created category:

Trauma- and Stressor-Related Disorders.

Also, the presence of a specific type of initial emotional reaction, --such as intense fear, helplessness, or horror, -- in response to the traumatic stressor is no longer a criterion. Such initial reactions have not been found to predict the development of core PTSD symptoms.

PTSD in DSM 5, additional changes

The core symptoms have been expanded from 3 to 4 categories:

Re-experiencing;

Avoidance;

Arousal; and

Persistent negative alterations in mood and cognition.

DM-ID adaptations for PTSD

- 1) In individuals with lower developmental levels, the phenomena of re-experiencing the traumatic event may manifest in symptoms that are more overtly behavioral (concrete) and may include self-injurious behavior and trauma-specific re-enactments
- 2) Trauma-specific re-enactments can look quite bizarre and it is important to distinguish such symptoms from psychotic disorder symptoms

More DM-ID adaptations for PTSD

- 1) Persistent avoidance behavior may be described as “non-compliance” by caregivers especially for individuals who cannot adequately verbalize their posttraumatic desire to avoid activities, places, or people that arouse recollections of the trauma.
- 2) In relation to the symptom of “feelings of detachment” or “estrangement”, caregivers may report that the individual isolates him or herself.
- 3) Traumatized people with ID may show evidence of the symptom “sense of fore-shortened future” in the same way as members of the general population. However, because of the cognitive limitation in thinking abstractly, individuals with ID may not be able to develop a normative set of ideas regarding their future, creating the possibility of a false positive for this symptom.

DX of Depression in People w/ ID

- From the DM-ID (Tsiouris, 2003): *8 most frequently reported SXs (of 30 listed)*
 - Anxiety: 86%
 - Depressed affect: 66%
 - Irritability 66%
 - Loss of interest: 54%
 - Social isolation: 54%
 - Lack of emotion: 49%
 - Sleep disturbance: 49%
 - Loss of confidence: 49%

Dx of Depression in People w/ID

- *From DM-ID:*
 - “Important lessons might be learned from the study of childhood depression. . . In both clinical populations, in years past, there was much doubt that individuals could experience depression. . . Depressed children had somatic complaints, tantrums, ran away, refused to go to school, and were restless.” (pp. 277-278).
 - “Masked Depression or Behavioral Equivalentents”

Dx of Depression in People w/ ID

- *From DM-ID*
- *When Depressed:*
- Children w/out ID, and children and adults w/ ID have been noted to present with:
- Increased rates of Conduct Problems;
- Social withdrawal;
- Irritable mood.
- ***NOTE: Problem of informant complaints, externalizing bias, and, lack of self-referrals.