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Assessment of a Man With a Dual Diagnosis

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Abstract: This case assessment of a man with dual diagnosis exemplifies the use of recent psychological measures, computerized programs, and structured assessment, including the Reiss Screen for Maladaptive Behavior, the Psychopathology Inventory for Mentally Retarded Adults, the Apperceptive Personality Test, and the Residential Services Indicator. In this case, computerized scoring of two very different tests (the Reiss Screen and the Apperceptive Personality Test) yielded very similar results.

Now that the concept of *dual diagnosis* is widely recognized (Eaton & Menolascino, 1982; Matson & Barrett, 1982; Stark, Menolascino, & Albarelli, 1987), much more attention is being paid to the development of appropriate assessment instruments. Reiss (in press) has suggested a distinction among the following three types of instruments: *behavior rating scales,* which are measures of specific behavioral problems; *dual diagnosis scales,* which are measures of psychiatric disorders and/or syndromes (clusters of symptoms); and *personality tests,* which are measures of individual differences that may help explain aberrant behavior or psychiatric disorder. Generally, dual diagnosis measures are designed for use with persons who have any level of mental retardation (mild, moderate, severe, or profound), personality tests are appropriate primarily for people without mental retardation and those with mild mental retardation, and behavior rating scales provide an alternative to personality testing with people who have severe mental retardation.

Probably the most widely used measures of dual diagnosis are the Reiss Screen for Maladaptive Behavior (Reiss, 1988) and the Psychopathology Inventory for Mentally Retarded Adults, hereafter called the Psychopathology Inventory, (Matson, 1988). The Reiss Screen is a 36-item rating scale in which each item refers to a category of symptomatology, or a psychiatric concept, rather than to a specific behavior. The alpha coefficient of internal reliability for the total score was estimated at .84 (Reiss, 1988). The scoring system for the Reiss Screen is based on factor analysis of caretaker ratings and validated against psychiatric diagnosis. The test has factor content validity, which means that caretakers using the scale group psychiatric symptoms in ways that are diagnostically meaningful (Reiss, 1990). The validity data include findings of a high degree of concordance between specific scale scores and specific psychiatric diagnoses and between Reiss Screen total score and professional opinions on the presence versus absence of dual diagnosis (Reiss, 1988; Reiss, in press). A version of the measure to be used with children, called the Reiss Scales, also has been developed (Reiss & Valenti-Hein, 1990). This scale has an alpha coefficient of internal reliability of .91 and provides a full standard deviation (*SD*) separation between groups of children with mental retardation who do and do not have dual diagnosis (Reiss & Valenti-Hein, 1990).

The Psychopathology Inventory, which has both ratings by others and self-report versions, uses a different scoring system than does the Reiss Screen (Matson, 1988). Whereas the Reiss Screen scoring system reflects the relative frequency of various psychiatric symptoms in populations of persons with mental retardation, the Psychopathology Inventory scoring system follows much more closely the major categories of the Diagnostic and Statistical Manual III-R (American Psychiatric Association, 1987). This suggests that the Reiss Screen may better describe common symptom clusters seen in people with dual diagnosis, but the Psychopathology Inventory may be more precise in delineating an exact DSM III-R diagnosis. Because the two measures complement one another, they often are used together. The Psychopathology Inventory has an alpha coefficient of internal reliability of .83 (Matson, 1988). The validity data consist of findings that scores on this instrument significantly discriminate between people with mental retardation who do or do not have a dual diagnosis (Kazdin, Matson, & Senatore, 1983; Matson, 1988).

Personality tests are administered to people with mental retardation to help understand the psychological factors that may underlie a behavioral or psychiatric disorder. The Thematic Apperception Test is probably the most widely used personality measure for this population because many people with mild or moderate mental retardation are more comfortable telling stories than responding to direct questions about their personality or behavior (Hurley & Sovner, 1985; Sarason, 1943). However, this test is outdated. The cards depict scenes with little contemporary relevance; minorities are not depicted, and the cards have a gloomy, depressive tone. Interpretation of the Thematic Apperception Test lacks objectivity and relies too much on the subjective opinion of the examiner.

The Apperceptive Personality Test represents a promising alternative to the Thematic Apperception Test (Karp, Holmstrom, & Silber, 1989). It provides a set of eight new stimulus cards depicting contemporary scenes. However, the unique feature of this test is that the subject completes a questionnaire about each story. In the questionnaire, the subject identifies the characters, indicates how the characters feel and behave toward one another, indicates whether the story has a happy ending, and rates each character on a series of bipolar scales. The subject's responses are typed directly into a computer. The Apperceptive Personality Test questionnaire not only makes possible a completely objective apperceptive test, but also creates a second opportunity for the subject to reveal his or her personality needs and attitudes.

The Apperceptive Personality Test is the most extensively validated of the new apperceptive tests. The initial normative data were based on 1,400 people. Condrell (1988) found that its cards and those from the Thematic Apperception Test elicited a similar range of psychological themes. Many of the 171 objective scores have face validity and are based on established psychological principles. The validity of the test is supported by findings of correlations between the Apperceptive Personality Test and corresponding Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1943) scales and findings that scores on the Apperceptive Personality Test discriminate psychiatric groups from mentally healthy groups.

The Residential Services Indicator is a comprehensive protocol for selecting a residential alternative and support services (Benson & McKinney, 1989). It provides a consistent way of organizing the information obtained from psychological, medical, and behavioral measures and tests. This protocol also has sections for assessing additional areas of interest, such as the individual's preferences regarding various possible residences; family desires; and data such as residential history, social history, and behavioral history. Because the Residential Services Indicator is not a test, it has not been evaluated for psychometric properties.

A psychological evaluation of a man with a dual diagnosis follows. The case study shows some of the progress that has been made in recent years in the assessment of dual diagnosis. The case exemplifies the use of the Reiss Screen, the Apperceptive Personality Test, the Psychopathology Inventory, and the Residential Services Indicator. The case is interesting partially because of a high degree of concordance among the key test results. Despite very different measurement technologies, the Reiss Screen and the Apperceptive Personality Test provided the same diagnostic indications.

Method

Subject

"Joe" was a 22-year-old black male who came from an urban poverty area. He was first identified as mildly retarded when he went to public school. Over the course of his childhood and adolescence, he had numerous behavior episodes in which he threatened others with violence. He frequently ran away from residential placements and went home and threatened his mother. He failed at numerous residential placements because of his behavior. He failed in facilities for people with mental illness and in facilities for people with mental retardation. His brothers and sisters rarely visited or showed much interest in him. The case files revealed that one of the siblings abused Joe when he was a child.

Referral Questions

The referral questions for this case were as follows: (a) Is Joe mentally ill, and if so, what is the diagnosis? (b) Are the behavior problems related to mental retardation, mental illness, both, or neither? (c) What are Joe's residential service needs?

Procedure

The data sources consisted of case records, subject and staff interviews, and the results of psychometric instruments. The author spent about 3 hours studying the case files. Brief interviews were conducted with the case manager and others concerned with the disposition of the case.

The Reiss Screen and the Psychopathology Inventory rating scales were sent via mail to Joe's most recent placement, which was about 150 miles from the mental health facility that was temporarily housing him at the time of the evaluation. The results were returned via mail and scored by computer.

The author interviewed the subject and administered psychological tests in a session lasting a little over 2 hours. During the session, the subject's mood, thought coherence, and level of anxiety/stress were observed. A modified version of the Apperceptive Personality Test and Section VIII of the Residential Services Indicator were administered. On the former, Joe first created a story for each of eight stimulus cards. The examiner then read shortened versions of some of the multiple-choice questions on the questionnaire. For example, the examiner asked Joe, "Does the story have a happy ending, a sad ending, or an average ending?" If Joe said that the story had a happy ending, the examiner asked, "a little happy or a lot happy?" In a similar manner, Joe rated each character in each story for intelligence (smart/stupid), kindness (kind/mean), and trustworthiness (Can we trust this person? A little or a lot?). Joe's responses were typed directly into the Apperceptive Personality Test Version 1.1 microcomputer scoring program.

Results

The results of the Reiss Screen and the Apperceptive Personality Test were as follows.

1. Joe had a mental illness called "intermittent explosive disorder."

Basis of Findings

The following is a summary of the reasoning and evidence underlying the diagnostic opinion. Because the diagnosis requires ruling out certain other diagnostic conditions, the reasons are given for not diagnosing these other conditions.

Joe was not psychotic. The primary signs of psychosis are confused thought patterns, hallucinations, delusions, and extreme behavior. During the interview, Joe did not show any of these symptoms. He was coherent. On the Apperceptive Personality Test, he did not provide extreme responses that are characteristic of the personality traits associated with psychosis. He tested negative for psychosis and schizophrenia on both the Reiss Screen and the Psychopathology Inventory.

Joe was not suffering from an affective disorder at the time of evaluation. The primary signs of affective (depressive) disorders are sadness, anxiety, lack of enjoyment of formerly pleasurable activities, slowness of action, sleep disturbances, eating disturbances, and poor self-esteem. In the interview, Joe did not show sadness. Although his scores for affective disorder were elevated on the Reiss Screen and on the Psychopathology Inventory, they were not high enough to suggest a diagnostic condition. He reported good appetite.

Joe did not have Antisocial Personality Disorder. An antisocial personality disorder is associated with a lifelong pattern of aggressive behavior. It is a modern term for *psychopath*, which often is used loosely to refer to people who are violent, cruel, and antisocial. Although Joe had a history of aggressive behavior incidents, he was not a psychopath. His violent behavior occurred as discrete episodes rather than as an always-present feature of his personality. Also, he showed too much remorse and too much anxiety/stress to be considered psychopathic.

Joe's behavior met the criteria for Intermittent Explosive Disorder. This is a psychiatric condition in which the diagnostic criteria are several discrete episodes of loss of control of aggressive impulses; the degree of aggressiveness during episodes is out of proportion to precipitating events; there are no signs of generalized impulsiveness or aggressiveness between episodes; and the person is not psychotic, or an antisocial personality, or a borderline personality. Joe met all of these criteria.

Additional evidence for dual diagnosis (i.e., diagnosis of mental illness in addition to mental retardation) was provided by the results of the Reiss Screen. Joe tested positive for dual diagnosis on the scales for Aggressive Disorder and for Paranoia. He also received a total score of 18, which suggests that the behavior disorder was severe. The Psychopathology Inventory results also were consistent with a dual diagnosis. On

the scales of this inventory, Intermittent Explosive Disorder should lead to elevated scores on the scale for Inappropriate Adjustment, which were found.

2. Joe's aggressive behavior was associated with paranoid personality processes in which he perceived nonexistent threats and/or was quick to exaggerate the degree of threat.

Basis of Findings

The following evidence suggests the relevance of paranoid personality processes for understanding Joe's aggressive behavior. (a) A computer printout of the results on the Apperceptive Personality Test indicated that, on average, Joe rated the story characters as hostile and suspicious to an unusually high degree. That is, Joe invented 14 story characters and then rated these fantasy characters as hostile and untrustworthy people. The fact that Joe rated the average person in his own stories as hostile suggests that Joe himself may project a great deal of hostility. Similarly, the fact that Joe indicated that he himself would not trust the characters in his own stories suggests that Joe may be an unusually suspicious or paranoid individual. (b) The data from the Reiss Screen showed positive test results on the scales for Aggressive Behavior and Paranoia. These results matched closely those obtained from the Apperceptive Personality Test, even though the two tests are very different from one another. (c) Like many people with paranoid traits, Joe experienced an above-average degree of social isolation. He had a long history of rejection and residential relocation. It was unclear whether there was any person in his current life who had known him since childhood. He lacked love from others and had no friends. He was alone. Not surprisingly, he was insecure and had an excessive need for attention and reassurance. (The elevated score on the Reiss Screen for dependent personality traits suggested an excessive need for attention.) (d) In the interview, Joe stated that he became angry when he did not get the attention he needed. Sometimes he became so angry he did not control himself and behaved in ways he later regretted.

The evidence suggests that Joe's behavior problems were associated with paranoid personality traits. When Joe did not get the attention he needed, or when he was criticized or not reassured, he was quick to feel threatened psychologically. He felt insecure, exaggerated the significance of loss of attention, and became suspicious. He experienced intense feelings of hostility. Given his relative social isolation, lack of trust in others, poor ability to understand social events, and poor ability to understand what he was experiencing or why, his imagination may have exaggerated the threat such that situations tended to escalate quickly. Although Joe sometimes became so angry he could not completely control himself, usually he managed to exercise some control in that much of the hostility was expressed through projected feelings and threats rather than through actual or sustained physical attacks. Later when he became calm, he experienced remorse and wished he could control himself better, but he also remained confused and suspicious of other people.

3. Like some dually diagnosed people, Joe's needs did not fit well into existing service programs. His total handicap was greater than the sum of his two handicaps. He required residential services in a program for dual diagnosis, habilitation, social skills training, anger management therapy, and care from a psychiatrist with experience with mental retardation.

Basis of Findings

In many places in the United States and elsewhere, there are some people with dual diagnosis who have such a unique combination of handicaps that they do not fit into the existing service systems. These people tend to be "bounced back and forth" from one facility to another. Such was the case of Joe.

Joe's needs did not fit well into the existing array of services. On the one hand, he did not belong in a mental hospital. The mental hospitals offered neither the anger management treatment programs nor the habilitation services Joe needed. Moreover, Joe resented placement in mental hospitals, where he had nothing meaningful to do and no appropriate peers.

Joe also did not belong in residential programs serving persons with developmental disabilities. His behavior problem was too disruptive for these programs; there was concern that he might not fit into the array of services because he had mild retardation and yet required around-the-clock supervision. Most programs for people with mild mental retardation do not provide around-the-clock supervision. In order to re-

ceive 24-hour supervision, Joe would have to be placed in programs for people with moderate mental retardation; however, Joe would have resented and related poorly to peers if placed with this population. He would have realized that he did not belong and wondered why he lived there, so that his social isolation and paranoia might become worse.

On the Residential Services Indicator, Joe expressed a desire to live in the country. He repeatedly stated his dislike of mental hospitals. He expressed remorse over his behavior episodes and asked if he could return to the previous placement. He stated that he did not like cities.

Based on the results of this evaluation, I recommended that Joe reside in a group home for dually diagnosed people who have mild mental retardation. The recommended habilitation services included job-training experiences and social skills training. The recommended therapy for Joe's behavioral problem included behavioral programming, anger-management training (Benson, 1986), and stable interpersonal relationships. I also suggested that the staff should include someone who was big enough physically to handle a person like Joe and not become fearful at the first signs of possible trouble.

Discussion

This case evaluation exemplifies the use of four new psychological instruments to evaluate dual diagnosis. The measures were used successfully in three different ways to help: (a) document the presence of mental illness (Reiss Screen, Psychopathology Inventory) (b) evaluate the possible relations between the behavioral problems and psychiatric diagnosis (Reiss Screen, Apperceptive Personality Test), and (c) identify additional consideration relevant to the selection of residential services (Residential Services Indicator).

It is interesting that there was a high degree of concordance between the results of the Reiss Screen and the results of the Apperceptive Personality Test. These measures are based on very different measurement technologies. The Reiss Screen is based on ratings of psychiatric symptom categories (Reiss, in press); the Apperceptive Personality Test is based on a new, two-step assessment process involving the production of fantasy stories and objective ratings of one's own stories. Despite the vast differences in measurement methodologies underlying these measures, completely objective (computer) scoring of the two tests yielded notably similar results: high scores for aggressive behavior/hostility, high scores for suspicion/paranoia, and only average scores for sadness/depression.

These results encourage future research on the relevance of the Personality Test for measuring personality traits in people who have mental retardation. In evaluating Joe, I had to adapt this test at the time of administration, and much of the power of the test was necessarily lost. For example, I did not ask many of the questions because the required reading level was too high for Joe, in addition, the ratings scales and multiple-choice questions had to be modified for an orally administered format. In order to avoid the need for makeshift modifications in this test, future research is needed to develop a version to be used with persons who have mental retardation—a completely objective, apperceptive personality test that includes stimulus cards directly relevant for persons with mild or moderate mental retardation.

As exemplified in this case, psychological measures are only one part of an overall assessment. Assessments should be based on a wide range of data in addition to formal psychological testing, including case files, observations, interviews, and medical reports (Reiss, in press). Professional opinion is required to evaluate when the results of a psychological test are valid for a particular individual.

This case exemplifies the contributions of dual diagnosis research to our understanding of behavior disorder. It was only a few years ago that a psychological assessment of Joe would have begun and ended with a detailed description of his behavior episodes. There would have been no consideration that the behavior problem might have been associated with paranoid traits. Today, it is widely recognized that people with mental retardation are vulnerable to the full range of psychopathology, and there are psychological instruments for assessing these conditions. If the promising results with the Apperceptive Personality Test are replicable, additional progress in the psychological assessment of people with dual diagnosis will soon be achieved.

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