



Is Accurate Diagnosis Necessary? Behavioral Health Issues in FASD

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SAMHSA
Fetal Alcohol Spectrum Disorders
Center for Excellence



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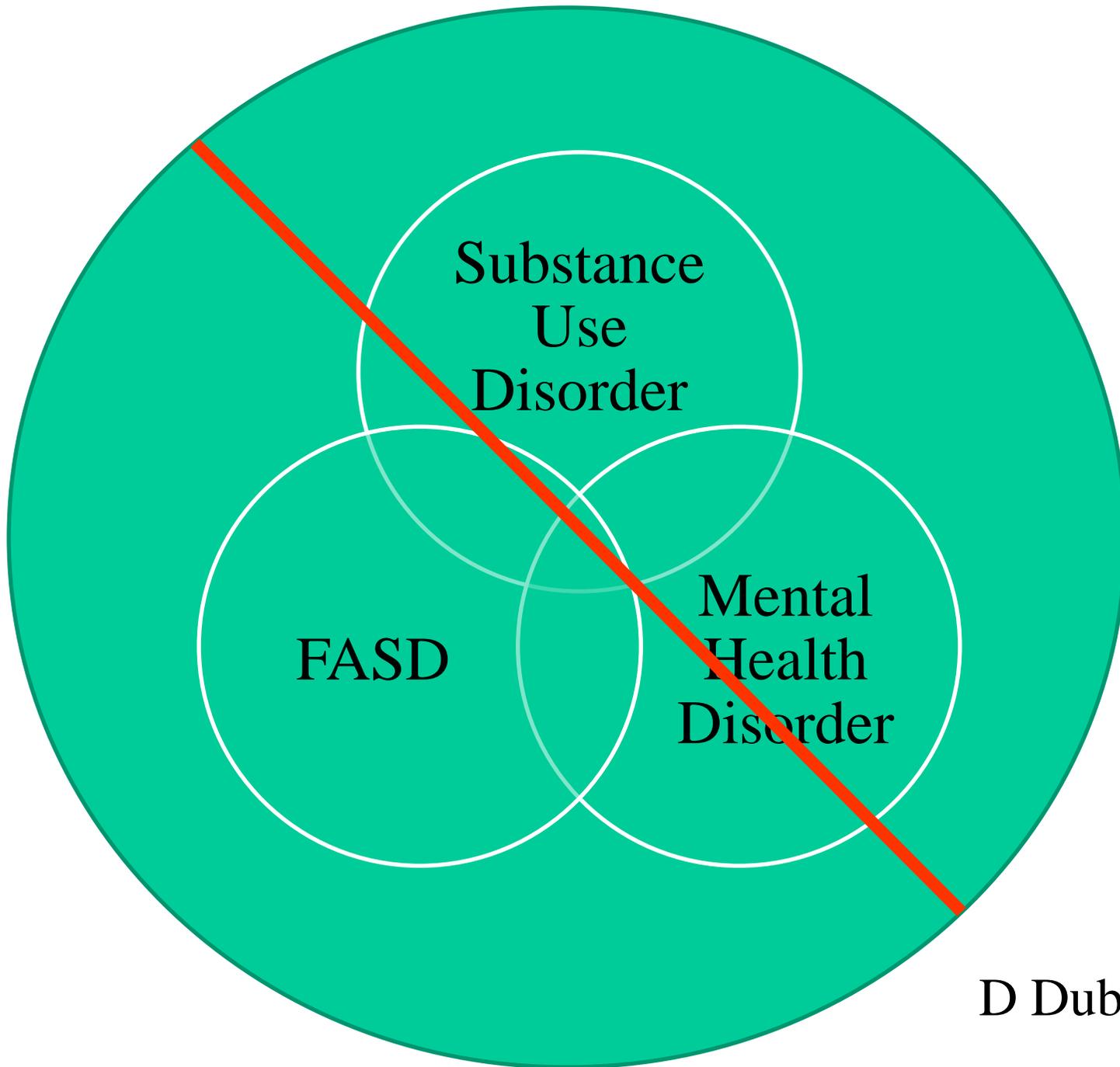


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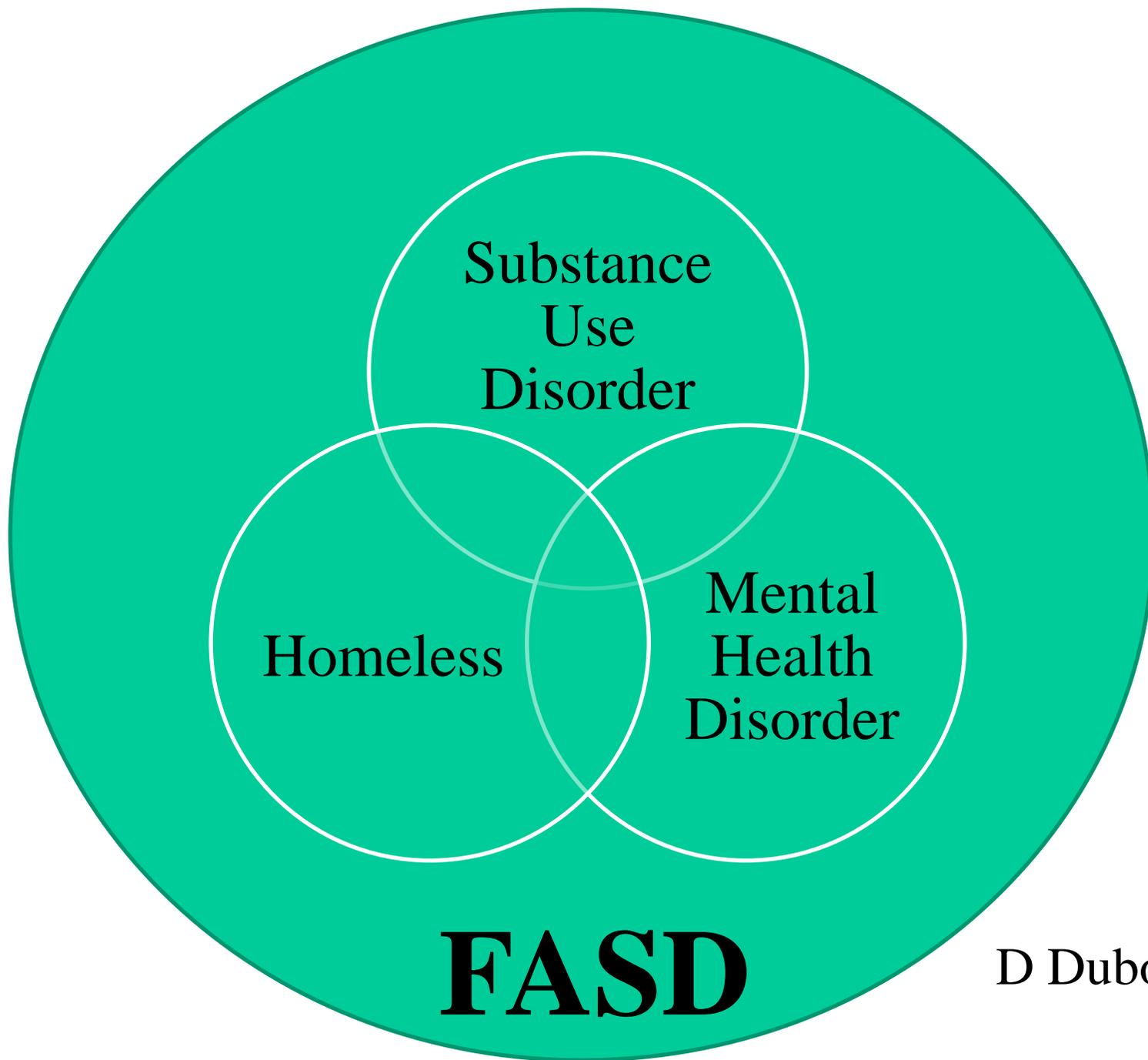
Person First Language



- “He’s a child with FAS” not “he’s an FAS kid”
- A person affected by prenatal alcohol exposure, not “the affected person”
- A mother with FAS, not “an FAS mom”
- “She has mental retardation” not “she is mentally retarded”
- “He has a mental illness” not “he is mentally ill”
- “He has schizophrenia” not “he is a schizophrenic”
- No one “is” FAS although a person may have FAS



D Dubovsky 2010



Substance
Use
Disorder

Homeless

Mental
Health
Disorder

FASD

D Dubovsky 2010

Issues in Accurately Diagnosing an FASD



- If there is a co-occurring FASD with other disorders, the treatment will need to be modified
 - › Due to differences in processing information
- If the wrong diagnosis is given, the wrong treatments may be prescribed
- If an FASD is not recognized, expectations for the individual may not be appropriate, thus setting the person up to fail
- **If the person continues to fail and doesn't know why, s/he may develop a self image of just being "bad"**
- If we do not recognize a possible FASD in family members, we often set them up to fail

Issues in Mental Health for Individuals With an FASD and Their Families



- We diagnose based on what we see on the surface
 - › We may not thoroughly investigate other possible causes for the behaviors that we see
- We treat based on diagnosis
 - › We utilize our typical treatment approaches
- All behavior is often thought to be due to the diagnosed illness (e.g., oppositional defiant disorder)
- The individual “fails” in typical treatment
- That failure is viewed as a lack of motivation on the part of the individual

Issues in Mental Health for Individuals With FASD and Their Families



- Most likely, a significant percentage of people with an FASD have co-occurring mental health disorders
 - › The 1996 Secondary Disabilities study found over 90% of those with an FASD had mental health problems
 - › A number of mental illnesses have a strong genetic link
 - E.g., schizophrenia, major depression, bipolar disorder, attention-deficit/hyperactivity disorder (ADHD)
 - › About 50% of those with mental illness use substances
 - › Illnesses with high rates of co-occurring substance use include ones with a strong genetic link

Profile of 80 Birth Mothers of Children With FAS

(Astley et al 2000)

- 96% had one to ten mental health disorders
 - 59%: Major depressive episode
 - 22%: Manic episode/Bipolar disorder
 - 7%: Schizophrenia
 - 77%: PTSD
- 95% had been physically or sexually abused during their lifetime
- 79% reported having a birth parent with an alcohol problem



Likely Co-occurring DSM Disorders With FASD



- Attention-Deficit/Hyperactivity Disorder
- Schizophrenia
- Depression
- Bipolar disorder
- Substance use disorders

Likely Co-occurring DSM Disorders With FASD



- Sensory integration disorder
- Reactive Attachment Disorder
- Separation Anxiety Disorder
- Posttraumatic Stress Disorder
- Traumatic Brain Injury
- Risk for Borderline Personality Disorder
- Medical disorders (e.g., seizure disorder, heart abnormalities)



Possible Misdiagnoses for Individuals With an FASD

- ADHD
- Oppositional Defiant Disorder
- Conduct Disorder

Comparing FASD, ADHD and ODD

D Dubovsky (2002)

	FASD	ADHD	ODD
Behavior	Does not complete tasks		
Underlying cause for the behavior	<ul style="list-style-type: none">•May or may not take in the information•Cannot recall the information when needed•Cannot remember what to do	<ul style="list-style-type: none">•Takes in the information•Can recall the information when needed•Gets distracted	<ul style="list-style-type: none">•Takes in the information•Can recall the information when needed•Chooses not to do what they are told
Interventions for the behavior	Provide one direction at a time	Limit stimuli and provide cues	Provide positive sense of control, limits, and consequences

Comparing FASD, ADHD and Conduct Disorder

D Dubovsky (2003)

FASD	ADHD	Conduct Disorder
May hit others	May hit others	May hit others
<ul style="list-style-type: none">-someone told them to-misinterpret intentions of others-may sense bump as attack-may respond from history of abuse	<ul style="list-style-type: none">-frequently an impulsive act	<ul style="list-style-type: none">-plan to hurt others-misinterpret intentions of others as attack or impending attack
Deal with misinterpretations at the time; 1-to-1 support	Behavioral approaches to address impulsivity	Consequences; cognitive behavioral approaches

Comparing FASD, ADHD and Conduct Disorder

D Dubovsky (2003)

FASD	ADHD	Conduct Disorder
Take risks	Take risks	Take risks
-do not perceive danger	-act impulsively	-push the envelope; feel omnipotent
Provide mentor; utilize a lot of repeated role playing	Utilize behavioral approaches (e.g., stop and count to 10)	Psychotherapy to address issues; protect from harm

Comparing FASD, Adolescent Depression and Adolescent Bipolar Disorder

D Dubovsky 2006

FASD	Adolescent Depression	Adolescent Bipolar Disorder
Acting out, antisocial behavior	Acting out, antisocial behavior	Acting out, antisocial behavior
Misreading social cues; modeling others; difficulty communicating thoughts and feelings	Depression	Mania or hypomania
Provide a mentor to model positive behaviors; utilize a lot of role playing;	Psychotherapy to address issues; protect from harm; medication (antidepressant) with careful monitoring	Psychotherapy to address issues; protect from harm; medication (mood stabilizer)



Possible Misdiagnoses for Individuals With an FASD

- Adolescent depression
- Bipolar disorder
- Intermittent Explosive Disorder
- Autism
- Asperger's Syndrome
- Reactive Attachment Disorder
- Traumatic Brain Injury
- Antisocial Personality Disorder
- Borderline Personality Disorder

Suicide Risk Among Individuals with an FASD

Whitney (2010)



- U.S. Surgeon General's Report (1999) identified 16 suicide risk factors
- 8 of the 16 are congruent with characteristics or common life experience of someone with FASD:
 - › Mental health disorders
 - › Substance abuse disorders
 - › Impulsivity and/or aggressive tendencies
 - › History of trauma/abuse
 - › Job or financial loss
 - › Relational or social loss
 - › Lack of social support or sense of isolation
 - › Barriers to accessing medical and psychiatric care

Suicide Risk Among Individuals with an FASD

Whitney (2010)



- The other 8 risk factors could apply depending on the clinical case:
 - › Previous suicide attempt
 - › Family history of suicide
 - › Easy access to lethal means
 - › Hopelessness
 - › Some major physical illnesses
 - › Local clusters of suicide that have a contagious influence or influence of significant people who have died by suicide
 - › Stigma associated with help-seeking behavior
 - › Certain cultural & religious beliefs

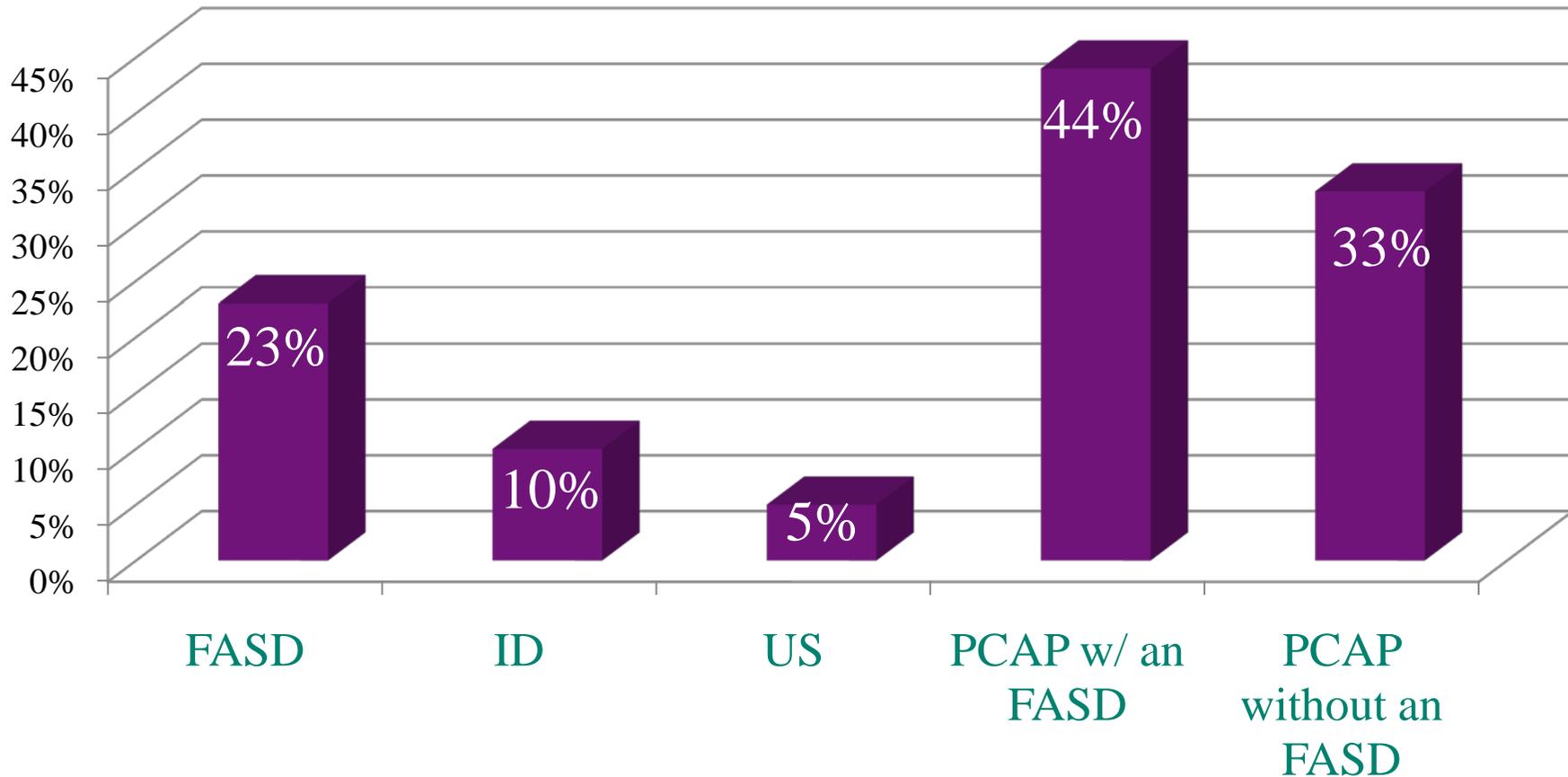
Suicide Risk Among Individuals with an FASD

Whitney (2010)



- Literal thinking can lead to a higher risk for suicide
 - › Language used in discussing suicide and other deaths
 - › “she is at peace”
 - › “he is just away”
 - › “he’s with God”
 - › “God wanted her with him”
- Wanting to be like others and “go along with the crowd”
- Response to other suicides in the community
 - › “If I kill myself, people will be upset”
 - › “It will show that people care about me”
 - › “It’s a way to get back at those I am angry with”
- Not truly understanding the finality of death

Adult Suicide Attempts: FASD, Intellectual Disabilities, U.S. Population, Women in the Parent-Child Assistance Program (PCAP)



¹Streissguth, Barr, Kogan, and Bookstein, 1996. Understanding the Occurrence of Secondary Disabilities in Clients with FAS & FAE. Final Report to the CDC, p. 35. ²Attempt rate for adults with an Intellectual Disability in mixed clinical & community samples (Hardan and Sahl, 1999; Lunsky, 2004. ³U.S lifetime rate of suicide attempts (1990-1992 National Comorbidity Study; Kessler, Borges, and Walters, 1999).

Recognition of a Co-occurring FASD Informs Interventions



- Do not rely on verbal processes
- Be careful about the words that are used
 - › Be literal, not abstract
- Do not expect the individual to think about things on their own and make decisions about their life
- Break things down to one step or rule at a time
- Utilize supportive psychotherapy

Recognition of a Co-occurring FASD Informs Interventions



- Do not take lack of follow through as lack of motivation
- Ask “what is causing this behavior?”
- Ask “what age behavior does this feel like?”
- Identify possible buddies (e.g., family, friends, church or other organizations), to ensure the person gets to their appointments, etc.

Recognition of a Co-occurring FASD Informs Interventions



- Establish a mentor/coaching approach
- Change reward/consequence based systems (e.g., point, level, or sticker systems) if they are not working to rewards systems
- Utilize a true strengths-based approach
- Re-assess concepts of dependency and enabling
- Modify typical approaches to:
 - › Mental health issues
 - › Trauma informed care
 - › Systems of care

Suicide Intervention/Prevention for Individuals with an FASD

Adapted from Huggins, et al (2008)



- Standard suicide assessment protocols need to be modified to accommodate neuropsychological deficits and communication impairments
 - › Instead of “How does the future look to you?” ask “What are you going to do tomorrow? Next week?”
 - › seriousness of the suicidal behavioral \neq level of intent to die
 - › Obtain family/collateral input
- Be careful about words used regarding other suicides or deaths

Suicide Intervention/Prevention

Huggins, et al (2008)



- Intervene to reduce risk
 - › Address basic needs and increase stability
 - › Treat depression
 - › Teach distraction techniques
 - › Remove lethal means
 - › Increase social support
- Do not use suicide contracts (impulsivity issue)
- Monitor risk closely
- Reinforce and build reasons for living
 - › Be literal
- Strengthen advocate-client relationship