Assessment & Communication: Working with Individuals with an Intellectual Disability and Mental Illness

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Founder and CEO
NADD

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Outline of Presentation

- Concept of Dual Diagnosis
- Vulnerability Factors
- Models of Problem Behavior
- Assessment & Diagnostic Procedures
- Diagnostic Procedures
  - Depression
  - Bi-Polar
- Overview of the DM-ID
- Supportive Strategies
WHAT IS NATIONAL ASSOCIATION FOR THE DULLY DIAGNOSED?

NADD
• NADD is a not-for-profit membership association

• Established for professionals, care providers and families

• To promote the understanding of and services for individuals who have developmental disabilities and mental health needs
MISSION STATEMENT

To advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.
• NADD Bulletin
• Conferences/Trainings
• Research Journal
• Training & Educational Products
• Consultation Services
• Accreditation and Certification Program
CONCEPT OF DUAL DIAGNOSIS
Concept Of Dual Diagnosis

• Co-Existence of Two Disabilities: Intellectual Disability and Mental Illness

• Both Intellectual Disability and Mental Health disorders should be assessed and diagnosed

• All needed treatments and supports should be available, effective and accessible
Terminology

Intellectual Disability
Mental Retardation
Developmental Disability
Intellectual Impairment
Learning Disability (UK)

Dual Diagnosis
Dual Disability
Co-Occurring MI-ID
Co-Existing Disorders
Diagnostic Criteria Of Intellectual Disability

A. Significant sub-average intellectual functioning
   1. IQ of 70 or below

B. Concurrent deficits in adaptive functioning

C. Onset before age 18 years
Deficits in Adaptive Functioning

- Self-care
- Language and communication
- Community use
- Independent living skills
Deficits in Adaptive Functioning (continued)

- Socialization skills
- Health and safety
- Work
- Self-direction
Four Levels of ID

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ Range</th>
<th>%</th>
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<tbody>
<tr>
<td>Mild ID</td>
<td>55-70</td>
<td>85</td>
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<tr>
<td>Moderate ID</td>
<td>35-55</td>
<td>10</td>
</tr>
<tr>
<td>Severe ID</td>
<td>20-35</td>
<td>3</td>
</tr>
<tr>
<td>Profound ID</td>
<td>below 20</td>
<td>2</td>
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MENTAL HEALTH PROBLEMS vs. MENTAL ILLNESS

People occasionally experience mental health problems that may:

• Change the way they think and understand the world around them
• Change the way they interrelate with others
• Change the emotions and feelings they have

These changes can have a short-term impact on the way they deal with day-to-day life

However, if the impact is very great (ongoing problems with repeated relapse episodes) then we talk about mental illness

Fletcher, 2011
What Is Mental Illness (MI)?

- MI is a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning.

- MI can affect persons of any age, race, religion, income, or level of intelligence.

- The DSM-IV-TR or the DM-ID provide a classification system of diagnoses.
Mental illness is a biological process which affects the brain. Some refer to it as a brain disorder.
Definition Of Mental Illness In Persons With Intellectual Disability

1. When behavior is abnormal by virtue of quantitative or qualitative differences

2. When behavior cannot be explained on the basis of development delay alone

3. When behavior causes significant impairment in functioning

Adapted from Enfield and Aman 1995
A Summary Of Similarities And Differences Between Intellectual Disability (ID) & Mental Illness (MI)

**ID:** refers to sub-average (IQ)

**MI:** has nothing to do with IQ

**ID:** incidence: 1-2% of general population

**MI:** incidence: 16-20% of general population

**ID:** present at birth or occurs before age 18

**MI:** may have its onset at any age (usually late adolescent)

Fletcher, 2004
<table>
<thead>
<tr>
<th>ID:</th>
<th>intellectual impairment is permanent</th>
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<tr>
<td>MI:</td>
<td>often temporary and may be reversible and is often cyclic</td>
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<table>
<thead>
<tr>
<th>ID:</th>
<th>a person can usually be expected to behave rationally at his or her developmental level</th>
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<tr>
<td>MI:</td>
<td>a person may vacillate between normal and irrational behavior, displaying degrees of each</td>
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<table>
<thead>
<tr>
<th>ID:</th>
<th>adjustment difficulties are secondary to ID</th>
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<tbody>
<tr>
<td>MI:</td>
<td>adjustment difficulties are secondary to psychopathology</td>
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</table>
Prevalence of MI in ID

Two to Four Times
as typical population
(Corbett 1979)

1/3 of People with ID have co-occurring
MI (NADD, 2005)
Prevalence

Total U.S. Population:
308,745,538
(U.S. Census Bureau, Census 2010)

Number of People In Total Population With ID:
5,156,050
(1.67% - AAIDD, 2010)

Number of People With ID Who Have MI:
1,701,496
(33% of ID – NADD, 2008)
Prevalence

Total Montana Population: 989,415
(U.S. Census Bureau 2010)

Number of People in Total Population With ID: 16,523
(1.67% - AAIDD 2010)

Number of People With ID Who Have MI: 5,452
(33% of ID – NADD 2008)
Characteristics Of Persons With ID/MI

- High Vulnerability to Stress
  - The impact of a minimally stressful situation can be experienced as significant.
• Challenges with Coping Skills

• Frequently lack the basic skills required for everyday living; e.g., budgeting money, using public transportation, doing laundry, preparing meals, etc.
Characteristics Of Persons With ID/MI

- Difficulty Working in the Competitive Job Market
  - People with ID/MI often have difficulty working in a competitive employment. They may have frequent job changes interspersed with long periods of unemployment
### Characteristics of Persons with ID/MH

#### Employment (community job)

<table>
<thead>
<tr>
<th></th>
<th>Hours worked in 2 weeks</th>
<th>Amount earned in two weeks</th>
<th>Hourly Wage</th>
<th>Earning at or above minimum wage (%)</th>
<th>Length at current job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Diagnosis</td>
<td>30.6</td>
<td>$170</td>
<td>$5.81</td>
<td>35%</td>
<td>56 months</td>
</tr>
<tr>
<td>ID Only</td>
<td>31.5</td>
<td>$201</td>
<td>$6.40</td>
<td>43%</td>
<td>66 months</td>
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</table>

NCI Survey Report, 2010
Characteristics Of Persons With ID/MI

• Difficulty with Interpersonal Relationships
  • Individuals with ID/MH typically have difficulty with interpersonal relationships
  • These interpersonal relationship problems can result in disruption in school, home, work, and social environments

Fletcher, 2011
Characteristics Of Persons With ID/MH

Relationships

NCI Survey Report, 2010
Characteristics of Persons with ID/MH

Type of Residence

- Institution
- Group Home
- Parent/Relative's Home

(nci survey report, 2010)
Characteristics of Persons with ID/MH

Use of Psychotropic Medications

NCI Survey Report, 2010
VULNERABILITY FACTORS FOR DEVELOPING PSYCHIATRIC DISORDERS IN PERSONS WITH ID
Persons with ID are at increased risk of developing psychiatric disorders due to complex interaction of multiple factors:

- Biological
- Psychological
- Social
- Family
Vulnerability factors for psychiatric disorders

Biological

• Brain damage/epilepsy
• Vision/hearing impairments
• Physical illnesses/disabilities
• Genetic/familial conditions
• Drugs/alcohol abuse
• Medication/physical treatments
Vulnerability Factors

Vulnerability factors for psychiatric disorders

Psychological

• Rejection/deprivation/abuse
• Life events/separations/losses
• Poor problem-solving/coping strategies
• Social/emotional/sexual vulnerabilities
• Poor self-acceptance/low self-esteem
• Devaluation/disempowerment
Vulnerability Factors

Vulnerability factors for psychiatric disorders

Social

- Negative attitudes/expectations
- Stigmatization/prejudice/social exclusion
- Poor supports/relationships/networks
- Inappropriate environments/services
- Financial/legal disadvantages
Vulnerability Factors

Vulnerability factors for psychiatric disorders

Family

- Diagnostic/bereavement issues
- Life-cycle transitions/crises
- Stress/adaptation to disability
- Limited social/community networks
- Difficulties “letting go”
CONCEPTUAL MODELS RELATED TO BEHAVIORAL PROBLEMS:
AN INTEGRATED ASSESSMENT APPROACH
I. Five Conceptual Models:

1. Medical Model
2. Communication Model
3. Behavioral Model
4. Psychiatric Model
5. Integrative Model (1-4)
1. Medical Model

- Problem behaviors are exhibited because of co-existing medical problems
- Assessment of potential medical problems involves conducting a full medical work-up
- Treatment focuses on addressing the underlying medical problem
2. Communication Model

• Views behavioral problems as reflecting “challenging behaviors” in persons who have deficits in language skills

• Behavioral problems due to communication deficits
2. Communication Model (continued)

• Assessment focuses on evaluation of skills, deficits and assets and elicits the communicative intent of the behaviors

• Treatment - teach communication skills
3. Behavioral Model

• Problem behaviors are viewed according to learning principles

• Assessment elicits the antecedent and consequences of the problematic behavior

• Treatment focuses on change in behavior through behavioral approaches, i.e., Positive Behavioral Supports
4. Psychiatric Model

- Views problem behavior as a possible manifestation of a mental disorder
- Presentation of problem behaviors may be associated with a psychiatric disorder
- Assessment based on a bio-psycho-social model
- Treatment focuses on underlying psychiatric disorders
Conceptual Models Related to Behavioral Problems

5. Integrative Model

- Communication Model
- Behavioral Model
- Medical Model
- Psychiatric Model

Integrative Model

Fletcher, 2012
Conceptual Models Related to Behavioral Problems

Case Vignette: John

- 15-year old male, IQ = 50
- Living with parents
- Becoming angry/hostile at school with other students
- Recent onset of behavioral problems
  - SIB
  - Property Destruction
- Sleep disturbance
- Displays agitation and aggression
- Limited verbal communication skills
- Appetite decreased
- Constipation
- No previous psychiatric history
### The Relationship of Challenging Behavior and Intellectual Disability

<table>
<thead>
<tr>
<th>Type of Model</th>
<th>Medical</th>
<th>Communication</th>
<th>Behavioral</th>
<th>Psychiatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Medical Evaluation by primary care physician</td>
<td>Standardized administered measure of expressive language</td>
<td>Functional Analysis</td>
<td>DM-ID</td>
</tr>
<tr>
<td>Problem Identification</td>
<td>Constipation</td>
<td>Speech and language impairment</td>
<td>Occurrence of problem behavior</td>
<td>Affective disorder, mania</td>
</tr>
<tr>
<td>Treatment</td>
<td>Medication for Bowel Movement (Laxative)</td>
<td>Functional communication skill training</td>
<td>Positive behavior support</td>
<td>Medication treatment, psychotherapy</td>
</tr>
</tbody>
</table>
BEST PRACTICES
IN
ASSESSMENT AND DIAGNOSTIC PROCEDURES
Best Practice Assessment: Bio-psychosocial Model

PERSON

BIO

SOCIAL

PSYCHO
Best Practice Assessment: Bio-psychosocial Model

1. Review Reports

2. Interview Family

3. Interview Care Provider

4. Direct Observation

5. Clinical Interview
I. Source of Information and Reason for Referral

II. History of Presenting Problem and Past Psychiatric History

III. Family Health History

IV. Social and Developmental History
I. Source of Information and Reason for Referral

• Who made the referral?
• What is different from baseline behavior?
• Why make the referral now?
II. History of Presenting Problem and Past Psychiatric History

- How long has the problem occurred?
- History of mental health treatment
Mental Health Assessment

III. Personal and Family Health History

- Medical, psychiatric, and substance abuse history
- Psychotropic medications
- Medical conditions
  - Genetic disorders
  - Hypo/hyper thyroid condition
  - Constipation
  - Epilepsy
  - Diabetes
  - Gastrointestinal problem
IV. Social/Developmental History

- Developmental milestones
- Relevant school history
- Work/vocational history
- Current work/vocational status
- Legal issues
- Relevant family dynamics
- Drug/alcohol history
- Abuse history (emotional/physical/sexual)
Behavioral Status Review Reports

A. Recent Changes

B. Problem Behavior

C. Quality of Life Issues
Behavioral Status: 
Recent Changes: A

Name: ________________________________   Today’s Date: ____________
Date of last appointment: ___________  Person completing this form ___________

A. Primary reason(s) for this consultation: ________________________________

B. Life changes that have occurred within the last six (6) months

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<tr>
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<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1.</td>
<td>Moves</td>
<td></td>
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<tr>
<td>2.</td>
<td>Deaths of significant others</td>
<td></td>
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<tr>
<td>3.</td>
<td>Staff or teacher changes</td>
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<tr>
<td>4.</td>
<td>New roommates/classmates</td>
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<tr>
<td>5.</td>
<td>Problems</td>
<td></td>
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<tr>
<td>6.</td>
<td>Loss of friend, pet, family member</td>
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<td>7.</td>
<td>Loss of key staff/teacher</td>
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<tr>
<td>8.</td>
<td>Evidence of a delayed grief reaction</td>
<td></td>
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<tr>
<td>9.</td>
<td>Change in employment, program or leisure activities</td>
<td></td>
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</table>

C. Acute medical problems or changes in past medical condition since last visit: ________________________________
## Behavioral Status:
### Problem Behavior: B

<table>
<thead>
<tr>
<th></th>
<th>C</th>
<th>A</th>
<th>E</th>
<th>N/A</th>
<th>Comments</th>
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<tbody>
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<td>1.</td>
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<td>6.</td>
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**Chronic:** Person displays behavior on a daily basis, but severity may wax and wane

**Acute:** Behavior represents a dramatic change

**Episodic:** Periods of disturbance and periods of normal functioning

**N/A:** Non-Applicable
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<th></th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>7. Engages in ritualistic behavior, compulsions</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Has self-stimulatory behavior</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Steals</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>10. Has tantrums</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>11. Is impulsive</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>12. OTHER (explain):</td>
<td>C</td>
<td>A</td>
<td>E</td>
<td>N/A</td>
</tr>
</tbody>
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**Chronic:** Person displays behavior on a daily basis, but severity may wax and wane

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**N/A:** Non-Applicable
**Behavioral Status:**
**Quality of Life Issues: C**

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
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<tbody>
<tr>
<td>Family</td>
<td></td>
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<tr>
<td>Friends</td>
<td></td>
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<tr>
<td>Living Situation</td>
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<tr>
<td>Leisure Activities</td>
<td></td>
</tr>
<tr>
<td>Staff Relations</td>
<td></td>
</tr>
<tr>
<td>Hobbies</td>
<td></td>
</tr>
<tr>
<td>Work</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
Minimal Data Collection

- Physical Health
- 24 Hours Sleep Data (month cycle)
- Medication Changes
- Eating Patterns
- Environmental Changes
- Mood Charting
  - Symptoms and Behavioral Manifestations
24-Hour Framework

Sleep Patterns
Eating Patterns
Mood Patterns
Myth: Individuals with Intellectual Disability (ID) Cannot Have a Verifiable Mental Health Disorder

PREMISE:
Maladaptive behaviors are a function of ID

REALITY:
The full range of psychiatric disorders can be represented in persons with ID

DIAGNOSTIC IMPLICATIONS:
Psychiatric diagnosis can be made using the DM-ID, DSM-4TR records, service providers, family input, and client interview
1. Persons with Intellectual Disabilities suffer from the full range of psychiatric disorders

2. Psychiatric disorders usually present as maladaptive behavior

3. The origin of psychopathology is multi-determined
4. An acute psychiatric disorder may present as an exaggeration of longstanding maladaptive behavior

5. Maladaptive behavior rarely occurs alone

6. The severity of the problem is not diagnostically relevant
7. The clinical interview alone is rarely diagnostic

8. It is very difficult to diagnose psychotic disorders in persons with very limited verbal skills
<table>
<thead>
<tr>
<th></th>
<th>Barriers to Diagnosis and Treatment</th>
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<tbody>
<tr>
<td>1</td>
<td>Diagnostic Overshadowing</td>
</tr>
<tr>
<td>2</td>
<td>Problems with Poly pharmacy</td>
</tr>
<tr>
<td>3</td>
<td>Communication Deficits</td>
</tr>
<tr>
<td>4</td>
<td>Atypical Presentation of Psychiatric Disorders</td>
</tr>
<tr>
<td>5</td>
<td>Limited Life Experiences</td>
</tr>
<tr>
<td>6</td>
<td>Medical Conditions</td>
</tr>
<tr>
<td>7</td>
<td>Acquiescence</td>
</tr>
<tr>
<td>8</td>
<td>Learned Behavior</td>
</tr>
<tr>
<td>9</td>
<td>Aggression and SIB</td>
</tr>
<tr>
<td>10</td>
<td>Sensory Impairment</td>
</tr>
<tr>
<td>11</td>
<td>Behavioral Overshadowing</td>
</tr>
<tr>
<td>12</td>
<td>Medication Masking</td>
</tr>
<tr>
<td>13</td>
<td>Episodic Presentation</td>
</tr>
<tr>
<td>14</td>
<td>Division of Services</td>
</tr>
<tr>
<td>15</td>
<td>Lack of Expertise</td>
</tr>
</tbody>
</table>
Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (1-3)

1) Diagnostic Overshadowing

2) Problems with Poly Pharmacy

3) Communication Deficits
Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (4-6)

4) Atypical Presentation of Psychiatric Disorders

5) Limited Life Experiences

6) Medical Conditions
Barriers to Diagnosis and Treatment

Complicating Diagnostic Factors (7-9)

7) Acquiescence

8) Learned Behavior

9) Aggression and SIB
10) Sensory Impairment

11) Behavioral Overshadowing

12) Medication Masking
<p>| | |</p>
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<tr>
<td>13)</td>
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<td>15)</td>
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</tbody>
</table>
It can be difficult to distinguish whether a behavioral problem is associated with:

- A symptom of a psychiatric disorder
- A learned behavior
- A medical condition
• Why do medical causes of problem behaviors get missed?

• Why do we have to be...... Sherlock Holmes
Medical Problems & 
Problem Behavior

Medical conditions can be present when behavioral problems are exhibited.

Medication effects / reactions can be present when behavioral problems are exhibited.

Medical conditions are often underdiagnosed.

Medical conditions can mask as behavioral problems.
Medical Problems & Problem Behavior

**DRUG SIDE EFFECTS**
Akathisia, Delirium, Dyskinesia

**INFECTIONS**

**ENDOCRINOLOGICAL PROBLEMS**
Thyroid problems  Diabetes

**NEUROLOGICAL PROBLEMS**
Epilepsy  Other movement problems

**OTHER**
Dental pain  Sleep apnea  Hearing and vision problems
Back pain  Headaches

Charlot, 2011
Condensed Medical Data in Chart

It is essential that all earlier medical data be available.

It is important that the past and present medical history be condensed in a format that can be easily read and placed in the person’s chart.
Medical Problems & Problem Behavior

Medical Problems may cause significant alterations in mood and behavior that mimic acute psychiatric illness.
Medical Problems & Problem Behavior

Medical Problems May Cause Distress & Look Like an Acute Psychiatric Problem

Frequency of Inpatients Diagnosed with Mental Disorder due to a Medical Problem

N = 198

Medical cause of Agitation = 82

41% = Percent of Patients with ID admitted to a psych unit, diagnosed with medical cause

Charlot, 2011
Medical Problems & Problem Behavior

Symptoms Reported by Informants:

Don’t confuse phenomenology with etiology

• **MANIA**
  • Irritable, restless, pacing, running back and forth, can’t sit still, can’t focus, can’t get to sleep

• **AKATHISIA**
  • Irritable, restless, pacing, running back and forth, can’t sit still, can’t focus, can’t get to sleep

• **DEPRESSION**
  • Crying, won’t get out of bed, decreased concentration

• **CONSTIPATION**
  • Crying, won’t get out of bed, decreased concentration

Charlot, 2011
1. **Sleep Pattern**

Quality and quantity of sleep can affect physical and mental health

For example:

a. Poor sleep $\Rightarrow$ fatigue $\Rightarrow$ irritability
b. Depression $\Rightarrow$ poor sleep $\Rightarrow$ irritability
c. Medical problem (discomfort caused by constipation) $\Rightarrow$ poor sleep $\Rightarrow$ irritability

**Assessment Strategy**

Maintain sleep data
2. Appetite Pattern

Changes in appetite can be clues in the assessment of mental health or physical problems.

Significant weight change may indicated a medical or mental health problems.

Assessment Strategy
Monitor and document a person’s weight on a weekly basis.
3. **Activity Level**

Activity level refers to the things a person usually does during the day. For example:

- going to work
- completing chores
- leisure time pursuits

**Assessment Strategy**

If a person’s activity level changes drastically, it may be an unrecognized medical or mental health problem.
Medical Problems & Problem Behavior

4. **Activity Level**

   **Examples:**

   Arthritis $\Rightarrow$ decreased activity $\Rightarrow$ refuses to go to work $\Rightarrow$ could be viewed as non-compliant

   Depression $\Rightarrow$ decreased activity $\Rightarrow$ refuses to go to work $\Rightarrow$ could be viewed as non-compliant
I. General Appearance and Behavior
II. Mood and Affect
III. Psychomotor Activity and Speech
IV. Thought Process and Content
V. Cognitive Functions
VI. Judgment and Insight
VII. Multi-Axial Diagnoses
I. General Appearance and Behavior

- Determines level of consciousness
- Assesses person’s attentiveness and effective participation in interview
- Notes person’s attitude toward examiner
- Assesses posture and general motor activity
- Notes facial expression
- Notes personal hygiene and grooming
- Assesses weight status

Note: All of the above is based on the cognitive developmental level of the individual with ID.
II. Mood and Affect

• Describe predominant mood

• Describe affect including range

Note: All of the above is based on the cognitive developmental level of the individual with ID.
III. Psychomotor Activity and Speech

• Assesses psychomotor activity and notes
  • Rate of psychomotor activity
  • Presence of abnormal movements

• Assesses speech and notes amount, volume, rate, organization of speech

Note: All of the above is based on the cognitive developmental level of the individual with ID.
IV. Thought Processes and Content

- Assess thought abnormalities
- Evaluates the content of thought
- Notes presence of delusions, hallucinations (if so, what type of hallucinations)

Note: All of the above is based on the cognitive developmental level of the individual with ID.
V. Cognitive Functions

- Assess patient’s orientations to time, place, and persons
- Evaluate patient’s attention and concentration
- Assess patient’s memory
- Assess intellectual functioning

Note: All of the above is based on the cognitive developmental level of the individual with ID.
VI. Judgment and Insight

- Assess person’s judgment in general
- Evaluates person’s insight in situation and illness

Note: All of the above is based on the cognitive developmental level of the individual with ID.
VII. Multi-Axial Diagnoses

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I</td>
<td>Clinical Disorders</td>
</tr>
<tr>
<td>Axis II</td>
<td>Intellectual Disability</td>
</tr>
<tr>
<td></td>
<td>Personality Disorders</td>
</tr>
<tr>
<td>Axis III</td>
<td>General Medical Conditions</td>
</tr>
<tr>
<td>Axis IV</td>
<td>Psychosocial and Environmental Problems</td>
</tr>
<tr>
<td>Axis V</td>
<td>Global Assessment of Functioning</td>
</tr>
</tbody>
</table>

Note: All of the above is based on the cognitive developmental level of the individual with ID.
Holistic Treatment Plan: Person Centered

Psychiatric Treatment:
  i.e., Medications, psychotherapy

Living Environment
  i.e., Natural environment or group home

Vocational
  i.e., School, special ed

Health: ________________________________

Leisure Time
  i.e., Sports, indoor/outdoor activities

Family/Friends: ________________________________

Other (Specify): ________________________________
DEPRESSION
Depression

- Can significantly disrupt school, work, family relationships, social life, etc.
- Onset tends to be more insidious and changes less dramatic (Deb et al., 2001)
- Increased prevalence in some symptoms as compared to typical population (Matson, 1988)
- Depression is among the most common psychiatric disorders in persons with ID (Lamon & Reiss, 1987)
## Depression

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressed Mood</strong></td>
<td>• Frequent unexplained crying</td>
</tr>
<tr>
<td></td>
<td>• Decrease in laughter and smiling</td>
</tr>
<tr>
<td></td>
<td>• General irritability and subsequent aggression or self-injury</td>
</tr>
<tr>
<td></td>
<td>• Sad facial expression</td>
</tr>
<tr>
<td><strong>Loss of Interest in Pleasure</strong></td>
<td>• No longer participates in favorite activities</td>
</tr>
<tr>
<td></td>
<td>• Reinforcers no longer valued</td>
</tr>
<tr>
<td></td>
<td>• Increased time spent alone</td>
</tr>
<tr>
<td></td>
<td>• Refusals of most work/social activities</td>
</tr>
</tbody>
</table>
## Depression

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Change/Appetite Change</td>
<td>• Measured weight changes</td>
</tr>
<tr>
<td></td>
<td>• Increased refusals to come to table to eat</td>
</tr>
<tr>
<td></td>
<td>• Unusually disruptive at meal times</td>
</tr>
<tr>
<td></td>
<td>• Constant food seeking behaviors</td>
</tr>
<tr>
<td>Insomnia</td>
<td>• Disruptive at bed time</td>
</tr>
<tr>
<td></td>
<td>• Repeatedly gets up at night</td>
</tr>
<tr>
<td></td>
<td>• Difficulty falling asleep</td>
</tr>
<tr>
<td></td>
<td>• No longer gets up for work/activities</td>
</tr>
<tr>
<td></td>
<td>• Early morning awakening</td>
</tr>
<tr>
<td>Hypersomnia</td>
<td>• Over 12 hours of sleep per day</td>
</tr>
<tr>
<td></td>
<td>• Naps frequently</td>
</tr>
</tbody>
</table>

Hughes, 2006
**Depression**

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychomotor Agitation</td>
<td>● Restlessness, Fidgety, Pacing</td>
</tr>
<tr>
<td></td>
<td>● Increased disruptive behavior</td>
</tr>
<tr>
<td>Psychomotor Retardation</td>
<td>● Sits for extended periods</td>
</tr>
<tr>
<td></td>
<td>● Moves slowly</td>
</tr>
<tr>
<td></td>
<td>● Takes longer than usual to complete activities</td>
</tr>
</tbody>
</table>

Hughes, 2006
# Depression

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue/Loss of Energy</td>
<td>● Needs frequent breaks to complete simple activity</td>
</tr>
<tr>
<td></td>
<td>● Slumped/tired body posture</td>
</tr>
<tr>
<td></td>
<td>● Does not complete tasks with multiple steps</td>
</tr>
<tr>
<td>Feelings of Worthlessness</td>
<td>● Statements like “I’m dumb,” “I’m retarded,” etc.</td>
</tr>
<tr>
<td></td>
<td>● Seeming to seek punishment</td>
</tr>
<tr>
<td></td>
<td>● Social isolation</td>
</tr>
</tbody>
</table>

Hughes, 2006
## Depression

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| Lack of Concentration/Diminished Ability to Think | • Decreased work output  
• Does not stay with tasks  
• Decrease in IQ upon retesting |
| Thoughts of Death | • Preoccupation with family member’s death  
• Talking about committing or attempting suicide  
• Fascination with violent movies/television shows |

Hughes, 2006
Depression

Treatment Strategies

- Antidepressant medication
- Psychotherapy (individual and/or group)
- Regular exercise
- Regular scheduling of pleasurable activities
- Learning stress management strategies
- Social skill training
- Positive behavioral supports
Case Vignette: Mary

- Mary is a 16 year old female with moderate ID
- Lives at home with mother
- Attends special ed at local public school
- Teacher noticed Mary not participating in class, as she did in the past
- In recent weeks, Mary would yell and scream at teacher when prompted to do her class work
- Mary’s performance at school declined
- She became socially isolated from peers
- Referred to school psychologist
- Psychologist suspected depression
- Psychologist referred Mary to psychiatrist
Case Vignette: Mary

Dx: Major Depression

Tx: Counseling by school psychologist
    Antidepressant medication by psychiatrist

Outcome: Gradual lifting of depression
          Return to her normal functioning within three (3) months
BIPOLAR DISORDER
Bipolar Disorder

• Causes mood swings

• Persons with Bipolar Disorder may have periods of mania and periods of depression as well as normal moods

• During manic episode, person will display oversupply of confidence and energy
## Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| Euphoric, Elevated or Irritable Mood | • **Smiling, hugging or being affectionate with people who previously were not favored by the individual**  
• **Boisterousness**  
• **Over-reactivity to small incidents**  
• **Extreme excitement**  
• **Excessive laughing and giggling**  
• **Self-injury associated with irritability**  
• **Enthusiastic greeting of everyone** |

Hughes, 2006
<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased Need for Sleep</td>
<td>• Behavioral challenges when prompted to go to bed</td>
</tr>
<tr>
<td></td>
<td>• Constantly getting up at night</td>
</tr>
<tr>
<td></td>
<td>• Seems rested after not sleeping (i.e., not irritable due to lack of sleep as is common in depression)</td>
</tr>
</tbody>
</table>

Hughes, 2006
### Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| Inflated Self-esteem/Grandiosity | • Making improbable claims (e.g., is a staff member, has mastered all necessary skills, etc.)  
• Wearing excessive make-up  
• Dressing provocatively  
• Demanding rewards |
| Flight of Ideas | • Disorganized speech  
• Thoughts not connected  
• Quickly changing subjects |

Hughes, 2006
### Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| **More Talkative/ Pressured Speech** | • Increased singing  
• Increased swearing  
• Perseverative speech  
• Screaming  
• Intruding in order to say something  
• Non-verbal communication increases  
• Increase in vocalizations |

Hughes, 2006
**Bipolar Disorder**

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distractibility</td>
<td>• Decrease in work/task performance</td>
</tr>
<tr>
<td></td>
<td>• <strong>Leaving tasks uncompleted</strong></td>
</tr>
<tr>
<td></td>
<td>• Inability to sit through activities (e.g., favorite TV show)</td>
</tr>
</tbody>
</table>

Hughes, 2006
### Bipolar Disorder

<table>
<thead>
<tr>
<th>DSM IV-TR Symptoms of Mania</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
</table>
| **Agitation/Increase in Goal Directed Behavior** | • Pacing  
• Negativism  
• Working on many activities at once  
• Fidgeting  
• Aggression  
• Rarely sits |
| **Excessive Pleasurable Activities** | • Increase in masturbation  
• Giving away/spending money |

Hughes, 2006
Bipolar Disorder

**Treatment Strategies**

- Mood stabilizing and antidepressant medication
- Psychotherapy with a focus on understanding and managing the disorder
- Environmental and social modification (i.e. increase supervision to insure safety)
- Positive Behavioral Supports
Case Vignette: Bob

- Bob is a 20 year old male with severe ID
- Mother reported sleep disturbance
- At school he began hitting other peers
- Mother reported weight loss
- Teacher reported increased agitation (i.e., rarely sits, fidgety, angry outbursts)
- Mother referred Bob to family physician
- Dx: Bi-Polar Disorder
- Tx: Mood stabilizing medication

Outcome: After eight (8) weeks, Bob’s behavior began to improve. At twelve (12) weeks, he was able to return to his normal daily routine without disruption
Overview of the Diagnostic Manual for Persons with Intellectual Disabilities DM-ID
Limitations of DSM System

- **Diagnostic Overshadowing** (Reiss, et al, 1982)

- Applicability of established diagnostic systems is increasingly suspect as the severity of ID increases (Rush, 2000)

- DSM and ICD Systems rely on self report of signs and symptoms
DM–ID: Two Manuals

Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

Robert J. Fletcher, DSW, ACSW, Chief Editor
Chief Executive Officer
National Association for the Dually Diagnosed, Kingston, NY

Earl Loschen, MD
Professor Emeritus, Department of Psychiatry
Southern Illinois University School of Medicine, Springfield, IL

Chrissoula Stavrakaki, MD, PhD
Professor, Department of Psychiatry
University of Ottawa, Ontario, Canada

Michael First, MD
Professor of Clinical Psychiatry
Department of Psychiatry
Columbia University, New York, NY
Editor of the DSM-IV-TR
Description of DM-ID

- An adaptation to the *DSM-IV-TR*
- Designed to facilitate a more accurate psychiatric diagnosis
- Based on Expert Consensus Model
- Covers all major diagnostic categories as defined in *DSM-IV-TR*
• Provides information to help with diagnostic process

• Addresses pathoplastic effect of ID on psychopathology (expression disorder)

• Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID
• Empirically-based approach to identify specific psychiatric disorders in persons with ID

• Provides state-of-the-art information about mental disorders in persons with ID

• Provides adaptations of criteria, where appropriate
Two Special Added-Value Chapters

• Assessment and Diagnostic Procedures

• Behavioral Phenotype of Genetic Disorders
Special Consideration

Language That Is Understandable

• Use simple language
• Create short sentences
• Check back with person for understanding
• Use of examples
Assessment of Medical Conditions

- Constipation → distress
- Hypothyroidism → depressive symptoms
- Hyperthyroidism → manic episode
- Diabetes → behavioral side effects
<table>
<thead>
<tr>
<th>Genetic Disorder</th>
<th>Genetic Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelman Syndrome</td>
<td>Prader-Willi Syndrome</td>
</tr>
<tr>
<td>Cri-du-Chat (5p-) Syndrome</td>
<td>Rubenstein-Taybi Syndrome</td>
</tr>
<tr>
<td>Down Syndrome</td>
<td>Smith-Magenis Syndrome</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td>Tuberous Sclerosis Complex</td>
</tr>
<tr>
<td>Fragile-X Syndrome</td>
<td>Velocardiofacial Syndrome</td>
</tr>
<tr>
<td>Phenylketonuria</td>
<td>Williams Syndrome</td>
</tr>
</tbody>
</table>
### Phenotype and Proposed Behavioral Phenotype for Down Syndrome

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>Proposed Behavioral Phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood</strong></td>
<td>Oppositional and defiant; Attention-Deficit/Hyperactivity Disorder (ADHD); social, charming personality “stereotype”</td>
</tr>
<tr>
<td><strong>Adulthood</strong></td>
<td>Depressive disorders; Obsessive-Compulsive Disorder; other anxiety disorders; dementia of the Alzheimer’s Type; mental disorders associated with hypothyroidism</td>
</tr>
</tbody>
</table>

Small head, mouth; upward slant to eyes; epicanthal folds; broad neck; hypothyroidism; hearing loss; visual impairments; cardiac problems; gastrointestinal; orthopedic, and skin disorders; obesity

DM-ID
Diagnostic Chapter Structure

• Review of Diagnostic Criteria
  • General description of the disorder
  • Summary of DSM-IV-TR criteria

• Issues related to diagnosis in people with ID

• Review of Literature/Research
  • Evaluating level of evidence
• Application of Diagnostic Criteria to People with ID

• General considerations

• Adults with Mild to Moderate ID

• Adults with Severe or Profound ID

• Children and adolescents with ID
• Etiology and Pathogenesis
  • Risk Factors
    • Biological Factors
    • Psychological Factors
    • Genetic Syndromes
## Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fletcher, 2007
## Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Adaptation of the DSM-IV-TR Criteria

1. Addition of symptom equivalents
2. Omission of symptoms
3. Changes in symptom count
4. Modification of symptom duration
Adaptation of the DSM-IV-TR Criteria

5. Modification of age requirements

6. Addition of explanatory notes

7. Criteria Sets that do not apply
**Adaptation of DSM-IV-TR Criteria**

**Change in Count and Symptom Equivalent**

### Major Depressive Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.</td>
<td><strong>A.</strong> <strong>Four</strong> or more symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure or (3) <strong>irritable mood</strong>.</td>
</tr>
</tbody>
</table>
Adaptation of *DSM-IV-TR* Criteria

Modification of Symptom Duration

**Intermittent Explosive Disorder**

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
<td>A. <strong>Frequent episodes that last for at least two months</strong> of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
</tr>
</tbody>
</table>
# Adaptation of *DSM-IV-TR* Criteria

## Modification of Age

### Antisocial Personality Disorder

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Individuals with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</td>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 18 years, as indicated by three (or more) of the following:</td>
</tr>
<tr>
<td>B. The individual is at least age 18 years</td>
<td>B. The individual is at least age 21 years</td>
</tr>
<tr>
<td>C. There is evidence of Conduct Disorder with the onset before age 15 years</td>
<td>C. There is evidence of Conduct Disorder with onset before age 18 years</td>
</tr>
</tbody>
</table>
**Adaptation of DSM-IV-TR Criteria**  
**Addition of Explanatory Note**

### Manic Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A distinct period of abnormally persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)</td>
<td>A. No adaptation.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Observers may report that the individual with ID; has loud inappropriate laughing or singing, is excessively giddy or silly; is intrusive, getting into other’s space; and smiles excessively and in ways that are not appropriate to the social context. Elated mood may be alternating with irritable mood</td>
</tr>
</tbody>
</table>
# Field Study of the Clinical Usefulness of the DM-ID

## Table 1: Clinician Impressions by Level of Intellectual Disability (%YES)

<table>
<thead>
<tr>
<th>Item</th>
<th>Level of Intellectual Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild N=305</td>
</tr>
<tr>
<td></td>
<td>Moderate N=237</td>
</tr>
<tr>
<td></td>
<td>Severe/ Profound N=285</td>
</tr>
<tr>
<td>Was the DM-ID easy to use (user friendly)?</td>
<td>72.4</td>
</tr>
<tr>
<td></td>
<td>68.6</td>
</tr>
<tr>
<td></td>
<td>62.6</td>
</tr>
<tr>
<td>Did you find the DM-ID clinically useful in the diagnosis of this patient?</td>
<td>74.9</td>
</tr>
<tr>
<td></td>
<td>67.8</td>
</tr>
<tr>
<td></td>
<td>66.0</td>
</tr>
<tr>
<td>Did DM-ID allow you to arrive at an appropriate psychiatric diagnosis for this patient?</td>
<td>85.6</td>
</tr>
<tr>
<td></td>
<td>83.3</td>
</tr>
<tr>
<td></td>
<td>80.2</td>
</tr>
<tr>
<td>Did DM-ID allow you to come up with a more specific diagnosis than you would have with the <em>DSM-IV-TR</em>?</td>
<td>36.1</td>
</tr>
<tr>
<td></td>
<td>38.0</td>
</tr>
<tr>
<td></td>
<td>35.9</td>
</tr>
<tr>
<td>Did DM-ID help you avoid using the NOS category?</td>
<td>63.2</td>
</tr>
<tr>
<td></td>
<td>63.3</td>
</tr>
<tr>
<td></td>
<td>54.9</td>
</tr>
</tbody>
</table>

Fletcher, et al, 2008
APPROACHES FOR TREATMENT AND SUPPORT
Myth: Persons with ID Are Not Appropriate for Psychotherapy

Premise: Impairments in cognitive abilities and language skills make psychotherapy ineffective.

Reality: Level of intelligence is not a sole indicator for appropriateness of therapy.

Treatment implications: Psychotherapy approaches need to be adapted to the expressive and receptive language skills of the person.
Psychotherapy/ Counseling

• Relationship between a client and a therapist/counselor

• Engaged in a therapeutic relationship

• To achieve a change in emotions, thoughts or behavior
General Similarities Between Life Issues Faced by Adolescents without ID and Adults with ID

- Both usually dependent on others
- Both tend to be in supervised settings
- Both have cognitive limitations in terms of:
  - Problem solving
  - Impulse control
  - Concrete thought
General Similarities Between Life Issues Faced by Adolescents without ID and Adults with ID

• Both struggle with issues of:
  Independence
  Peer group
  Identity choices
  Vocational
  Sexual identity
  Authority issues

• Both referred to therapy by others
Types of Stress Experienced by Persons with Intellectual Challenges

I. Ordinary situations which are not typically stressful to the general population
   a. social interactions
   b. meeting new people
   c. going to public places

II. Stress from difficult to manage situations for all people, even more stress for people with disabilities
   a. Major changes in one’s life
      1. job
      2. death in family
      3. home relocation
   b. Adult expectations
      1. sexuality issues: dating, sex,
      2. money management
      3. living independently
      4. employment

Duetsch, 1989
"I'M AFRAID THAT YOU'RE SIMPLY GOING TO HAVE TO GIVE UP STRESS."
Principles for Achieving a Therapeutic Relationship

- Empathetic understanding
- Respect and acceptance of client
- Therapeutic genuineness
- Concreteness
- Accept the client’s life circumstances
• Be consistent
• Confidentiality
• Draw the client out
• Express genuine interest in your client
• Be aware of your own feelings
Considerations in Therapy with Persons Who Have Mental Illness and ID

Special Considerations

- Watch for pleasers
- Slow progress
- Multiplicity of problems
- Reliability of reporting
- Difficulty relating to analogies
- Problems with terminating
Confidentiality

• Nothing discussed in therapy will be released without the person’s permission

• With the client’s permission, the therapist will work collaboratively other care providers
Help People Better Cope With Problems

1. **Listen**
2. **Reflect**
3. **Probe**
4. **Support**
5. **Facilitate problem solving**
6. **Evaluate outcome**
Therapy Techniques for Promoting Mental Wellness

Active Listening

- Attentive
- Interested
Reflect

- Repeat a few words

- Reflection demonstrates active listening
Therapy Techniques for Promoting Mental Wellness

**Probe**

- Ask direct questions
- Avoid interrogation
- *How* and *what* questions are usually easier to answer than *why* questions
Support

- Supportive statements indicate understanding
- Express that you care
- Acknowledge having been in a similar situation
Therapy Techniques for Promoting Mental Wellness

Facilitate problem solving

• Explore alternative options
• Support acceptable solutions
Therapy Techniques for Promoting Mental Wellness

Evaluate outcome

- Was outcome acceptable?
- Was it positive?
- What was learned?
OK -
We took our clothes off and I got on top...
When does it start feeling good?

I don't know but I already have a headache!
Guiding Principles:

- Use language that promotes hope
- Raise expectations of what people are capable of accomplishing
- Stay focused on strengths
Therapy Techniques for Promoting Mental Wellness

- Build everyone’s hope, because hope is the energy that moves transformation forward

- Move people to the “helper” role as soon as possible
Therapy Techniques for Promoting Mental Wellness

- Celebrate accomplishments
- Find ways to listen to our consumers
• Stressful events may exacerbate or trigger acute psychiatric problems

• People tend to underestimate the impact of stressful life events in people with DD
• Greater exposure to negative life events
• Peer rejection (Philips)
• Residential transfers (Berkson, Heller)
• Negative self-image (Edgerton)
• Transition (Rusch & Chadsey-Rusch)
• Sexual abuse (Ryan)
• Communication of needs (Carr)
There are a number of transitional stages that an individual with ID and his or her family experience throughout the life course. Each one of these transitional stages can contribute to increased stress on the individual and family.

Each one of these transitional stages can result in a crisis situation. If we can identify these stages before they occur, and if we can provide supportive therapy, then we can work toward avoiding a crisis.
Predictable Crisis and Prevention

- Confirmation/realization of diagnosis of ID
- Birth of siblings
- Starting school
- Puberty and adolescence
Predictable Crisis and Prevention

- Sex and dating
- Being surpassed by younger siblings
- Emancipation of siblings
- End of education

Levitas and Gilson, 1989
Predictable Crisis and Prevention

- Out-of-home placement and/or residential moves
- Staff/client relationships
- Loss of peers, friends & parents
- Medical illness & Psychiatric Illness

Levitas and Gilson, 1989
1. Communication Tone
2. Environmental
3. Choice and self determination
4. Relaxation techniques
5. Verbal strategies
1. The Importance of Communication:
   Setting the Tone

   • Begin your interaction socially.
   • Use a non-demanding approach.
   • Give choices whenever possible.
2. Environmental Contributors to Problem Behaviors

- Important to evaluate the environment
- To look for things that might be contributing to, or triggering problem behaviors

NOTE:

Important to look at environment from the person’s perspective.

Gardner, Griffiths, and Nugent, 1999
3. Providing Choice and Self Determination

A. Guiding Principles of Choice has positive benefits:
   - increases community integration
   - increases adaptive behavior
   - improves overall quality of life
   - decreases problem behavior
4. **Relaxation Techniques**

The purpose is to help the individual self manage and reduce stress, tension and/or angry feelings.

Relaxation strategies distract the person from the source of the stress and places focus and appropriate behavior.
5. Verbal Strategy

- Verbal techniques can help an individual feel acknowledged and supported
- Verbal techniques can be used by direct care staff as well as clinical staff
  a) Validating
  b) Exploring
  c) Problem Solving

Hughes, 2006
5. a) Validating

Validating involves confirming the person’s emotions.

An example of this is shown in the following scenario:

Jack: “Everybody around here hates me!”

Staff: “It sounds as though you are pretty angry.”
5. b) Validating & Exploring

Validating and Exploring can be combined and involve encouraging the individual to further explain whatever it is the individual is trying to communicate.

An example of this is shown in the following scenario:

Jack: “Everybody around here hates me!”

Staff: “It sounds like you are pretty angry. Can you tell me what you are so mad about?”
5. c) Problem Solving

Identifying the nature of the problem from the client's point of view.

Explore alternative solutions to the problem.

Implement the best alternative solution.

Hughes, 2006
There are certain communication techniques which can be very helpful in de-escalating situations. These include:

1. Active Listening
2. Empathetic responses
3. Maintain a non-judgmental attitude

Continued . . .
Effective Communication Strategies

4. Avoid power struggles
5. Watch your posture and body language
6. Validate how they are feeling
7. Put the choices back to the person

McGilvery & Sweetland, 2011
It is very important to be skilled at helping to de-escalate an agitated individual. There are both verbal techniques and non-verbal techniques which can be used to de-escalate a situation. Being well prepared to use the non-verbal techniques is very important when working in settings where there are individuals who are prone to exhibit unsafe reactions when agitated.
Crisis Management

Non-Verbal De-Escalation Strategies

1. Monitor your body position and body language
2. Avoid physically putting yourself in harm’s way
3. Maintain a demeanor of calmness, neutrality, and confidence

McGilvery & Sweetland, 2011
Crisis Management

Verbal De-Escalation Strategies

1. Use a calm tone of voice
2. Use reflective listening
3. Avoid threatening punishment
4. Avoid power struggles
5. Do not ignore escalations of behaviors that could lead to severe behaviors

Continued . . .

McGilvery & Sweetland, 2011
6. Change staffing if necessary
7. Affirm that you understand
8. Change the subject if it appears to agitate the person more to talk about it

Continued . . .
9. Change aspects of the environment

10. Be limit setting by reminding the person of the rules but do so in a firm, fair manner and with a non-emotional tone of voice

11. Remind the individual of the undesirable consequences that can occur if he or she engages in the behavior

McGilvery & Sweetland, 2011
RATIONAL APPROACH TO PSYCHOPHARMACOLOGY
MYTH: MEDICATION TREATMENT IS USED TO CONTROL MALADAPTIVE BEHAVIORS

Premise:
Medication therapy directly affects behavior.

Reality:
Behaviors such as self-injury and aggression are too nonspecific to be considered as direct targets for drug therapy.

Treatment implications:
The appropriate targets for medication therapy are the changes in neurophysiological function that mediate behavior associated with psychiatric disorders.
Pharmacotherapy is therapeutic and may be the first choice treatment for some psychiatric disorders:

- Major depression
- Mania states
- Schizophrenia

Medication treatment should be diagnostically related to a DSM-IV or the DM-ID
A RATIONAL APPROACH FOR MEDICATION TREATMENT

Used as one aspect of a balanced treatment/habilitative approach:

- Medication treatment
- Therapy/counseling
- Behavioral interventions
- Family supports
- Quality of life opportunities
Inter-Systems Collaboration
Purpose/Function of A Dual Diagnosis Task Force/Committee

• Gather relevant data/formation

• Identify strengths in service delivery systems

• Identify challenges in service delivery system
Purpose/Function of A Dual Diagnosis Task Force/Committee

- Generate options for improvement in service delivery systems
- Promote cross systems education/training to enhance staff competencies
- Advocate for policy initiative that advance cross systems collaboration
Inter-Systems Collaboration

Stakeholders from other than MH & IDD systems could be included as appropriate, perhaps on an “as needed” basis. These include, but are not limited to representatives from:

- Substance abuse
- Criminal Justice
- Health Department
- Social Services
- Parents
- Consumers
- Advocacy Organizations
- Special Education
- Early Intervention
- Child Welfare
- Coordinated Children’s Services
- Service Providers
Inter-Systems Collaboration

Mental Health

- Substance Abuse
- Criminal Justice
- Health

PERSON

- Child & Family Serv.
- Vocational
- Education
- Social Serv.
- IDD

Fletcher, 2007
NO QUICK FIX
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THANK YOU