

# **Intellectual Disability and Psychiatric Disorders: Understanding Diagnosis**

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# Section 1: What is Dual Diagnosis?

## Dual Diagnosis Definition:

Dual Diagnosis is defined as a person who has both an **intellectual disability** and a **psychiatric (mental) disorder**.

## Intellectual Disability Definition (The American Association on Intellectual and Developmental Disability) :

Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18 (age of 22 in Pennsylvania).

**Intellectual functioning**—also called intelligence—refers to general mental capacity, such as learning, reasoning, problem solving, and so on.

One criterion to measure intellectual functioning is an IQ test. Generally, an IQ test score of around 70 or as high as 75 indicates a limitation in intellectual functioning.

Standardized tests can also determine limitations in **adaptive behavior**, which comprises three skill types:

Conceptual skills—language and literacy; money, time, and number concepts; and self-direction.

Social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.

Practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

On the basis of such many-sided evaluations, professionals can determine whether an individual has an intellectual disability and can tailor a support plan for each individual.

But in defining and assessing intellectual disability, the American Association on Intellectual and Developmental Disabilities (AAIDD) stresses that professionals must take additional factors into account, such as the community environment typical of the individual's peers and culture.

Professionals should also consider linguistic diversity and cultural differences in the way people communicate, move, and behave.

Finally, assessments must also assume that limitations in individuals often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period.

### **Psychiatric (Mental) Disorder Definition (Diagnostic and Statistical Manual of Psychiatric Disorders IV- Text Revision):**

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.”

### **How Does Someone Receive a Diagnosis of a Psychiatric (Mental) Disorder?**

A person usually receives a diagnosis of a psychiatric (mental) disorder from a psychiatrist. This usually occurs when the person themselves or those close to them schedule the person an intake for a psychiatric evaluation. The best way to provide the most accurate diagnosis is by providing a wealth of information to the psychiatrist.

Obtaining information to inform psychiatric diagnosis comes from:

- Behavioral Data
  - Biopsychosocial assessments
  - Medical records
  - Clinical Interview
  - Clinical Assessment
  - Family psychiatric history
  - Self-reports from the person
  - Reports from staff or family
  - Target Symptoms vs. Behaviors
- Psychiatrists, and sometimes nurse practitioners and other primary care physicians make formal psychiatric diagnoses. **It is considered best practice that a person should seek a psychiatrist if there are questions concerning a person's mental health.**

## **What References Does a Psychiatrist Use To Diagnose Psychiatric Disorders?**

**The Diagnostic and Statistical Manual of Mental Disorders IV (4) -Text Revision (DSM IV-TR)**, contains the current psychiatric diagnostic criteria approved by the American Psychiatric Association for use in the diagnosing of mental illness. The DSM 5, which will be the new and updated version, is set to be distributed in May of 2013.

**The Diagnostic Manual-Intellectual Disability (DM-ID)** was published in 2007 by the National Association for the Dually-Diagnosed (NADD). It was developed to provide adapted criteria that could be considered when making a psychiatric diagnosis for individuals with an intellectual disability. Many of the criteria between the DSM-IV-TR and DM-ID remain the same.

The DSM-IV-TR and, occasionally, the DM-ID are utilized by psychiatrists as a reference to make a formal psychiatric diagnosis.

## **What Does a Psychiatric Diagnosis Look Like?**

**A psychiatric diagnosis is currently given based on what is called the 5 axes:**

### **Axis I:**

- Axis I is where the psychiatrist will place the mental health diagnosis or disorder that the psychiatrist feels is most appropriate due to the individual's mental health target symptoms.
- Axis I includes diagnoses such as: Bi-Polar Disorder, Anxiety Disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), Depression etc.

### **Axis II:**

- Axis II is where the psychiatrist will place any personality disorders diagnosis and if an individual has an Intellectual Disability.
- The Axis II diagnosis should include the severity of an individual's Intellectual Disability.
  - Mild, Moderate, Severe or Profound
- Examples of Axis II diagnoses: Borderline Personality Disorder, Moderate Intellectual Disability.

### **Axis III:**

- Axis III is where the psychiatrist will place all medical diagnoses that the individual has.
- These diagnoses may be short-term (acute) or long-term (chronic) conditions.
- Examples of Axis III diagnoses are: GERD, seasonal allergies, seizure disorder, hypothyroidism etc.
- Syndromes may also appear in the Axis III diagnoses
  - Down's Syndrome

### **Axis IV:**

- Axis IV is utilized to outline past and current life problems, stressors and issues.
- Axis IV is used to understand the things that have gone on or are currently going on in the life of the person you support. Such as:
  - Unemployment
  - Poor relationships with family
  - Death of family members
  - No supports/friends
  - Past history of being abused, neglected

### **Axis V:**

- Axis V is the Global Area of Functioning (GAF) score.
- This score is determined based on a scale located in the DSM-IV-TR.
- Scores range from 100 to 0.
- The lower the GAF score, the more psychiatrically impaired an individual is.

**An example of a completed psychiatric diagnosis on the 5 axes would look like this:**

Axis I: Bi-Polar I Disorder

Axis II: Moderate Intellectual Disability

Axis III: Seasonal allergies, GERD

Axis IV: Past history of abuse and neglect

Axis V: Global Area of Functioning (GAF) 32

This multi-axial assessment is telling us that the person is diagnosed with Bi-Polar I Disorder, has a moderate intellectual disability, has seasonal allergies and gastroesophageal reflux disease, a history of being abused and neglected and that their current functioning ability is very poor.

**Can More Information Be Provided On the 5 Axes For a Person's Psychiatric Diagnosis?**

The answer is yes. A psychiatrist may opt to utilize what is called *specifiers* to provide more detail to person's psychiatric diagnosis.

***Specifiers* provide relevant information to aid in understanding:**

- Why a diagnosis was given
- When the onset of the psychiatric illness became present
- Features of a disorder present within a particular illness
- Patterns of psychiatric episodes
- The amount of insight an individual has into their own psychiatric issues
- And more

**Some examples of *specifiers* are:**

- Obsessive-Compulsive Disorder with Poor Insight
- Post-Traumatic Stress Disorder- Chronic with Delayed Onset
- Bi-Polar Disorder, Most Recent Episode Depressed With Melancholic Features and With Rapid Cycling

**For these examples, the *specifiers* tell us the following information:**

- Obsessive-Compulsive Disorder with Poor Insight
  - o The person has OCD and does not recognize that their OCD is irrational or a serious problem.
- Post-Traumatic Stress Disorder- Chronic with Delayed Onset
  - o The person has chronic ongoing PTSD. Their symptoms did not immediately occur right after the traumatic incident.

- Bi-Polar Disorder, Most Recent Episode Depressed With Melancholic Features and With Rapid Cycling
  - The person has Bi-Polar Disorder. The most recent mood episode was depression. Melancholic features may mean that they would awake early in the morning for several hours and then sleep most of the day. The person also rapidly cycles from being depressed to being manic which means that their mood can be very unpredictable.

*Specifiers* can help aid us in understanding why a person may be behaving in the ways in which they are. It is encouraged that team members speak to the attending psychiatrist regarding *specifiers* as knowing this information may aid you in providing better and more consistent direct care and more positive treatment outcomes.

### **Why is Diagnostic Information So Important?**

**Treatment is generally matched to a diagnosis. The wrong diagnosis can result in the wrong treatment. The wrong treatment can then result in no improvement or worsening psychiatric symptoms.**

There are many issues that can arise that can make diagnosis and appropriate psychiatric treatment difficult:

- **Differential Diagnosis**
  - When two or more psychiatric disorders have over-lapping psychiatric symptoms, the attending psychiatrist may have to rule out other diagnoses
    - **Examples:** Depression and Bi-Polar Disorder
- **Co-Morbid Diagnosis**
  - Two or more diagnoses that are interrelated and common to one another
    - Anxiety and Depression
- **Diagnostic Overshadowing**
  - Confusion because behavior is often ascribed to EITHER intellectual disabilities OR symptoms of mental illness
  - Target symptoms of mental illness in people with intellectual disabilities may or may not differ in presentation from people without intellectual disabilities
  - People who cannot communicate well pose a challenge to clinicians who rely on verbal communication for diagnosis
  - **Example:** an individual who reports talking with imaginary friends could be psychotic or it could be the coping mechanism of someone who has an intellectual disability who is not psychotic.
- **Is it a Psychiatric Disorder or a Behavioral Issue?**
  - Psychiatric target symptoms are symptoms of a psychiatric illness and demonstrate ongoing psychiatric concerns.
  - Behaviors, although sometimes disconcerting and severe, are not always typical of a psychiatric illness.



– **Examples of such behaviors are:**

- Elopement
- Physical aggression
- Verbal aggression
- Property destruction

For these examples, these behaviors may be severe and potentially dangerous but they are simply not enough to say for certain that a person has a psychiatric disorder. In order to understand whether or not these behaviors are actually symptoms of psychiatric disorder, more information is needed.

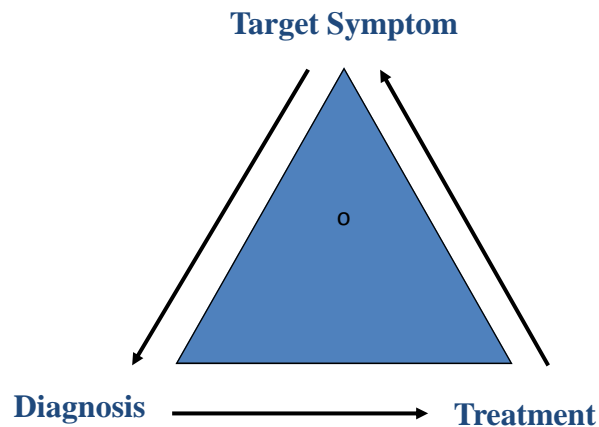
**Here is an example:**

**\*Susan was reported to be continuously attempting to elope from her home. The team continued to attempt to find ways to avoid having Susan elope from the home. They believed that Susan was eloping from the home to “run away” or to avoid doing her chores. One day Susan was talking with her mother about why she was trying to elope. Susan said that she wanted to “run out in front of a bus and die”. Susan reported that she had been trying to run out of the house every time she saw a bus because she wanted to kill herself. This was not a “behavior”; Susan was not really eloping but engaging in suicide attempts. It was later discovered that Susan had Major Depression. Susan began therapy as well as prescribed an anti-depressant. Susan got better and stopped attempting to run out of the house to get hit by a bus.**

In this example, it shows that Susan’s “behavior” may have been looked at as simple elopement. However, with good support and strong direct work from her mother to find out WHY Susan was trying to run out of the house, Susan was able to get the treatment she desperately needed.

As you can see, diagnostic information is VITAL in order to provide someone with the best possible psychiatric treatment to help reduce symptoms of a psychiatric disorder. Accurate information is necessary for an accurate treatment. Here is a visualization of why this is important:

# Behavior vs. Target Symptoms of Mental Illness



The diagram above shows the relationship between how the diagnosis, the symptoms of the diagnosis and the treatment for the symptoms of the diagnosis needed to be aligned in order for good positive psychiatric outcomes. If you had a headache, you may take an aspirin. But, if you had a rash, an aspirin won't make your rash go away. You would need some kind of topical cream or anti-biotic. The same goes for psychiatric disorders, if you are being treated with the wrong medicine, your symptoms will most likely not get better.

Here is a breakdown of what happens when psychotropic medication treatment and the psychiatric diagnosis is not accurate:

## Psychotropic medication and a:

- Accurate diagnosis
  - Can assist in reducing symptoms in 60-80% of people with mental illness
- Inaccurate diagnosis
  - Can assist in reducing symptoms between 10-20% of people with mental illness

**Now that you have some understanding in regards to the psychiatric diagnostic process, let us look at some specific psychiatric disorders.....**

## **Section 2: Anxiety Disorders**

**There are 13 various disorders on the Anxiety Spectrum. This handbook is not all inclusive but will provide information regarding background information on understanding and supporting people who have an anxiety related diagnoses.**

### **Anxiety Disorders**

1. Panic Attack
2. Agoraphobia without history of panic disorder
3. Panic Disorder without Agoraphobia
4. Panic Disorder with Agoraphobia
5. Obsessive-Compulsive disorder (OCD)
6. Acute Stress Disorder
7. Post-traumatic stress disorder (PTSD)
8. Social phobia (or social anxiety disorder)
9. Specific Phobias
10. Generalized Anxiety Disorder (GAD)
11. Anxiety Disorder Due to a general medical condition
12. Substance induced Anxiety disorder
13. Anxiety Disorder Not Otherwise Specified (NOS)

### **Panic Attacks**

A Panic Attack is when a person feels that they are completely out of control over either themselves or a situation in which they fear there is no escape. A strong example of the physical symptoms of Panic Attacks is that people who had Panic Attacks most often report that they “felt or feel like they were going to die”. A Panic Attack has various emotional and physical symptoms:

### **Panic Attack**

#### **Emotional**

- Intense apprehension
- Fearfulness or terror
- Feelings of Impending doom
- Fear of going crazy / losing control

#### **Physical**

- Shortness of breath
- Palpitations, chest pains/discomfort
- Choking/smothering sensations
- Abnormal sweating

When supporting a person suffering from a Panic Attack, attempt to use relaxation techniques such as deep breathing and encourage the person to focus on you or something/someone that will provide a sense of safety. Reassure the person that they are ok. If the person continues to suffer from a Panic Attack, try to encourage the person to leave the area with you so that they can find a “safe zone” to regain control and feel safe again.

### **Agoraphobia**

**Agoraphobia is anxiety about and/or the avoidance of:**

- Places
- Situations where escape may be difficult or embarrassing
- Situations where help may not be available in the event of panic attack or panic-like symptoms
- In extreme cases-fear of leaving home for any reason
- People who become agoraphobic may be terrified to leave their house or a particular area close to home.

Agoraphobia is usually preceded by the presence of a Panic Attack or several Panic Attacks, these Panic Attacks cause the person to feel “out of control” or “unsafe”. The person then will attempt to stay close to areas they feel most in control and emotionally safe. Agoraphobia usually develops from a person’s intense fear of losing control in public area where there are no “safe zones”. In these situations, clinical assistance utilizing therapy, behavior consultation and psychiatric treatment may be very necessary.

### **Panic Disorder without Agoraphobia**

- Recurrent or unexpected Panic Attacks about which there is ongoing and persistent concern that another Panic Attack will occur.

### **Panic Disorder with Agoraphobia**

- Both recurrent unexpected Panic Attacks and Agoraphobia

### **Panic Disorder**

- Panic Disorder is when a person has ongoing Panic Attacks or has intense fear and apprehension about having ANOTHER Panic Attack. The person may attempt to avoid situations in where they may have another Panic Attack at all costs.

### **Specific Phobia**

- Significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior

- Fear of specific things like: snakes, spiders, heights, small spaces like being in an elevator, needles, doctors, clowns, deep water etc.

### **Social Phobia (Social Anxiety Disorder)**

- Significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.
- Fear of social situations can be things like: parties, large crowds, talking in front of people etc.

### **Anxiety Due to a General Medical Condition**

- Anxiety symptoms that are a direct consequence of a medical condition.
- Examples of such conditions can be: hypo/hyperthyroidism, heart conditions and respiratory conditions.
- It is extremely important to observe and report any possible correlations between a person's medical conditions and if they are demonstrating signs of clinical anxiety.

### **Substance-Induced Anxiety Disorder**

- Symptoms of anxiety that are a direct result of drug abuse, a medication, or toxin exposure.
- **We over-estimate how the side effects of prescribed medications can impact mental health. You should always be aware of the possible side effects of the medications that the people you support may have.**

### **Obsessive-Compulsive Disorder (OCD)**

Cycling thoughts and compulsive behaviors become so excessive that they **interfere with daily life**. And no matter what is done, they are very hard to overcome.

**OCD is characterized by:**

- Uncontrollable, unwanted thoughts
- Repetitive, ritualized behaviors

**A person with OCD usually believes that they have to perform the behaviors to prevent something “bad” from happening.**

Even when someone knows that the thoughts and behaviors are irrational, he or she feels unable to resist them and break free.

*Like a needle getting stuck on an old record, obsessive-compulsive disorder (OCD) causes the brain to get stuck on a particular thought or urge.*

## **“Normal” vs. “Abnormal” Behaviors- OCD**

### **Normal Behaviors**

- To go back and double-check that the iron is off
- To see if your door is locked.
- Brush your teeth a set number of strokes

### **Abnormal (Possible OCD)**

- Check the stove twenty times to make sure it’s really turned off,
- You wash you’re your hands until they’re scrubbed raw, or
- Drive around for hours to make sure that the bump you heard while driving wasn’t a person you ran over.

## **OCD: What are Obsessions and Compulsions?**

### **Obsessions**

Involuntary and seemingly uncontrollable

- Thoughts,
- Images
- Impulses

These obsessions occur over and over again in your mind. You don’t want to have these ideas – in fact, you know that they don’t make any sense. But you can’t stop them. These obsessive thoughts are usually disturbing and distracting.

**They are not worries over real life problems.**

**Examples of common obsessions are:**

- **Fear of being contaminated by germs or dirt or contaminating others**
- **Fear of causing harm to yourself or others**
- **Intrusive sexually explicit or violent thoughts and images**
- **Excessive focus on religious or moral ideas**
- **Fear of losing or not having things you might need**
- **Order and symmetry: the idea that everything must line up “just right.”**
- **Superstitions; excessive attention to something considered lucky or unlucky**

**FOR SOMEONE WITH AN INTELLECTUAL DISABILITY, IT IS VITAL TO DISCERN WHAT IS CONSIDERED A REAL LIFE PROBLEM TO THEM AND NOT OUR OWN OPINION OF WHAT WE CONSIDER A REAL LIFE PROBLEM!**

**Compulsions**

- Behaviors or rituals that one feels driven to act out again and again.
- Performed in an attempt to make obsessions go away.
- The relief rarely lasts. Obsessive thoughts usually come back stronger.
- The compulsive behaviors often end up causing anxiety themselves as they become more demanding and time-consuming.

**Examples of compulsions: turning the doorknob thirty times to make sure it is locked, constantly washing your hands/face (possibly to the point where your hands may become raw and bleeding).**

**OCD “Categories”**

**Examples of OCD categories are:**

**Washers** –

**Fear of contamination. Cleaning or hand-washing compulsions.**

**Checkers**

**Repeatedly check things (oven turned off, door locked, etc.) Fear of harm or danger.**

**Doubters and sinners**

**Fear that if everything isn't perfect or done just right something terrible will happen or they will be punished.**

**Counters and arrangers**

**Obsessed with order and symmetry. They may have superstitions about certain numbers, colors, or arrangements.**

**Hoarders**

**Fear that something bad will happen if they throw anything away. They compulsively keep things that they don't need or use.**

**\*\*\*Most people with Obsessive-Compulsive Disorder (OCD) have both obsessions and compulsions, but some people experience just one or the other. The symptoms of OCD may wax and wane over time. Often, the symptoms get worse in times of stress.\*\*\***

### **OCD: Did You Know?**

- Many people have mild obsessions or compulsions that are strange or irrational, that does not disrupt daily living
- Obsessive-Compulsive Disorder- thoughts and behaviors can cause tremendous distress, take up a lot of time, and interfere with routine, work, or relationships.
- OCD is not uncommon with people with intellectual and developmental disabilities.
- Sometimes a person can have symptoms that look like OCD but are other disorders, such as Autism, or Tourette's Syndrome,
  - Thorough medical and psychological exams are essential before any diagnosis of OCD is made.
  - **It's also important to note that OCD is an anxiety disorder. What's most important is to make environmental and behavioral changes to reduce the person's anxiety.**

### **Generalized Anxiety Disorder**

- Anxiety is common in individuals with Intellectual Disabilities
- Children with I/DD, as compared to children without I/DD, were more likely to report specific fears and generalized anxiety.
- There were, however, more similarities than differences between these two groups.
- Anxiety problems often emerge early in life in children with an intellectual disability and remains relatively stable over time.

These emotional problems cause much distress and interfere with the development of adaptive functioning skills necessary for successful integration within the community, work and home settings.

- Features of anxiety that can be seen in people with intellectual disability include appearing *fearful*, trembling, flush, irritable etc.
- Avoidance of specific situations reported by those with standard intellectual functioning may not always be evident in persons with ID since opportunities for choice may be limited.

Avoidance of specific situations reported by those with standard intellectual functioning may not always be evident in persons with ID since opportunities for choice may be limited.---- This means that you may not realize a person with an intellectual disability tries to avoid certain people, places and things because they may not have the ABILITY to be exposed to things that they may try to avoid.



- Symptoms of anxiety may be hidden due to the sedation by psychotropic medication.
- Anxiety Disorders can be diagnosed reliably with few modifications in individuals with Mild-Moderate ID.
- If anxiety cannot be expressed, in those with more severe disability, it may present as a behavior disorder

### **Physical Complaints of People with a Generalized Anxiety Disorder (GAD)**

- Headaches
- Muscle tension
- Muscle aches
- Difficulty swallowing
- Trembling, twitching
- Irritability, sweating
- Nausea, lightheadedness
- Having to go to the bathroom frequently
- Feeling out of breath, and hot flashes

**It is important to note that all of these physical symptoms may be due to an actual medical issue. Medical issues should be explored and ruled out prior to making assumptions that the person is “simply anxious”.**

### **Anxiety Disorder Not Otherwise Specified (NOS)**

- Anxiety that does not meet all criteria for any specific anxiety disorder

### **Anxiety Disorder vs. Impulse Control Disorder**

- Anxiety Disorders
  - One of the most under-diagnosed psychiatric disorder categories in the ID population
  - Most often misdiagnosed as Impulse Control Disorder Not Otherwise Specified (NOS)
  - Chances of misdiagnosis of an anxiety disorder as Impulse Control Disorder increases the more intellectually disabled a person is
  - Chances of misdiagnosis of an anxiety disorder as Impulse Control Disorder also increases if the person has limited or no communication (non-verbal) (Loschen & Saliga, 2000)

## **Supporting People Who Have a Diagnosis of an Anxiety Disorder**

- Try and reduce anxiety in the person's environment by reducing situations or things that you know make the person anxious
- Encourage the person to use relaxation techniques like deep breathing exercises or asking the person if they want/need to find a place where they feel safe
- **Do not punish people for their reactions to anxiety! This only increases anxiety!**
- Consistent and ongoing observation is key to understanding the focus of anxiety related symptoms
- Data from observations should be communicated to the attending psychiatrist, therapist and behavior specialist

Keep track of what makes the people you support anxious in order to assist in reducing future anxiety producing situations.

BE FUN! People with anxiety don't just need someone to discuss their problems with, they also need friends that can make their lives fun and enjoyable. Without putting too much pressure on yourself or significantly trying to alter a strong relationship, being a fun and relaxing person to be around can make you an invaluable support.

**Remember: Anxiety is something that we all experience and it is the most successfully treated of all disorders.**

# Section 3: Mood Disorders

## Types of Mood Disorders

- Depression
- Manic Episodes
- Mixed Episodes
- Hypomanic Episodes
- Bi-Polar Disorder
- Mood Disorder due to a general medical condition
- Substance-Induced Mood Disorder

For Mood Disorder due to a general medical condition and Substance-Induced Mood Disorder, think back to the Target Symptoms of Mental Illness versus Behaviors. Think about how illnesses and medications can look like psychiatric problems.

## Bi-Polar Disorder:

- **Occurs when a person experiences episodes of depression and mania over a distinct period of time**
- **Causes a marked impairment in occupational or social functioning.**

## What Does a Manic Episode Look Like?

- Inflated self esteem /Grandiosity (very good mood, person feels powerful)
- Can often be psychotic during the episode
  - **Examples of Psychotic: thinking that you are God, that aliens are coming to kidnap you, that the government is controlling your thoughts, and many more.**
- Decreased need for sleep
- More talkative or pressure to keep talking
- Distractibility (decrease in goal directed behavior)
- Increase in goal directed behavior (socially, sexually, school or work)
- Excessive involvement in pleasurable activities that have high potential for **painful consequences**

3 or more of these symptoms should be noted in a week. This is why it is important that you document accurately and detail what is happening when working with those you support. This is **NEED TO KNOW INFORMATION.**

**Serious sleep disruptions such as not sleeping at all (insomnia) or sleeping the majority of the time (hypersomnia) is also something that should be tracked and documented if the person you support has a Mood Disorder.**

## What Does a Hypomanic Episode Look Like?

- Hypomania literally means “below mania”
- Hypomania is considered less severe than a manic episode.
- Persistent and pervasive elevated or irritable mood, and thoughts
- **Distinguished from mania by the absence of psychotic symptoms and by its lower degree of impact on functioning.**
- Not due to drugs or medical treatment

## What Does a Depressive Episode Look Like?

**Depression = 5 or more of following symptoms for at least 2 weeks.** Again, this is why it is important that you document accurately and detail what is happening when working with those you support. **This is NEED TO KNOW INFORMATION.**

1. Depressed mood most of day nearly every day
2. Loss of interest in almost all activities
3. Weight loss w/out diet (5% of wt)
4. Insomnia or hypersomnia
5. Agitation or slow movement
6. Fatigue or energy loss daily
7. Feeling worthlessness, guilty daily
8. Poor concentration or decision making
9. Recurrent suicide thoughts or plans

## **Symptoms of Bi-Polar Disorder**

### Negative Symptoms

- **Depressed**
- **Withdrawn**
- **Refusal to participate**
- **Oversleeping**
- **Mood swings**
- **Low energy**
- **Unable to focus**
- **Substance abuse**

### Positive Symptoms

- **Irritability (fighting/yelling)**
- **Relationship problems**
- **Impulse control problems**
- **Insomnia (up all night)**
- **Anxious(fearful behaviors)**
- **Overly focused (talkative)**
- **Rule breaking or trouble with the law**

CME LLC: Unipolar Depression or Bipolar Depression? Differentiating Patients in your Practice. AstraZeneca

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### **Is It a Manic or Depressive Episode? What Else can it be?**

- Not caused by a chemical imbalance due to medications
- Behavior done to communicate a need or a want?
- Side effect of medications?
- Physical illnesses or medical conditions which may be observed as manic or depressive episodes?
- Is what the person doing possibly related to a syndrome? A neurological disorder? Organic Disorder?
- Behaviors only occur around certain people or in certain places?

### **What Information is Important When Tracking Symptoms of a Mood Disorder?**

- Communication Style: How does the person you support communicate their wants, needs and desires?
- List of behaviors: what challenging behaviors does the person exhibit?
- Frequency of behaviors: how often do these behaviors happen?
- Intensity of behaviors: how disruptive, problematic or dangerous are these behaviors?
- Are there any Warning Signs that a person may be about to engage in challenging behavior?
- Triggers: did anything appear to CAUSE the behavior?
- Social Interactions: how does the person interact with others?
- Life changes: have there been any significant changes to the person's day to day life?
- Poor relationships: are there any people in their life that upset them in some way?
- Favorite People: who does the person you support like? Who do they seem to "gravitate" to?
- Medications, including over the counter (OTC) medications.

### **Supporting People Who Have a Diagnosis of a Mood Disorder**

- Don't take what a person does in a manic or depressive state personally.
- Don't punish the person. They cannot control what is happening.
- Don't always assume that the person understands what they are doing is wrong. Try and encourage them to stop and think about what is happening.
- Try and maintain the person's usual routine. Lots of changes may increase the manic or depressive episode in intensity and duration.
- Try and reduce stressors in the person's life, especially things that you know make them nervous or that anger/upset them.
- Do not try and have long conversations with the person. This can increase agitation.
- Try and reduce the amount of stimulation in their environment.
- Do not "feed in" to a person's manic episode or grandiose beliefs. Try and keep the person realistic.
- DO NOT ARGUE WITH THE PERSON
- Encourage the person to sleep if they are having insomnia: relaxing music, limit light, anything that can help the person sleep.

# Section 4: Psychotic Disorders

## Types of Psychotic Disorders

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Psychotic Disorder Due to a General Medical Condition
- Substance-Induced Psychotic Disorder
- Psychotic Disorder Not Otherwise Specified (NOS)

## Psychiatric Target Symptoms of Psychotic Disorders:

- **Hallucinations (hearing voices, seeing things not present, smelling things not present)**
- **Delusions**
- **Disorganized Speech**
- **Grossly disorganized or catatonic behavior**
- **Negative symptoms (affective flattening, alogia, avolition)**
  
- **Hallucinations**
  - False sensory perceptions
    - Hearing voices or sounds
    - Seeing things that are not there
    - **It is important to rule out visual and auditory concerns before assuming that a person is having hallucinations.**
  
- **Delusions**
  - Fixed false beliefs unresponsive to logic
    - Believe that the CIA or FBI are after them
    - Tracking devices implanted in body
    - Refusal to eat because believe food has been poisoned
  
- **Disorganized Speech**
  - Frequent derailment or incoherence of speech
    - Example: “I’m sure I got my medication as much as that picture has a headache”
  - Neologism and Idiosyncratic Language
    - Making up of words which do not exist in any language or have any point of reference
      - “A lep is a ball”, “rahfeelski”, “blittygasts”
    - Sometimes two words will become combined as one word to give a new meaning and definition
      - “I’m feeling happatired” (happy and tired)

- **Grossly Disorganized or Catatonic Behavior**
  - Stupor/inactivity,
  - Mania
    - This means that people are engaging in observed behavior which may seem chaotic with no real direction or goal.
  - Rigidity or extreme flexibility of the limbs
    - Rigidity : “freezing”, becoming stiff
    - Flexibility: candle wax, putty, Play-Doh...etc. Can move the person’s limbs into various and seemingly uncomfortable positions.
- **Alogia**
  - The lessening of speech fluency and productivity, thought to reflect slowing or blocked thoughts, and often manifested as short, empty replies to questions.
  - Alogia can sound like “trailing off”....it is almost like the person is forgetting what they were going to say.
- **Affect Flattening**
  - Blank, blunted facial expression or less lively facial movements or physical movements.
- **Avolition**
  - Reduction, difficulty, or inability to initiate and persist in goal-directed behavior; it is often mistaken for apparent disinterest.
    - Examples: No longer interested in going out and meeting with friends, no longer interested in activities that the person used to show enthusiasm for, no longer interested in much of anything, sitting in the house for many hours a day doing nothing

### **Psychotic Disorder Not Otherwise Specified (NOS)**

- **Commonly coined as “Psychosis NOS”**
  - Psychotic Disorder NOS is defined as:
    - Psychotic symptomology (i.e. delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific psychotic disorder.
    - Simply put, Psychotic Disorder (Psychosis) NOS is a very non-specific diagnosis
    - **The very definition of the diagnosis indicates the difficulty in formalizing a relevant diagnosis either due to inadequate or contradictory information to the psychiatrist or difficulty in diagnosing due to the cognitive and communication difficulties of the ID person.**

## **Problems in Diagnosing Psychotic Disorders When a Person Has an Intellectual Disability**

- Based upon the diagnostic criteria there are many considerations to be made:
  - The developmental age of the person
    - Imaginary friends and play vs. auditory hallucinations
  - Affect and communication styles due to a syndrome or autism spectrum disorder
    - Example: restricted affect due to Asperger Syndrome vs. Psychotic Disorder
  - Difficulties understanding questions asked by psychiatrists or mental health assessors
    - “Do you hear voices?” “Do you see things that aren’t there?”
      - Difficult to interpret and answer for children and people who have an intellectual disability or an autism spectrum disorder
      - Example:
        - Psychiatrist: “Do you hear voices?”
        - Person: “Yes”
        - Psychiatrist: “Do the voices sound like anyone you know?”
        - Person: “Yes. They sound like me telling me things”
          - Auditory Hallucinations vs. Self-talk?
          - How we phrase questions is extremely important to try and “tease out” possible psychotic symptoms

Because of these issues, careful, detailed longitudinal approaches are advocated for these diagnoses. Long-term observation and historical documentation is important.

Accurate and detailed documentation from you, the DSP, is needed to understand what is going on with the person you support.



## Supporting People Who Have a Diagnosis of a Psychotic Disorder

- Do not argue that what the person says they see or hear is not real. It is real to them and they need your support to feel safe BUT do not engage in the hallucination with them either.
  - **Example: if someone who is suffering from a psychotic episode jumps on the couch screaming that the floor is on fire, don't jump on the couch and pretend the floor is on fire with them. Instead, acknowledge that they believe that the floor is on fire and try to support them by assisting them to an area where they feel safe (this is just a suggestion).**
- Try to not take any delusion or hostile statements personally.
- Practice dignity treatment: do not laugh at or make judgments about a person's hallucinations or delusions.
- Take the time to talk with them if they are psychotic. Make sure you have their attention before talking to them.
- Do not rush your speaking; the person may need extra time to process what you are saying because their own thoughts may be currently disorganized.
- Ensure that the person is taking their psychotropic medications. Document and report immediately if they stop taking them.
- Get immediate assistance if the person becomes a danger to themselves or others.

# Section 5: Personality Disorders

## What is a Personality Disorder?

- Symptoms have been present for an extended period of time, are inflexible and pervasive, and are not a result of alcohol or drugs or another psychiatric disorder. The history of symptoms can be traced back to adolescence or at least early adulthood.
- The symptoms have caused and continue to cause significant distress or negative consequences in different aspects of the person's life.
- Symptoms are seen in at least two of the following areas:
  - *Thoughts* (ways of looking at the world, thinking about self or others, and interacting)
  - *Emotions* (appropriateness, intensity, and range of emotional functioning)
  - *Interpersonal Functioning* (relationships and interpersonal skills)
  - *Impulse Control*

**Personality Disorder = a chronic and maladaptive way in which how a person perceives and reacts to their environment. “Like seeing the world through broken glass”.**

## Types of Personality Disorders

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder
- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder

## **What is Borderline Personality Disorder?**

### **Borderline Personality Disorder is characterized by:**

- Frantic efforts to avoid real or imagined abandonment
- Unstable and intense relationships
- Poor self-esteem
- Impulsive (don't think before they act)
- Suicidal, threatening suicide, talking about suicide, self mutilation
- Emotionally unstable
- Love/Hate relationships with others
- Can occasionally become paranoid or can dissociate from reality

People with BPD often need extensive mental health services, and account for 20 percent of psych hospitalizations.

Sometimes people with BPD view themselves as fundamentally bad or unworthy.

They may feel unfairly misunderstood or mistreated

May result in efforts to avoid being alone by acting out

- i.e. impulsive behavior or suicide attempts.
- Are often bored, feel “empty” and have little idea of who they are.
- Treatments for BPD have improved in recent years:
  - Medication
  - Behavior supports
  - Individual psychotherapy
  - Group therapy

## **Considerations For People Who Have an Intellectual Disability**

- People who have an intellectual disability may truly **DEPEND** on others for their care and their access to the community.
- This is different than being dependent on others for the sake of **NEEDING** others to want to care for us such as in Dependent Personality Disorder or Borderline Personality Disorder.
- Long-term assessment and functional behavior assessment is needed to determine the reasons why a person with an intellectual disability utilize their behaviors.
- Long-term longitudinal observation and historical documentation is needed before making any diagnosis of a Personality Disorder for a person with an Intellectual Disability
- A diagnosis of a Personality Disorder should not be considered until a person with ID is at least 21 years old
- All medical and environmental factors should be studied and addressed
- The way in which a person copes with stress and their inability to access resources should also be considered
- We must figure out a whole lot of things before making assumptions that someone has a personality disorder

## **Supporting People Who Have a Diagnosis of a Personality Disorder**

- Most people with a personality disorder feel isolated and lacking in social support. Being there for them and trying your best to not be judgmental is one of the most important things you can do.
- To try and change how someone with a personality disorder thinks about others, you have to try and show them what they believe about people is not true. Lead by example and be a friend.
- Create and maintain a stable environment. Keep to a routine the person is comfortable with and accepting of. Prepare the person in advance if you know there will be changes to their routine.
- Be patient at all times. Moods can change from good to bad quickly and often. Maintain patience and remember that there will be good times and bad times. Roll with resistance and do not attempt to confront or argue with them.
- For additional resources for Personality Disorders: [www.outofthefog.net](http://www.outofthefog.net)

# **Section 6: Substance Abuse/Dependence Disorders**

## **Substance Abuse/Dependence Disorders and Intellectual Disability**

- Little to no research has been done regarding Substance Abuse/Dependence and the intellectual disability population
- However, it is safe to assume that addiction and dependence issues are as prominent in the intellectual disability population as much as the general population when prescribed addictive medications for long-term use or are able to engage in the consumption of alcohol and other drugs.
- **There are people with an intellectual disability who are addicted to illicit drugs such as crack, heroin and cocaine. We have supported people who smoke marijuana daily. We have also supported people who are alcoholics. People with an intellectual disability are NOT IMMUNE TO ADDICTION.**

## **Most Common Addictive Psychotropic Medication Prescribed to People With an Intellectual Disability**

- Benzodiazepines
  - Ativan
  - Xanax
  - Klonopin,
  - Valium
- **Addictive with potential for physical and psychological withdrawal**

## Benzodiazepine Withdrawal

- Anxiety
- Tension
- Depression
- Insomnia
- Restlessness or irritability
- Confusion
- Sweating
- Dizziness
- Personality changes
- Sensitivity to sound or light
- Numbness or tingling
- Nausea, vomiting, or diarrhea
- A rapid heartbeat (tachycardia)
- Heart palpitations
- Hallucinations
- Memory loss
- Panic attacks
- Seizures
- Fever.

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**Note how these symptoms of physical withdraw from a medication may be missed or misrepresented in the intellectual disability population. Also, it is important to realize that you and I can take the same medications but we will all have different reactions or feel different side effects even though we are taking the exact same medication.**

### **Other Psychotropic Medications That May Result in Physical Withdrawl**

- Prozac
- Paxil
- Seroquel
- Ritalin
- Adderall
- And many others....

### **Substance Abuse/Dependence and Intellectual Disability**

- For people with ID, they may not be able to correlate their physical/emotional changes or withdraw symptoms to the medication that has been changed or discontinued.
- They may present with other atypical signs of addiction/withdraw:
  - Head-banging, mood lability, self-injurious behavior, personality changes, agitation, explosive outbursts, physical health complaints.

### **When Addictive Medications are Discontinued:**

- Documentation and behavior tracking is VITAL
- It may take time to see positive behavior changes
- Sudden spikes in challenging behaviors when taken off of medications is common for physical and psychological withdraw.
- Symptoms may “rebound” and the person may demonstrate increased signs of the condition the person was being treated for coupled with physical health complaints
  - **Example of “rebound”:** anxiety symptoms may intensify and the person may seem much more anxious or demonstrate severe anxiety coupled with physical health complaints
    - **Examples of physical health complaints:** headaches, nausea, inability to eat or meal refusals, vomiting etc.

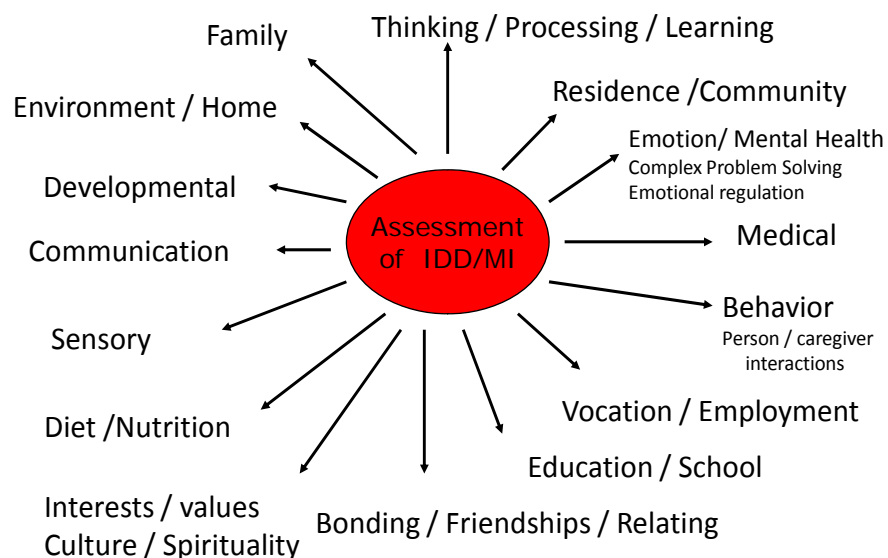
### **Supporting People Who Have a Diagnosis of Substance Abuse/Dependence Disorder or Who May Be Experiencing Withdraw From a Psychotropic Medication:**

- Recognizing an addiction is the first step. Communication between all treating doctors and specialists is important in order to seek help for the person if they are suffering from a substance abuse/dependence issue.
- If a person you support is suffering from addiction. Please have the person seek medical advice.
- Keep detailed documentation regarding a person’s medications. Keep detailed documentation of the person’s behavior and physical health when medication changes are made.
- If a person you support has an addiction to illegal drugs and/or alcohol, encourage the person to attend support groups such as 12-step meetings or to seek treatment.
- Do not give the person any additional money out of your own pocket.
- If you witness the person actively using drugs and/or alcohol. Document the information clearly. Also, follow your agency’s protocol in reporting the information. You may need to inform a supervisor.
- Do not encourage the person to use drugs/alcohol. Do not engage in drinking alcohol with those you support.

## Section 7: What You Should Remember

- There are a vast array of psychiatric diagnoses
- Many psychiatric diagnoses can overlap
- Ongoing observation and target symptoms of mental illness data tracking is of the utmost importance
- Dual Diagnoses treatment involves recognizing, not just psychiatric concerns, but the whole person

### Holistic Approach for Individuals with ID/DD/MI



**Holistic Care is key to understanding those you support. All of these things are vital into, not just uncovering a psychiatric issue but also supporting the person if they do.**



### **What You Should NOT Do:**

- DO NOT diagnose people yourself
- DO NOT recommend medications
- DO NOT try and do “therapy” on the person
- DO NOT tease, judge or argue with the person
- DO NOT ignore the person’s symptoms
- DO NOT try and tell them that their mental illness is not real or that they are faking it

### **What You SHOULD Do:**

- Support the person and try and make the environment as pleasant and supportive as you can
- Encourage the person to engage in and work towards mental health recovery
- Document behavior when it occurs. This means document both GOOD and NOT SO GOOD behavior.
- Use detail when writing your notes: Who? What? When? Where? Should all be answered.

**\*\*\*When a person is doing well, this is just as, if not MORE important than when they are not doing well. If someone is doing well then it could mean that something is WORKING for that person. Documenting it is VERY IMPORTANT so that others can know the information and perhaps utilize the information to make things EVEN BETTER in the person’s life. \*\*\***

**Thank You for your time and patience in reading this handbook. Hopefully you now have increased your understanding of psychiatric disorders and intellectual disability.**

## References

- **American Association for Intellectual and Developmental Disabilities (AAIDD). [www.AAIDD.org](http://www.AAIDD.org)**
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- **Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). *Diagnostic Manual -- Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*. Kingston, NY: NADD Press.**