# Developing and Implementing Therapeutic Supports for: Individuals with Intellectual and other Developmental Disabilities Experiencing Mental Health Disorders

**with Tom Pomeranz Ed.D.**



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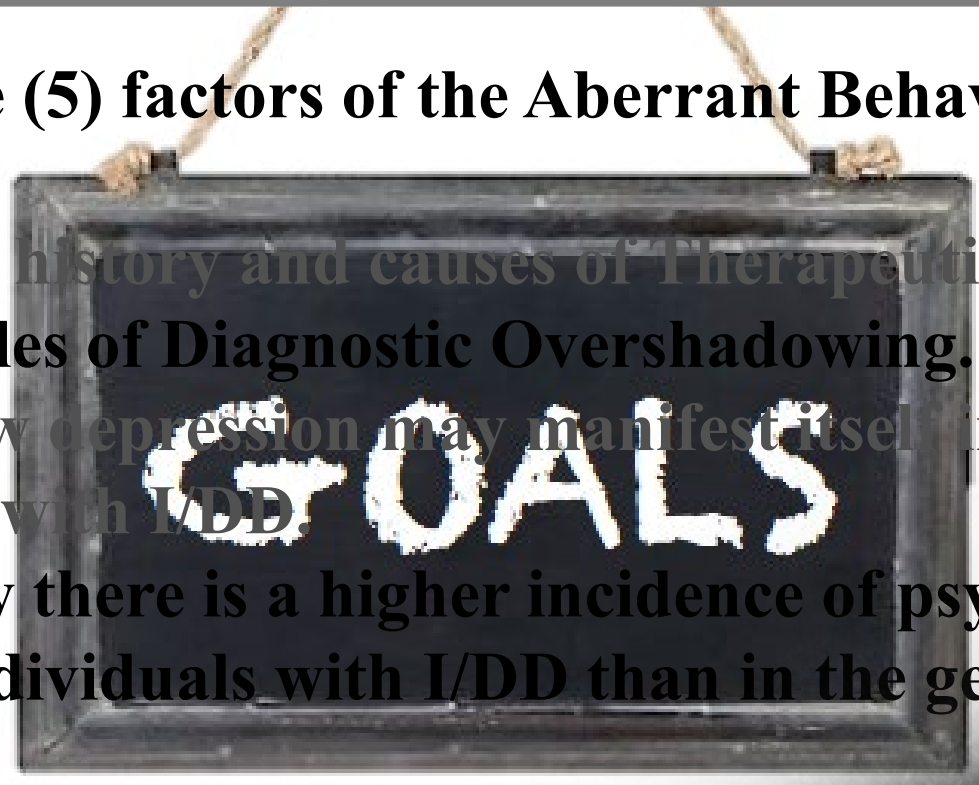
# Session Goals

**Participants of "Developing and Implementing Therapeutic Supports for Individuals with Intellectual and Other Developmental Disabilities Experiencing Psychiatric Disorder/s" will be able to:**

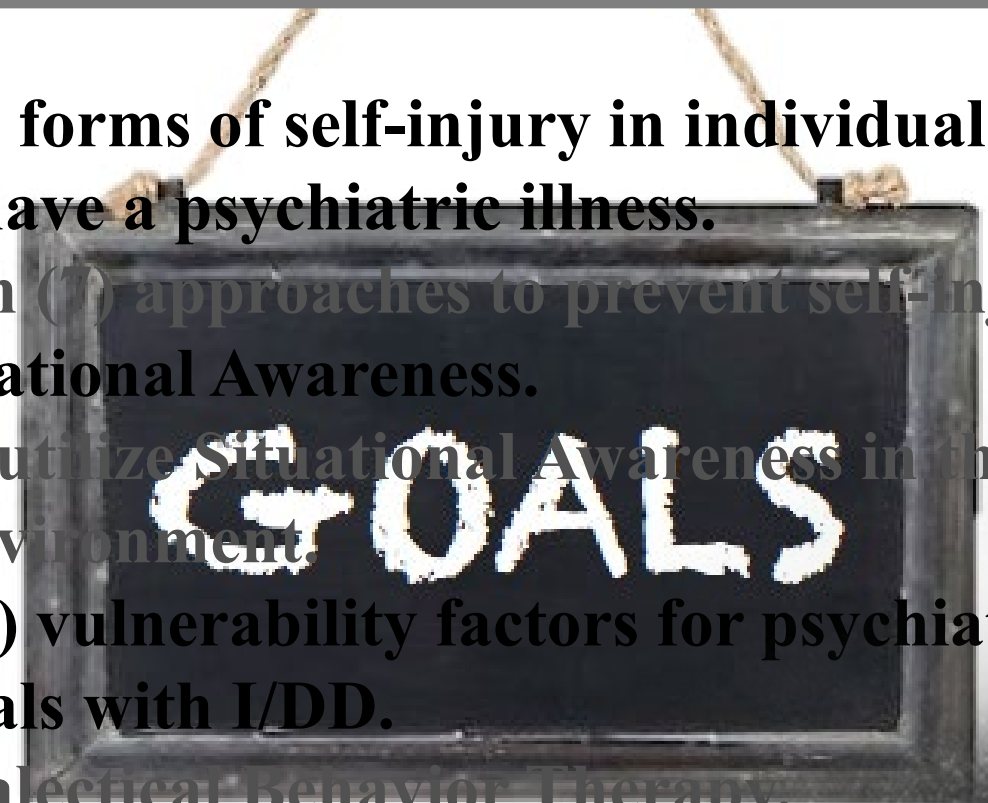
- **List the five (5) factors of the Aberrant Behavior Checklist.**
- **Explain the history and causes of Therapeutic Disdain.**
- **Cite examples of Diagnostic Overshadowing.**
- **Identify how depression may manifest itself in individuals with I/DD.**
- **Discuss why there is a higher incidence of psychiatric illness in individuals with I/DD than in the general population.**



# Session Goals (cont'd…)

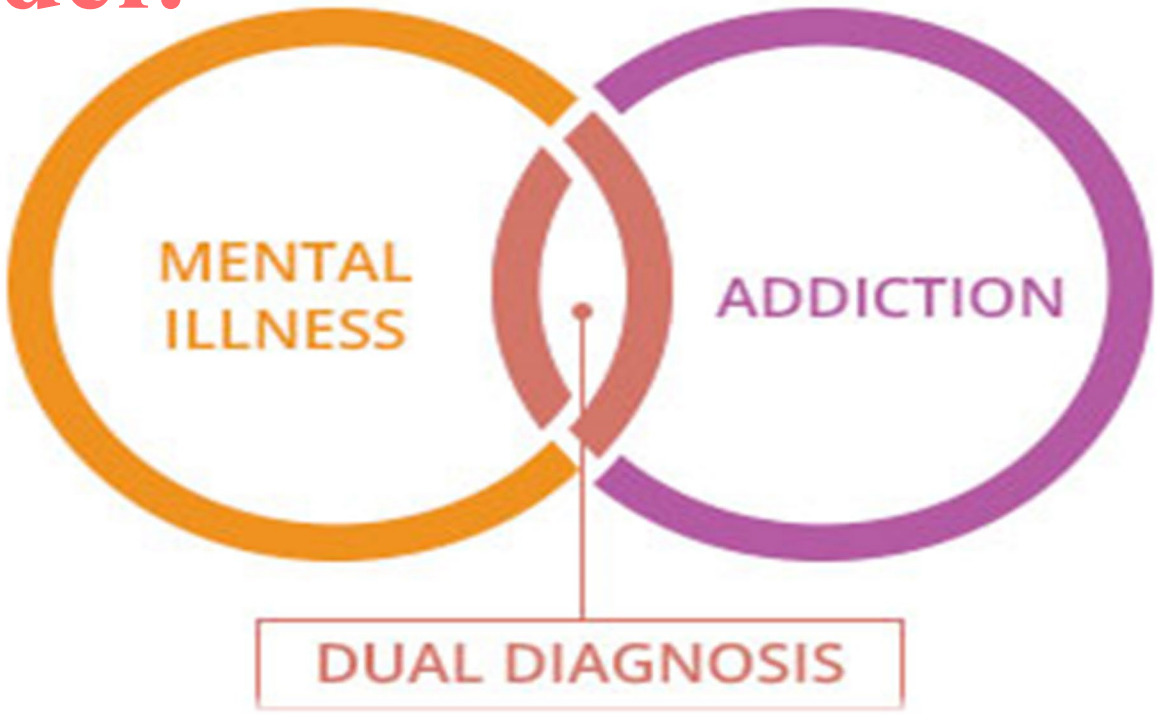
**Participants of "Developing and Implementing Therapeutic Supports for: Individuals with Intellectual and Other Developmental Disabilities Experiencing Psychiatric Disorder/s" will be able to:**

- **List five (5) forms of self-injury in individuals with I/DD who have a psychiatric illness.**
- **Detail seven (7) approaches to prevent self-injury.**
- **Define Situational Awareness.**
- **Effectively utilize Situational Awareness in their working environment.**
- **List four (4) vulnerability factors for psychiatric illness in individuals with I/DD.**
- **Explain Dialectical Behavior Therapy.**



# Basic Facts

**Most commonly "dual diagnosis" refers to individuals with mental illness and substance use disorder.**



# Basic Facts (cont'd)

**People with Intellectual Disabilities and mental illness pose significant challenges for professionals.**

**People with Intellectual Disabilities are at significantly higher risk of mental illness**

**The estimated prevalence is 33% with some sources reporting much higher**

**The populations susceptibility is increased by biological and social factors**

**An already-damaged brain is at higher risk of biochemical imbalances**

**Most importantly, social isolation and exclusion with no hope of change, combines with an already-existing brain difference, sets the stage for mental illness.**

Co-Occurring Mental Illness and Developmental Disabilities
By Maria Qurntero PhD and Sara Flick MD
Social Work Today Vol 10 No 5 P 6

# Diagnosing

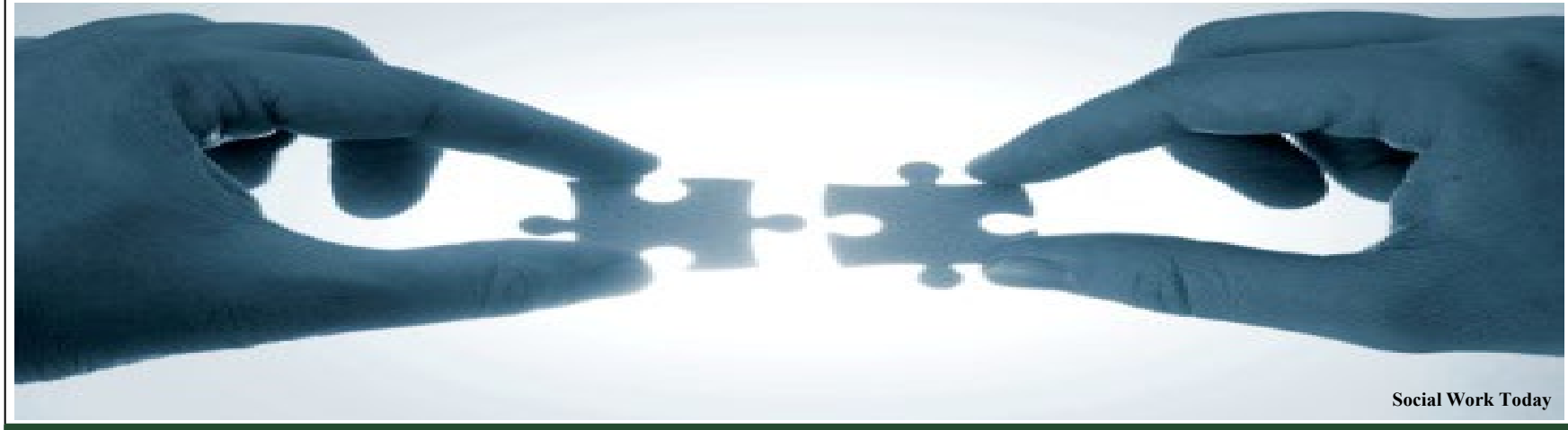
**Given the prevalence of mental illness co-occurring with developmental disabilities, why is this dual diagnosis not better known by clinicians?**

- **Seldom do medical school or graduate programs include dual diagnosis in their standard curriculum**
- **There is often a tendency by clinicians to recognize only the developmental disability (delay), attributing behavioral anomalies to the developmental disability**
- **Diagnostic overshadowing "blinds" the clinician from interpreting the behavioral anomalies as mental illness**

**Social Work Today**

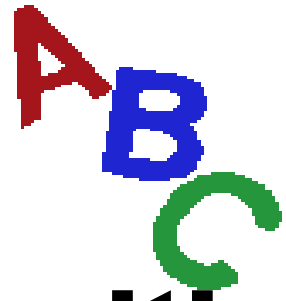
# Diagnosing (cont'd)

- **The limited communication skills of many people with IDD compounds the diagnostic challenge.**
- **The individual's cognitive limitations can result in intellectual distortions of what they are experiencing as normal.**
- **Limited social experience impair the individual's ability to compare their experience against normative standards.**



# ABC

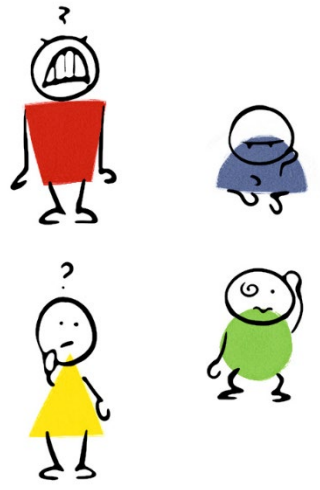
**Aberrant Behavior Checklist (ABC): A checklist of symptomatic behaviors common among people with intellectual disabilities. Developed by Aman and Singh (1986) and is reportedly the most widely used assessment tool in the world for its target population.**



# ABC (cont'd)

## ABC is a five factor scale:

1. Irritability, Agitation, Crying
2. Lethargy, Social Withdrawal
3. Stereotypic Behavior
4. Hyperactivity, Noncompliance
5. Inappropriate Speech



# START

**The START (Systemic, Therapeutic, Assessment, Resources and Treatment) model serves a target population of people diagnosed with co-occurring diagnosis of I/DD and behavioral (mental) health needs.**

**START is designed to improve the care of individuals with I/DD through the combined effects of a well-trained work force and utilizing a multidisciplinary, coordinated approach to assist individuals with I/DD and behavioral challenges.**

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# START (cont'd)

**The three A's are the cornerstones to the model:**

**Access to Care and Supports**

**Appropriateness of Care**

**Accountability – through measureable outcomes of care**

**START has been providing person – centered clinical service supports and therapeutic emergency planned services since 1989 when it was founded by Joan Beasley, PhD in Northeast Massachusetts.**

# FEIS

The FEIS (Family Experiences with Mental Health Services for Persons with Intellectual and Developmental Disabilities, Beasely, 2013) is a validated instrument that has been adapted from the The Family Experience Interview Schedule (Tessler & Gamache) to be used with families who care for family members who have an I/DD and co-occurring mental/behavioral issues.

F E I S

# FEIS (cont'd)

The tool is designed to gain valuable information from family members regarding their experiences and satisfaction with mental health services.

Questions asked in the FEIS address each of the 3 A's that are the cornerstone of effective services for people with I/DD:

**accountability**
**appropriateness**
**accessibility**

# Chemical Restraint


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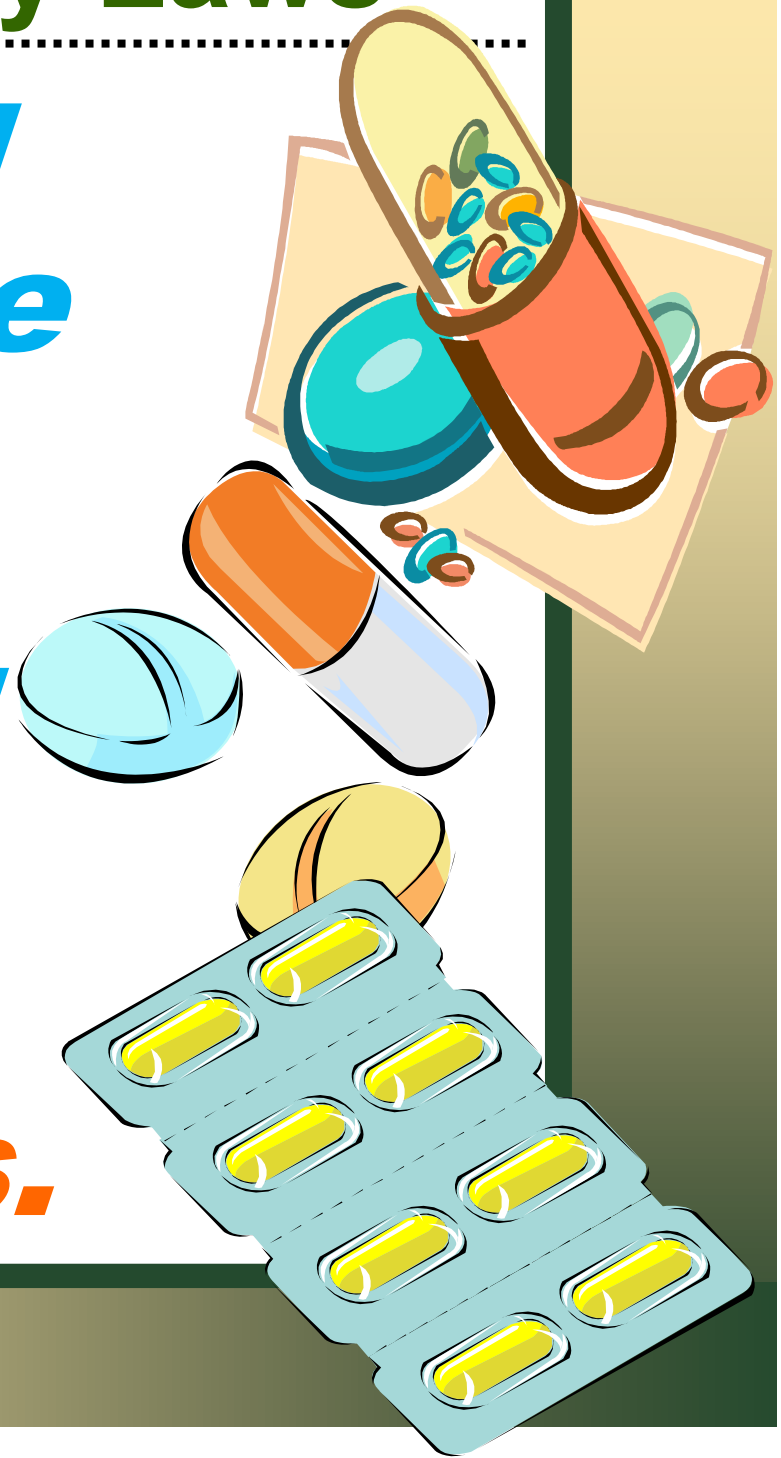
# Psychopharmacology Laws

***The right drug doesn't fix the wrong environment.***

***Drugs treat disorders, not behaviors.***



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# Etiology of Diagnosis

**Bob has a disability-----**

**Bob hits people**

**People get hurt**

**Staff write BMP**

**Bob hits people**

**MD pressured for help**

**MD renders DSM IV**

**Axis I Diagnosis**

**Bob has Intermittent Explosive Disorder**

**Bob takes Paxil**

**Bob hits people**

**You would be explosive too if you didn't have a life!**

# Drugs Used on Aggression in Those With Low I.Q.'s Provide No Benefit, Study Says

By BENEDICT CAREY

The drugs most widely used to manage aggressive outbursts in intellectually disabled people are no more effective than placebos for most patients and may be less so, researchers report.

The finding, being published Friday, sharply challenges standard medical practice in mental health clinics and nursing homes in the United States and around the world.

In recent years, many doctors have begun to use the so-called antipsychotic drugs, which were developed to treat schizophrenia, as all-purpose tranquilizers to settle threatening behavior — in children with attention-deficit problems, college students with depression, older people with Alzheimer's disease and intellectually handicapped people.

The new study tracked 86 adults with low I.Q.'s in community housing in England, Wales and Australia over more than a month of treatment. It found a 79 percent reduction in aggressive behavior among those taking dummy pills, compared with a reduction of 65 percent or less in those taking antipsychotic drugs.

The researchers focused on two drugs, Risperdal by Janssen, and an older drug, Haldol, but said the findings almost certainly applied to all similar medications. Such drugs account for more than $10 billion in annual sales, and research suggests that at least half of all prescriptions are for unapproved "off label" uses — often to treat aggression or irritation.

The authors said the results were quite likely to intensify calls for a government review of British treatment standards for such patients, and perhaps to prompt more careful study of treatment for aggressive behavior in patients with a wide variety of diagnoses.

Other experts said the findings were also almost certain to inflame a continuing debate over the widening use of antipsychotic drugs. Patient advocates and some psychiatrists say the medications are overused.

Previous studies of the drugs' effect on aggressive outbursts have been mixed, with some showing little benefit and others a strong calming influence. But the drugs have serious side effects, including rapid weight gain and tremors, and doctors have had little rigorous evidence to guide practice.

"This is a very significant finding by some very prominent psychiatrists" — one that directly challenges the status quo, said Johnny L. Matson, a professor of psychology at Louisiana State University in Baton Rouge, co-author of an editorial with the study in the journal Lancet.

While it is unclear how much the study by itself will alter prescribing habits, "the message to doctors should be, think twice about prescribing, go with lower doses and monitor side effects very carefully," Dr. Matson continued, adding:

"Or just don't do it. We know that behavioral treatments can work very well with many patients."

Other experts disagreed, saying the new study was not in line with previous research or their own experience. Janssen, a Johnson & Johnson subsidiary, said that Risperdal only promotes approved uses, which in this country include the treatment of irritability associated with autism in children.

*A finding challenges practices in clinics and nursing homes.*

In the study, Dr. Peter J. Tyrer, a professor of psychiatry at Imperial College London, led a research team who assigned 86 people from ages 18 to 65 to one of three groups: one that received Risperdal; one that received another antipsychotic, the generic form of Haldol; and one that was given a placebo pill. Caregivers tracked the participants' behavior. Many people with very low I.Q.'s are quick to anger and lash out at others, bang their heads or fists into the wall in frustration, or singe the air with obscenities when annoyed.

After a month, people in all three groups had settled down, losing their temper less often and causing less damage when they did. Yet unexpectedly, those in the placebo group improved the most, significantly more so than those on medication.

In an interview, Dr. Tyrer said there was no reason to believe that any other antipsychotic drug used for aggression, like Zyprexa from Eli Lilly or Seroquel from AstraZeneca, would be more effective. Being in the study, with all the extra attention it brought, was itself what apparently made the difference, he said.

"These people tend to get so little company normally," Dr. Tyrer said. "They're neglected, they tend to be pushed into the background, and this extra attention has a much bigger effect on them that it would on a person of more normal intelligence level."

The study authors, who included researchers from the University of Wales and the University of Birmingham in Britain and the University of Queensland in Brisbane, Australia, wrote that their results "should not be interpreted as an indication that antipsychotic drugs have no place in the treatment of some aspects of behavior disturbance."

But the routine prescription of the drugs for aggression, they concluded, "should no longer be regarded as a satisfactory form of care."

**The drugs most widely used to manage aggressive outbursts in intellectual ly disabled people are no more effective than placebos for most patients and may be less so, researchers report.**

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# Can't Prove It….

**…but I believe that:**

**60% of all individuals with a primary diagnosis of developmental disabilities and a secondary diagnosis of mental illness have a "trumped up" diagnosis of the mental illness to meet best practice guidelines for prescribing medication.**

# What do you think?

# Misdiagnosed

**Reasons why people with a primary diagnosis of mental illness may be incorrectly diagnosed with a secondary diagnosis of intellectual disabilities:**

- **Institutional deprivation**
- **Medication depresses functioning**
- **Mental illness may depress IQ scores**
- **More service options for people with intellectual disabilities**

**Intellectual disability diagnoses lead to a self-fulfilling prophecy.**

# MEDS

**The MEDS (Matson Evaluation of Drug Side Effects) was developed by Matson and Baglio (1998). It is an instrument designed specifically to suggest the presence of a side effect or adverse event related to treatment with psychiatric medicine for people with an intellectual disability. The MEDS has strong psychometric properties and has been widely used in clinical settings and research.**

# Therapeutic Disdain

***Historically, individuals with intellectual disabilities were rejected and overlooked as psychotherapeutic candidates. People with intellectual disabilities, it was believed, should be excluded from psychotherapy, despite clinical evidence.***

***Bender (1993) critiqued the history of this exclusion and described it As "therapeutic disdain" of mental health professionals.***

Forensics/Mental Health

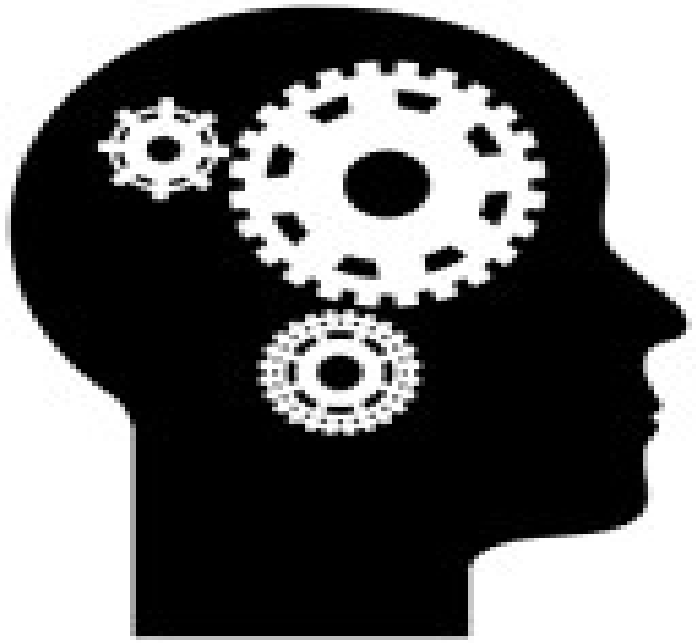
# Therapeutic Disdain (cont'd)

***Bender proclaimed that the intimacy of psychotherapy is more difficult to tolerate and demands more energy when the individual is perceived as "unattractive".***

***What are the implications of therapeutic disdain that may impair our relationships with those we support?***

# A New Understanding

**Frank Menolascino, Irving Philips and George Tarjan – began the "dual diagnosis movement" in the 1970's by pushing beyond the narrow behaviorism understanding of individuals with Intellectual Disabilities.**



- **They were the first to broaden the clinical perspective that individuals with Intellectual Disabilities are vulnerable to the full range of psychiatric disorders.**

**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**

# A New Understanding(cont'd)


- They faced significant opposition at the time but it launched new dialogue and research in the field.
- **Evidence was collected to show that dual diagnosis is common.**
- In the 1980's more appropriate clinical interventions and services emerged to demonstrate that individuals with Intellectual Disabilities could benefit from treatment.
- **Over the years, numerous promising practices have emerged. However, there remains a great need to attract more professionals to this area of specialty practice and provide them with adequate training.**

# Overshadowed

**In 1983, Steve Reiss coined the term, "diagnostic overshadowing" to describe the tendency to assess individuals with intellectual disabilities less accurately.**


**Dual Diagnosis:**
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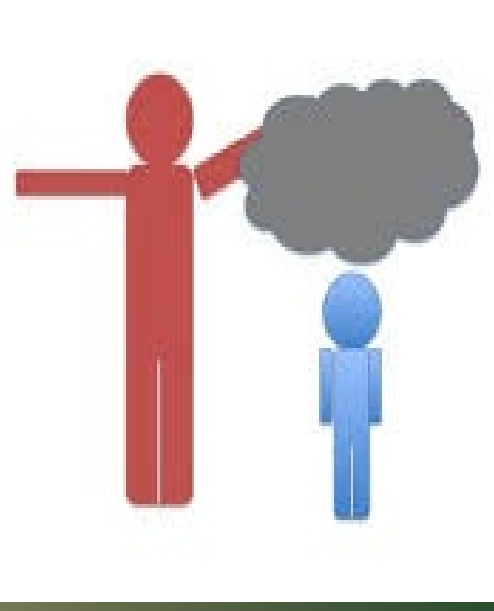
# Overshadowed (cont'd)

- **Intellectual disability was such an obvious and important characteristic that it overshadowed professionals' perceptions to the point that they couldn't see the individual's signs of emotional distress and illness.**
- **Diagnostic Overshadowing refers to a bias impacting a clinician's judgment regarding co-occurring disorders in individuals who have intellectual disabilities or other mental illness.**



**Dual Diagnosis:**
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# Expressed Differently

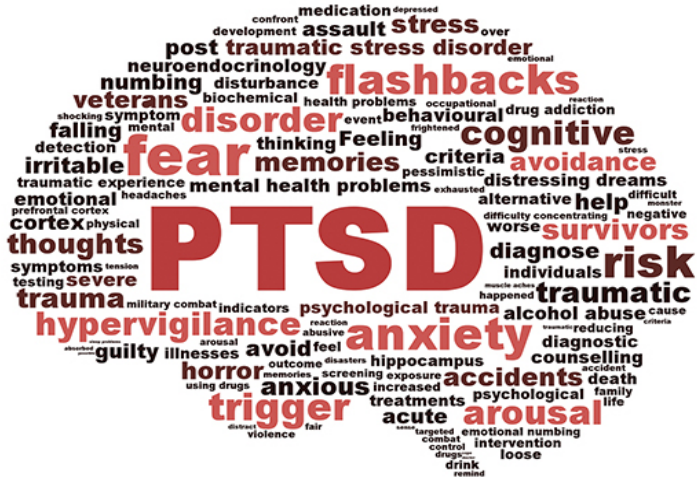
**Research provides descriptions of symptoms that may vary from those more commonly seen in the nondisabled population.**

- **Individuals with intellectual disabilities experiencing depression frequently talk to themselves out loud rather than ruminate silently.**
- **Individuals with intellectual disabilities may be more likely than non-impaired adults to experience irritable rather than sad moods when depressed.**
- **Angry, aggressive and self-injurious behaviors may also be displayed by depressed individuals with intellectual disabilities.**


**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**

# Expressed Differently (cont'd)

**Many referral problems are initially presented by staff as noncompliance, temper tantrums, self-abuse, or going off with no provocation.**




**Individuals with intellectual disabilities who exhibit such behaviors are often depressed and frequently, although not always, have histories of traumatic exposure.**

**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**

# Higher Incidence

**Individuals with intellectual disabilities experience the full range of mental illnesses and the incidence is much higher in the DD population than in the overall population.**

# Mental Health & Self-Harm

**Self-harm…**

also called self mutilation, excessive piercing, burning or cutting is defined as any intentional injury to one's own body. Usually, self-harm leaves marks or causes tissue damage.

**Self-harm can involve any of the following behaviors:**

# MENTAL HEALTH & SELF-INJURY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## MENTAL HEALTH & SELF-INJURY

# Burning

"branding" with hot objects

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# MENTAL HEALTH & SELF-INJURY

body piercing

Excessive

tattooing

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## MENTAL HEALTH & SELF-INJURY

# Picking

skin and reopening wounds

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## MENTAL HEALTH & SELF-INJURY

# Hair Pulling

(Trichotillomania)

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## Mental Health & Self Injury

# Head Banging

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# MENTAL HEALTH & SELF-INJURY

Hitting

with a hammer
or other objects

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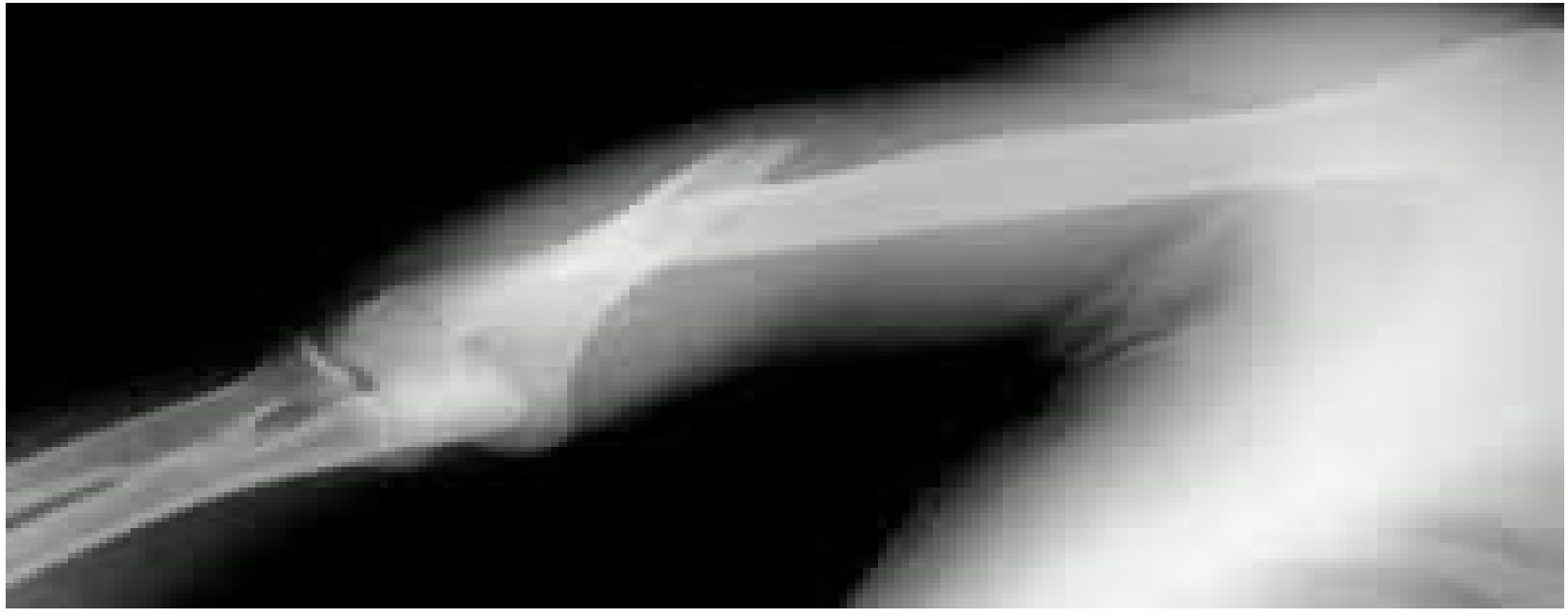
## MENTAL HEALTH & SELF-INJURY

# Bone Breaking



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# MENTAL HEALTH & SELF-INJURY

**Usually an attempt is made to hide these behaviors.**

Web MD

# What Leads to Self-Injury?


**When one is faced with what seems like overwhelming or distressing feelings.**

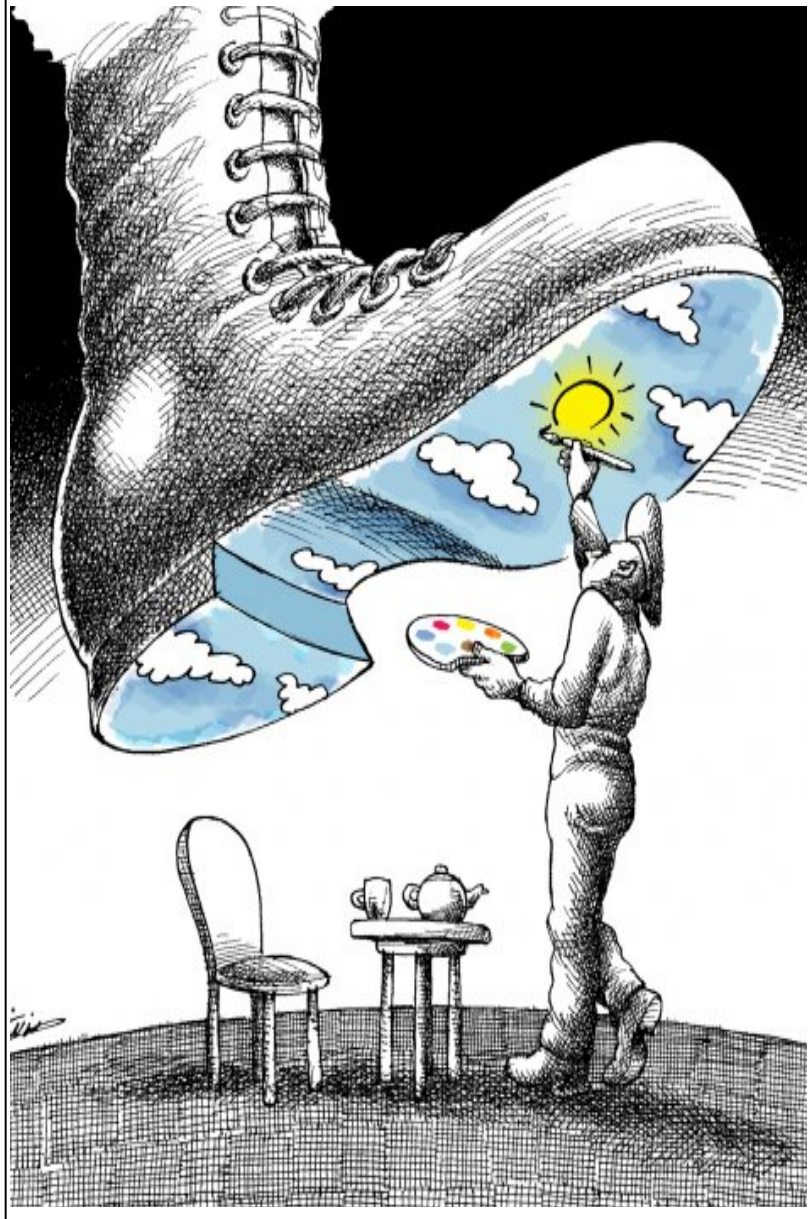
**It can also be an act of rebellion or a rejection of parent's values and is a way of individualizing one's self.**

# What Leads to Self-Injury? (cont'd)

**Sufferers may feel that self-injury is a way of:**

- **Temporarily relieving intense feelings, pressure or anxiety**
- **Being a means to control and manage pain – unlike the pain experience through physical or sexual abuse or trauma**
- **Providing a way to break through emotional numbness (self-anesthesia that allows someone to cut without feeling pain)**
- **Asking for help in an indirect way or drawing attention to the need for help**
- **Attempting to affect others by manipulating them, making them care, feel guilty or go away**

# Oblivion



**Self-harm is a way of realizing oblivion for some individuals.**

**The fact or condition of forgetting or being forgotten, especially the condition of being oblivious, the state of being unconscious or unaware, the state of not knowing what is going on around you**

Merriam Webster

# How Is Self-Injury Diagnosed?

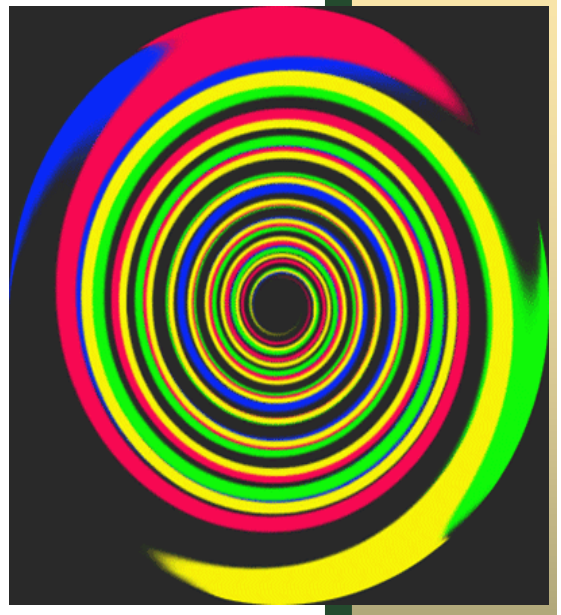
## Self-injury can be a symptom of a psychiatric illness including:

- Personality disorders (particularly borderline personality disorder)
- Substance use disorders
- Bipolar disorder
- Severe depression
- Anxiety disorders (particularly OCD)
- Schizophrenia

Web MD

# How Is Self-Injury Treated?

**Treatment for self-injury may include:**



- Psychotherapy
- Dialectical Behavior Therapy
- Post-Traumatic Stress Therapies
- Group Therapy
- Family Therapy
- Hypnosis and other self-relaxation techniques
- Medication: antidepressants, anti-anxiety medication may be used to reduce the initial impulsive response to stress

# Who Engages in Self-Harm?

**Self-harm occurs across the spectrum.**

**Self-harm occurs most often among:**

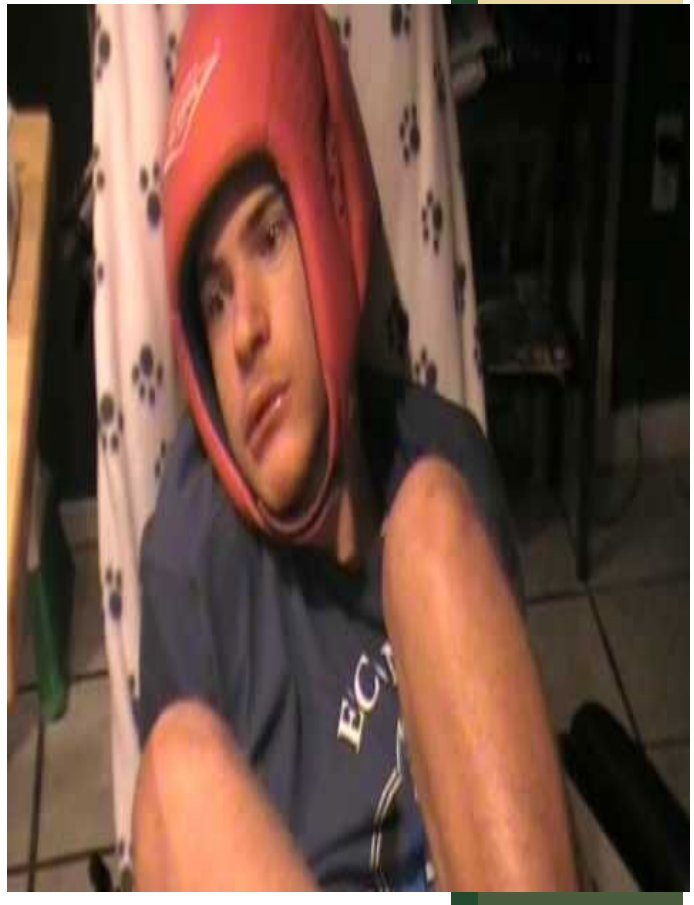
- **adolescent females**
- **people with a history of physical, emotional or sexual abuse**
- **people with co-existing problems, obsessive compulsive disorders, eating disorders**
- **individuals raised in families that discouraged the expression of anger**
- **individuals who lack skills to express their emotions and lack a good social support network**

# Self-Harm vs. SIB

**Self-Injurious Behavior (SIB) occurring in persons with developmental disabilities differs from self-harm demonstrated by persons with co-occurring diagnoses.**

**Characteristically SIB:**

- **Is spontaneous – not premeditative**
- **Is not intended to inflict injury**
- **Is demonstrated publically vs. privately**
- **Is in response to immediate environmental stimuli (transitioning, sensory input)**
- **Is a response to primary emotions of fear, anxiety, panic, frustration**
- **Lacks understanding of consequences**



# Situational Awareness

**(SA) is the perception of environmental elements with respect to time or space, the comprehension of their meaning, and the projection of their status after some variable has changed, such as time, or some other variable, such as a predetermined event.**

Wikipedia

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# Situational Awareness (cont'd)

## SA Considerations

### Primary purpose of SA is to:

- Avoid injury to those supported, staff and others
- Be aware of one's own emotional attitude, physical well being, tiredness and make necessary adjustments

# Situational Awareness (cont'd)

## SA Considerations

Primary purpose of SA is to:

- **Tell yourself to pay attention – scan for things; let your Reticular Activating System (RAS) take over & make a choice**

# Situational Awareness (cont'd)

## SA Considerations

Primary purpose of SA is to:

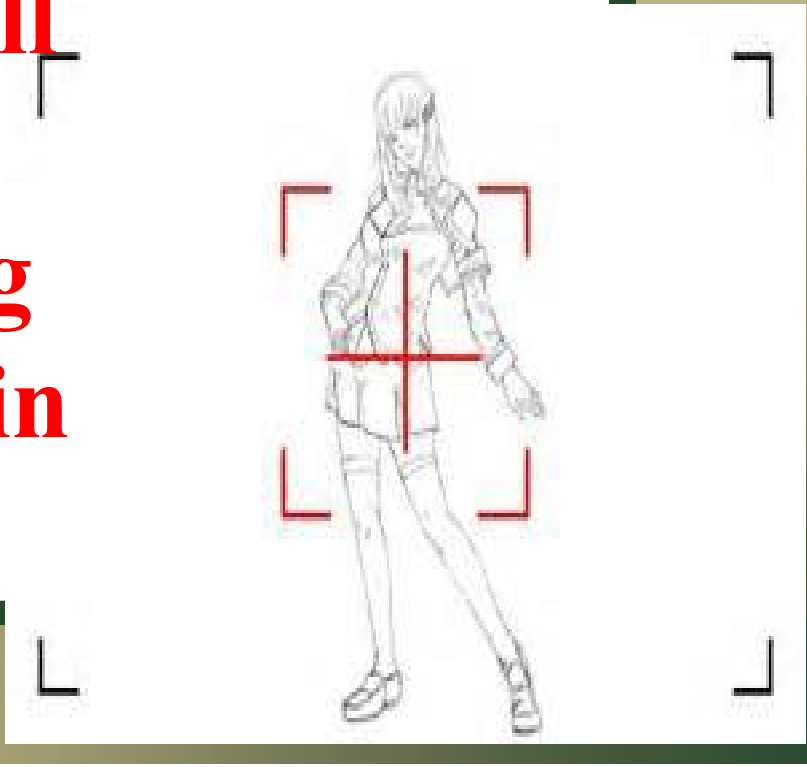
- **You must know the baseline – in order to identify variances**
- **Continually monitor the baseline**

# Situational Awareness (cont'd)

## SA Considerations

Primary purpose of SA is to:

- **Avoid Focus Lock – an engaging form of distraction, focusing all of our awareness on one thing and blocking all the other stimulus in our environment**

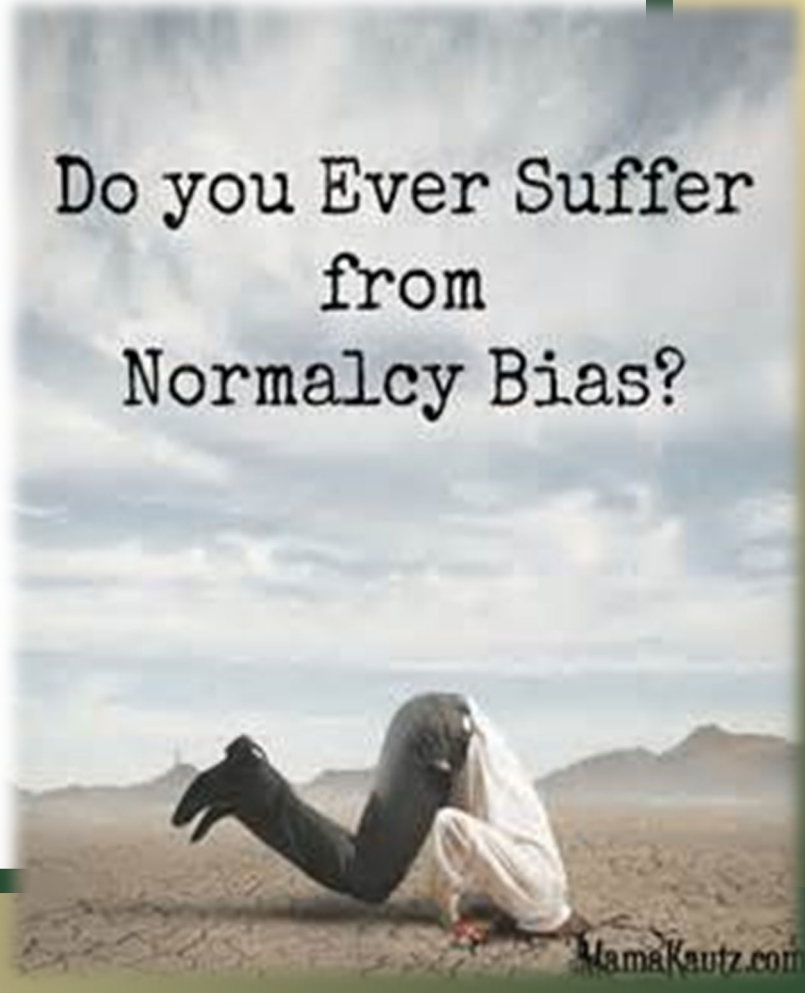


# Situational Awareness (cont'd)

## SA Considerations

Primary purpose of SA is to:

- **Fight Normalcy Bias! This necessitates an initial degree of paranoia to develop baseline sensitivity variance**

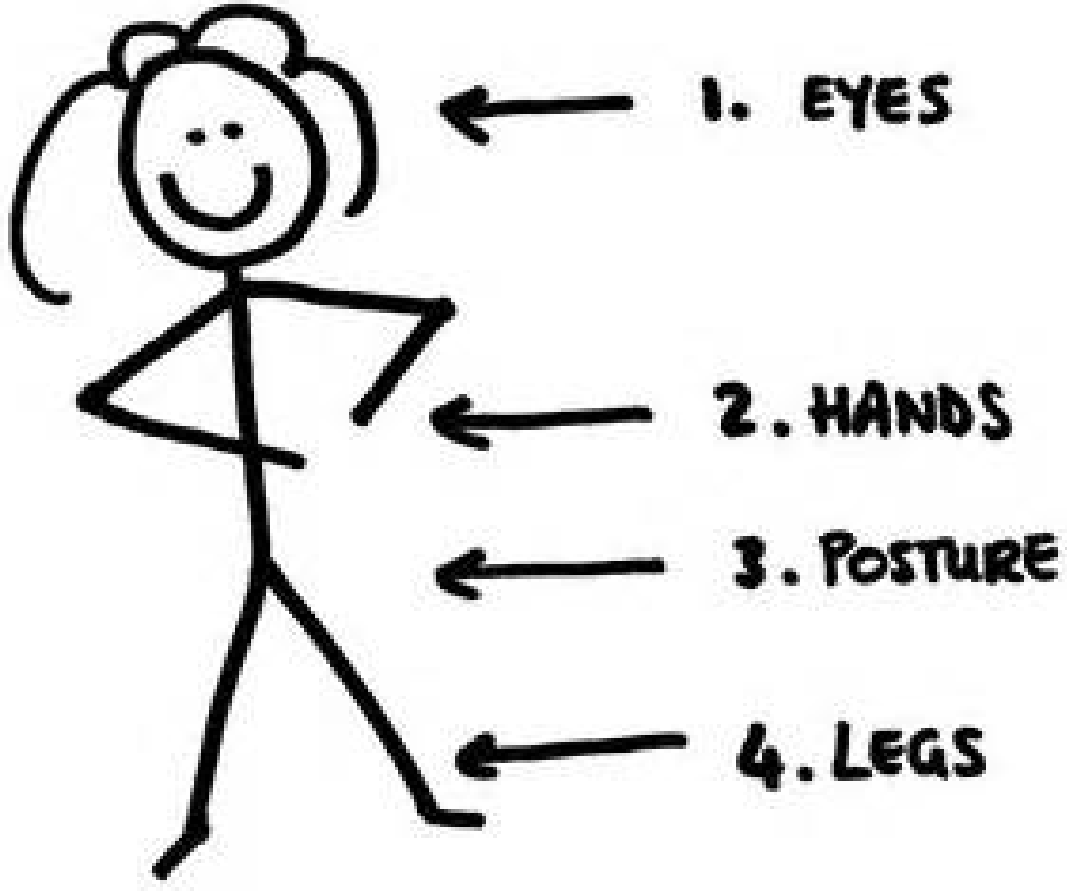


# SA Indicators

**Situational Awareness necessitates a primary focus on the person in the context of their environment.**

**Be vigilant of precursors of self-harm or aggression:**

**Voice Volume**
**Rate of Speech**
**Vocal Tone**
**Facial Affect**
**Speech Fluency**
**Head Alignment**
**Body Positioning**
**Response Latency**
**Eye Contact**
**Respiration Rate**



# Vulnerability Factors in ID

**Organic**

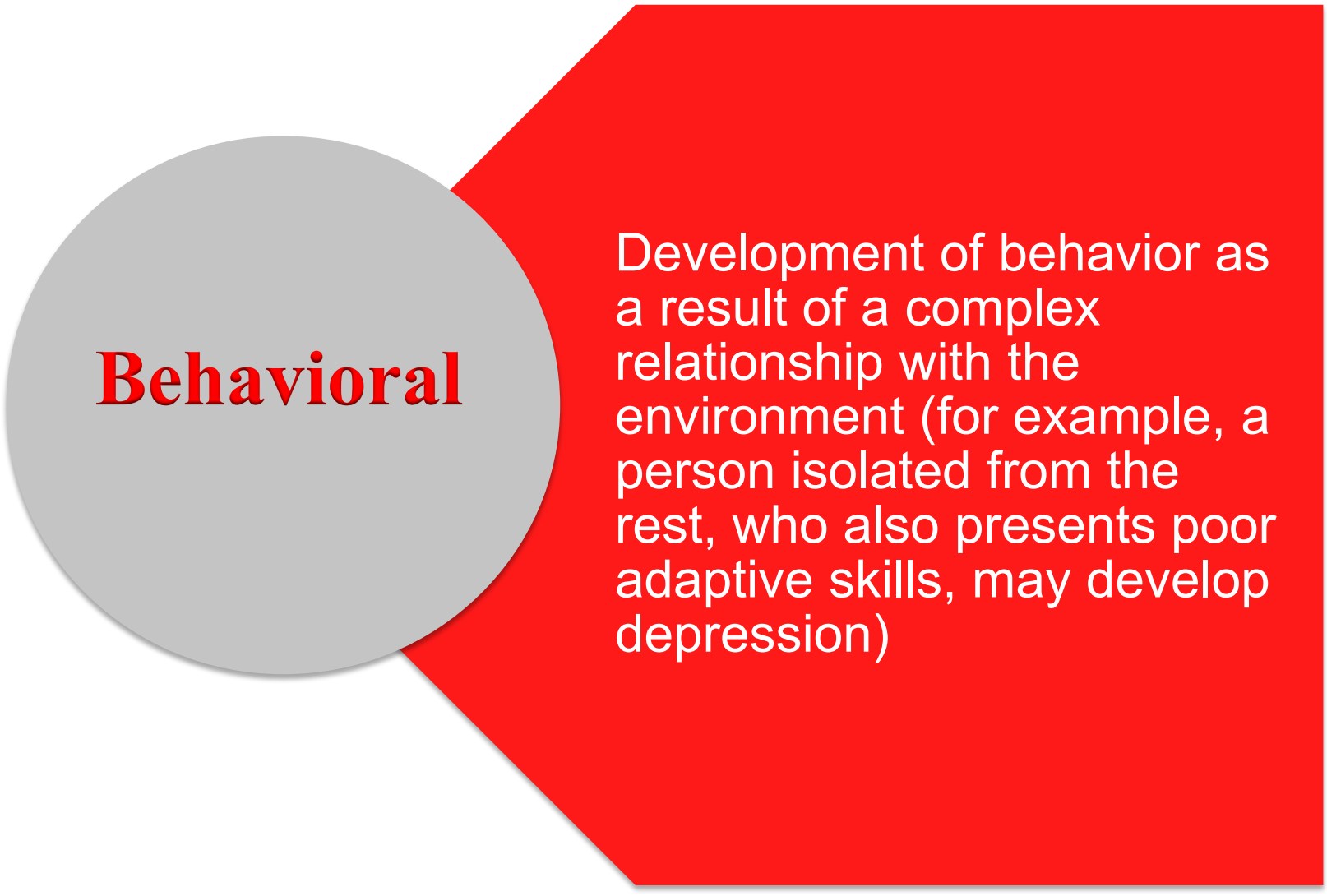
-Physiological alterations (abnormalities in the cerebral structures or epilepsy)

-Biochemical alterations (prone to the appearance of illnesses such as schizophrenia or depression)

-Genetic alterations (for example, genetic relation between Down syndrome and Alzheimer-type dementia)

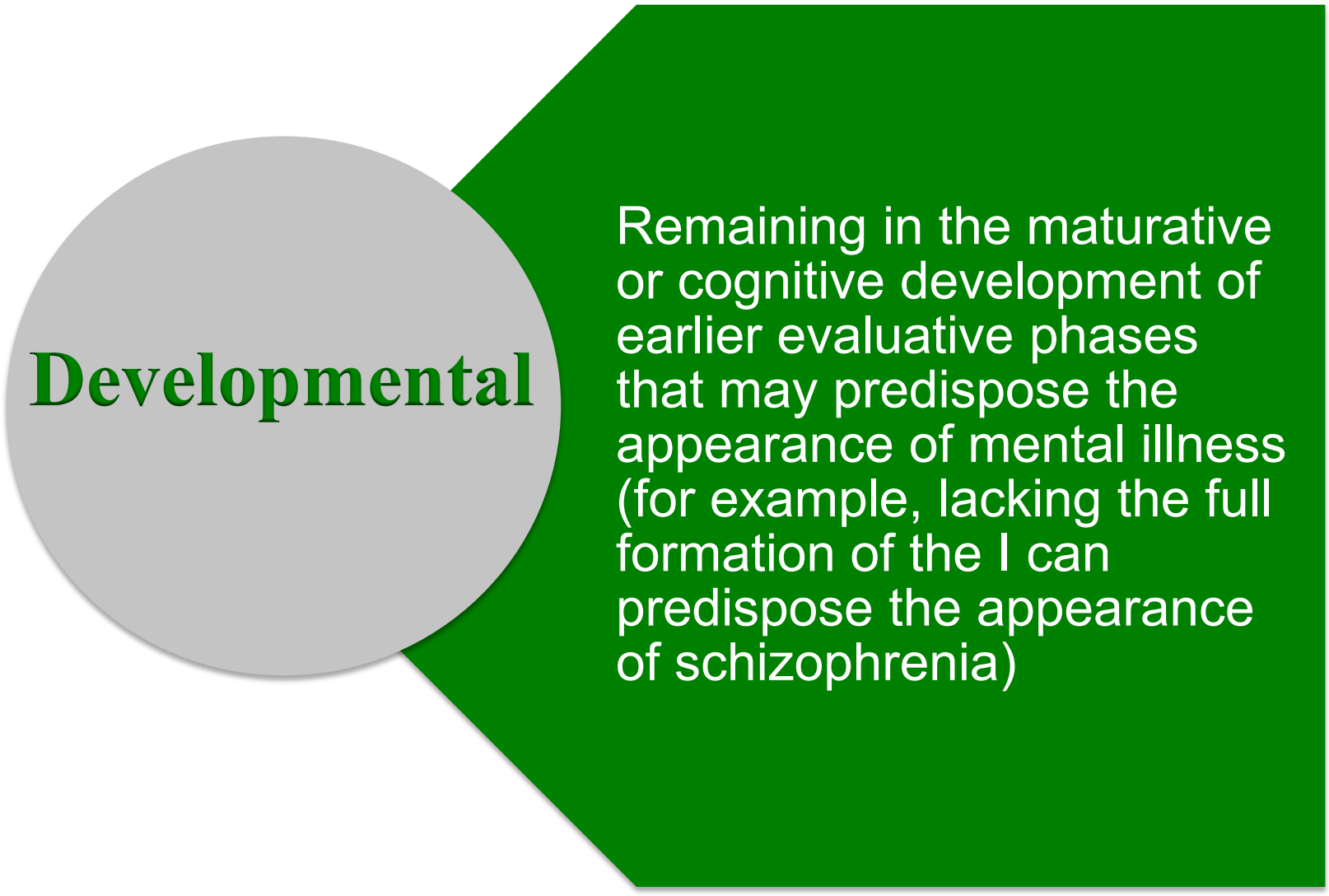
Matson and Sevin, 1994

# Vulnerability Factors in ID (cont'd)




Matson and Sevin, 1994

# Vulnerability Factors in ID (cont'd)




Matson and Sevin, 1994

# Vulnerability Factors in ID (cont'd)


Matson and Sevin, 1994

# Socio-Economic Factors

**Parental educational and economic status can have a dramatic impact upon the occurrence of co-occurring diagnoses.**

- **There may not be a recognition that the child is experiencing psychiatric/psychological challenges**
- **The child's developmental disability may mask the psychiatric issue**
- **Families who are impoverished may lack the financial resources for counseling/treatment**
- **Availability of competent care givers (child care workers) may not be available in the parents' absence, thus a greater probability of trauma events**

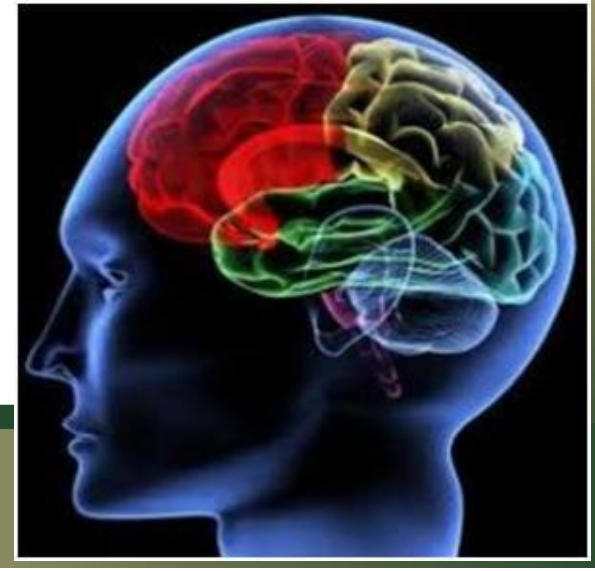
# Higher Incidence

- Nearly 1 out of every 3 individuals with a developmental disability will also have a mental illness.
- There is a 3 to 6 time increased rate of psychiatric and behavior problems in individuals with ID compared to the general population.
- In the general population, it is estimated that 1 out of every 5 individuals will experience a mental health problem in their lifetime.

# Higher Incidence (cont'd)

- **The prevalence of anxiety and mood disorders within the ID population is more than double that of the general population (American Psychiatric Association, 2000).**
- **When psychiatric disorders are more broadly defined to include the range of "behavioral disturbance" commonly seen in individuals with intellectual disabilities, prevalence rates have been reported to be as high as 80% (Razza and Tomasulo, 2005).**

**Exactly what constitutes a psychiatric disorder in individuals with intellectual disability is a subject of ongoing study.**



# Label Feeling States

The therapist may need to interpret behavior for an individual with ID by identifying and labeling the emotions that are tied to the events discussed in the session. For example, "you look sad when you talk about how sick your grandmother is." Other activities that can facilitate the labeling of feelings and emotions include:

- Use of pictorial representations of faces to facilitate identification of emotions
- Use of journaling if they have
- Use of picture journaling as a ubstitute for w drawing pictures or putting pic res in a jou
- Expressions through music

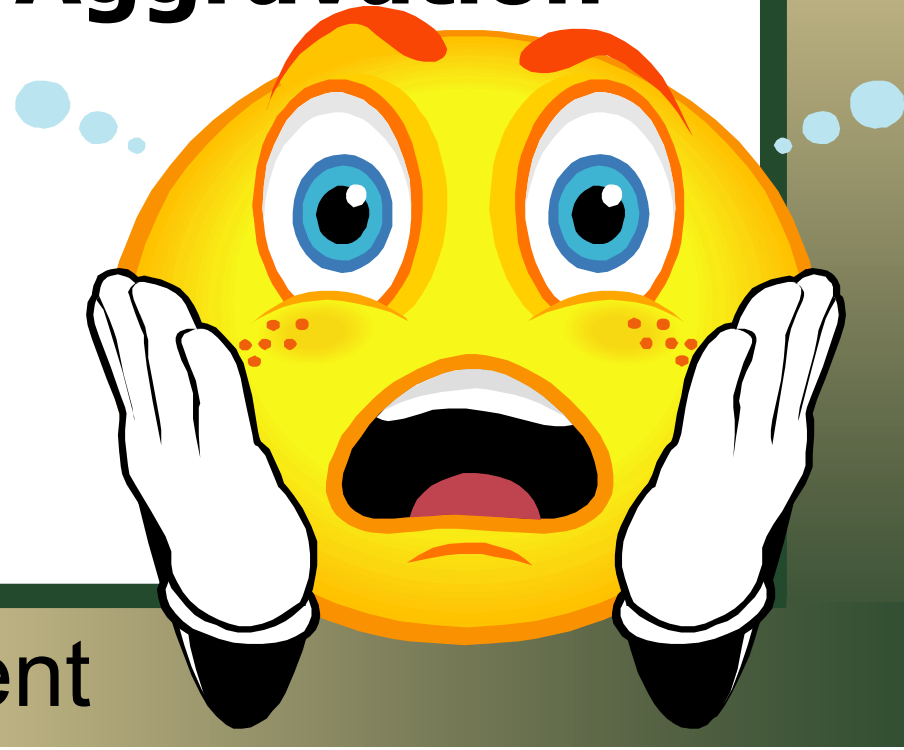
**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System (Gentile, 2012, p. 286)**

# Primary Emotions

## Anger is a secondary emotion to:

**Fear**
**Frustration**
**Grief**
**Anxiety**
**Disappointment**
**Paranoia**
**Inferiority**
**Confusion**
**Suppression**
**Repression**

**Depression**
**Panic**
**Loneliness**
**Hysteria**
**Aggravation**



# Primary Emotions (cont'd)

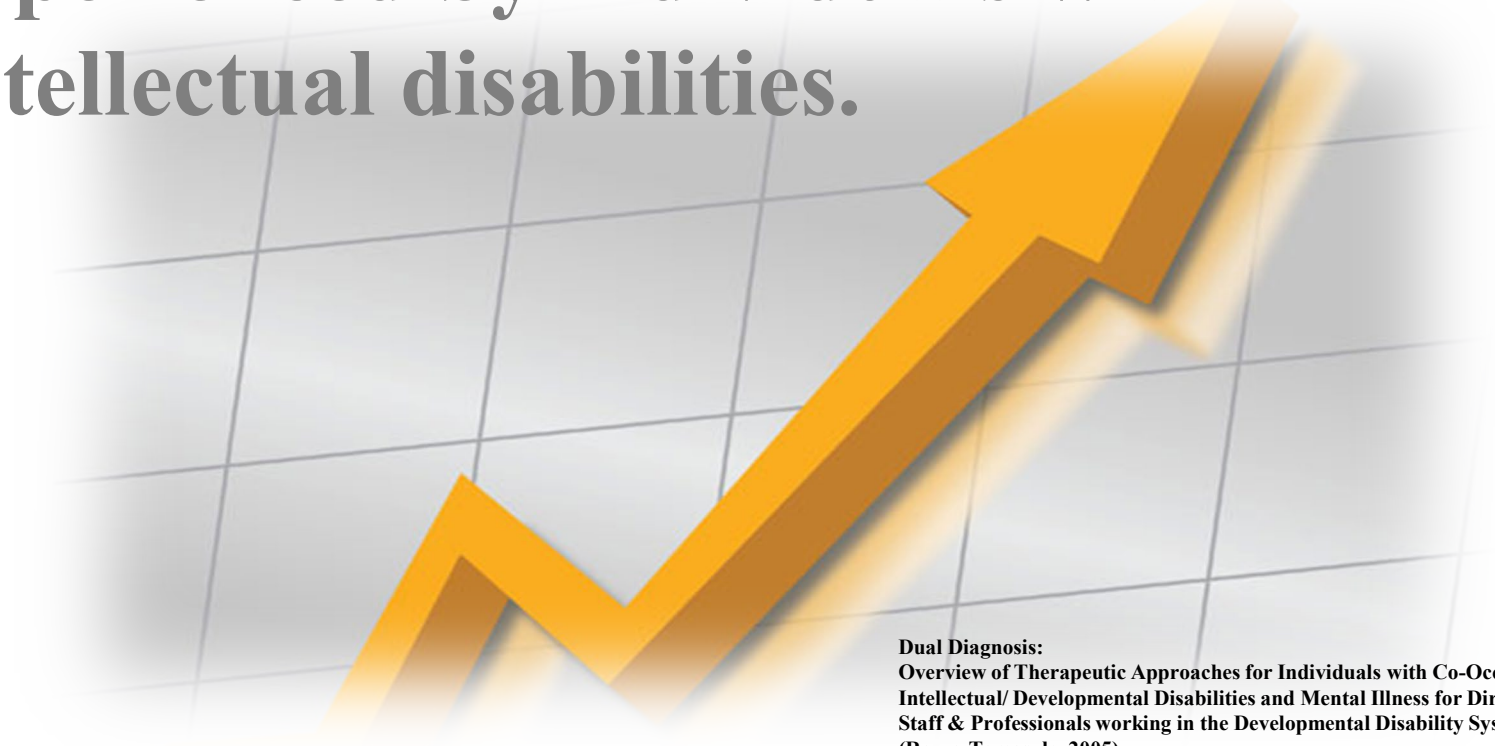
**Disillusionment**
**Subjugation**
**Impatience**
**Rejection**
**Hopelessness**
**Remorse**
**Overwhelmed**
**Jealousy**
**Ineptness**
**Sadness**
**Deprivation**
**Exhaustion**

**Inability to manage these emotions may result in anger.**

**What role does intellect play in processing these emotions?**

# Contributing Factors

**A broad array of factors have been found to contribute to the higher than average rates of psychiatric disorders experienced by individuals with intellectual disabilities.**



**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System (Razza-Tomasulo, 2005)**

# Contributing Factors (cont'd)


- Low levels of social support
- Poorly developed social skills
- A sense of learned helplessness and correspondingly low sense of self-efficacy
- Low socioeconomic level
- Increased presence of physical disabilities, especially epilepsy
- Heightened family stress and heightened maternal stress

**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System (Razza-Tomasulo, 2005)**

# Contributing Factors (cont'd)

- Increased likelihood of central nervous system damage
- Increased presence of reading and language dysfunction
- Increased likelihood of experiencing early trauma and abuse
- Decreased opportunities to learn adaptive coping styles
- Increased likelihood of chromosomal abnormalities, metabolic diseases and infections

**Dual Diagnosis: Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**
**(Razza-Tomasulo, 2005)**

# Speaking/Interviewing

**The following guidelines were developed by Dr. Gentile for use when speaking with individuals with intellectual disabilities.**

- **Be honest when you do not understand an individual's speech or communication and feel free to ask them to repeat the response or enlist the help of collateral sources in the room when appropriate.**
- **Ask permission to involve collateral data sources.**
- **Use "who," "what," and "where," questions rather than "when," "how," and why."**
- **Avoid hypothetical or abstract future-oriented questions.**

**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**

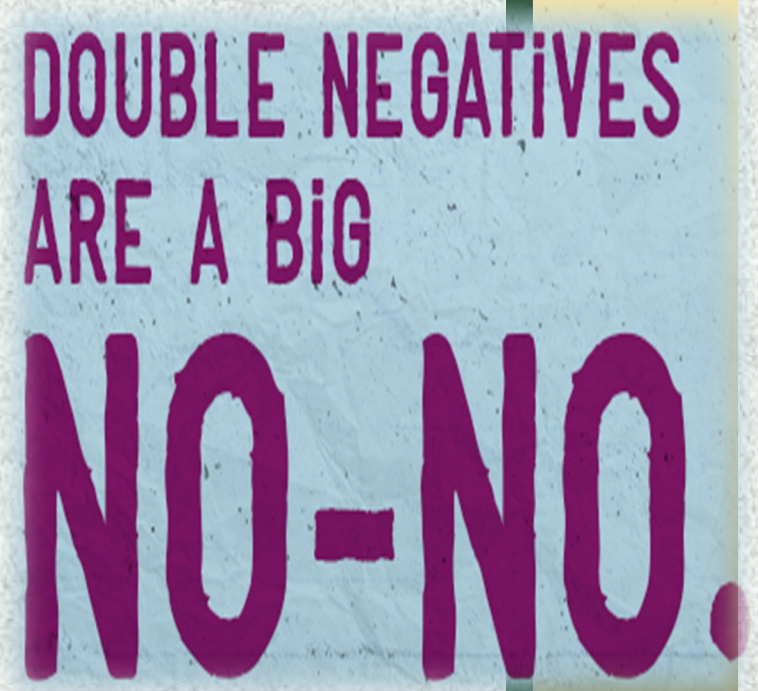
# Speaking/Interviewing (cont'd)

- **High yield accurate information will most likely be gained from the use of pictorial multiple-choice and factual yes/no questions, closely followed by subjective yes/no questions.**
- **Avoid jargon or slang, as well as other technical language.**
- **Use concrete descriptions and avoid figurative language.**
- **Avoid conversational punctuations such as "really" and "you know" because they may be taken literally.**
- **Frequently check understanding of conversation with the individual with ID.**


**Dual Diagnosis:**
**Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System**

# Speaking/Interviewing (cont'd)

- Ask what particular words mean to the individual, and use their words when possible.
- Match questions and answers with the individual's expressive language.
- Avoid double negatives.
- Use words that they use for body parts.
- Avoid abstract concepts.
- Use alternative language systems – picture and line drawings as adjunct when needed.
- Match the interviewee's mean length of utterance.
- Use plain language or language less than 6th grade level.




Dual Diagnosis: Overview of Therapeutic Approaches for Individuals with Co-Occurring Intellectual/ Developmental Disabilities and Mental Illness for Direct Support Staff & Professionals working in the Developmental Disability System

# Speaking/Interviewing (cont'd)

- Use single clause sentences.
- Use active verbs rather than passive ones.
- Use present tense whenever possible.
- Use time anchors when discussing the past.
- Avoid idioms – i.e., do not say "you can't teach an old dog new tricks."
- Avoid direct comparisons – i.e. How do you like your new home AND job – ask each as separate questions.
- Yes/no questions are higher yield when used regarding activities and events, but they are not as accurate with feelings and emotions.

# Speaking/Interviewing (cont'd)

- Avoid confrontational or potentially embarrassing yes/no questions.
- Avoid leading questions – "you knew what you were doing was wrong, didn't you?"
- Use caution with "why" questions.
- Exercise caution with use of humor.
- Eliminate irrelevant stimuli in the office which may steal the attention or create distraction.
- Assure that the individual's assistive devices are available for use.
- Learn the basics of sign language for commonly used words – thank you, bathroom, please, sad, happy, good, and bad.

# Universal Facial Expressions of Emotion

**Paul Ekman has been a pioneer in the study of emotions and their relation to facial expressions. He classified six facial expressions which correspond to distinct universal emotions: disgust, sadness, happiness, fear, anger, surprise.**



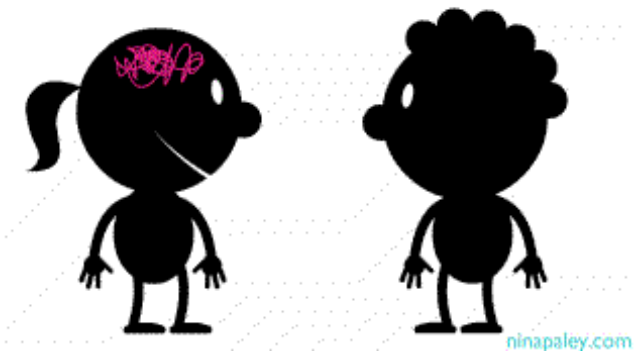
# Universal Facial Expressions (cont'd)

| Expression | Cues |
|---|---|
| Happiness | *Raising and lowering of mouth corners *crinkles appear around the eyes *cheeks raised |
| Sadness | *Lowering of mouth corners *eyes may tear *raise inner portion of brows |
| Surprise | *brows arch *eyes open wide to expose more white *jaw drops |
| Fear | *brows raised *eyes open *mouth opens slightly |
| Disgust | *upper lip is raised *nose bridge is wrinkled *cheeks raised |
| Anger | *brows lowered *lips pressed firmly *eyes bulging |

**These facial expressions may be of particular importance when trying to interpret the emotions of persons with an Intellectual Disability.**

# Role of Support Staff

**Therapists often need collateral information from support staff, as individuals with ID are poor historians.**




- **Their support staff and parents may be able to provide valuable information about sleep records, weight changes, appetite changes, medical conditions, documentation of unexplained sadness, isolative behavior, etc.**
- **They are often able to help when the individual has very limited language skills as they are more familiar with their speech patterns.**
- **The support staff are also valuable in helping ensure that the treatment recommendations are followed and homework is complete.**

**Dual Diagnosis:**
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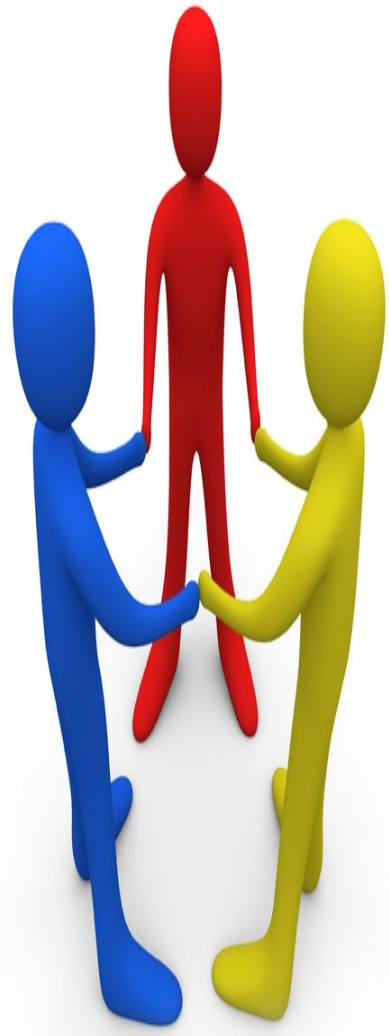
# Therapeutic Role

**Relationship is the single most important therapeutic modality for ameliorating threats of violence, emotional crises and the need for restraint.**



**Peter Breggin, M.D. Psychiatrist**

# Clarifying Therapist Role

Individuals with ID may have no understanding of how the therapist's role is inherently different than all the other members of their team.

- **They may have no idea about what therapy is and what confidentiality means.**
- **They frequently experience the free sharing of personal information between multidisciplinary team members and may have concerns that the information disclosed in therapy will be treated in the same manner.**
- **This can also be true about some of the team members as well who may expect to know what is shared with the therapist in the therapy session.**

# Be Innovative

**Developing Therapeutic Plans frequently results in a collision between interventions that are:**

**innovative, pioneering, groundbreaking, state of the art and inventive vs.**

**traditional, typical, conservative, consistent with regulation, policy and customary practice.**

**vs.**

Universal Enhancement

# Mental Health Hospice…

**…is a type and philosophy of care that focuses on the relief and soothing of the psychiatric symptoms without affording an effective treatment. The hospice service is provided to individuals with severe psychiatric symptoms for whom no effective therapeutic interventions are known.**

**The hospice provides compassionate care to help address the individuals fears and concerns as well as palliative comfort for physical symptoms. A wide range of environmental modifications and pharmacological options may be utilized to minimize the detrimental consequences of the psychiatric symptoms.**

Universal Enhancement

# Dialectical Behavior Therapy

**DBT was developed by Marcia Linehan in 1993 to address the needs of individuals diagnosed with borderline personality disorder who were chronically suicidal and not benefitting from traditional treatment.**

(Fletcher, 2011, p. 14 & p. 18) Margaret Charlton, Ph.D. and Eric Dykstra, Psy. D have adapted it for the DD population (DBT-SP)

Universal Enhancement

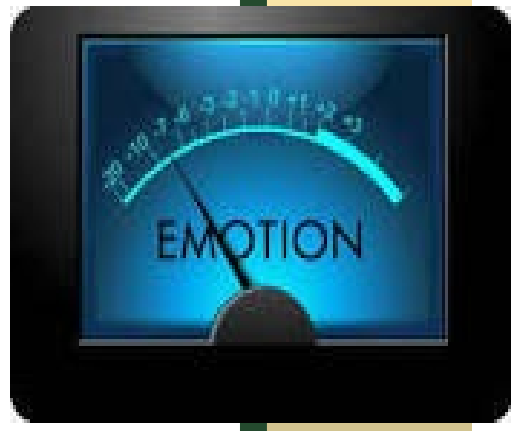
# Dialectical Behavior Therapy (cont'd)

- **DBT is based on the premise that the combination of exposure to an invalidating environment, along with unknown biological factors, contribute to the development of emotional instability and abnormal reactions to emotional stimulation.**
- **The goal of DBT is to validate that the individual's behaviors and reactions are understandable, without agreeing that they are the best or only approach to solve the problem.**


(Fletcher, 2011, p. 14 & p. 18) Margaret Charlton, Ph.D. and Eric Dykstra, Psy. D have adapted it for the DD population (DBT-SP)

# Dialectal Behavior Therapy (cont'd)

- DBT focuses on helping them learn to regulate their emotions and improve their ability to cope with stress and their interpersonal relationships.
- It postulates that some people have a higher than typical baseline arousal level and are highly emotionally reactive to their environments and that they have a harder time returning to a baseline arousal level.
- The treatment has been expanded to address the needs of a wide variety of individuals with a range of disorders in a variety of settings – suicidal adolescents, eating disorders, treatment resistant depression, bi-polar disorder, etc.




(Fletcher, 2011, p. 14 & p. 18)
Margaret Charlton, Ph.D. and Eric Dykstra, Psy. D have adapted it for the DD population (DBT-SP)

# Dialectical Behavior Therapy (cont'd)

## DBT is based on these working assumptions:

- Individuals are doing the best they can in the moment.
- Individuals need to do better, try harder. Wanting to change is not enough.
- Individuals have not caused all of their problems but they have to solve them anyway.
- Individual's lives are unbearable as they currently are.
- Individuals must learn new ways of being in all relevant situations.
- Individuals cannot fail in treatment – either the treatment failed or the treaters failed.
- Treaters need assistance and support when working with individuals with intensive problems.

DBT uses a combination of weekly individual therapy sessions and weekly group therapy sessions that focus on internalization of skills from four different modules: core mindfulness skills, distress tolerance skills, emotional regulation skills, and interpersonal effectiveness skills.

(Fletcher, 2011, p. 14 & p. 18) Margaret Charlton, Ph.D. and Eric Dykstra, Psy. D have adapted it for the DD population (DBT-SP)

# NADD Recommendations

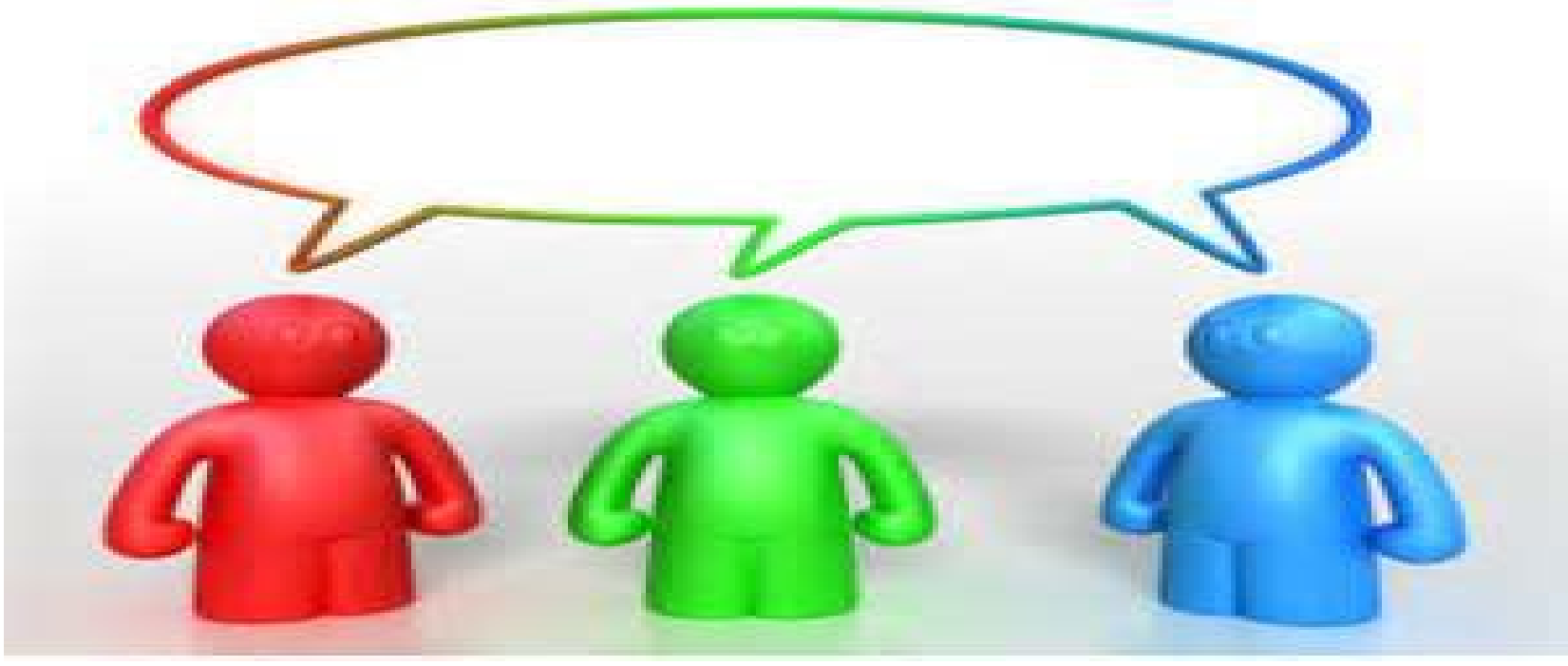
NADD recommends that states consider the following principles as they develop plans to restructure their service systems.

# NADD Recommendations (cont'd)

1. **Community Living: People with co-occurring disabilities should be supported to have friends and to live, attend school, and/or work in the community consistent with ADA and the Olmstead ruling.**

# NADD Recommendations (cont'd)

2. **Knowledge and Expertise: All key stake holders should be included in the design of new services, supports, and funding options.**



# NADD Recommendations (cont'd)

3. **Person Centered Services: People with co-occurring disabilities should have services that are individualized and person-centered, according to their needs.**

# NADD Recommendations (cont'd)

4. **Workforce Competencies and Training: Training should emphasize specialized skills, especially diagnosis and treatment.**

# NADD Recommendations (cont'd)

5. **Readiness Review:**
   **States should complete a "readiness review" - to fully inform their consideration of new funding methodologies, support strategies, provider requirements and quality and performance expectations.**

# NADD Recommendations (cont'd)

6. **Funding: Funding priorities, rates and mechanisms should be flexible and designed to reward the achievement of high quality and cost effective performance outcomes that support community based placements, adequate direct support professional staff salaries and braided government funding.**

# NADD Recommendations (cont'd)

7. **Support for Families: Services and supports including respite care, integrated care coordination, preventative behavioral supports and crisis prevention and stabilization must be designed to address the needs of recipients of services across the lifespan and their family members.**

# NADD Recommendations (cont'd)

8. **Inter-Systems Service Coordination: Efforts must ensure that the historically fragmented services delivery systems are integrated, result in effective services provision, and provide the service recipient (including the family) with the ability to advocate for needed services.**

# NADD Recommendations (cont'd)

9. **Quality and Performance Expectations: Quality and performance expectations should be be consistent with current national efforts for persons receiving support, for peers and the family movement. These outcomes should be publicly stated and measurable.**

# NADD Recommendations (cont'd)

10. **Support to Develop Proven Models of Care and Treatment: Enhanced research supporting the provision of evidenced-based practices is necessary to help address the current inappropriate use of psychotropic medications, seclusion and restraint, the criminal justice system, emergency rooms and institutional-based long term care for this population.**

# Self-Efficacy…

**…"an individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments**

(Bandura 1977,1986, 1997)

**…reflects confidence in the ability to exert control over one's own motivation, behavior and social environment"**