Welcome to the Pennsylvania Dual Diagnosis Direct Support Curriculum training on *Intellectual Disability and Psychiatric Disorders.*
The Commonwealth of Pennsylvania’s Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Developmental Programs (ODP) have undertaken a joint initiative to address the needs of people who have an intellectual disability as well as mental health challenges. People who have both of these challenges are commonly referred to as those who have Dual Diagnosis. For the purpose of this training, Dual Diagnosis is not referring to co-occurring mental health challenges and substance abuse or dependence, although people can have substance abuse or dependence issues as well as a Dual Diagnosis of an intellectual disability and mental health challenges. The curriculum was designed for Direct Supporters, Supports Coordinators and others who work in either the intellectual disability field or the mental health field.

The ultimate goal of this training curriculum is to provide information that can aid in the understanding of the struggles and the triumphs of those you support or will support. This curriculum was designed to demonstrate the complexity of Dual Diagnosis and the factors that need to be considered to best support those with whom you come into contact. The Pennsylvania Dual Diagnosis Direct Support Curriculum was also designed to demonstrate that all people in this world, regardless of their challenges, are much more alike than they are different.
The information presented to you today is to increase your awareness. It is not intended to replace medical advice. This training is not all inclusive and does not discuss all psychiatric disorders. Some disorders were separated into their own Dual Diagnosis Direct Support Curriculum training modules due to both the complexity and importance of understanding the material and some disorders are not discussed at all. For example, Trauma-Related Disorders are covered in the Understanding Trauma-Informed Care and Stressful Life Events curriculum module. Likewise, Autism Spectrum Disorders are covered in the Autism Spectrum Disorders module.

Certain categories of disorders were selected based upon the frequency of these diagnoses within the state of Pennsylvania. If this training module does not cover information on a specific disorder pertaining to an individual you support, or if you believe you or someone you support have these conditions or concerns, please seek the advice of a physician.
By the end of this presentation the participants will be able to recognize the symptoms of selected mental health challenges; have increased knowledge of how to better support someone with an intellectual disability and a psychiatric disorder; and recognize the importance of accurate documentation of symptoms to share with the psychiatrist or prescribing health care professional.
To improve your chances of having a positive outcome for a person with an intellectual disability and a mental health challenge, you need to start with an accurate assessment of symptoms. Getting an accurate assessment of symptoms can lead to a more accurate psychiatric diagnosis. From an accurate assessment of symptoms and an accurate psychiatric diagnosis a treatment plan is formed. According to the DSM-V, once a treatment plan is in action it can reduce the symptoms of a mental health challenge in 60-80% of the people.

If the person is non-verbal, you may observe behaviors that may be an expression of behavioral health symptoms. You need to accurately share the challenging behaviors you see with the person’s health care practitioners to help them in the diagnostic process. According to the DM-ID-2, having the correct diagnosis and treatment will reduce the symptoms of a mental health challenge in 60-80% of people. Getting the correct diagnosis for a physical health problem is often easier than getting the correct diagnosis for a mental health challenge. A diagnosis can only be made by a qualified health care professional.

Let’s take a look at some physical health symptoms. Imagine you are the patient and you go to your primary care practitioner or PCP because you feel sick. You tell your practitioner that you have a sore throat, chills, fever, fatigue, muscle pain, and a cough.

- Do you just have a cold, the flu or is something else making you feel sick? Your PCP does a physical exam. He/she feels your neck and says you have swollen glands. Your PCP then asks you to open your mouth. The back of your throat and is red and swollen. There are also tiny red spots on the roof of your mouth near the back of your throat and white spots on your tonsils. Your PCP says, “I think you may have strep throat. I would like to do a strep test.” A sterile swab is rubbed on the back of your throat. The swab is analyzed and your PCP confirms the diagnosis of strep throat.

Your PCP prescribes an antibiotic to treat the strep bacteria and tells you to rest, drink plenty of fluids, and take extra strength acetaminophen (Tylenol) every 6 hours for pain. You follow your health care practitioner’s orders. Because your symptoms go away, you can safely conclude that you received the correct diagnosis and the right treatment.

It is not our job to make a diagnosis. And, although most of us would recognize the symptoms of a cold, most of us are not that familiar with the symptoms of a mental health challenge. Recognizing symptoms of a mental health challenge and sharing what we have observed with a health care practitioner, could be very helpful in the process of diagnosing a mental health challenge. It is because of this that we are presenting the material in this training.
The holistic approach to assessment of a health problem takes into account every aspect of a person’s life and results in a view of the whole person. Holistic assessment and care is a method used to understand a person, no matter who they are and what they are experiencing. All of the areas on the slide convey the vital information about who a person is and can help us to provide comprehensive and person centered support. By looking at everything on this slide, one could see that the person may have a physical, environmental or a mental health challenge.

Please take a minute to review all of the areas on this slide and think about how a problem in any area might make someone act differently.
The treatment model on this slide can be used for symptoms or symptomatic behaviors that are identified. A group of symptoms that are identified leads to a diagnosis of a health problem. The diagnosis then leads to treatment. If the diagnosis and treatment are correct, most people being treated will have less symptoms of an illness. If the individual ends up having less symptoms of illness it is considered a positive health outcome.
It is important to understand how the diagnosis of an intellectual disability is made in Pennsylvania because without a diagnosis of an intellectual disability, a person cannot receive services from the intellectual disability system. According to the Diagnostic and Statistical Manual of Mental Health Disorders Fifth Edition, or the DSM 5, an intellectual disability is a developmental disorder that includes significant limitations in adaptive and intellectual functioning.

To have the diagnosis of an intellectual disability the following 3 criteria must be met:

1. There must be deficits in intellectual functioning. These include reasoning, problem solving, planning, abstract thinking, judgement and academic learning. These deficits must be confirmed by a clinical assessment and testing resulting in an IQ of 70 or less.
2. There must be deficits in adaptive functioning in one or more activities of daily life, such as communication, social participation and independent living. These deficits must result in a failure to meet developmental, social, and cultural standards for independence.
3. The onset of the intellectual and adaptive disability must occur during the developmental period, which in Pennsylvania is considered to occur before the person’s 22nd birthday.

Many factors may affect IQ test scores and clinical judgement is needed in interpreting IQ tests. The DSM 5 puts more emphasis on adaptive functioning than on an IQ score. The various levels of severity of an intellectual disability in the DSM 5 are defined on the basis of adaptive functioning and not IQ.
This presentation will provide an overview of 7 categories of psychiatric disorders. It does not attempt to address every mental health challenge. Some mental health challenges will be discussed in more detail than others based upon the prevalence of particular diagnoses in the intellectual disability population or because of important changes made in the DSM-5 regarding a specific category.

- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Depressive Disorders
- Bipolar and Related Disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Personality Disorders
- Substance-Related and Addictive Disorders
Anxiety Disorders cover several different forms of mental health challenges. Many of these disorders are characterized by excessive worrying, uneasiness, apprehension, and/or fear about the future based on real or imagined events.

Most often these mental health challenges affect both physical and psychological health. People diagnosed with an anxiety disorder may fit in one of two categories: they experience continuous symptoms such as in Generalized Anxiety Disorder or they experience episodic symptoms such as in Panic Attacks or Specific Phobias. It is important to note that Anxiety Disorders are one of the most underdiagnosed mental health challenges in the intellectually disabled population. Anxiety Disorders are most often misdiagnosed as Impulse Control Disorder or Unspecified Impulse Control Disorder. Chances of misdiagnosing an Anxiety Disorder as an Impulse Control Disorder increases when the person has more cognitive disability. The chances of misdiagnosis also increases if the person has limited verbal skills (Loschen & Saliga, 2000).
Common symptoms that are seen with Panic Attacks in people with an intellectual disability are: aggression, agitation, screaming and/or crying, physical health complaints, refusing or resisting to go out in the community, increased dependency on others, making 911 calls, wanting to go to the hospital, frequent visits to the ER and elopement.

Some people have recurring Panic Attacks (Panic Disorder) at night. The person may state they are having “nightmares”. The person most likely will wake up in the middle of the night in an agitated state, may start pacing, may become aggressive and may not respond to redirection. If a person is only having panic attacks at night, it is important to rule out possible medical causes such as sleep apnea, GERD, nocturnal angina and actual nightmares. Some medications may cause abnormal and vivid dreams as an adverse side effect. It is always important to consider all the potential side effects of medications.
Situational nervousness is a natural emotional response to potentially stressful events such as going on a blind date, giving a speech, or interviewing for a new job. Once the event is over the nervousness goes away.

Anxiety is a much stronger emotional response than just being nervous. Anxiety is not considered a normal response to a stressful situation. Unlike nervousness, anxiety continues even when the stressful event is over. Anxiety is often accompanied by: nervous behavior, such as pacing, physical complaints of aches and pains, muscle tension, restlessness, fatigue, or problems concentrating. Anxiety is also accompanied by unpleasant feelings of dread over something unlikely to happen, such as a person feeling that their death is imminent even though the person is young and physically healthy.

The most important thing that differentiates being “nervous” and being “anxious” is that clinical anxiousness impacts your social, emotional and occupation functioning. For example, as I began this presentation, I may have been NERVOUS. I may have stumbled on some of my words and felt uneasy. But, as I continue the presentation, I gain confidence and my nervousness may disappear. However, if I had the symptoms of a Social Anxiety Disorder, I may have cancelled this presentation or have been unable to finish the presentation because of my anxiety about it. The difference between being “nervous” and being “anxious” is the severity of these feelings and their impact on your functional abilities.
Consistent and ongoing observation are necessary to understand the focus of anxiety related symptoms. Are symptoms present in a particular situation or around particular people or does it occur with anyone at anytime? The data from observations should be documented and communicated to the attending psychiatrist, therapist, behavior specialist, and other team members. It is also important that environmental adjustments and individualized supports are considered and utilized. Since anxiety involves persistent and intrusive thoughts and irrational fears, sometimes simply distracting the person in a fun way can be the best intervention as it can halt the irrational thoughts and break the negative thought cycle.

**Listen to the following example:**

*Tammy is a 23 year old female with a history of chronic anxiety. When Tammy’s anxiety reaches a certain severity, Tammy can become extremely emotional and engages in self-injurious behavior, cutting and/or biting herself. Tammy’s team recognized that often before engaging in the self injurious behavior, Tammy would pace around the room, talk to herself and verbalize her anxiety about family members. Simple redirection or ignoring Tammy’s pacing and talking to herself usually led to the escalation of her behaviors to cutting and/or biting herself. The team also knew that Tammy loved Michael Jackson’s music. When Tammy began pacing her room and verbalizing her fears to herself, her support staff would play Michael Jackson music loud enough to get Tammy’s attention. Her staff would then “moon walk” or dance past her door until she noticed them. This would lead to Tammy laughing and then joining in on the dancing. This form of redirection was much more effective then just talking to Tammy and it was fun for both Tammy and her staff.*
When supporting people with an anxiety disorder it is important to identify and reduce situations that you know make the person anxious. If the environment itself is the trigger, the person will remain anxious as long as the person is in that environment. It is important for supporters to discuss possible ways to help reduce anxiety related situations in the person’s environment. Encourage relaxation techniques like deep breathing. Ask the person if there is a place where they feel safe. If the person can not tell you where they feel safe, try to work with the person to find that safe place. Observe the person’s behavior, paying particular attention to what activities, habits or items you see the person utilize to reduce their anxiety.

You may be able to create a “worry box” or “anxiety box” filled with things that seem to help reduce the person’s anxiety. If a person is experiencing clinical anxiety and is attempting to utilize the coping strategy they developed to reduce the anxiety, redirection may only increase and intensify anxiety symptoms. The person may also begin to act out. Allow the person time to cope with their anxiety as long as their way of coping does not have the potential to physically endanger themselves or others.

For a person who experiences Panic Attacks, it is important that you suggest that the person stay in a “safe place” until the panic passes. This could take up to 2 hours. Try and focus their attention on something visible like a picture, a show, a desired item, etc. Encourage slow breathing and attempt to use relaxation techniques. Remind the person that you are there to help in any way that you can.
We will now discuss Obsessive-Compulsive and related disorders.

There is an old saying “Don’t step on a crack or you’ll fall and break your back”. Although we know this is not true, some people with OCD may believe this is possible and will spend much of their time avoiding stepping on cracks in streets or sidewalks out of fear something bad will happen. This is just a simple example of how OCD can impact a person’s life.

Obsessive-Compulsive Disorder (OCD) used to be classified as an Anxiety Disorder. However, in the new DSM 5, Obsessive-Compulsive Disorder and other related disorders have been given their own category. The treatment for OCD still remains the same and many of the therapies and medications utilized to treat Anxiety Disorders are also effective in the treatment of OCD.
Obsessive-Compulsive Disorder is defined by having obsessions which are recurrent and persistent thoughts, urges or images that are intrusive, unwanted and cause anxiety and/or distress in most individuals. The individual attempts to ignore or suppress these obsessions or attempts to neutralize them with some specific thought or action (the compulsion).

Compulsions are repetitive behaviors such as hand-washing, ordering or arranging things, repeated checking etc. or mental acts such as praying, counting, repeating words or phrases silently that the individual feels driven to perform according to rules that must be applied rigidly. These behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation from occurring. However, these behaviors or mental acts are not connected in a realistic way to what they are supposed to neutralize or prevent. Compulsions are clearly excessive and interfere with normal functioning.

It is important to note that individuals with an intellectual disability may not be able to articulate that their obsessions are unwanted and distressing. It is also important to note that individuals with an intellectual disability may not be able to tell you why they are engaging in their compulsive behaviors or mental acts.
To meet the requirements for an Obsessive compulsive disorder, the obsessions and/or compulsions must be time-consuming – for example, last more than an hour each day. They would also cause clinically significant distress or impairment in functioning. The obsessive-compulsive symptoms must not be part of a medical problem or side effect of a medication. They should not be better explained by another mental health challenge such as the restrictive, repetitive behaviors seen in Autism Spectrum Disorders.

**Differentiating OCD and symptoms associated with Autism is discussed more in depth in the Autism Spectrum Disorders Dual Diagnosis Curriculum module.**

It is also important that, if a person does meet the criteria for OCD, that if the OCD symptoms are tic related (such as in Tourette Syndrome) that this be specified. It is possible that individuals who have OCD may experience Panic Attacks as well as feelings of disgust, tension or a sense of “incompleteness” when obsessions occur. People with OCD may also avoid people, places and things that may trigger their OCD. For example, a person with OCD may actively avoid public bathrooms for fear of being contaminated.

**To summarize the significance of OCD, I am going to discuss a case example with you:**

*Joe is a 42 year old intellectually disabled male who was admitted for psychiatric hospitalization due to aggressive outbursts, property destruction and depressive symptoms (withdrawn, crying/sadness daily and suicidal ideation) that has been occurring for approximately 8 months. It was reported that Joe had been kicking and smacking the kitchen table, his dressers, his parent’s dresser and the televisions stand daily. Joe has also been smacking his work table at his workshop constantly and, when attempted to be redirected, he would become aggressive and increase smacking the table with his hands. Joe also would reportedly cry out “I’m not a bad man!” and “I hate the chair!” when engaging in the smacking and kicking of furniture. Joe was evaluated at the psychiatric hospital and Joe’s smacking and kicking behavior increased dramatically during the time at the hospital. The hospital felt that Joe’s symptoms were behavioral problems and felt that he did not have a psychiatric concern. Joe was released from the hospital and continued having the same symptoms. Joe was evaluated by an outpatient therapist who documented Joe’s smacking and kicking behaviors. The therapist noted that Joe would smack/kick furniture 8 times, every time with slight pauses. The therapist also documented the phrases Joe...*
would say when engaging in this behavior (I’m not a bad man! And I hate the chair). The therapist asked Joe about “the chair” he was talking about. Joe stated that the chair “shocked people” and “killed them”. Joe’s therapist asked his parents about electric chairs and whether or not Joe had been exposed to seeing an electric chair or hearing about it on TV or in movies. Joe’s father reported that Joe watched the movie *The Green Mile* (which has a very graphic scene in it regarding an electric chair) with him and that they had watched the movie approximately 9 months ago. When asked for further information, Joe’s dad informed the therapist that Joe asked his father “What are they doing to that man?” and Joe’s father jokingly stated to Joe: “That is what happens to bad men so you better be good!”

Here in this case example, we can see that, sometimes, especially with people with intellectual disabilities and also children, environmental conditions and things that they may see, hear or experience in other ways can potentially trigger the onset of OCD. The development of Joe’s OCD stemmed from a constant fear of being “a bad man”. His compulsion of smacking and kicking of the furniture was Joe’s way of alleviating the fear of being a “bad man”. When Joe would get in trouble for smacking or kicking furniture, it would only increase his anxiety and distress and lead to an increase in compulsive behaviors. This is also why Joe’s compulsions increased dramatically when he was psychiatrically hospitalized as his fear grew to sheer terror as he really did believe he would be executed in an electric chair. Once the team discovered the root of Joe’s fear, treatment and support was put in place to actively address Joe’s OCD. With the proper treatment and support, Joe has been symptom free for approximately 15 months. This case example also shows how a little joke can leave a lasting impact. It is always important that you be mindful of what you say to those you support because you never know how what you say will be perceived by others.
Research conducted by Lew (1995) found several factors that may predispose people with intellectual disabilities to acquire Obsessive-Compulsive Disorder. These factors are institutionalization, limited responses in behavioral options, boredom, lack of empowerment, secondary gains, and genetic syndromes and other medical conditions. Institutionalization and its restricted environments and stimulation can lead a person developing limited responses to the environment. The person did not learn skills to act differently in different or less restricted environments. Cognitive deficits may have resulted in the person having limited responses in behavioral options. This can also be true for many challenging behaviors. If a person has not learned better coping skills to manage stress, anxiety, frustration, anger, sadness, etc., the person may use basic instincts to react to the environment. This can include aggression (both verbal and physical), self-injurious behaviors, property destruction and fleeing from situations that make the person anxious or angry (elopement). Compulsive behaviors can develop over time as a way to cope with severe boredom. Because of the lack of empowerment, compulsive symptoms may be one of the few things a person can utilize to
gain or maintain a feeling of control in their life that supporters cannot stop. Compulsive behavior may produce attention or escape from unwanted or undesirable demands or situations, called secondary gains, which further reinforces the compulsion. It is important to rule out other medical or genetic concerns that may contribute or correlate with OCD. Examples include but are not limited to: Tourette Syndrome, Tic Disorders, Movement Disorders, neurological conditions and Phenylketonuria.
Many individuals with intellectual disabilities and Autism Spectrum Disorders can become mislabeled as having Obsessive-Compulsive Disorder. It is important to compare ritualistic behaviors and clinical compulsions in OCD. Some rituals or habits may become challenging but cannot be effectively treated with medications or therapies utilized for OCD. It is important to note that usually symptoms of anxiety are observed prior to engaging in a compulsion. However, some individuals with intellectual disabilities or Autism Spectrum Disorders may present with a happy mood and may have an intense desire or drive to perform a compulsion. Generally, self-injurious behaviors and aggression may be observed when a person is redirected from engaging in a compulsion. However, individuals with Autism Spectrum Disorders who present with rigid thinking and a need for specific routines may also aggress or become self-injurious when redirected even though they may not have OCD. The best way to uncover whether or not a person’s behavior is obsessive-compulsive is by observing possible levels of distress or anxiety as well as attempting to redirect a person engaging in what looks like compulsive behavior with something that the person might find more appealing such as toys, snacks, or activities the person is known to enjoy. A person who is engaging in compulsions MUST complete their compulsions whereas a person engaging in ritualistic behaviors not related to compulsions can choose to continue or not continue a ritual.

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<tr>
<th>Compulsions</th>
<th>Ritualistic Behavior NOT Related to OCD</th>
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<tbody>
<tr>
<td>Symptoms of anxiety sometimes observed before behavior begins</td>
<td>Anxiety not present before behavior begins</td>
</tr>
<tr>
<td>Behavior provides temporary relief from anxiety (maybe)</td>
<td>Behavior is calming for the person</td>
</tr>
<tr>
<td>Person may try to resist behavior</td>
<td>Person willingly engages in the behavior</td>
</tr>
<tr>
<td>Engaging in the behavior upsets the person</td>
<td>Engaging in the behavior does NOT upset the person</td>
</tr>
<tr>
<td>Behavior is NOT related to escaping situations or demands</td>
<td>Behavior is used to escape situations or demands</td>
</tr>
<tr>
<td>Presence of obsessions (difficult to determine for people with ID)</td>
<td>No obsessions</td>
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When supporting people who have an Obsessive-Compulsive and related disorders, DO NOT participate in the person’s compulsions! This only reinforces the compulsion! Clearly explain the behavior you desire from the person rather than asking them to stop the challenging behavior. Encourage the person to use new or more positive behaviors that are being learned. Acknowledge and praise their attempts at using new or more positive behaviors. Avoid giving the person reassurance. Attempts to reassure a person with an obsessive-compulsive disorder only increases anxiety levels. The people have to experience for themselves that stopping their compulsions will not result in terrible things happening.
Boredom can be a huge trigger for hair-pulling (Trichotillomania) and skin-picking (excoriation) symptoms. The more engaged physically and mentally a person is, the less likely the hair-pulling and skin-picking can occur. If a person’s hair-pulling/skin-picking begins to intensify when trying to engage them, relax the demands or attempts to engage. It is extremely important to rule out medical causes for hair-pulling/skin picking behaviors. Lab work, dermatology and Primary Care consults are highly recommended if a person you support is engaging in such behaviors. Behavioral Support can be an invaluable resource when attempting to manage hair-pulling or skin-picking behaviors. Sometimes a person’s hair-pulling or skin-picking becomes habitual. The best way to reduce such behavior is to make the person aware that they are doing it. If a person you support is seen picking their skin or pulling out their hair, respond by saying “I see you are picking your skin” or “I see you are pulling out your hair”. If you don’t see the person physically pulling or picking but notice open picked wounds or missing patches of hair, respond by saying “I see you have new pick marks” or “I see you have been pulling your hair” and point to the affected area. Making a person mindful of their behavior is a strong step towards the person learning how to reduce it.
We will discuss Depressive Disorders in the next few slides.
Major depressive disorder is a fairly common mental health challenge. We will use the presentation of symptoms to a psychiatrist for a person with and without an intellectual disability for comparison.

Both people are seeing the psychiatrist because their symptoms are causing them difficulty in doing the things they usually can do or usually want to do. The person without the intellectual disability goes to the psychiatrist and says, “I feel sad all of the time, and I feel like I do not have the energy to do anything. I have not been sleeping well and I do not think I will ever get better. I think about death and dying a lot. I haven’t been trying to lose weight, but I have lost 25 lbs. in the last 3 months.” Everything this person has said would help a psychiatrist make a diagnosis of Major depressive disorder. The psychiatrist makes the diagnosis and prescribes an antidepressant for the person. The person takes the anti-depressant as prescribed and, in about 6 weeks, most, if not all, of the symptoms of depression are no longer present. The person is not sad all of the time; the person feels like they have the energy to do what they need to or want to do; the person is sleeping better and the person has stopped losing weight.
The person with the intellectual disability is non-verbal, and is accompanied to the psychiatric appointment by a staff person. Residential staff have observed the following over the last 3 months. The person used to sleep through the night but now the person gets up several times every night. The person appears sleepy and is cranky and irritable everyday. The person used to look forward to going to their day program but now it is really hard to even get the person out of bed. When asked if the person wants to go to their program the person shakes his/her head to indicate “No.” The person has lost 25 lbs. in the last 3 months without being on a weight loss diet. The staff person with the person with the intellectual disability shares what residential staff have observed with the psychiatrist. Staff reporting of observations combined with what the psychiatrist sees results in the psychiatrist making a diagnosis of Major depression disorder. The psychiatrist prescribes an anti-depressant, the person takes the anti-depressant as prescribed and in about 6 weeks, most, if not all, of the person’s symptoms of depression are gone.

I think you would agree that it was easier for the psychiatrist to make a diagnosis for the person that could self report symptoms than with the person who could not tell the psychiatrist how they were feeling. With the non-verbal person the psychiatrist was dependent on who ever came with the person on the appointment to share accurate information about how the person was acting to get an idea of how the person was feeling.
When supporting people with Depressive Disorders, it may be helpful to ask the person if they are having any thoughts about hurting him/herself. If the person is non-verbal look for any increase in self-injurious behavior or the sudden onset of self-injurious behavior. Any verbalizations about self harm or any observed self-injurious behavior should be reported to the person’s psychiatrist immediately. Altering the environment very subtly can help alleviate some depressive symptomology. For example, increase the natural light in the home gradually by opening window blinds, shades and curtains. Attempt to keep the environment peaceful with music they enjoy at a moderate to low volume that also may be helpful. Relax demands. Try to be more supportive and help with daily chores. Try to engage the person in activities the person seemed to enjoy in the past. Make future plans with the person. Developing events and situations to look forward to can help reduce feelings of hopelessness and can help elevate mood. Speak calmly and quietly. People experiencing depression can be hypersensitive to the moods and communication of others. Keep your tone calm, relaxed, quiet and supportive. Focus on one topic and keep your discussion of whatever you are talking about simple. People experiencing depressive may have difficulty concentrating. Take
time and care when communicating with them and do not “pepper” them with questions. Be patient. People experiencing depressive symptoms may need increased time to respond as their mind and body may be working more slowly due to their depression. Encourage movement. This can include exercise, walking around the house, swimming, biking...anything to get the person physically moving. Movement and exercise can help reduce the intensity of depression symptoms.
The next section will describe Bipolar and related disorders found in the DSM-5. People with Bipolar disorders suffer from symptoms of depression, which we just spoke about, and hypomania or mania, which we discuss in the next slides.
A manic episode is defined by the DSM 5 as “A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy lasting at least 1 week and present most of the day nearly every day.” During this period, individuals must also have at least 3 to 4 of the symptoms that I will describe.

• One of the symptoms is inflated self-esteem or grandiosity. An example of this is that the person thinks they can do things that they really are not capable of doing.

• There is a decreased need for sleep or insomnia.

• The person is more talkative than usual or demonstrating pressure to keep talking which is called pressured speech.

• The person has flights of ideas or racing thoughts which means they cannot finish a thought; thoughts and ideas keep rushing into the person’s head.

• The person has distractibility or the inability to concentrate or complete tasks.
• There is increased goal-directed activity or psychomotor agitation which means the person wants to take on every task or cannot stop moving.

• There is excessive involvement in activities that have a high potential for negative consequences, such as criminal activity, dangerous sexual behavior, or impulsive spending.

These symptoms have a major impact on the person’s social, emotional and/or occupational functioning.

On the next few slides, we will attempt to show you the differences in presentation of manic and hypomanic symptoms in people with an intellectual disability and in people without an intellectual disability.

With a typical presentation you would see elevated mood or irritability. People with ID may present as loud, playful and constantly excited. People with intellectual disabilities may have increased giggling, smiling and laughing. Screaming and yelling may be observed due to irritability or an overwhelming feeling of elation. People with intellectual disabilities with an unusually elevated mood may tease peers or supporters and be more open to redirection.

With a typical presentation you may see an inflated self-esteem or grandiosity. This is a sudden belief that the person is capable of doing things they are incapable of doing or a sudden beliefs that they hold a job or career that they do not. An example of someone with ID might be that a person being supported, who has never learned to drive a car, suddenly demands your car keys saying they want to drive your car. The person may suddenly insist that they are a staff person, program specialist or house manager etc. People experiencing mania may become extremely hostile and engage in verbal and physical aggression if they are told that, what they believe is not true, or if their demands are not met.
With a typical presentation you may see the person experience decreased sleep or insomnia or the inability to maintain a normal sleep pattern. In people with ID, the person may sleep less or may appear not to sleep at all. The person may report difficulty falling asleep and/or staying asleep. The person may also exhibit bizarre or challenging behaviors in the middle of the night. It would be important to use 24 hour sleep charts for people having sleep problems.

With a typical presentation you may see the person’s speech is rapid, disorganized, and out of control. The person has a strong desire to engage in continuing discourse with others and is not easily redirected to other activities. In the presentation in people with ID, the person may speak more quickly then normal and demand attention. The person may have increased vocalizations such as quickened grunts, humming or singing. Frequent or increased yelling may be present and difficult to stop. Uncontrollable laughter, repetitive questions and frequent interruptions of other people’s conversations may also be present.

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<tr>
<th>Typical Presentation</th>
<th>Presentation in People With ID</th>
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<tr>
<td>Decreased sleep</td>
<td>Sleeping less, bizarre and challenging behavior prominent in the middle of the night</td>
</tr>
<tr>
<td>Pressured speech</td>
<td>Increased speech, vocalizations, singing or humming at a more rapid pace than normal</td>
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With a typical presentation you may see the person having racing thoughts. The person may say they feel like they cannot stop a steady stream of different thoughts from popping into their head. In the presentation in people with ID, the person may present with disorganized speech, disconnected thoughts, difficulty concentrating and bouncing from one topic of conversation to another. The person may self-report that their mind is racing.

With a typical presentation the person has difficulty concentrating and is easily distracted from completing a task. In the presentation in people with ID, the person may have sudden decreased performance at home, work or school. The decreased performance is due to an inability to concentrate or focus on an activity to its completion. The person may also demonstrate an inability to sit through a pleasurable activity such as watching their favorite TV show.
With a typical presentation you may see that the person is in constant motion. The person may be much more restless than normal and may only be able to sit or stay still very briefly. The person will exhibit an increase in goal-directed activity, and unfortunately the person may not be able to complete any task. In the presentation in people with ID, the person may have extreme difficulty sitting still, display aggressive behavior, have sudden refusals to cooperate - much more than usual, and speak very negatively and demonstrate an increase in ritualistic or compulsive behavior with much greater frequency than usual for the person.

With a typical presentation you may see a person exhibit excessive involvement in activities that have a high potential for severe consequences by making sudden attempts to open credit cards or bank accounts; not recognizing social boundaries or the ownership rights of others; becoming hypersexual; and become aggressive when others try to redirect the person to more socially appropriate behaviors. In the presentation in people with ID, the person with ID may exhibit many of the behaviors seen in a person without ID. The person with ID may engage in public masturbation and may no longer be willing to follow previous

<table>
<thead>
<tr>
<th>Typical Presentation</th>
<th>Presentation in People With ID</th>
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<tbody>
<tr>
<td>Psychomotor agitation/increase in goal-directed activity</td>
<td>Restlessness, can no longer sit still, aggression, speaking very negative, sudden refusals to cooperate, increased ritualistic or compulsive behavior</td>
</tr>
<tr>
<td>Excessive involvement in activities that have a high potential for severe consequences (shopping sprees, hypersexuality)</td>
<td>Sudden attempts to open credit cards, bank accounts, stealing/demanding money, sudden public or excessive masturbation, attempts at hugging, kissing, fondling others, no longer able or willing to follow previous rules or limits. Sudden need to binge eat is also common.</td>
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rules. Sudden binge eating is also common in people with ID.

At least several symptoms that we described in the last few slides are needed to confirm a true diagnosis of mania.
The following information is important to know about a person who is suspected of having a Bipolar or related disorder.

- How does the person communicate their wants, needs and desires?
- What challenging behaviors does the person exhibit?
- How often do specific behaviors happen?
- How disruptive, problematic or dangerous are behaviors?
- Are there any warning signs that a person may be about to engage in a challenging behavior?
- Does anything appear to cause the behavior?
- How does the person interact with others?
- Has there been any significant changes to the person’s day to day life?
- Are there people in the person’s life that upset them in some way?
- Who does the person like?
- Who does the person seem to “gravitate” to?
- What things does the person like?
- What does the person like to do?

This information can help determine if the person may be reacting to environmental issues or is experiencing symptoms of Bipolar and related disorders.
When supporting a person with a Bipolar or related disorder be positive and never give up hope! Don’t take what a person does in a manic or depressive state personally. These are symptoms of the mental health challenge, not you. Don’t punish the person. The person has a mental health challenge and may not be able to control their challenging behaviors. Try to encourage the person to stop and think about what is happening and what kind of behavior might work better for the person and the people around them. Try and maintain the person’s usual routine. Any change in a person’s routine 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, angry or upset them. Keep your conversations short, simple and relevant to what’s going on in the person’s life. Reduce or increase stimulation in the environment. If a person is experiencing symptoms of mania or hypomania, try reducing the amount of light, noise, people and other distractions from the person’s environment. If a person is experiencing symptoms of depression, try increasing natural light and color in the person’s environment. Try to keep the person realistic; do not feed into a person’s grandiose beliefs. Be encouraging and kind. Sometimes just giving someone an encouraging smile or kind words can make a big difference.

These are some general rules of thumb when supporting people with Bipolar and related disorders. If a person is manic, try to reduce the use of stimulants. Examples of some stimulants are coffee, caffeine, chocolate, sweets, etc. Keep conversations brief and as concrete as possible. The person may have difficulty concentrating and may be easily frustrated.
Our next section will describe Schizophrenia Spectrum and related disorders found in the DSM-5.

You may be wondering what is going on with this picture. This picture is about perception which is what we know is real versus what we believe is real.

How would you react if you opened a can of beans and saw an eyeball floating in the beans? Most of us would react with disgust and get rid of that can as quickly as they could. Now, let’s say you are experiencing visual hallucinations, or seeing things that aren’t really there, which is a psychotic symptom. You open a can of beans and see an eyeball floating in the beans. The eyeball really isn’t there but you really believe it is there because of your psychosis. Would your reaction be any different than someone actually seeing an eyeball in a can of beans? Probably not, you would probably react with disgust and get rid of that can of beans as fast as you could.
Let’s take our example one step further. Imagine that someone is with you and that person is not suffering from visual hallucinations. That person grabs the can of beans, pours some of the beans into a bowl, and says it’s time to eat. How would you react? Would you get angry? Would you walk away? What if the person with you insisted that you eat, what you believe are disgusting, contaminated beans. Wouldn’t it be reasonable for you to become angry?

What we believe we see, hear or feel makes it real to us, even if others do not experience the same things. If I hallucinate and believe an eyeball is really in a can of beans, then, I really believe it is there. I might blink and no longer see the eyeball, but I may still feel no desire to eat any beans from that can, and depending on how disturbed I was by my hallucination, I may not want to eat anything from a can.

Psychotic symptoms can be extremely distressing for a person experiencing them. Psychotic symptoms can be extremely puzzling and difficult to manage for those helping a person with psychotic symptoms.
With a typical presentation delusions are fixed false beliefs. A person says, "The FBI is following me." However, there has never been any interaction between the person and the FBI, there really is no reason that the FBI would have an interest in the person, and no one has ever seen anyone following the person. Another example might be that a person believes a stranger who smiled at them is in love with them and that they are in a relationship despite having never even seen each other before that day.

For people with intellectual disabilities, delusions may take the form of new behaviors or statements that indicate serious suspicion of others or feelings of being controlled, drugged, poisoned, etc. People experiencing delusions may make wild accusations that their neighbors are planning to hurt them in some way. The person may make accusations about people who they believe are in a position of authority and may report feeling these people are conspiring against them. For people with intellectual disabilities, it is very important to determine if what they say has some basis in reality. It is also important to consider the person’s developmental level and communication issues before assuming the person is delusional.
or paranoid.

With a typical presentation hallucinations are hearing, seeing or smelling things that are not present. For example a person says, "I saw my dead mother today" or “My dead mother keeps talking to me and she is not happy with what I am doing.” A patient will often self report having auditory or visual hallucinations because they’re often distressing to the person.

For people with ID, it is extremely difficult to determine if someone is having auditory or visual hallucinations if a person cannot self-report having them. Observable behavior may help with the possibility of hallucinations but it is not guaranteed. Someone may appear to be talking or yelling at non-existent people, seem to be looking at something that isn’t there, or experiencing an odor that no one else smells. People with Down syndrome often engage in self talk as a way of preparing for something. This may appear to others as hallucinations but actually is helpful to the person.

It is also important to remember that high levels of aggression and self-injurious behaviors may be related to the person’s developmental disability and may not be a symptom of a psychotic disorder. Developmental level and communication issues may impact observed behaviors. Ongoing assessment, data tracking, observation and historical records are extremely important in the diagnosis and treatment of psychotic disorders.
Disorganized speech is speech that is so disorganized it is not understandable. For example: a person may say something like “I had a good day as much as that picture had a headache”. A person may also make up new words for things such as calling a table a “blittygast”. Some people experiencing this symptom may also combine words to create their own new words. For example, the person might say “I’m happatired” to mean they are happy and tired.

In people with an intellectual disability regression in language skills may make them difficult or impossible to understand. The frequency of verbal communication may also decrease. It is important to be aware that for people on the Autism Spectrum, a disorganized speech pattern may occur even though the person is not experiencing a psychotic disorder.

People who are grossly disorganized may have difficulty performing activities of daily living, or ADLs, such as dressing, cooking and maintaining personal hygiene. They may become unpredictable and engage in inappropriate sexual behavior. Their affect may become inappropriate. For example they may laugh while describing a personal tragedy.
Catatonia is characterized by muscular tightness or rigidity and lack of response to the environment. The person may begin assuming unusual positions or stop moving at all for extended periods of time. Thoughts may become confused and seem to either speed up or slow down. The person may have extreme difficulty following conversations, instructions, and remembering things.

For people with intellectual disabilities, catatonia may present with the sudden appearance of new and unusual behaviors or mannerisms. The person may begin assuming unusual positions or stop moving at all for extended periods of time. A significant decrease in performance across all skill areas is usually seen. Agitation, aggression, or sudden loss of speech may be present. If you observe these symptoms in a person you support, it is important to rule out any medication or medical issues that may have symptoms similar to those present in catatonia. A serious and potentially life-threatening health issue may be misinterpreted as catatonic behavior.
We have just gone over the positive target symptoms of psychotic disorders. Psychotic disorders also have negative symptoms.

Negative symptoms include a blunt or flat affect or showing no emotion, loss of pleasure in almost everything, called anhedonia, very limited verbalization, or very slow movement, called psychomotor retardation, and no interest in personal hygiene or appearance.

For people with intellectual disabilities, negative symptoms may present as a total lack of interest in almost all activities including previously motivating people, places and things. The person may have no interest in personal hygiene or self-help skills. The person may appear completely without emotions, appear depressed or exhibit inappropriate emotional reactions to situations. They may exhibit very little movement or very slow movement or psychomotor retardation. They may speak extremely softly or stop speaking entirely. For individuals who are non-verbal, there may be a significant decrease in all vocalizations such as humming, yelling, grunting, etc.
It is very important to know that many medical conditions can cause psychotic symptoms, and people with intellectual disabilities often have many medical conditions. It is important that all of a person’s medical practitioners communicate well with each other to determine correct diagnoses and treatments for a person who experiences psychotic symptoms.

Medical conditions that can produce psychotic symptoms include:

- Temporal lobe epilepsy/seizures
- Endocrine disorders, such as hypo or hyperthyroidism, hypo or hyperparathyroidism, and diabetes
- Metabolic disorders such as PKU and others,
- Autoimmune disorders such as Lupus
- Huntington’s disease
- Hepatic or renal diseases such as hepatitis
- Severe migraines
- Tumors
- Traumatic brain injuries
• Multiple sclerosis
• Various cancers
• Injuries due to the auditory or visual nerves
• Deafness,
• Infections, and
• Fluid and electrolyte imbalances
This slide shows some common medications prescribed for people with an intellectual disability. Many medications may have adverse side effects that cause mental health symptoms. The medications listed on this slide all have the potential to cause psychotic symptoms. It is important that a person’s medications and potential side effects are discussed regularly with all prescribing physicians.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Possible Side Effects</th>
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<tbody>
<tr>
<td>Albuterol (Ventolin, Proventil)</td>
<td>Hallucinations, paranoia</td>
</tr>
<tr>
<td>Anticonvulsants (Depakote, Lamictal, Keppra, Dilantin)</td>
<td>Tactile, visual and auditory hallucinations</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>Antihypertensives (Lisinopril, Clonidine)</td>
<td>Visual and auditory hallucinations</td>
</tr>
<tr>
<td>Atropine</td>
<td>Paranoia, auditory hallucinations</td>
</tr>
<tr>
<td>Prednisone, Corticosteroids</td>
<td>Paranoia, hallucinations</td>
</tr>
<tr>
<td>Propranolol</td>
<td>Hallucinations, paranoia</td>
</tr>
<tr>
<td>Levodopa</td>
<td>Paranoia, hallucinations</td>
</tr>
<tr>
<td>Benzodiazepines (Xanax, Klonopin, Ativan, Valium)</td>
<td>Hallucinations, paranoia</td>
</tr>
</tbody>
</table>
Supporting people with ID and psychotic disorders is not easy. Here are some suggestions that may be helpful:

Don’t challenge the person’s belief that something is real even if you cannot see or hear what the person is seeing or hearing. What the person is seeing or hearing is real to the person. You need to be supportive and help the person feel safe.

On the other hand don’t engage in the person’s delusion or hallucination. For example, if someone 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 and bring the person back to reality. Point out that you are standing on the floor and you do not feel any fire.

Remember you are dealing with an illness and it is not personal. Try not to take any delusional or hostile statements personally because it’s not about you but about the person’s mental health challenge.

Don’t laugh or make a judgment about a person’s hallucinations or delusions. Treat people with respect and the way you would want to be treated. Judging or teasing
people about their symptoms can only make the symptoms worse.

Take the time to talk with the person if the person is struggling with psychotic symptoms, but make sure you have the person’s attention before talking to them. Using the person’s name should help get the person’s attention. If the person doesn’t believe their name is what you know it is, don’t use that name. However, if the person believes he or she is the Archangel Michael, don’t start calling the person Michael.

Speak slowly because the person may need extra time to process what you are saying.

Try to make conversations meaningful but brief and to the point. If the person reports to you that they are no longer taking their medication, won’t take their medication, or that the medication is poison, document what the person says and report it immediately to your supervisor.

Call 911 if the person becomes a danger to themselves or others.
Borderline Personality Disorder (BPD) is a condition characterized by difficulties regulating emotion. This means that people who experience BPD feel emotions intensely and for extended periods of time, and it is harder for them to return to a stable baseline after an emotionally triggering event. This difficulty can lead to impulsivity, poor self-image, stormy relationships and intense emotional responses to stressors. Struggling with self-regulation can also result in dangerous behaviors such as self-harm. The key signs and symptoms include frantic efforts to avoid real or imagined abandonment, having unstable relationships, experiencing a distorted and unstable self-image, impulsive and dangerous behavior, self-harming behaviors including suicidal threats or attempts, dissociative feelings or disconnecting from thoughts and identity, stress related paranoia and possible brief episodes of psychosis.
Personality Disorders are considered over-diagnosed and rare in people with ID. Behavior is often better explained due to communication issues, medical concerns, and reactions to environmental barriers or situations. Other psychiatric disorders may mimic personality disorders in the ID population. Consideration also needs to be given to a person’s developmental age, abilities, cognition and receptive communication abilities. Consideration must also be given depending upon genetic syndromes, acquired syndromes such as Fetal Alcohol Syndrome, and other neurodevelopmental concerns such as Autism Spectrum Disorders. Personality Disorders are difficult to diagnose in the general population and even more difficult to diagnose in the ID population.
Supporting someone with a personality disorder is difficult, but here are some suggestions which may be helpful.

People with a personality disorder often feel socially isolated. Being there for them and trying your best to not be judgmental is one of the most important things you can do.

Try to be a good role model and lead by example. If the person sees a better, more effective way of behaving, the person may emulate the behavior.

People with a personality disorder do not easily trust other people and often think other people do not want them to be successful. Try to show the person with a personality disorder that the negative things they believe about people are not true. Make sure your actions support what you are saying and that you can be trusted.

Create and maintain a stable environment and routine that the person is comfortable with and accepts. Prepare the person in advance if you know there will be a change in the routine.
Be patient and remember that change is very difficult for someone struggling with a personality disorder.

Roll with resistance and remember there will be good and bad days.

Do not attempt to confront or argue with a person with a personality disorder. If you sense resistance, it’s time for you to back away.

Maintain firm boundaries and remember you must maintain a professional relationship with the person with the personality disorder.
Very little research is available on substance use disorders and people with ID. We do know that people with ID may develop a substance use disorder from prescribed medications. Benzodiazepines are often prescribed for people with ID for long periods of time. People with ID may suffer from withdrawal symptoms when the dosages of benzodiazepines are lowered or discontinued.
Listed above are examples of benzodiazepines. Benzodiazepines are a class of drugs usually used in the treatment of clinical anxiety, seizure disorders and sleep disturbance. Benzodiazepines are safe and effective medications when used as directed. Benzodiazepines are often prescribed for a short period of time, but only the prescriber can determine the length of treatment that is right for their patient. However, because physical dependence may develop in only 2 weeks of daily use, caution should be used in discontinuing benzodiazepines because of potential withdrawal symptoms.

The generic and trade names for common benzodiazepines prescribed for people with ID are shown above. Since you are more likely to know the trade names of these medications, we will use the trade names here: Xanax, Klonopin, Valium, Ativan and Restoril.
Many but not all of the benzodiazepine withdrawal symptoms are listed on this slide. Many of the symptoms are quite serious and can result in someone’s death. Close observation for physical and behavioral symptoms of withdrawal is recommended for the safe reduction and discontinuation of benzodiazepines. The longer someone has been on benzodiazepines, the longer it will take to safely discontinue the medication. It is important that there is good communication between all team members before starting, increasing, reducing or stopping benzodiazepines.
Withdrawal symptoms can resemble other psychiatric symptoms and the challenging behaviors associated with withdrawal can be difficult to manage. People with an intellectual disability may not be able to relate their physical, emotional and behavioral changes to the medication reduction or discontinuation. People with intellectual disabilities may present with any of the symptoms of withdrawal listed on the previous slide but people with ID can also have the symptoms of withdrawal listed on this slide such as head-banging, mood lability, self-injurious behavior, personality changes, agitation, explosive outbursts and physical health complaints.
It may take time to see negative or positive behavioral changes when there is a medication change. There may be changes in physical health as well. Sudden spikes in behaviors when taken off medications like benzodiazepines, are common and may be related to withdrawal or the mental health challenge being treated. Documenting and tracking is of the utmost importance! Keep detailed documentation regarding any changes to medications in combination with behavioral and physical health observations, reports, and data.
This slide provides a simple example of the relationship between medication discontinuation and behavioral data. In this graph, you can see that physical aggression decreased while the person was prescribed Ativan. However, when the Ativan was suddenly discontinued, aggression quickly increased. There may be other reasons that could have caused the quick increase in aggression such as changes in the person’s environment or physical health. If the increased aggression continues, another change in this person’s medication might be helpful.

Simple graphing of behavior can help people have a better picture of what may be going on with a person.
As we conclude this presentation, please remember that Dual Diagnosis is complicated. Assessing and supporting people with Dual Diagnosis encompasses all facts of their life, not just their ID or mental health challenge. The best support and care is holistic which means looking at the whole person and everything involved in their life. People are greater than the sum of their challenges and deficits. There is a lot more to people than labels or diagnoses. We are all more alike than different!
Throughout this training we discussed ways to recognize symptoms and support people who may have a host of psychiatric diagnoses. Remember to always follow the person’s specific support plan. Always provide dignity and respect for the people you help and yourself.
Congratulations, you have successfully completed the *Intellectual Disability and Psychiatric Disorders* training.
Thanks for your participation in this presentation.