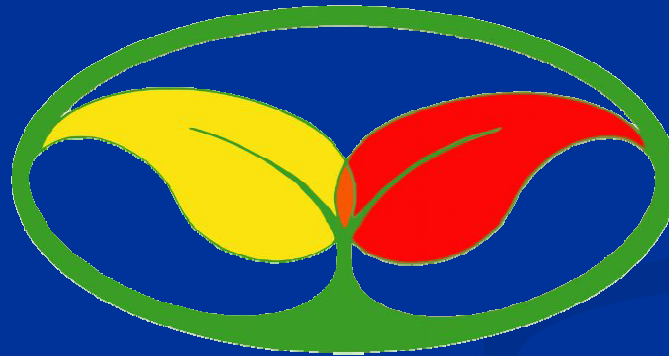


# Mental Illness and Developmental Disabilities: Some Basics



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# MIDD-CCOE

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# Mental Illness and Developmental Disabilities

- ✿ About one-third of people with developmental disabilities also have a mental illness of some type.
- ✿ In developmental centers or other institutions, the number can be as high as 7 out of 10.

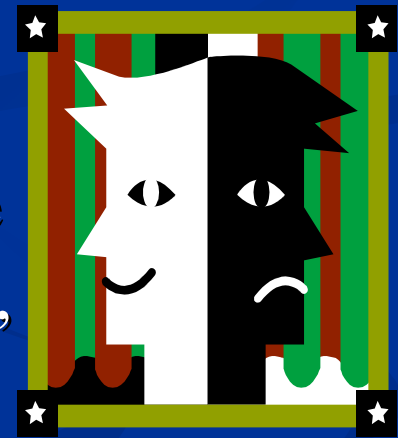
*(National Core Indicators, 2010)*



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# What Kinds of Mental Illness?

- ☀ This can mean a mood disorder, like depression, anxiety or bipolar disorder (“manic depression”). These disorders can make people sad, anxious, worried, overly happy/excited, or aggressive.
- ☀ Behavior disorders can include things like conduct disorders, which can make people impulsive, not care about others, dishonest or aggressive.



## Mental Illness, continued

- ✿ Personality disorders, like borderline personality, can make people seem needy, overly dramatic and emotional, or manipulative.
- ✿ Thinking disorders include schizophrenia and other psychotic disorders. These disorders make it hard for individuals to know what's real and what isn't.



# Common Myths about Mental Illness and Developmental Disabilities

- ✿ People with a developmental disability do not have mental illnesses severe enough to need therapy.
- ✿ People with a developmental disability cannot participate in or benefit from psychotherapy.
- ✿ People with developmental disabilities already live in a therapeutic environment and do not need mental health services.

- *Carroll Jackson, LISW-S, 2010*



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# Reality

- ✿ Level of intelligence does not predict how well someone will do in psychotherapy.
- ✿ Mental health treatment can and does improve the overall quality of people's lives.
- ✿ Recovery from mental illness IS possible.



- Carroll Jackson, LISW-S, 2010



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# Common Types of Mental Illnesses

- ✿ Anxiety Disorders
- ✿ Mood Disorders
- ✿ Personality Disorders
- ✿ Thought Disorders



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# Anxiety

Anxiety is related to chemicals in the brain and can be helped with medication. The right medication can take a while to figure out, but should help the anxiety go down without leaving someone too sedated or “zombified.”

A primary care physician or psychiatrist should work carefully to reduce the anxiety, and the behaviors should subside.



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# Anxiety Disorders: PTSD, OCD, and Trauma



One type of disorder, called Anxiety Disorders, is common with people who have Autism or Autism Spectrum Disorders. Obsessive Compulsive Disorder (OCD) is an anxiety disorder. People with Obsessive Compulsive Disorder have frightening thoughts, like “something terrible is going to happen.”



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# Obsessive Compulsive Disorder (OCD)

To try not to have the thoughts and to feel better, people with OCD will feel driven to do something to “ward off” the thought, like wash their hands, check locks or light switches, count, or many other things. Sometimes, this behavior gets out of control and takes up a lot of time, or disrupts others.



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# Obsessive Compulsive Disorder: 'How to Help'

Someone who is engaging in a compulsive behavior is trying to feel safe and calm. Becoming angry, or trying to make them stop, doesn't help and usually makes them feel worse. Sometimes getting into a power struggle over a compulsive behavior will even make someone lash out.



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# Obsessive Compulsive Disorder (OCD)

The best thing to do is try to think about the anxiety underneath the behavior. Create a safe space that will not disrupt others (a room where someone can count tiles or turn the light on and off, etc). Then try to find out what makes someone feel safe. This may take a long time but it is worthwhile.



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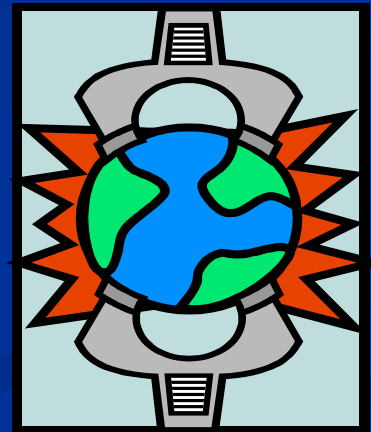
## Remember!

As a Direct Service Professional, you have some of the best information about whether compulsive behavior or “scary thoughts” are getting better or worse. You can also notice if someone seems too “drugged.” Be sure to document and share what you notice with the rest of the treatment team.



# Another Cause of Anxiety: Trauma

- ☀ Trauma is any experience or series of experiences that make the individual feel that he or she is in danger of dying, or of being emotionally “wiped out” or annihilated.



- ☀ Many people experience trauma.

People with developmental disabilities are at greater risk for being victimized or abused (*NCI, 2010*).

They are also more likely to have “everyday” stresses or losses build up and become traumatic.



# Post-Traumatic Stress Disorder (PTSD)

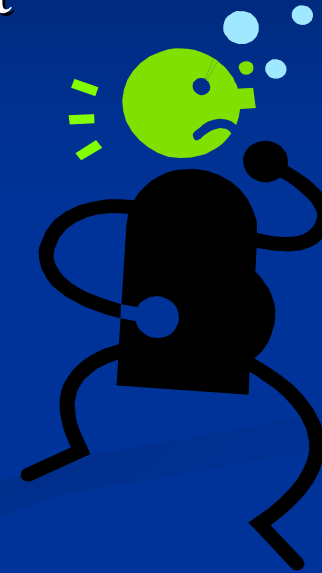
People who have been through a traumatic experience may develop short-term symptoms (Acute Stress Disorder) or longer-term symptoms (Post Traumatic Stress Disorder, “PTSD”). Not everyone who experiences trauma will develop a stress disorder, but many people will experience some symptoms, and some will experience almost all of them.





# A Major Trauma Could Be:

- ✿ Sexual Assault/Physical Assault
- ✿ Natural or manmade disasters
- ✿ Catastrophic illness
- ✿ Loss of a loved one
- ✿ Humiliation
- ✿ Bullying
- ✿ Moving to a new home or significant change at home
- ✿ Deprivation and powerlessness to act on one's own behalf



*“EMDR Psychotherapy for  
People with I/DD  
Experiencing Trauma and  
Distress”,  
Ford, Adler-Tapia, 2009*



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# “Ordinary” Life Event Trauma Could Be:

- ✿ Feeling different
- ✿ Not being accepted
- ✿ Not being able to do what others do
- ✿ Knowing that one has a disability and is “different” than others
- ✿ Not being listened to
- ✿ Being misunderstood
- ✿ Failing at a task
- ✿ Getting confused and overwhelmed



*“EMDR Psychotherapy for People with I/DD Experiencing Trauma and Distress”, Ford, Adler-Tapia, 2009*



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# Trauma Symptoms

Traumatic stress symptoms come in three clusters:

- Hypervigilance (always on “red alert”)
- Constriction (avoiding things)
- Intrusion (having upsetting memories, thoughts and dreams)

These symptoms come from the brain being flooded with “fight or flight” chemicals. Sometimes the brain can be permanently changed after a severe or persistent trauma.



# Hypervigilance

- ✱ Startling easily/frequently
- ✱ Irritability
- ✱ Difficulty concentrating
- ✱ Difficulty relaxing
- ✱ Difficulty falling or staying asleep
- ✱ Needing to be near or in sight of exits; agitation when blocked



# Constriction

- ✱ Avoids activities, places, people, things to keep from being reminded/”triggered” (can ripple out, become more and more removed from obvious triggers of incident)
- ✱ Can’t remember important parts of the trauma
- ✱ Much less interest in significant activities
- ✱ Feeling detached from others
- ✱ Narrow range of emotions, numbness
- ✱ Lack of a sense of future



# Intrusion

- ✦ Flashbacks
- ✦ Nightmares
- ✦ Disturbing images/thoughts/fantasies
- ✦ Physical response (sweating, shaking, freezing, lashing out) to internal or external triggers that resemble the event (this is very common!)



# Other Ways Symptoms Might Be Observed...

## ✿ Physical:

- Eating disturbances (more or less than usual)
- Sleep disturbances (more or less than usual)
- Sexual dysfunction
- Low energy;
- Chronic, unexplained pain



## ☀ Emotional:

- Depression, spontaneous crying, despair and hopelessness
- Anxiety
- Panic attacks
- Fearfulness
- Compulsive and obsessive behaviors
- Feeling out of control
- Irritability, anger and resentment
- Emotional numbness
- Withdrawal from normal routine and relationships





## ☀ Cognitive:

- Memory lapses, especially about the trauma
- Difficulty making decisions
- Decreased ability to concentrate
- Feeling distracted
- ADHD symptoms (restless, agitated)



## Remember!

People with developmental disabilities may not be able to verbally express the things that are bothering them. Look for non-verbal signals of distress and anxiety, especially new or increased complaints. Non-verbal distress can be a sign of many problems besides trauma, and a medical evaluation may be needed, but it's a good indicator to pay close attention to find out more.



# Visible Signs of Anxiety:

- ✿ Tremulousness/shaking
- ✿ Sweating
- ✿ Agitation
- ✿ Excessively upright posture/stiffness
- ✿ Tense jaw muscles
- ✿ Chewing nails/grinding teeth
- ✿ Rapid breathing



*- Julie P. Gentile, MD & Carroll Jackson, LISW-S, 2010*



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# Behavioral Changes:

- ✱ Behavioral problems
- ✱ Non-compliance
- ✱ Aggression/screaming/etc.
- ✱ Disintegration of verbal skills
- ✱ Baseline exaggeration
- ✱ Recurrence of “institutional” behavior (hoarding, stealing, etc.)



*- Julie P. Gentile, MD &  
Carroll Jackson, LISW-S, 2010*



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# Other verbal and non-verbal distress signals...

- ✱ New problems with controlling bowels or bedwetting
- ✱ Headaches
- ✱ Stomach aches
- ✱ Back pain
- ✱ Repetition of statements about an event that seem unrelated to the current situation
- ✱ “Phobic mannerisms” as person avoids situations
- ✱ Self-soothing behaviors (alcohol, food, other addictive activities)
- ✱ Decline in skill development



- *Focht-New, Clements et al, 2008*



# What a Treatment Team Should Do...

- ☀ Look for changes in baseline
- ☀ Talk with the people who know the individual best
- ☀ Rule out medical/psychiatric issues
- ☀ Watch for “diagnostic overshadowing” (attributing everything to DD or MH)
- ☀ Be concerned about losses in previous skills, especially speech, or ‘regressive’ behaviors



“Individuals with Dual Diagnosis are more vulnerable to anxiety disorders. They are also more afraid of failing and may not report something bothering them or someone hurting them. They are often targets for abuse or maltreatment compared to the general population. High turnover rates of staff can make it difficult to feel safe and secure”

*-Julie P. Gentile, MD, 2010*



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# Trauma

## ‘How to Help’

- ✿ Check to see if someone has a history of trauma (abuse, neglect, frightening experiences, lots of stress and loss), or a diagnosis of Post-Traumatic Stress Disorder (PTSD).
- ✿ If there is no history that you are aware of, remember that it’s possible trauma has not been reported or noticed.





# Trauma-Informed Care

People who have been traumatized often feel unsafe and out of control. Find as many ways as you can to help people feel safe.

This could mean changing the environment (leaving a light on at night, letting them sit near a door), or helping them figure out what soothes them (a blanket, music, staying near staff, etc).



# Trauma-Informed Care

Next to safety, control is the biggest issue for people with trauma. You can help people feel *in control* by giving them the chance to make as many of their own decisions as possible. Also, make decisions in your setting by consensus-reaching an agreement together-- instead of power (threats, yelling, “I’m staff, so what I say goes,” etc.)



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# Trauma-Informed Care

Research suggests that many, if not most, people have some form of traumatic event in his or her lives (*SAMSHA, 2010*). For people with DD this is even higher. It makes sense to treat **EVERYONE** as if trauma has possibly occurred. Making sure someone feels safe and in control of their own lives will help someone with trauma, and will not hurt anyone who does **NOT** have a history of trauma.



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# Trauma-Informed Care: A Universal Precaution

Just like we treat blood or bodily fluids as if *EVERYONE* has a communicable disease by



using universal precautions (gloves, bleach, etc.), treat *EVERYONE* as if safety and control are important to them. These are the “universal precautions” for trauma. After all, we all want to feel safe, loved and in control of our own lives.



# Bipolar Disorder

Bipolar Disorder (sometimes called “manic depression”) is a mood disorder with very high points (mania) and very low points (depression). It can be treated with medication and counseling. People with untreated bipolar disorder can have very disruptive behavior. Make sure to let your treatment team know if you think someone is suffering from some of these symptoms, or if their symptoms are not getting better.



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# Bipolar Disorder and Developmental Disabilities

Sometimes symptoms of Bipolar Disorder look different in a person with dual diagnoses:

- ✿ He or she might have delusions, not of grandiosity, but of normalcy, and will describe themselves as a person that they see as having power or respect, such as a teacher, police officer, nurse, doctor, etc.
- ✿ They may also, developmentally, still have “imaginary friends” that are not hallucinations. One indicator might be that the individual seems to be “directing the action” in imaginary play or conversations. This is not unusual and is not a sign of mental illness.



# Symptoms of Bipolar Disorder (Manic Episode) How to Help



- ☀ Symptom: Elevated, expansive mood help the individual find positive activities
- ☀ Symptom: Irritable mood
  - Encourage in a positive manner
  - Avoid being critical
  - Allow space



# Manic Episode

- ☀ Symptom: Physical agitation, restlessness
  - Find constructive ways to use energy—try big muscle exercise
  - Recognize agitation, allow the person to leave the activity that is making the problem worse
- ☀ Symptom: Increased goal-directed activity (drive to make plans, accomplish projects)
  - Make sure activities are not destructive or dangerous





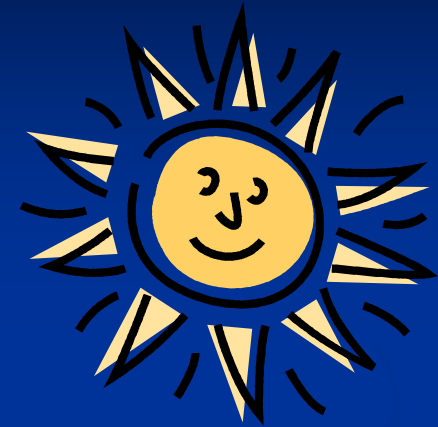
# Manic Episode

## ☀ Symptom: Distractibility

- Make expectations clear and realistic – one step at a time, using language the person can understand
- Keep tasks and activities focused
- Provide frequent prompts
- Use small steps
- Minimize distractions like too much noise, light or activity



# Manic Episode



- ☀ Symptom: Decreased need for sleep
  - Find activities that allow the individual to be awake without disrupting others
  - Limit stimulation



# Manic Episode

- ✦ Symptom: Excessive involvement in pleasurable activities
  - Provide supervision as needed to assure safety
  - Safeguard resources such as money
  - Limit other dangerous or expensive activities such as excessive long-distance phone calls, internet shopping, etc.
  - Redirect inappropriate sexual activity



# About Sex

This can be an uncomfortable topic any time, and a manic episode can increase sex drive. However, your setting addresses sexual behavior, it's best to be direct and unembarrassed. Also, help make sure others are not made uncomfortable. Overly sexual talk, unwanted sexual advances, public nudity, public masturbation, etc. should be calmly and firmly redirected.



# Appropriate Sexual Activity

- ✿ A good alternative if someone is not in a consensual adult relationship is masturbation in the privacy of one's own room. That means:
  - No roommate present
  - Nobody else present



# Manic Episode

- ✦ Symptom: More talkative than usual
  - Find places where talking will not cause a problem



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# Depression: The Low Point of Bipolar Disorder

Sometimes people with bipolar disorder will have several weeks or months of normal mood, then slide into depression. Other people will go right from mania to depression.

The symptoms of depression can also happen without mania. This is called Unipolar Depression, or Major Depression.



# Depressive Symptoms: How to Help

- ☀ Symptom: Loss of interest in activities
  - Offer varied, preferred activities
  - Allow space when needed
  - Have favorite staff work with the individual
  - Minimize other unpleasant distractions or sensations
  - Explore other possible reasons for sadness such as grief, loss or trauma
  - Help give words for feelings and encourage talking with staff and friends





# Depressive Episode



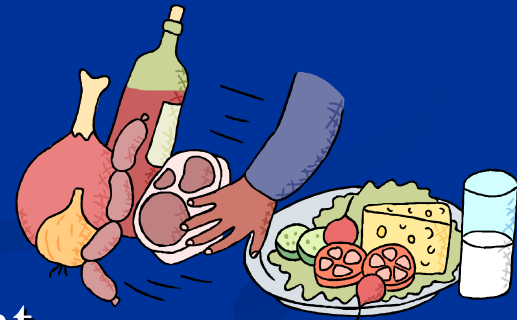
## ☀ Symptom: Diminished Interest

- Be flexible and find creative ways to allow for participation to the extent the person can manage
- Point out accomplishments
- Provide encouragement for participation
- Do not force involvement in long activities
- In the community, have staff who can take the person home if they tire
- Wait for a time and try again



# Depressive Episode

- ☀ Symptom: Weight loss
  - Prepare preferred foods
  - Have food available throughout the day
  - Reinforce any efforts to eat
  - Provide small portions/amounts easier to eat/swallow
  - Make eating environment pleasant (use favorite bowl or plate, new cup or spoon)
  - Provide several small meals
  - Monitor to assure individual is healthy



# Depressive Episode

☀ Symptom: Weight gain

DO NOT get into power struggles about eating!

Instead:

- Provide healthy snacks for the individual who is overeating
- Provide low calorie substitutes for favorite foods
- Remove excessive high calorie foods
- Encourage exercise (e.g. walk to get a low calorie snack)



# Depressive Episode

## ☀ Symptom: Insomnia

- Encourage a regular sleep schedule
- Minimize nighttime disruptions
- Allow quiet activity that will not bother others
- Limit naps during the day
- Offer less-stimulating alternatives to alcohol, nicotine, & caffeine (including chocolate)  
Caffeine-free soft drinks, herbal tea, decaf coffee, water, etc. are good alternatives



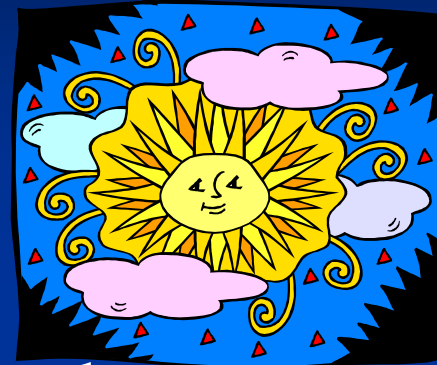
# Depressive Episode

- ✿ Symptom: Insomnia cont'd.
  - Encourage exercise, but not late in the evening
  - Help the individual develop a sleep ritual (getting ready, calming down, saying prayers, looking through scrapbook, etc.: same things, same order every night)
  - Help the individual go to bed at the same time every night



# Depressive Episode

- ☀ Symptom: Insomnia cont'd.
  - Help the individual find ways to relax before bedtime: reading (or being read to), taking a warm bath, etc.
  - Discourage the individual from going to bed too early
  - Don't force the individual to go to bed
  - Encourage the individual to sleep in a cool, dark, quiet bedroom



# Depressive Episode

- ✿ Symptom: Physical agitation, restlessness
  - Find constructive ways for the individual to use energy
  - Recognize the restlessness, allow the person to leave the situation if it seems to be making things worse



# Depressive Episode

- ☀ Symptom: Fatigue, moving slowly
  - Provide brief activities
  - Recognize that the person may be tired
  - Allow the person to leave activities when tired
  - Adjust activities and expectations to the level of energy you observe
  - Don't push the depressed person to take on too much too soon
  - Limit noise and racket
  - Allow time for recovery





# Depressive Episode

- ✿ Symptom: Feelings of worthlessness
  - Recognize feelings; help the individual put feelings into words
  - Let the individual know that you know it hurts to feel that way
  - Gently point out things you think are special and important about him or her
  - Offer meaningful tasks
  - Provide gentle praise and encourage the person to recognize his or her accomplishments



# Depressive Episode

## ☀ Symptom: Feelings of hopelessness

- These sound like “What’s the point? Nothing I do will help” or “nothing will get better”
- Explore actual reasons someone might feel discouraged and see if these can be addressed
- Ask the person to think of times things turned out better than they thought
- Help the person figure out things they do to help others, or ways they are important to others (finding meaning in life)
- May also explore meaning in religious beliefs



# Depressive Episode

## ☀ Symptom: Feelings of helplessness

- These sound like “It’s too big for me” or “I don’t know what to do”
- Explore and address ways the individual may actually be made to feel helpless (others doing too much, lack of decision-making)
- Explore ways the individual can feel more powerful and competent in daily life (can include teaching to appropriately assert self)
- Break down big problems into small pieces
- Encourage the individual to find *own* solutions to “smaller pieces”



# Depressive Episode

## ✦ Symptom: Feelings of guilt

- Encourage the person to realistically assess those things for which they feel guilt. If there is a reason for guilt, help think about ways to make the situation better, apologize, etc.
- If guilt seems unrealistic, help talk about that
- Individuals may be reluctant to accept praise, so don't overdo it
- Remember that too many demands can increase feelings of failure



# About Suicide

*Listen closely* when someone talks (directly or indirectly) about feeling worthless, hopeless and/or helpless. One, two or all three of these feelings can sometimes lead people to consider killing themselves.

It is a myth that people with developmental disabilities do not commit suicide. If you think there is ANY risk of this, let your supervisor or a health professional know *right away*.



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# Depression and Suicide

## ✿ Symptom: Thoughts of death

- Do not ignore talk about suicide. Ask questions calmly and clearly: Are you thinking about doing this? What have you thought about doing?
- Spend time with the person. *If the person says he or she is actively suicidal, do not leave him or her alone until there is a safety plan.*
- *Do not allow access to harmful objects or situations until there is a safety plan.*
- Consult with clinical staff immediately.



# Remember!

Not all “thoughts of death” are about suicide. Often, people with developmental disabilities are discouraged from thinking or talking about “sad” things like death or loss. It is important to encourage expressions of grief and sadness about a loss, or natural curiosity about death. Consult with a mental health professional or the treatment team for help in telling the difference between grieving, depression, and suicide.



# Depressive Episode

- ✿ Symptom: Less able to concentrate
  - Be brief, repeat questions or concerns
  - Speak slowly, quietly
  - Avoid giving several directions at once
  - Provide frequent and brief instructions
  - Provide praise
  - Break tasks into smaller tasks
  - Narrow the choices a person has to make





# Personality Disorders

Personality disorders are not fully understood, but seem to be present from a very young age, possibly from birth. Environmental factors can make Personality disorders better or worse. Personality disorders can be helped with therapy and some medications, but are not “cured” the way some other mental illnesses such as mood disorders can be.



# Personality Disorders

## ☀ Common disorders:

- Borderline Personality Disorder
- Histrionic Personality Disorder
- Antisocial Personality Disorder

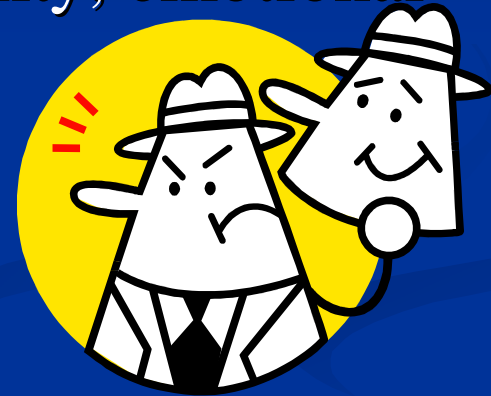
## ☀ Less Common Disorders:

- Schizotypal Personality Disorder
- Paranoid Personality Disorder
- Dependent Personality Disorder



# Borderline Personality Disorder

- ✿ Characterized by displays of hostility, emotional dysfunction, mood lability and aggression (*Wilson, 2001*)
- ✿ Some people believe that BPD occurs in people with developmental disabilities more often than in the general population. (*Nugent, 1997*)



# BPD in People with DD

## ☀ Can look like:

- Over-reaction to typical requests
- Verbal aggression that is personally upsetting to victim
- Verbal aggression that leads to physical aggression
- Over-attachment to some staff and devaluation of others (“splitting”)
- Extreme changes of mood, leading to over-reaction to environmental events
- Self-injuring
- Apparent inability to see connection between behavior and consequences

- *Wilson, 2001*



# Borderline Personality Disorder

## 'How to Help'

- ☀ Do not get pulled into crises. Stay calm and focused.
- ☀ Beware of “splitting.” Do not respond to accusations about other staff without checking with those staff. Also, do not be swayed by manipulation; “you’re my favorite...” etc.
- ☀ Help the individual with overwhelming feelings by:
  - listening calmly
  - not arguing
  - not getting upset
  - helping the individual gradually calm down



# “Interrupt” the Feelings

- ✱ When feelings are overwhelming, it’s hard to remember coping skills
- ✱ Briefly “interrupting” the feelings in small ways (not fixing or changing them) can help the person pause and remember skills or calm down
- ✱ Encourage the individual to do something that has a physical sensation:
  - breathing slowly
  - walking in grass
  - holding an ice cube
  - eating a hot cinnamon candy



# How to Help

- ✱ Any injurious behavior should be addressed and treated if needed. Do not ignore it as “attention-seeking.” Stay calm. Do not make it an exciting event.
- ✱ Do remind the individual of positive ways to get attention. Schedule time frequently “every hour I will spend ten minutes talking with you, if you’re upset or not.” This can help the individual meet the intense need for attention or reassurance without resorting to acting out.
- ✱ Do not “call their bluff” on threats. This can escalate the situation.



# How to help

- ✿ Calmly but firmly address aggression to others
- ✿ Be consistent with structure and rules
- ✿ If an individual shows intense symptoms of BPD, consider getting special training from a supervisor on Dialectical Therapy Techniques to help manage feelings and build coping skills





# Psychosis

Psychosis is the inability to process reality correctly. It can be part of a diagnosis of a specific disorder, like schizophrenia, or stand alone, like psychotic disorder NOS (not otherwise specified).





Some classic psychotic symptoms include:

- ✱ Hallucinations (seeing what isn't there; hearing voices)
- ✱ Delusions (misinterpreting what *is* there; for example, thinking the newscaster on TV is the Devil)
- ✱ Paranoia (thinking people are secretly trying to hurt or control them)
- ✱ Odd or bizarre speech



# Psychosis

Some psychosis is a symptom of another problem, like a severe mood disorder, and will get better or disappear when the mood disorder is treated. Other psychotic symptoms are part of long-term illness like schizophrenia and other thinking disorders. These can also be treated with medication, but the symptoms may be more persistent.



# Negative Symptoms

Along with “positive” symptoms, in the sense of something extra that shouldn’t be happening, like hallucinations, some psychotic disorders also cause “negative” symptoms: normal qualities that are missing. People with severe schizophrenia often have less expression in their faces or voices, avoid contact with people and have “flatter” emotions. Frequently, self-care and grooming are neglected.



# Is it a Psychotic Symptom?

- ✿ Consider other explanations
  - Wishful thinking
  - Imaginary friends
  - Stress/coping mechanism
  - Functional behavior
  - Lack of understanding



# Is it a Psychotic Symptom?

- ✿ Consider Possible Misunderstanding by Others
  - Failure/inability to explore circumstances
  - Failure/inability to explore meaning of response



# Remember!

Your careful observation over time can provide information that helps mental health professionals and doctors distinguish between misunderstandings and true psychotic symptoms.



# Psychotic Episode

Many individuals with developmental disabilities see others as being more powerful than themselves. If you are asking about unusual experiences (seeing things, hearing things), they may want to tell you what you want to hear, or avoid making you angry by giving the “wrong” answer.



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# Psychosis

- ✿ Avoid leading questions (“You’re not hearing voices, are you?”)
- ✿ Ask open-ended questions, not yes-or-no
- ✿ Don’t give a list of possible answers. The individual might simply repeat the last thing he or she heard
- ✿ Ask questions more than once, and in more than one way. See if the answer is consistent
- ✿ Let them know *any* answer is OK



# Psychotic Symptoms: 'How to Help'

- ✱ Don't argue with the person's perceptions
- ✱ Don't collude (pretend that you see the hallucination too)
- ✱ Help the individual feel safe and in control (universal precautions!)
- ✱ Educate – help them to understand the problems associated with the illness and how to deal with them
- ✱ Manage the environment
  - Try to minimize stressful things, people and situations when possible



# Psychotic Episode

- ☀ Symptom: Disorganized speech
  - Attempt to clarify, but don't push too far
- ☀ Symptom: Withdrawal, Neglect of Self
  - Prompt for grooming, speech, eye contact
  - Offer preferred activities near others
  - Provide opportunities to interact with safe, reassuring people, but allow for space if the individual gets uncomfortable. Don't force interaction



# Differentiating Mental Illness from “Behaviors”

- ✦ Combination of factors make persons with DD vulnerable to:
  - Mental Disorders
  - Demonstration of behavior disturbances
    - ✦ Excitability
    - ✦ Explosiveness
    - ✦ Hyperactivity
    - ✦ Agitation
    - ✦ Irritability
    - ✦ Other destructive and stereotyped behaviors



# Mental Illness vs. Learned Behaviors

☀ Odd or disruptive behavior may reflect any number of things:



- Mental disorders
- Abuse or neglect
- Developmental level far below chronological age
- Seizure disorder or other medical condition



# Behavior as Communication

- ✦ Individuals with developmental disabilities may not have the necessary skills to label or to communicate feelings. This makes it harder for them to:



- Identify and express emotions
- Communicate concerns
- Problem solve
- Develop options





This means that behaviors may very often communicate feelings. Fear, anger, loneliness or powerlessness may be feelings that result in annoying, disruptive or aggressive behavior. Trying to stop or control the behavior without helping the feeling that caused it doesn't work for long.



# Behavior as Communication: 'How to Help'

- Stay calm, and try not to react before finding out more about what is happening
- Help to teach words for feelings “You feel *angry* when someone takes your things”
- Give permission and encouragement to express feelings *in words*
- *Remember other things that may be expressed with behavior: pain, illness, etc.*





# Is it Mental Illness.....or Not?

Sometimes people working with someone with mental illness and developmental disabilities may wonder if difficult or strange behavior is the result of a mental illness (not deliberate) or is an effort to avoid something or get something (in other words, deliberate).



# Mental Illness vs. Learned Behaviors

☀ Ask yourself:

- What purpose does the behavior serve?
- What makes the behavior worse?
- What makes the behavior better?



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# Mental Illness vs. Learned Behavior

- ✿ Clues that the behavior may be learned:
  - The behavior is an effective way for the individual to avoid something that they don't want to do or get something that they want, such as attention.
  - The behavior often occurs when the individual is asked to do something that they don't want to do.



# Mental Illness vs. Learned Behavior

## ☀ More clues:

- The behavior is effective and has been used for a long time.
- The person has spent long periods of his/her life in places where the behavior was reinforced for one reason or another (for example, being aggressive to get his or her way in a group home).



## So, what if it is learned?

Whether or not a behavior is learned, is a result of a mental illness, trauma or grief, or is simply an attempt to get something, there are a few things to always remember . . .



# Always...!

- Think about what *need or desire* the behavior is trying to meet (safety, control, attention, nurturing, excitement, predictability, etc.)
- Think about ways the individual can get that need met *before* using the disruptive behavior (universal precautions!)
- Think about *what else* the behavior could be communicating (feelings, problems and concerns, physical pain/illness)



And finally.....

Remember, when you take the time to get to know an individual, and when they know that you care about helping them feel safe, in control and cared for, you can help with many of the scariest parts of mental illness and developmental disabilities.



*“It is the relationship that heals.”*

*- Irving Yalom*



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# References

## A Four-Stage Model for Management of Borderline Personality Disorder in People With Mental Retardation

Susan R. Wilson, M.A. *Mental Health Aspects of Developmental Disabilities* April/May/June 2001 Vol. 4, No. 2

## Improving Lives: EMDR Psychotherapy for People with I/DD Experiencing Trauma and Distress

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