Section 1: Co-occurring Development Disabilities and Mental Health Issues

Modules:

1. a) People with Co-occurring Developmental Disabilities and Mental Health Disorders – Definitions and Resources, Tangeman
   b) Abridged Definitions, Stratton & Clay
   (See Section 6: Medications, Medical Issues, and Mental Health Diagnoses for additional information)
   c) Commonly Used Terms Referenced in Manual

2. Significant Behavioral Issues, Stratton

3. a) Accessing Community Mental Health Services – An Overview, Greenwood
   b) Supporting Individuals with Complex Needs – Community Awareness, Perez (DVD)
      i. About the presenter
      ii. Pre/Post test (Blank and Key)
      iii. PowerPoint presentation

4. a) Co-occurring Diagnoses and Treatment Approaches – Social conflicts for People with Developmental Disabilities: A Clinical Perspective, Mates (DVD)
      i. About the presenter
      ii. Presentation Outline
      iii. Pre/Post test (Blank and Key)
      iv. PowerPoint presentation
   b) Autism History & Facts
   c) Understanding Autism – Characteristics and the Brain Functions, OTAC
      i. Pre/post test (Blank and Key)
      ii. PowerPoint presentation

5. Understanding Personality Disorders – With a focus on Borderline Personality Disorder, Clay (DVD)
   i. About the presenter
   ii. Pre/Post test (Blank and Key)
   iii. PowerPoint presentation

Resources:
DM-ID - http://www.dmid.org/
Section I: Co-occurring Developmental Disabilities and Mental Health Issues

Training Outcomes:
- A working knowledge of mental health terminology and co-occurring diagnoses for individuals with a developmental disability
- Knowing the first steps to access mental health services
- Understanding the complex support needs of individuals with co-occurring disorders
- Awareness level understanding of Autism

Ideas for Training:
1. Use the case studies as examples of the diagnoses you may encounter in your work.
   a. Read information from the Training Manual about the diagnoses listed in the each case study.
   b. List and discuss significant behavior issues and challenges an individual may encounter because of that diagnostic issue.
   c. List and discuss ways the mental health diagnostic issue(s) may increase in intensity or complexity when co-occurring with a developmental disability.
2. Develop your own case studies with information that describes individuals with co-occurring issues (mental health issues and developmental disability) living or working at your own site.
   a. Read information from the Training Manual about the diagnoses listed in the each case study.
   b. List and discuss significant behavior issues and challenges an individual may encounter because of that diagnostic issue.
   c. List and discuss ways the mental health diagnostic issue(s) may increase in intensity or complexity when co-occurring with a developmental disability.
3. Brainstorm with staff the following questions:
   a. What are the unique challenges faced by individuals with mental health issues co-occurring with a developmental disability?
   b. How can those challenges be addressed with support to that individual?
4. Use the Mental Health Jeopardy example. Develop cards with answers for each category. After training staff to the diagnoses, divide the group into teams to play the game.
5. Watch the DVDs included and complete the pre-post test.
6. Divide into small groups. Ask each group to read an article in section I, and then present it the whole group.
### Identified Enhanced Competency Area

#### C. Diagnoses and Symptoms

**Competency**

1) Recognizes symptoms and behaviors associated with psychiatric disorders and developmental disabilities for specific individuals supported by identified staff (from the White Paper).
   b) Demonstrates knowledge of individual’s specific disabilities*

2) Demonstrates understanding of executive functioning.

* Mental Retardation, Autistic Disorder, Sex Offender, Impulse Control Disorder, Pervasive Developmental Disorder, Pervasive Developmental Disorder – NOS, Bipolar Disorder, Obsessive Compulsive Disorder, Schizophrenia, Dissociative Disorder, Schizoaffective Disorder, Bipolar Type. Adjustment Disorder with Anxiety and Depression. ADHD Combined Type, Post Traumatic Stress Disorder, Intermittent Explosive Disorder.

### Identified Enhanced Competency Area

#### F. Mental Health Supports and Treatment (*If applicable)

**Competency**

1) Demonstrates basic knowledge of the mental health system and terminology.
Section 1: Co-occurring Development Disabilities and Mental Health Issues

Module 1:
People with Co-occurring Developmental Disabilities and Mental Health Disorders, Tangeman

Abridged Definitions, Stratton and Clay

Commonly Used Terms Referenced in Manual, Stratton

Simple definitions are provided across commonly diagnosed mental health diagnoses and how they manifest in someone with developmental disabilities
People with Co-occurring Developmental Disabilities and Mental Health Disorders

Definitions and Resources

This section of the manual provides basic descriptions of many commonly diagnosed mental health disorders or other related neurocognitive deficits and how they manifest themselves in someone with a Developmental Disability.

To understand the complex needs of individuals with both developmental disabilities (including intellectual disability) and mental health disorders, it is important to know 3 basic facts:

1) Research consistently has found for more than 30 years that almost all forms of mental health disorders occur more often and are usually more severe in individuals with Developmental Disabilities,
2) Individuals with intellectual disability are inherently more vulnerable to abuse and exploitation due to the co-occurring diagnoses,
3) Individuals with intellectual disability often (though not always) experience mental health disorders in a different manner than individuals without such developmental concerns.

By combining data from research, the Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) and the Diagnostic Manual- Intellectual Disability (DM-ID), this manual will describe that manner in which many mental health disorders are expressed in a population with Developmental Disabilities (DD). Given that many Developmental Disabilities involve a diverse set of strengths and weaknesses, the listing of each mental health disorders with the term “Developmental Disability” must by definition be very general. For further reading and research, this manual will provide a list of resources that any reader may use to learn more. Given this understanding, many mental health disorders will be summarized in a brief format with instructions as to how to locate more in depth information. This manual is intended to offer a summary of many common mental mental health disorders and is not intended to allow the reader to diagnose mental health disorders. Specific diagnosis of a mental health disorder requires the clinical evaluation of a psychologist or psychiatrist.
Abridged Definitions

Common Diagnoses

This section of the manual will seek to provide basic, easy to digest descriptions of many commonly diagnosed mental illnesses or other related neurocognitive deficits and how they manifest themselves in someone with a Developmental Disabilities.

By combining data from research, the Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) and the Diagnostic Manual- Intellectual Disability (DM-ID), this manual will elucidate that manner in which many mental illnesses are expressed in a population with Developmental Disabilities (DD). Given that many Developmental Disabilities involve a diverse set of strengths and weaknesses, the listing of each mental illness with the term “Developmental Disability” must by definition be very general. For further reading and research, this manual will provide a list of resources that any reader may use to learn more. Given this understanding, many illnesses will be summarized in a brief format with instructions as to how to locate more in depth information.

This manual is intended to offer a summary of many common mental illnesses and is not intended to allow the reader to independently make psychiatric diagnoses. It should be noted that only those with special training in psychodiagnostics are allowed to make diagnoses.

Prelude

When attempting to understand the complex needs of those with both Developmental Disabilities (including intellectual disability) it is important to know 3 basic facts:

1) Research consistently finds and has found for more than 30 years that almost all forms of mental illness occur more often and are usually more severe in Individuals with Developmental Disabilities

2) Individuals with ID diagnoses are inherently more vulnerable to abuse and exploitation based on point 1

3) Individuals with ID diagnoses often (though not always) experience mental illness in a different manner than Individuals without such developmental concerns.

Acute Stress Disorder- Very similar to Post Traumatic Stress Disorder (PTSD). This diagnosis involves the actual perceived threat to the physical or psychological integrity to the individual with the following 4 primary symptoms; Avoidance of similar circumstances, Pronounced anxiety, Re-experiencing the event in some form (almost always in dreams or recurrent, unwanted, imagery) and an acute and sudden feeling of psychological “numbness”.

For Individuals with DD Diagnoses:
While the DM ID does not offer many, if any adaptations, clinical experience indicates that many Individuals with disabilities “talk to unseen others” following a trauma. This is often mis-diagnosed as a psychotic process, but is actually a response to the trauma.

Agnosia- A brain based difficulty with naming objects. Expressed in a similar way for both Individuals with DD and without disabilities.
**Angelman Syndrome**- A genetic “Sister Syndrome” to Prader-Willi Disorder. The associated syndrome is drastically different. This DD is characterized by smaller than normal heads, unusual movements, seizures, bouts of laughter, absence or limited expressive language and severe or profound Mental Retardation (MR).

**Aphasia**- A brain based difficulty with receptive language and language production. Expressed in a similar way for both Individuals with DD and without disabilities.

**Anxiety Disorder**- There are several primary types of Anxiety Disorder:
- General Anxiety disorder (GAD)
- Obsessive Compulsive Disorder (OCD)
- Panic Disorder
- Post Traumatic Stress Disorder (PTSD)
- Social Phobia

For Individuals with Development Disabilities: It should be noted that Anxiety disorders have many types of expression but are fundamentally based on the experience of feelings of tension, fear, discomfort, restlessness, etc. Individuals with complex needs often experience a great deal of anxiety on a daily basis. In addition, heightened anxiety may be experienced in new situations, with new Individuals, with confusion or any number of other environmental stimuli, Anxiety can manifest through verbal communication, or in those cases where an individual has trouble with communication, the only way to detect mounting anxiety may be a thorough knowledge of the individual paired with a thorough functional assessment.

- **General Anxiety Disorder (GAD)**
  This is a disorder most characterized by Individuals who cannot relieve themselves of worry about at least 2 “real-life” worries (as opposed to obsessions found under “Obsessive-Compulsive Disorder) for at least 6 months. These are not simply nagging thoughts, these worries are consuming.

For Individuals with DD Diagnoses:
Studies by Mental Health Professionals indicate that this disorder in the classic form is one of the very few that occurs less often in Individuals with ID diagnoses. While no studies could be located explaining this, clinical experience indicated many individuals diagnosed with ID have caregivers and that the caregivers often provide substantial assistance with based function such as paying bills, getting to work, finding supported employment etc. While it cannot be said that Individuals with ID diagnoses have no worries, it can be said that it appears there is a difference in the way these individuals experience worry.

- **Obsessive Compulsive Disorder (OCD)**
  This is a disorder characterized by both Obsessions and Compulsions (although there is a rare form where only obsessions are found). Obsessions are recurrent thoughts that do not relate to real life, are recognized as excessive and are intrusive and unwanted.
Compulsions are Behaviors most often related to Obsessions. For example, if a person cannot stop thinking about germs and cleanliness, their compulsion may be a reluctance to touch others compared with excessive hand-washing.

**For Individuals with DD Diagnoses:**
Diagnosis of this disorder in this population can be very difficult and sometimes cannot be assured. Specifically, Individuals diagnosed with Developmental Disabilities often have verbal and cognitive deficits that may impair their ability to express Obsessions or to recognize that their pattern of thought is unusual. Further, for many Individuals with Developmental Disabilities, there exists stereotyped behaviors. These behaviors are repeated very often, sometimes to the excess of almost all other behavior. Again, without sufficient verbal or cognitive development, determining what is compulsive and what is stereotyped is very difficult. One thing to note here is that compulsions are usually perceived as unpleasant, necessary and invasive, while stereotyped behavior is often perceived as soothing.

- **Panic Disorder**
Panic disorder is characterized by a series of panic attacks that either become debilitating by occurring or become disabling due to fear of another attack. A limited number of panic attacks in isolation is not considered a disorder. In fact, it is common for Individuals in their mid-twenties to experience at least one panic attack (often due to stressful life occurrences such as marriage, graduation from higher education, bearing children etc.) and is a common reason for older adults to visit the hospital thinking they are having a heart attack.

Symptoms of a panic attack include: chest pain; heart palpitations, a feeling of impending dread or doom, intense fear, sensations that the person will “go crazy” or die, and many others. It should be noted that, if a person is having the above symptoms and has not been given the “all clear” by a physician, they should immediately be taken to an ER or 911 should be called.

**For Individuals with DD Diagnoses:**
The symptoms are often very similar in non-disabled and disabled individuals. It must be considered though, that in non-verbal individuals or individual with limited verbal capacity, the symptoms may be evident as self-harm, assaults on others, property destruction, etc.

- **Post Traumatic Stress Disorder (PTSD)**
There is a surprising diversity in the manner in which symptoms of this disorder can be manifest. However, the following must be present:

There must be an actual or perceived threat to the person’s physical or emotional integrity. Research indicates, the more personalized the trauma, the more severe the symptoms. For example an earthquake may be very frightening, but in a general way, while something like an assault, or worse, a sexual assault, is much more personal.

The individual must re-experience the event in some form, most often in intrusive memories and nightmares. However, it is important to note that sometimes, hallucinations of aspects of the event may be present.
The individual must avoid circumstances that remind them of the trauma. For example, if a person was abused in a dark room, they may feel a strong need to keep the light on at night.

The person must show signs of hyper-arousal. This is an enhanced sensitivity to the environment. For example, the person will likely startle easily and be very sensitive to loud noises.

The symptoms must last for 1 month or more.

For Individuals with DD Diagnoses:
Again, there is significant diversity in the way Individuals with disabilities experience this disorder. Individuals with ID are more likely to experience more severe symptoms and are innately more sensitive to PTSD than Individuals without disabilities.

- Social Phobia
While there are a number of associated symptoms and diagnostic consideration, this disorder is essentially the fear of social settings.

For Individuals with DD Diagnoses:
The symptoms are often very similar in non-disabled and disabled individuals. It must be considered though, that in non-verbal individuals or individual with limited verbal capacity, the symptoms may be evident as self-harm, assaults on others, property destruction, etc.

Attention Deficit Hyperactivity Disorder (ADHD)
This is a commonly diagnosed disorder that is almost always evident in childhood, however, adult cases are possible. This disorder is evident in a variety of settings (i.e. school, home, with friends) and is expressed by a persistent difficulty either maintaining attention, being hyperactive, or both. To be diagnosed, these symptoms must be present in a manner that is excessive and persistent given both age and disability. For example, it is relatively normal for young children to show a difficulty holding attention on one subject. In order for a diagnosis to be made, symptoms of inattention must be pronounced and persistent in several domains.

For Individuals with DD diagnoses:
It is important to recognize that Individuals with ID diagnoses have, by definition, varying levels of cognitive development. If an individual takes an Adaptive Test like the Vineland and scores in the same range as a young child, this does not mean the individual thinks like a young child, but it may mean that certain areas of their function are similar to that of a younger child. In this case, it is considered normal for children of a certain age to be extremely active and have difficulty paying attention. So care and consideration must be paid to these factors before making this diagnosis.

Autism Spectrum Disorder
- Asperger’s
- Autism

Autism spectrum disorders (ASDs) are a group of developmental disabilities defined by significant impairments in social interaction and communication and the presence of unusual behaviors and interests. Many Individuals with ASDs also have unusual ways of learning, paying attention, or
reacting to different sensations. The thinking and learning abilities of Individuals with ASDs can vary – from gifted to severely challenged. ASD begins before the age of 3 and lasts throughout a person's life. It occurs in all racial, ethnic, and socioeconomic groups and is four times more likely to occur in boys than girls.

- **Asperger’s**
  As with the Autism Spectrum and Autism itself, Asperger’s may be quite severe, or very subtle. Sometimes Individuals with Asperger’s syndrome are profoundly disabled by their social, emotional, executive and psychiatric symptoms while others may have such understated symptoms that symptoms are not obvious when a stranger first meets the individual diagnosed with Asperger’s.

- **Autism**
  As noted above, Autism is part of the Autism Spectrum of Disorders that is usually considered to run from Severe Autism, where the person is non-verbal, shows profound social deficits and fundamental communication impairments to High Functioning Asperger’s Disorder where there may be little noticeable change in the individuals functioning (however, as stated above, it should be noted that some forms of Asperger’s may be extremely severe).

**Behavioral Phenotype**
A behavioral phenotype is the expression of a genetic genotype. A genotype is a genetic predisposition to behave in a certain manner while the phenotype is that behavior itself. For example, in Individuals with Prader-Willi, there is a genetic mis-code where a person is unable to feel satiated with food. Therefore, the expression of this genotype (or the phenotype) is for the individual diagnosed with Prader-Willi to seek food perpetually. For specific Phenotypes and Genotypes, please refer to the DM-ID.

**Cerebral Palsy**
Cerebral palsy refers to a group of disorders that affect a person's ability to move and to maintain balance and posture. It is due to a non-progressive brain abnormality, which means that it does not get worse over time, though the exact symptoms can change over a person's lifetime. Individuals with cerebral palsy have damage to the part of the brain that controls muscle tone. Muscle tone is the amount of resistance to movement in a muscle. It is what lets you keep your body in a certain posture or position.

**Communication Disorders**
This is a general description for a wide range of communication difficulties including, perhaps most prominently, expressive/receptive language disorder. While all communication disorders involve some kind of impairment in relating with others, expressive/receptive language disorder is characterized by difficulty both learning how to speak and understanding the spoken word. One can easily see how the presence of this disorder would confuse diagnosis with the Autism Spectrum of disorders.

**Developmental Disability**- Developmental disabilities are a diverse group of severe chronic conditions that are due to mental and/or physical impairments. People with developmental disabilities have problems with major life activities such as language, mobility, learning, self-help, and
independent living. Developmental disabilities begin anytime during development up to 22 years of age and usually last throughout a person’s lifetime.

Down Syndrome
Down Syndrome is the most common of the Developmental Disabilities occurring about once in every 700-1000 live births. The physical, developmental and cognitive symptoms include: altered and stereotyped facial structure; substantial risk for heart attack and dementia; a wide range of intellectual disability with most individuals in the borderline to mild range of MR. For a more thorough review of this important and well researched DD, please refer to the DM-ID.

Delirium
Delirium is a profound change in attention span paired with a wide range of other neurocognitive symptoms. This is the most common reason for visits to Emergency Rooms (ER’s) and may be caused by a surprising number of variables including: head injury; drug use; drug withdrawal, stroke etc. Onset and recovery are often very swift.

For Individuals with Disabilities:
There is typically almost no difference in the way this is experienced by Individuals with disabilities. It is important to note however, that delirium must represent a significant change from the individual’s baseline behavior. This means if a person with disabilities often has attentional problems and appears confused, they may not have delirium. It is important to get these diagnoses determined with a complete diagnostic evaluation.

Dementia
Unlike delirium, dementia has a slow onset and is primarily focused on memory deficits that grow worse over time. This memory deficit is paired with a wide variety of other neurocognitive symptoms. Like delirium, there are many causes for dementia including, most famously Alzheimer’s.

For Individuals with Disabilities:
There is typically almost no difference in the way this is experienced by Individuals with disabilities. It is important to note however, that dementia must represent a significant change from the individual’s baseline behavior. This means if a person with disabilities often has memory problems with other neurocognitive symptoms, they may not have dementia. It is important to get these diagnoses determined with a complete diagnostic evaluation.

Dual Diagnosis/ Co-occurring Disorders
Individual has both a developmental disability (DD) and/or intellectual disability (ID) in conjunction with a co-occurring diagnosis of mental illness. According to the National Association for the Dually Diagnosed (NADD) individuals with ID are 2-4 times more likely than those in the general population to experience psychiatric disorders. Individuals with ID and mental health issues are often under-identified.
Executive Function
Executive function is a process that involves reasoning, logic, sequencing, intentional action and memory searches. Executive function is not tied to any one area of the brain but involves the processing across multiple areas.

For Individuals with Disabilities:
There is frequent occurrence of executive functioning issues that result in daily living difficulties and possibly result in attempts to cope through challenging behavior. Many specific disorders of developmental disabilities list executive functioning problems as a common trait or characteristic.

Fetal Alcohol Spectrum Disorders (FASD)
Prenatal exposure to alcohol can cause a range of disorders, known as fetal alcohol spectrum disorders (FASDs). One of the most severe effects of drinking during pregnancy is fetal alcohol syndrome (FAS). FAS is one of the leading known preventable causes of intellectual disability and birth defects. If a woman drinks alcohol during her pregnancy, her baby can be born with FAS, a lifelong condition that causes physical and mental disabilities. FAS is characterized by abnormal facial features, growth deficiencies, and central nervous system (CNS) problems. Individuals with FAS might have problems with learning, memory, attention span, communication, vision, hearing, or a combination of these. These problems often lead to difficulties in school and problems getting along with others. FAS is a permanent condition. It affects every aspect of an individual’s life and the lives of his or her family.

Fetal alcohol spectrum disorders (FASDs) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

FASDs include FAS as well as other conditions in which individuals have some, but not all, of the clinical signs of FAS. Three terms often used are fetal alcohol effects (FAE), alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD). The term FAE has been used to describe behavioral and cognitive problems in children who were prenatally exposed to alcohol, but who do not have all of the typical diagnostic features of FAS. In 1996, the Institute of Medicine (IOM) replaced FAE with the terms ARND and ARBD. Children with ARND might have functional or mental problems linked to prenatal alcohol exposure. These include behavioral or cognitive abnormalities or a combination of both. Children with ARBD might have problems with the heart, kidneys, bones, and/or hearing.

All FASDs are 100% preventable—if a woman does not drink alcohol while she is pregnant.

Fragile X
Fragile X is a family of genetic conditions, which can impact individuals and families in various ways. These genetic conditions are related in that they are all caused by gene changes in the same gene, called the FMR1 gene.

Fragile X includes fragile X syndrome (FXS), the most common cause of inherited mental impairment. This impairment can range from learning disabilities to more severe cognitive or intellectual
disabilities. Symptoms can include characteristic physical and behavioral features and delays in speech and language development.

**Intellectual Disability (Mental Retardation) (ID)**

Intellectual disability is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. Intellectual disability is sometimes referred to as a cognitive disability or mental retardation.

Children with intellectual disability can and do learn new skills, but they develop more slowly than children with average intelligence and adaptive skills. There are different degrees of Intellectual Disability, ranging from mild to profound. A person's level of Intellectual disability can be defined by their intelligence quotient (IQ), or by the types and amount of support they need.

**MOOD DISORDERS**
- Major Depressive Episode
- Dysthymia
- Manic Episode
- Hypomania
- Bi-Polar Disorder
- Major Depressive Episode

Depression is very common. In order to be diagnosed, symptoms must be severe enough to significantly impair functioning in several domains (with family, work, school) for at least two weeks. There are many associated symptoms, but some of the most important are: A feeling of depression, irritability, anhedonia (a loss of pleasure in otherwise pleasant activities), loss of concentration, guilt, thoughts of suicide or suicide attempts, changes in weight or sleep and others. Lastly, in order to be diagnosed in the non-disabled, both depression and anhedonia must be present. If symptoms go uncontrolled and become more severe, psychosis may emerge.

**For Individuals with Disabilities:**
This disorder is experienced in much the same way, but in Individuals with communication difficulties, much of the diagnosis is based on careful observation of symptoms. Two of the cardinal symptoms that can be easily tracked are weight and sleep. Lastly, in order to be diagnosed with depression, irritability can substitute for depression. Essentially, this means that a person who is diagnosed with ID does not need to express depression to be diagnosed with a major depressive episode.

- **Dysthymia**
  A less severe form of depression that lasts for at least two years where the individual either reports or is observed to have some, but not most of the criteria for a major depressive episode.

**For Individuals with Disabilities:**
Clinical experience indicates the individual may express these symptoms for 1 year instead of 2 and may show irritability instead of depression.
• Manic Episode
Mania is characterized by a feeling of euphoria, impulsivity, irritability, a need for less sleep, weight loss and other related symptoms. These symptoms must last at least 1 week or until hospitalized. If symptoms go uncontrolled and become more severe, psychosis may emerge.

For Individuals with Disabilities:
Clinical experience indicates there is little difference between the way Individuals with disabilities and those without experience this cluster of symptoms. But, as in many cases, those with limited communication ability may act out by destroying property, self-harm and attempts to harm others.

• Hypomania
A less severe form of mania that lasts at least 4 days.

For Individuals with Disabilities:
Clinical experience indicates there is little difference between the way Individuals with disabilities and those without experience this cluster of symptoms.

• Bi-Polar Disorder
This disorder is characterized by shifting emotions that go from either a manic episodes to “normal” moods or manic episodes to major depressive disorder. If this happens more than 4 times in a year, it is characterized as “Rapid-Cycling”.

For Individuals with Disabilities:
Clinical experience indicates this experience is very similar for those with and without disabilities. However, it may result in quicker cycling, so that, instead of 4 times per year, the bi-polar experience may happen once a month or more.

Neurocognitive Symptoms
These are any symptoms directly due to brain function. Any abnormality attributed to brain function such as: executive function, language problems, delirium or dementia, and many others may fall under this large umbrella term.

Pedophilia
This disorder is characterized by intense sexual fantasies that impair day-to-day living or actions between a perpetrator who is over 16 years of age and a child, who is at least 5 years younger than the perpetrator. This does not apply if there is a consensual interaction between a 16 year old and a 12 or 13 year old. As stated by the DM-ID one must be incredibly careful in applying this diagnosis to Individuals with an ID diagnosis because this may be the only age that they have been exposed to and so may have come to sexualize Individuals that think and act more like children than adults. Of course, due to Oregon abuse reporting laws, we must all report any pedophilia activities, even if merely touching, to our local police or to DHS advocates immediately.

PERSONALITY DISORDERS
Two things should be noted immediately: Personality Disorders are diagnosed in Clusters (Cluster A, Cluster B and Cluster C); and, many personality disorders pose little threat to the person or to others.
This manual provides a listing of all personality disorders according to Cluster and then includes a definition of each:

Cluster A:
- Paranoid
- Schizoid
- Schizotypal

Cluster B:
- Antisocial
- Borderline
- Histrionic
- Narcissistic

Cluster C
- Avoidant
- Dependent
- Obsessive Compulsive Personality Disorder

In the field of psychology, personality disorders are not diagnosed in individuals less than 18 years of age.

**Cluster A:**

- **Paranoid**
  As with most personality disorders, this disorder is found more in institutions than in the community. It is characterized by a pervasive distrust of others that does not rise to the point of Paranoid Schizophrenia, but is clearly pathological. Some have posited the following model:

  ![Diagram](image.png)

- **Schizoid**
  This diagnosis has symptoms that include a desire to be separate from others, eccentric habits and no expressed interest in the opposite sex. It can be discriminated from autism by the cluster of other symptoms such as disordered language and a strict adherence to sameness. Schizoid personality tends to develop as a child and worsen into adulthood.

**For Individuals with Disabilities:**
There is a significant difference between a Schizoid Disorder are noticeable from a Developmental Disability. A psychological clinician must be the professional to determine the psychodiagnostics or a mistake may be made that could put the individual in a type of classroom and supported living that is entirely not appropriate.
• **Schizotypal**
  This is a personality disorder that is very similar to a less severe form of Schizophrenia (please see “psychotic disorders”). The individual is usually very socially uncomfortable and may have rituals or compulsions. They also may show brief periods (less than a few hours) of delusions or hallucinations.

**For Individuals with Disabilities:**
This disorder may present very similarly in individuals with and without disabilities. However, in those with disabilities that are non-verbal, it may be difficult or impossible to discern when a hallucination or delusion is happening. Perhaps the most tell tale sign is emotional instability changing within the hour paired with intense fear.

**Cluster B:**

• **Antisocial Personality Disorder**
  Antisocial Personality Disorder is a condition characterized by persistent disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Deceit and manipulation are central features of this disorder. For this diagnosis to be given, the individual must be at least 18, and must have had some symptoms of Conduct Disorder (i.e., delinquency) before age 15. This disorder is only diagnosed when these behaviors become persistent and very disabling or distressing.

• **Borderline Personality Disorder (BPD)**
  The central feature of borderline personality disorder is a pervasive pattern of unstable and intense interpersonal relationships, self-perception, and moods. Impulse control is markedly impaired. Diagnostic criteria require at least 5 of the following features: Frantic efforts to avoid expected abandonment, unstable and intense interpersonal relationships, markedly and persistently unstable self-image, impulsivity in at least 2 areas that are potentially self-damaging (e.g., sex, substance abuse, reckless driving), recurrent suicidal behaviors or threats or self-mutilation, affective instability, chronic feelings of emptiness, inappropriate and intense anger, or transient paranoia or dissociation.

Between 8% and 15% of Individuals with BPD will die at their own hands, often accidentally. The preferred method for suicidal gestures is deep scratches or moderate cuts with a knife, usually to the arm or somewhere visible to others. The most frequent and dangerous suicide attempt measure is an overdose of prescription drugs with alcohol.

• **Histrionic (HPD)**
  HPD is a type of personality disorder in which the affected individual displays an enduring pattern of attention-seeking and excessively dramatic behaviors beginning in early adulthood and present across a broad range of situations. Individuals with HPD are highly emotional, charming, energetic, manipulative, seductive, impulsive, erratic, and demanding. HPD has a unique position among the personality disorders in that it is the only personality disorder explicitly connected to a patient's physical appearance. Researchers have found that HPD appears primarily in men and women with above-average physical appearances. Some research has suggested that the connection between HPD and physical appearance holds for women rather than for men. Both women and men with HPD
express a strong need to be the center of attention. Individuals with HPD exaggerate, throw temper tantrums, and cry if they are not the center of attention. Patients with HPD are naive, gullible, have a low frustration threshold, and strong dependency needs. In their inter-personal relationships, individuals with HPD use dramatization with a goal of impressing others. The enduring pattern of their insincere and stormy relationships leads to impairment in social and occupational areas.

- Narcissistic
  This diagnosis is one of the few that clinical experience occurs less often in a population with ID. It is characterized by a heightened sense of the self, feeling that the individual has a special purpose and is more important than others. This person is easily frustrated by mistakes or setback and frequently holds a grudge against others.

**CLUSTER C:**

- Avoidant
  This individual avoids social situations at all costs and if they cannot escape a social situation, they may endure it with great distress. Very similar to social phobia with the primary difference being age at onset. Avoidant Personality Disorder usually sets on slowly over the course of a person’s adolescence. Social Phobia may have acute onset at any time throughout the lifespan, often in teens or twenties.

  For Individuals with Developmental Disabilities:
  This disorder is often expressed in the same manner. Even if a person is non-verbal, their fear of and avoidance of any social setting and preference to be alone remain diagnostic keys.

- Dependent
  This is a personality where the most common features are a pervasive need to be around others and a reliance on others to make important decisions. One might see that this is often an adaptive skill for many individuals who are ID. Individuals with behavioral, self-care and cognitive deficits need to be paired with staff to negotiate an increasingly complex world. Of course, adequate SVS support and skills training may often reduce dependent features.

- Obsessive Compulsive Personality Disorder
  This is perhaps the most misleading name in the DSM-IV-TR and the DM-ID. Obsessive compulsive PERSONLITY disorder does not involve either obsessions or compulsions as previously discussed. Rather, this disorder is most characterized by a miserly, restricted way of life. This person will have a place for everything and everything in its place so much so that it interferes with the ability of an individual to lead a fulfilling life. Many individuals with and without disabilities report have some tendencies from this disorder. It must be stressed that a few, isolated symptoms of this disorder does not constitute a mental disorder. The symptoms must be of sufficient number and sufficient severity to impair a person’s ability to lead a meaningful, hopeful and independent life.

**Prader-Willi Syndrome (PWS)**
PWS is a complex non-hereditary birth defect resulting from an abnormality on the 15th chromosome. It occurs in males and females equally and in all races. PWS typically causes low muscle
tone, short stature if not treated with growth hormone, incomplete sexual development, and a
chronic feeling of hunger that, coupled with a metabolism that utilizes drastically fewer calories than
normal, can lead to excessive eating and life-threatening obesity. The food compulsion makes
constant supervision necessary. Average IQ is 70, but even those with normal IQs almost all have
cognitive deficits and require special education. Social and motor deficits also exist. At birth the infant
typically has low birth weight for gestation, hypotonia (weak muscles), and difficulty sucking due to
the hypotonia (“failure to thrive”). The second stage (“thriving too well”), with onset between the
ages of two and five throughout lifetime, usually is characterized by increased appetite, weight
control issues, and motor development delays along with often severe behavior problems and
medical issues.

Prenatally Drug-Affected Children-
Infants and children affected by prenatal exposure to cocaine, crack, methamphetamines, alcohol
and other drugs may exhibit a range of developmental conditions and behaviors that are life-long.
These behaviors include: lack of self-control, failure to understand cause and effect, sudden mood
swings, violent behavior, inappropriate social behavior, inability to recognize patterns, inability to
learn by watching, no conscience, and no remorse. There are also typical learning and memory
problems.

PSYCHOSIS
• Brief Psychotic Disorder
• Schizophrenia
• Delusional Disorder
• Schizoaffective Disorder
• Brief Psychotic Disorder
This disorder is essentially Schizophrenia (see below) that is emergent for 1-30 days and no more.

• Schizophrenia
All of these disorders are characterized by the presence of:
1) Thought Disorder: Thought disorder is a disturbance in the way a person organizes thought and a
dysfunction in logic and sequencing. This, of course, can only be evident through speech, which
varies from relative mild tangentiality (speaking about the same general topic over and over, to
the more severe word salad where an individual expresses entirely unrelated words that do not
relate to questions asked for and particular theme).
2) Hallucination: Hallucination occurs when a person feels, sees, hears, smells or tastes something
that is not there. This is not simply a misperception or illusion, it is a person generally
experiencing and believing something is not there. The most common sensorium in which this
occurs is hearing voices. Almost always the voices either comment on the action the individual is
doing or gives them command hallucinations. It can be viewed in a positive light that only 1/3 of
Individuals who experience these command hallucinations act on them.
3) Delusion: Delusions are beliefs that are either almost certainly or complexly certainly impossible.
They range from overvalued ideas (something such as that there is a triumvirate of oil companies
controlling all the word) to a much more sinister type of bizarre delusional belief such as “I am
made of metal and cannot be hurt”. It is easy to see how this bizarre delusion is very dangerous.
When a person has a combination of these experiences, has even one bizarre belief or has command hallucinations, they are on the psychosis continuum:

| Brief Psychotic Episode is characterized by symptoms that last at least 1 day and up to 30 days. | Schizophreniform disorder is characterized with symptoms that last from 30 days to 6 months. | Schizophrenia has many types, but to be diagnosed with any type, symptoms must be present for more than 6 months. |

As noted, there are a wide variety of schizophrenic symptoms including catatonic, disorganized, residual and others. It is not important to have a thorough understanding of this complex disorder, rather, a basic understanding of its more common manifestation will suffice.

- **Delusional Disorder**
  A very rare condition whereby an individual experiences a Non-bizarre Delusion and does not experience profound changes to pre-morbid functioning. For example, a person may come to believe that there are more than 10 times as many air accidents as there are and that the deaths are being covered up by the FAA. Clearly not Bizarre, and this individual should continue to work and pay a mortgage with that belief, but it may impair his social life.

- **Schizoaffective Disorder**
  This disorder is among those that can be very complex. Suffice it to say that this mental illness represents a combination of psychosis and a mood disorder. So, one might record that the individual experienced by Schizophreniform disorder and major depressive disorder at the same time. The timelines and other circumstances surrounding this disorder make it among the most difficult to assign and grasp. A simple understanding of the process of the two diagnoses occurring together should, again, suffice.

  **For Individuals with Developmental Disabilities:**
  It is widely understood that all forms of psychosis are more common in individuals with an ID diagnosis. Unfortunately, the interconnectedness and similarity between the disorders, makes their expression in individuals with disabilities so complex as to be almost impossible to have a full understanding. Some important aspects include that, simply because an individual with ID is talking to themselves, does not immediately imply a psychotic disorder. It could just as easily be caused by any number of reasons in the individual with Developmental Disabilities (i.e., tendency for echolalia in that individual, personal trauma that may have occurred to that individual, or the reliving of memories both pleasant and unpleasant).

  **Psychopathy**
  This is Anti-Social Personality Disorder: Severe along with Narcissism: Severe. These Individuals are often part of the criminal justice system and will not hesitate to hurt another person if they can gain by it.
For Individuals with Developmental Disabilities:
This is thought to be a disorder that is actually LESS prevalent in individuals with intellectual disability. However, in the unfortunate cases where it does occur, the criminal thinking may be much less sophisticated.

**Pyromania**
This is an disorder of impulse control where an individual feels an overwhelming need to set fires. There is mounting pressure before the act of setting the fire followed by a pronounced gratification. There is almost indefinitely the involvement of law enforcement individuals and charges of Arson may follow an episode of acting out.

**Substance Related Disorders**
This diagnosis has been found in more than 30 studies to be one of the least common (usually not present) psychiatric disorders among those with ID diagnosis. However, there is concern that it may be under-reported in those who live with family support, live on their own or live with minimal supports (Semi-Independent Living; SILP).

Simply staff should be aware that for nearly all substances that have the potential for addiction there will be some signs including:

1) Acute intoxication
2) “Hangover”
3) Withdrawal when the substance cannot be obtained
4) An obsession with the substance
5) Spending excessive time trying to obtain or recovering from its use

**Tic Disorders**
These disorders describe chronic and intrusive motor and vocal “tics” that are not due to a medical condition. Tourette’s is a Neurological disorder where both motor and vocal tics are present. Contrary to popular belief, the presence of foul language tic (coprophagia) is only about 10% of those diagnosed with Tic Disorders.
References:

- The Drug Affected Website, 8316 N. Regent Rd., Fox Point, WI 53217

- The Prader-Willi Syndrome Association (USA)
  8588 Potter Park Drive, Suite 500
  Sarasota, Florida 34238 USA

- Internet Mental Health, Dr. Phillip Long, M.D.

- The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services.

- The National Fragile X Foundation, PO Box 37, Walnut Creek, California 94597

- National Association for Dual Diagnosis, 2009
  o [http://www.thenadd.org](http://www.thenadd.org)

- Diagnostic and Statistical Manual IV-TR (DSM-IV-TR)

- Diagnostic Manual- Intellectual Disability (DM-ID)
Commonly Used Terms Referenced in Manual

BSP - Behavior Support Plan- A behavior support plan is a roadmap of how support persons will change their own behavior, adjust the environment, and teach new skills.

CDDP - Community Developmental Disability Program- A CDDP is an entity that is responsible for planning and delivery of services for persons with mental retardation or other developmental disabilities in a specific geographic area of the state under a contract with the Department or a local mental health authority.

Crisis cycle- Typical response to acutely stressful situations. The crisis cycle consists of seven phases. These are Phase 0: Current status, Phase 1: Triggering event, Phase 2: Escalation, Phase 3: Crisis, Phase 4: De-Escalation, Phase 5: Post Crisis Depletion, Phase 6: Stabilization.

DSM - Diagnostic and Statistical Manual- The DSM is a publication by the APA that contains all currently recognized mental health diagnosis used by mental health professionals to identify and describe psychiatric conditions.

Multi-axial system:
The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:

**Axis I**: clinical disorders, including major mental disorders, as well as developmental and learning disorders  
**Axis II**: underlying pervasive or personality conditions, as well as mental retardation  
**Axis III**: Acute medical conditions and physical disorders.  
**Axis IV**: psychosocial and environmental factors contributing to the disorder  
**Axis V**: On the final axis, the clinician rates the person's level of functioning both at the present time and the highest level within the previous year. This helps the clinician understand how the above four axes are affecting the person and what type of changes could be expected.

The DSM-IV-TR states, because it is produced for the completion of Federal legislative mandates, its use by people without clinical training can lead to inappropriate application of its contents. Appropriate use of the diagnostic criteria is said to require extensive clinical training, and its contents “cannot simply be applied in a cookbook fashion”. The APA notes diagnostic labels are primarily for use as a “convenient shorthand” among professionals. The DSM advises laypersons should consult the DSM only to obtain information, not to make diagnoses, and people who may have a mental disorder should be referred to psychological counseling or treatment. Further, a shared diagnosis/label may have different etiologies (causes) or require different treatments; the DSM contains no information regarding treatment or cause for this reason. The range of the DSM represents an extensive scope of psychiatric and psychological issues or conditions, and it is not exclusive to what may be considered “illnesses”. (APA, 2009)
**Fatal four**- Specific risks for people with developmental disabilities. There are four major health issues that are more common in people with developmental disabilities and cause both morbidity and mortality. They are frequently referred to as the "fatal four": aspiration, dehydration, constipation and epileptic seizures.

Aspiration, dehydration, and constipation may be insidious conditions that often go unrecognized until they cause a major illness and/or even death. Many of the symptoms of these conditions are subtle and persons with disabilities may not be able to express their discomfort or give indications that they are not feeling well.

If a person has epileptic seizures, it is the suddenness and the unpredictability of this disorder that places the person at risk. Hospitalizations and/or death may be caused by injury, aspiration, drowning, or status epilepticus. Astuteness of the staff and careful monitoring can greatly minimize the risks and ensure timely interventions. The following information will help the RN identify persons that have "fatal four" risks and help guide them in their assessment, plan of care and protocols. (Oregon DHS, 2007)

**FA - Functional (Behavior) Assessment**- Functional Assessment is a process of gathering information about the circumstances that influence an individual’s behavior. The process helps in determining what is triggering the behavior, what is maintaining (or reinforcing) the behavior as well as identifying the context of the behavior.

**ISP - Individual Support Plan**- Individual Support Plan means the written details of the supports, activities and resources required for an individual to achieve personal goals. The Individual Support Plan is developed to articulate decisions and agreements made during a person-centered process of planning and information gathering. The ISP is the individual's Plan of Care for Medicaid purposes.

**OAR - Oregon Administrative Rule**- Standards, responsibilities and procedures designed assure service delivery in Oregon is in compliance with federal and local guidelines.

**OIS - Oregon Intervention System** - OIS is a process for developing, maintaining, practicing and reviewing positive behavior supports within a framework of person-centered planning and self-determination.

**PBS - Positive Behavior Supports** - PBS considers what is important to the person and for the person and implements those values into a comprehensive plan to address challenging behavior. PBS focuses on valued outcomes such as teaching or strengthening skills, enhancing relationships, and increasing participation in the community.

**Protected Person**- A person for whom a guardian or a conservator has been appointed by a Court.
Self Determination- A movement that gives people with developmental disabilities control over how public funds are spent on the services and supports they use. Self-determination is based on five guiding principles:
1. People with disabilities have the freedom to plan their lives with support from people they choose.
2. People with disabilities have authority and control over money used to purchase their supports and services.
3. People with disabilities have the formal and informal support they need including resources and personnel.
4. People with disabilities take responsibility for living in interdependent communities.
5. Confirmation of the important leadership role that people with disabilities must play in a newly redesigned system.

SVS- Structure and Visual Strategies- The principles of SVS are used to develop support strategies that help an individual with complex needs have better understanding of information in their environment. Support strategies may include visual information possibly along with verbal or by itself, arrangement of the environment, or interaction practices of support staff. SVS is based on the components of Structured Teaching as defined by Division TEACCH, University of North Carolina, and the teachings of Positive Behavior Support (PBS).

Substituted Judgment- The principle that a Guardian or a Conservator makes decisions as a surrogate for the protected person, putting themselves in the person’s shoes. In other words, the fiduciary bases his/ her decisions on what the protected person would do if he/ she had capacity and/ or was financially capable.

References:

- National Association for Dual Diagnosis, 2009 - http://www.thenadd.org
- Oregon Department of Human Services - http://www.oregon.gov/DHS
- Positive Behavior Support
  - http://www.apbs.org/
- Division TEACCH
  - http://www.teacch.com/
Section 1: Co-occurring Development Disabilities and Mental Health Issues

Module 2:

Significant Behavioral Issues*, Stratton, 2009

This overview paper focuses on significant behavioral issues that our society has trouble accepting and supporting. It provides a quick look at understanding how these destructive behaviors can impact the people we support.

*See Section 5: Other Complex Issues and Treatment/Training Approaches
Significant Behavioral Issues

Individuals with complex needs find themselves at risk in society due to their level of daily stress and resulting inability to cope with the complexities of daily life. Generally, people with complex needs have serious difficulty learning how to do things most people are able to learn incidentally. Their thinking occurs in categories rather than using inductive or deductive reasoning. Previous teaching and learning often has used too many abstract concepts rather than concrete situations which contributes to the deficit. All people with complex needs are capable of learning new skills. However, they are often in settings or situations where they do not understand and are in turn misunderstood. The result for many individuals with complex needs is the expression of stress and anxiety into significant behavior issues.

There are vast differences in personal profiles defining individuals with complex needs. Some have psychiatric issues; many do not. Some are funny and fun, patient and caring while some are short-tempered and impatient; many move between a wide range of emotion. Some are truthful, and some are not; most, like the rest of us, are truthful most of the time but not always. Some have great difficulty expressing thoughts and feelings in words; others may have good verbal and social skills but lack cognitive understanding. In general, people with complex needs have trouble with complex ideas or situations, and with reasoning, analysis, and judgment. In some ways, an individual’s good verbal skills can present difficulty in that he may act as if he understands a situation when he does not. Often, to get along in society, many individuals with complex needs have learned:

- to act or say they understand when they do not.
- to be acquiescent (nod agreement, go along, fake understanding, say “yes”).

Or, to survive anxiety and frustration, many individuals have learned:

- to strike out when they do not understand
- to seek predictability through destructive behavior

One aspect of individuals with complex needs is a higher risk to engage in destructive behavior issues. At times those issues cross the societal boundaries set by the law. These individuals may commit crimes. When this occurs they don’t do well in jail, prison or Mental Health facilities. They certainly don’t know much about the workings of the legal system.

Not all undesirable behavior is destructive. The subtypes of undesirable behavior are generally referred to as distracting, disruptive, and destructive.

Distracting:

Behavior that may be annoying to others but is not disrupting the individual’s life. This behavior can be ignored by those around the individual even though they may find it annoying. Example: Asking the same question over and over, talking about the same thing non-stop.
Disruptive:
Behavior that interferes with daily living routines to the extent that there is difficulty obtaining wants and needs, completing tasks, or interfering with quality of life. This level of difficult behavior warrants intervention. It can be pursued by degree and change occurs over a period of time.

Destructive:
Behavior that is life threatening, dangerous, or significantly interrupts daily life.

To determine which subtype a behavior falls in, complete a thorough description of each particular behavior with accompanying frequency and severity descriptions. Frequency and severity will be supported by data when available including how often the behavior occurs and what impact it has on the life of the individual and others.

Destructive behavior can often be defined in categories:
Aggression
Property Destruction
Theft
Sexual misconduct
Self harm
Institutional behavior

This is not an all inclusive list of destructive behavior but these are often the most significant issues encountered by individuals with complex needs.

An in depth look at destructive behavior defines it as conduct that, due to its intensity and/or frequency, presents an imminent danger to the person who exhibits the behavior, to other people, or to property. Accordingly, intervention is necessary for the individual engaging in the destructive behavior, for those against whom the aggression is directed, and for the protection of property. Seriously destructive behaviors can take unusual forms among persons with developmental disabilities, especially those with intellectual disability. The range and form of these behaviors are broad, and they vary in severity, duration, and intensity.

Self Harm
Cutting
It’s a practice that is foreign, frightening, to parents. It is not a suicide attempt, though it may look and seem that way. Cutting is a form of self-injury -- the person is literally making small cuts on his or her body, usually the arms and legs.

Self Injurious Behavior (SIB)
Self-Injurious Behavior (SIB) refers to acts people direct toward themselves that result in tissue damage.

The prevalence for individuals with Intellectual Disabilities ranges from 5% to 16%. Some syndromes report a close to 100% prevalence.
There are common characteristics associated with SIB. They may take the form of repetitive movements, episodes or bouts. SIB may start out as avoidance, but continue on its own once the pattern is established. When looking for the reasons that SIB exists for an individual it may occur at a particular locus which may indicate the reason.

Institutional behavior
Effects of restrictive placements or institutionalization on individuals
The impact of environment on behavior has been studied in a variety of ways since the 1960s with the advent of the civil rights movement. This movement impacted the world of developmental disabilities throughout the 1960s into the 1970s through normalization. This concept introduced the idea that “hiding” away individuals with developmental disabilities from the community limited the potential and learning of the individual. Large institutions were closed and alternatives in the community were established. For many individuals with developmental disabilities integration into the community successfully occurred.

For other individuals the institutional lifestyle continued. With the closure of large institutions, the placement has often taken the form of a community setting but without community integration. For some individuals it includes incarceration or lock-up in a mental health facility. There are various causes for the restricted or institutional placement such as behavior that hurts self or others. Often these individuals are identified as having complex needs and dual diagnosis of a developmental disabilities and a mental health diagnosis.

There are a variety of side effects of placement in restricted settings.
• Learned helplessness
• Inability to transfer to less restrictive settings due to severe increase in anxiety and/or severe behavior issues.
• Continuance of excess behavior difficulties that bring further sanctions on the individual which in turn lengthens or increases the restrictiveness of the setting or actions of others within the setting.
  o Increased holds by staff
  o Less community contact.

What role does past victimization due to abuse or neglect play in later destructive behavior patterns?
Abuse and neglect are too often factors in the history of individuals with complex needs. Statistics show they are 3.4 times more likely than same-age peers to be maltreated by:
• physical and verbal abuse
• neglect of care.
• Sexual abuse.

Victimization is an issue for children as well as adults with complex needs as well as children with complex needs. It is widely reported that adults with complex needs experience high rates of physical and sexual abuse. (VERMONT, March 2005) Learned helplessness is one outcome of the emotional numbing and maladaptive passivity sometimes following victimization. Victims may learn during the victimization episode that responding is futile. This will work in their lives as learned helplessness and yet greater vulnerability. (Peterson, C. and Seligman, M.E.P. 1983)
Sexual

Human sexuality and stages of development

“Mental age” is an outdated concept sometimes used to describe individuals with complex needs especially when an intellectual disability is present. It is important to avoid falling into this trap when considering needs for individuals with complex needs. An adult with an IQ of 60 does not have the emotions and feelings of an eight-year-old, even though he or she may read or do math on a third grade level. Society often expects adults with intellectual disabilities to act childlike, and people become surprised or upset that a person with complex needs has adult feelings of sexuality, anger, caring, and anxiety.

People with complex needs usually develop sexual drives and feelings at the same ages as other individuals. However, they typically have less knowledge about sex and often have trouble picking up and giving subtle social cues.

An additional difficulty for individuals with intellectual disabilities in American society is the discrimination, stigma, or disadvantage on account of disability. For example, being called a "retard" is a common insult in our society. Many adults are reluctant to identify themselves as having an intellectual disability and resist being given that label. People with complex needs develop their own individual emotional responses and coping skills in reaction to these adversities. (VERMONT, March 2005)

What is the impact of sexual deviancy on individuals with complex needs?

In the past a guide about successful community supports required for sex offenders with developmental disabilities was not needed. Many were committed for life to institutions such as Fairview Training Center. Some were locked up for long sentences in jail. Many were sent home by a perplexed legal system to families and communities who had few, if any, supports for these complex issues. Often, the offending does not stop, there are more victims, and the cycle continues.

This guide reflects our belief that sex offenders with developmental disabilities and co-occurring disorders can live and receive treatment safely in their communities. It also reflects a belief that the best methods for support and treatment are not self-evident—that many approaches have been tried, and some have proven much more useful and effective than others. Not all the answers are currently available even in most supportive setting and there is need to keep reassessing practices. This guide should not be seen as the last word but rather the current word. (VERMONT, March 2005)

Criminal Issues

Definitions

Murder and nonnegligent manslaughter — the willful (nonnegligent) killing of one human being by another. Deaths caused by negligence, attempts to kill, assaults to kill, suicides, and accidental deaths are excluded. Justifiable homicides are classified separately.

Robbery — The taking or attempting to take anything of value from the care, custody, or control of a person or persons by force or threat of force or violence and/or by putting the victim in fear.
• **Aggravated assault** — An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm. Simple assaults are excluded.

• **Burglary - breaking or entering** — The unlawful entry of a structure to commit a felony or a theft. Attempted forcible entry is included.

• **Arson** — Any willful or malicious burning or attempt to burn, with or without intent to defraud, a dwelling house, public building, motor vehicle or aircraft, personal property of another, etc.

• **Larceny-theft (except motor vehicle theft)** — The unlawful taking, carrying, leading, or riding away of property from the possession or constructive possession of another. Examples are thefts of bicycles or automobile accessories, shoplifting, pocket-picking, or the stealing of any property or article which is not taken by force and violence or by fraud. Attempted larcenies are included. Embezzlement, confidence games, forgery, worthless checks, etc., are excluded.

• **Motor vehicle theft** — The theft or attempted theft of a motor vehicle. A motor vehicle is self-propelled and runs on the surface and not on rails. Motorboats, construction equipment, airplanes, and farming equipment are specifically excluded from this category.

**Unlawful sexual behavior**

*Is there a relationship between developmental disabilities, mental health issues, and sexual offending?*

Developmental disabilities do not cause sexual offending. There is no definitive study that shows that people with complex needs are either more likely or less likely than others to offend sexually. Most people with complex needs are law-abiding citizens. A small proportion is offenders and need to have legal constraints for the protection of society.

The U.S. Supreme Court has said that people with intellectual disabilities may be less able than others to consider the consequences of their actions and to control them. The court referred to problems with “diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others’ reactions” as a definition for diminished capacity. Atkins v. Virginia, 536 U.S. 304 (2002) Although an individual with complex needs may meet a legal definitions and be legally involved it does not alter the type of support needed to learn new skills as alternatives to inappropriate sexual behavior. Legal requirements including level of supervision may be the most significant difference.

*Are some individuals with complex needs labeled “sex offender” wrongly?*

People with complex needs often lack sexual knowledge and misperceive social boundaries and rules. Some people with complex needs may engage in behavior that is perceived as deviant, but actually reflects the individual’s lack of understanding of social rules. For these individuals, the label of “sex
offender” is misleading. Social skills training and support for positive social relationships is of paramount importance for these individuals. Other individuals with complex needs have deviant sexual arousal and are drawn to sexually abusive behavior for the same reasons as other sexual offenders and will need specialized treatment and supervision as sex offenders. (VERMONT, March 2005)

Contact with Law Enforcement
What are the effects of young people who spend significant amounts of time in restrictive or confined setting as they mature?
Growing up in confinement has a significant effect on the adolescent maturing process in typically developing and developmentally disabled populations in the following areas:

- Maturation of biological systems
- Development of cognitive abilities and personality
- Interaction with others. (The National Center of Education, Disability, and Juvenile Justice)

Unique needs of individuals with developmental disabilities who are judicially involved
The effects of most programs toward deterring future acts of criminality, drug use, or violence deteriorate quickly once individual leave the program and return to their original environment (neighborhoods, families, peer groups). There is often initial success during the course of treatment (in the facility) but lacks long term effect that generalizes to natural settings.

Unique problems of individuals with developmental disabilities when interfacing with the criminal justice system.
These may include the following:

- Initial contact with law enforcement – Individuals with an intellectual disability who become suspects in criminal cases often:
  - Lack the ability to fully comprehend questions and directions from law enforcement officers.
  - Lack understanding of the criminal justice system and rights afforded to those arrested, i.e. Miranda warning.
  - Try to hide their intellectual disability, which results in compliant, acquiescent behavior towards law enforcement and those in authority. (Association of Regional Center Agencies Forensic Task Force, “Final Report,” January 2002).

- Competence to Stand Trial – Persons with developmental disabilities often stand trial even though they may not be competent to understand the proceedings or to assist in their own defense. (Association of Regional Center Agencies Forensic Task Force, “Final Report,” January 2002).

- Incarceration – Defendants with intellectual disability are at greater risk of being incarcerated than non-disabled suspects and are more likely to endure less favorable treatment and to suffer abuse (physical and verbal) from other inmates.

- Probation is less frequently granted to offenders with intellectual disability and they have more difficulty adjusting to prison routines,(Association of Regional Center Agencies Forensic Task Force, “Final Report,” January 2002).
Resources

MR/ID Clients and the Legal Systems They Encounter, Lee Savage lsavage@forois.org

Forensic Project, Guidebook and Resource Directory, South Central Los Angeles Regional Center, 2002

Self Injury in Individuals with Intellectual Disabilities: Author: Kelley M Gordham
Oregon Intervention System,


Cutting & Self-Harm: Warning Signs and Treatment, Jeanie Lerche Davis, WebMD Feature


Carol Cramer Brooks, Growing up in Confinement ,NJDA Center for Research and Professional Development School of Criminal Justice, Michigan State University, , 2001
Section 1: Co-occurring Development Disabilities and Mental Health Issues

Module 3:

Accessing Community Mental Health Services – An Overview, Greenwood, 2009

This overview provides a quick look at:
- how to access mental health services
- how these services are funded
- when to consider a Mental Health Assessment
- treatment options

Supporting Individuals with Complex Needs – Community Awareness, Perez, 2009

- 2 DVDs (See GRO DVD Presentation Notebook: Supporting Individuals, Perez)

This is a PowerPoint presentation.

This presentation provides awareness information about DD/MH Diagnoses with a focus on specific diagnoses: PTSD, Bipolar, and Borderline Personality Disorder. Information about Characteristics, Facts, and Treatment is presented and how executive functioning can affect the person. This presentation concludes with support strategies focusing on environmental and the combined approaches used in the Mental Health and Developmental Disabilities fields.
Accessing Community Mental Health Services

An Overview

Access to Mental Health Services

People who experience a developmental disability may have mental health needs that require attention from a mental health professional in the same way that they have physical health needs that require assistance from a dentist, nurse or doctor. While the incidence of co-occurring DD and mental health diagnoses for adults in Oregon is unknown, crisis data for the state indicates that about 40% of the DD referrals to the regional crisis system report a co-occurring mental health diagnosis.

In Oregon, services for adults who experience developmental disabilities are managed by Community Developmental Disability Programs (CDDPs) or brokerages. These agencies assist with service development, crisis services and information and referral. They can be a resource for an individual, family member or provider who is trying to find mental health services for someone with a developmental disability. A list of CDDPs and brokerages can be found on the state Seniors and People with Disabilities website at http://www.oregon.gov/DHS/spd/.

Mental Health Service Funding

Mental health (also referred to as behavioral health) services are generally paid for by an individual’s insurance plan. People may have private insurance, Oregon Health Plan (OHP) insurance or Medicare. Mental health benefits through the OHP are explained in the OHP member handbook which can be found on the web at http://dhsforms.hr.state.or.us/Forms/Served/HE9035.pdf. Local mental health programs in Oregon also receive funds to help low income people who are uninsured access mental health services. A CDDP services coordinator or brokerage personal agent can assist with locating these resources.

When to consider a Mental Health Assessment

While each individual is unique, mental health issues may develop in children or in adults. A rule of thumb for families and providers is to first rule out a medical cause for any new behavior that is different from “baseline” for someone. A painful ear infection, urinary tract infection or toothache can cause behaviors that mimic some of the signs of mental illness. When medical causes for extreme behavior changes have been ruled out and the behavior/behaviors persist, a referral to a mental health professional may be appropriate.

As with accessing medical treatment, it is important for someone involved in an individual’s life to be able to describe what a person is doing that is of concern. The quality of a mental health assessment depends on the quality and accuracy of the report given to the assessor. While it is not necessary for the reporter to have a mental health background, it is helpful to be able to describe symptoms in a factual way i.e. “he is sleeping less, more”, “she is more withdrawn and not relating to others in her typical way”, “she has been crying a lot”, “he appears to hear voices that are not there’, etc.
**Treatment Options**

Depending on the outcome of a mental health assessment and whether or not a mental health diagnosis is warranted, an individual may need short term or long term treatment from a mental health professional. This treatment may include individual and/or group therapy, medication or in some cases, hospitalization. In addition to self-reporting, the mental health professional or team of professionals will rely on an individual’s advocate from the DD system to report changes in behavior, reactions to medications, etc. Successful treatment depends on the DD and mental health team members working together.

**Summary**

Steps you can take to help someone who experiences a developmental disability and may need mental health services:

- Contact a local CDDP or brokerage for referral information
- Become acquainted with the individual's insurance benefits for mental health services
- Use observation and communication skills to make appropriate referrals
- Cultivate relationships with mental health providers once they become involved in someone's life
Supporting Individuals with Complex Needs - Community Awareness, Christie Perez

i. About the presenter

ii. Pre/Post test (Blank and Key)

iii. PowerPoint presentation
Supporting Individuals with Complex Needs
Community Awareness

Presenter: Christie Perez

Christie has worked with children and adults with developmental disabilities and/or mental health diagnoses in various settings for over 14 years. She is experienced in providing assistance to families and support providers in agencies and homes regarding technical assistance, functional behavioral assessment of challenging behaviors and the development of behavior support plans. She is a skilled OIS instructor and is a member of the OIS Steering Committee. Christie has worked collaboratively with many agencies and families around the state to ensure effective delivery of support. Before coming to OTAC in 1996, she received a Bachelor of Science degree in Psychology and English/Writing from Linfield College.
Supporting Individuals with Complex Needs: Community Awareness 2009
Presenter: Christie Perez

Pre/Post-Assessment

1) Individuals who have difficulty with the executive functioning of the brain: (Circle the most accurate answer)
   a. Cannot be supported without medications
   b. Need immediate medical assistance
   c. Can benefit from cognitive behavioral and environmental supports
   d. Require constant supervision and assistance

2) The “executive functioning” processes of the mind: (Circle the most accurate answer)
   a. Is often referred to when describing such combined cognitive abilities of planning, organizing, strategizing, and impulse control
   b. Primarily assists in the execution of basic bodily functions such as breathing, heart rate, and digestion
   c. Functions as the primary construct to assist in understanding spatial and temporal relationships
   d. Aids in constipation issues
   e. All of the above

3) The primary purpose of structure is to: (Circle the most accurate answer)
   a. Prevent non-compliance
   b. Get people to adhere to the schedule
   c. Prevent problem behaviors
   d. Provide a prosthetic to assist the person’s brain with processing and understanding to improve functioning levels in areas of daily living
   e. Avoid having to write incidents reports

4) Individuals with intellectual and/or cognitive disabilities have higher rates of mental health issues than the general population. (Circle one)
   True   False

5) Individuals with mental health issues are best supported with an individualized approach that provides the person choice and control in their life and treatment in addition to environmental and cognitive behavioral approaches. (Circle one)
   True   False
Supporting Individuals with Complex Needs: Community Awareness 2009
Presenter: Christie Perez

KEY
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Growing Resources in Oregon

Individuals with Complex Needs
General Information and Supports

Overview

- Developmental Disabilities
- Mental Health
- Dually Diagnosed
- PTSD, Bipolar, and Borderline Personality Disorders
  - Characteristics
  - Facts
  - Treatment
  - DM-ID
- Executive Functioning and deficits
- Environmental and Behavioral Supports with emphasis on Recovery Model and PBS

Developmental Disabilities
Definition of developmental disabilities

- Term used to describe life-long disabilities with genesis within the brain which affects mental and/or physical disabilities that manifest prior to the individual reaching a certain age, requires ongoing and/or specialized supports, and effects functionality in areas of:
  - Self care
  - Receptive/expressive language
  - Learning
  - Mobility
  - Self direction
  - Financial self sufficiency
  - Capacity for independent living

Common types of developmental disabilities

- Intellectual Disability (ID)
- Developmental Disability (DD)

Intellectual Disability

- Must be determined prior to the age of 18 years
- Generally IQ of 69 or lower for clearly defining ID
- Questionable 66-75
Developmental Disability

- Must manifest prior to the age of 22 years
- Medical or clinical diagnosis which significantly and directly impairs functioning
  - Autism Spectrum Disorder (ASD)
  - Cerebral Palsy (CP)
  - Traumatic Brain Injury (TBI)
  - Down Syndrome
  - Fragile X Syndrome
  - Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE)

Associated Issues

- Physical health
- Mental health
- Communication
- Social
- Exploitation and Abuse
- Behavioral

Accessing the DD System

- The county in which the individual lives determines eligibility based primarily on the review of professional documentations and formal evaluations/assessments
- Contact the local County Developmental Disabilities Program (CDDP)
- Eligibility process should begin within 10 working days after the CDDP receives the application for services
DD Support

- Based on eligibility findings, individual needs, and area resources
- Common types
  - Service coordination
  - Support services
  - Comprehensive support

Additional information: http://oregon.gov/DHS/dd

Mental Health

Definition

- Mental Health:
  "Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder" (Wikipedia).

- Mental Illness or Mental Health Issue:
  "A mental disorder or mental illness is a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture" (Wikipedia).
Diagnosing mental health issues

- Diagnostic and Statistical Manual of Mental Health Disorders

Axis- what does that mean?

- The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:
  - **Axis I**: clinical disorders, including major mental disorders, as well as developmental and learning disorders
  - **Axis II**: underlying pervasive or personality conditions, as well as mental retardation
  - **Axis III**: acute medical conditions and physical disorders
  - **Axis IV**: psychosocial and environmental factors contributing to the disorder
  - **Axis V**: Global Assessment of Functioning or Children’s Global Assessment Scale for children and teens under the age of 18

General Categories of Axis I or II Psychiatric Disorders

- Mood Disorders
  - Depression, Bipolar
- Anxiety Disorders
  - Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD), Generalized Anxiety Disorder
- Thought Disorders
  - Schizophrenia, schizoaffective
General Categories cont...

- Disruptive and Impulse Control Disorders
  - Oppositional Defiant Disorder, ADHD, Intermittent Explosive Disorder

- Sex and Gender Identity Disorders
  - Sexual Dysfunctions, Paraphilias, Gender Identity

- Personality Disorders
  - Borderline, Antisocial, Histrionic, Schizoid Personality Disorders

Accessing Mental Health Services

- State, County, and private mental health providers can be accessed for in-patient or out-patient care:
  - Private medical insurance
  - Medicare/Medicaid
  - Private pay
  - As a result of court order

Supports

- Case management
- Medication management
- Therapy and counseling
- Support groups
- Child and adolescent day treatment
- Residential
- Foster Care
- Supported employment
- Hospitalization
Resources

- American Psychiatric Association
  1000 Wilson Boulevard, Suite 1825
  Arlington, VA 22209-3901
  (888) 357-7924
  www.psych.org

- American Psychological Association
  750 First Street, NE
  Washington, DC 20002
  1-800-374-2721
  http://locator.apa.org/

Resources continued...

- National Association of Social Workers
  750 First Street, NE, Suite 700
  Washington, DC 20002
  (202) 408-8600
  www.naswdc.org

- This Mental Health Services Locator may also be of help:
  mentalhealth.samhsa.gov/databases/default.aspx

Dually Diagnosed
Dually Diagnosed

Individual has both a developmental disability (and or intellectual disability) in conjunction with a co-occurring diagnosis of mental illness.

“We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower.”

John F. Kennedy

According to the National Association for the Dually Diagnosed (NADD)

- Individuals with ID are 2-4 times more likely than those in the general population to experience psychiatric disorders.
- Individuals with ID and mental health issues are often underidentified.
- Sufficient mental health treatment for this population is lacking.
Our focus....

- The characteristics and research on Post-Traumatic Stress Disorder, Bipolar and Borderline Personality Disorder
- Behavioral theory and positive behavior support tools

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When Sam drags his bag into work, is otherwise slow moving, and does not make eye contact (FAE, PTSD, Depression)

- Assess Sam's status every morning
- Provide visual schedule
- Structured activity systems
- Increase exercise

- Staff use assertive communication
- Alter task/person or environment
- Use schedule to prompt transition
- Reduce demands on days Sam is demonstrating these behaviors

Sam yells, throws chairs and smaller items, and threatens staff

- Teach self control and stress management
- Teach to use a problem solving card to ask for a schedule check, a break in the lunch room, or access to his headphones
- Reward use of problem solving structure
- Reward all smooth transitions
- Go for a walk to the store after work everyday

In an attempt to avoid working with Tom and avoid work in the bathroom

- Provide visual schedule
- Structured activity systems
- Increase exercise

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Posttraumatic Stress Disorder - PTSD
A. Exposure to a traumatic event that elicited intense fear, helplessness, or horror.
B. The traumatic event is persistently re-experienced.
C. There are persistent efforts to avoid feelings, thoughts, or conversations about the trauma.
D. Persistent feelings of increased arousal.

General PTSD Facts
- Individuals diagnosed with PTSD oftentimes have co-occurring mental health diagnoses
- PTSD patients have higher rates of medical visits
- Risk factors for a diagnosis of PTSD include IQ level, lower educational levels, poor sense of personal control, and pre-trauma mental health co-morbidity.

Treatment
- Exercise
- Cognitive Behavioral Therapy (CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Family therapy
- Medication
- Environmental structure and visual strategies
  - Choice and control
  - Understand, avoid and cope through triggers and stressors
  - Stress and stress management plans
- Practice and prompt alternative strategies
- Communication/social skills
- Executive functioning deficits
DM-ID under category of PTSD

- Individuals with ID and DD are more susceptible to the development of PTSD
- Events that appear to be “non-traumatizing” can illicit the development of PTSD in individuals with ID
- Oftentimes providers may report the individual is “non-compliant” however these may be efforts to avoid or symptom of diminished interest

PTSD and ID continued

- Individuals oftentimes act out their PTSD symptoms behaviorally as opposed to having “flashbacks” or recurrent thoughts, images, or memories of the abuse.
- Reports of frightening dreams without recognizable content,
- Individuals with ID can and do benefit from psychopharmacology and therapy.

Bipolar I Disorder

A. Presence of one or more manic or mixed episode
B. Presence of one or more major depressive episode
Manic Episode

A. Elevated, expansive, or irritable mood lasting at least 1 week or any duration if severe enough to be hospitalized.
B. The person demonstrates with 3 or more symptoms of elevated or expansive mood (4 if the mood is only irritated).

Major Depressive Episode

A. 5 or more symptoms must be present in the same two week period and is a marked departure from typical behavior. Symptoms will occur nearly every day.
B. Does not meet criteria for a mixed episode.
C. The symptoms are not due to drugs, medicine, or medical causes and is not due to loss of a loved one.

General Bipolar Facts

- Bipolar has a genetic link
- Extreme stress, disrupted sleep patterns, and drugs/alcohol may trigger mood episodes in vulnerable individuals
- Rates for Bipolar Disorder and Major Depressive Disorder increase markedly after puberty
- Affects men and women equally
- 15-19% of individuals with a bipolar diagnosis will commit suicide
Treatment

- Medications
- Cognitive Behavioral Therapy
- Family therapy
- Environmental structure and visual strategies
  - Choice and control
  - Communication/social
  - Coping strategies and self management plans
  - Daily charting of moods and triggers
  - Relaxation strategies
  - Executive functioning deficits

DM-ID Recommendations for Accurate Diagnoses

- May take longer to achieve an accurate diagnosis than with general population
- Diagnosticians should spend additional time reviewing family history, gaining information on baseline level of functioning, interviewing the person and provider, and observing behaviors
- Marked changes in mood that are significant may occur as a result of rapid changes in medication, sleep problems, health issues, and drug side effects

DM-ID Adapted Criteria for Manic Episode

- Observers may report:
  A. Loud inappropriate laughing, singing, or vocalizations. Giddiness or silly behaviors. Individual may increasingly violate personal and conversational boundaries. May smile excessively in contexts where it does not make sense to smile. Elated mood and depressive mood may alternate.
Adapted Criteria cont...

- For individuals with considerable issues with expressive communication, during the period of mood disturbance, the individual need only demonstrate two or more symptoms and three if the mood is only irritable:
  1. Claims of extraordinary skills/abilities/power
  2. May sleep 0-3 hrs/night
  3. Increase in talking or vocalizations
  4. Changes conversational topic quickly
  5. Distractibility
  6. Increased psychomotor activity
  7. Great increase in pleasurable activities

Adapted Criteria for Major Depressive Episode

- Four of more symptoms during the same 2 week period and at least one must be either a depressed or irritable mood or loss of interest/pleasure
  1. Change in eating patterns/loss or gain weight
  2. Sleep issues
  3. Psychomotor agitation
  4. Fatigue, lethargy, or loss of energy
  5. Excessive feelings of worthless or guilty
  6. Easily distracted and difficulty concentrating
  7. Suicidal ideation or acts

DM-ID under category of Bipolar Disorder

- Individuals with ID experience more rapid cycling between depressive and manic states than does the general population
- Individuals with ID and Bipolar Disorder often present with self injurious and assaulitive behaviors in both depressive and manic states
- Individuals with ID are at higher risk for sleep disorders or problems which may act as a trigger for manic or mixed episodes
Abnormal serotonin levels may play a role in the development of mood disorders.

Medical issues including higher rates of thyroid dysfunction may increase risk for depression and may be a risk factor for rapid cycling.

Individuals with Down Syndrome are at increase risk for depression but diagnoses of bipolar are relatively rare.

Individuals with Fragile X and Fetal Alcohol Syndrome may be at increased risk for bipolar disorder.

Research indicates nearly 70% of individuals diagnosed with Velo-Cardio-Facial Syndrome demonstrate with bipolar symptoms by adolescence and 100% by adulthood.

Increased risk of depression for individuals with Phenylketonuria. Without treatment, mania can be a risk with a phenyl-free diet.

Clustering A (odd, eccentric)
  - Paranoid
  - Schizoid
  - Schizotypal

Cluster B (dramatic, emotional)
  - Antisocial
  - Borderline
  - Histrionic
  - Narcissistic
The central feature of borderline personality disorder is a pervasive pattern of unstable and intense interpersonal relationships, self-perception, and moods. Impulse control is markedly impaired. Transiently, such patients may appear psychotic because of the intensity of their distortions. Diagnostic criteria require at least 5 of the following features:

- Frantic efforts to avoid expected abandonment
- Unstable and intense interpersonal relationships
- Markedly and persistently unstable self-image
- Impulsivity in at least 2 areas that are potentially self-damaging (eg, sex, substance abuse, reckless driving)
- Recurrent suicidal behaviors or threats or self-mutilation
- Affective instability
- Chronic feelings of emptiness
- Inappropriate and intense anger
- Transient paranoia or dissociation
More common diagnoses for women than men
Between 40-71% of patients report a significant abuse history
High rate of self injurious behavior, but not necessarily suicidal attempts
Often occurs with other psychiatric diagnoses such as bipolar, depression, anxiety, substance abuse, and other personality disorders
Recent research indicates that individuals with a history of childhood trauma have smaller than usual hippocampus, amygdala, corpus callosum, and prefrontal cerebral cortex (including executive functioning)

People with ID are oftentimes more reliant on support providers
Identity disturbance may be very difficult if not impossible to accurately ascertain without sophisticated judgment
Self injurious behaviors are higher in the ID population and may occur in several MH diagnoses

CBT
Dialectical Behavioral Therapy
- Stress management plans
- Coping strategies
- Relaxation strategies
- Communication /social skills
Individual Therapy
Group Therapy
Family Therapy
Medications
- Environmental structure and visual strategies
  - Choice and control
Executive Functions

- Planning
- Organizational skill
- Maintaining a mental set
- Selective attention
- Inhibitory control

Executive Functioning allows us to:

- Make and achieve goals
- Plan
- Organize
- Sequence
- Keep track of time
- Prioritize
- Initiate
- Have flexible thinking
- Adapt socially

- Keep track of more than one thing at once
- Problem solve
- Inhibit
- Shift
- Pace
- Evaluate plans
- Self-monitor
- Control emotions*

ISIS

- When there is dysfunction in the executive function, it occurs within the “infrastructure” referred to as “ISIS”:
  - Initiate
  - Sustain
  - Inhibit
  - Shift
“Sub-Functions” of Executive Function

- Operation of working memory
- The internalization of self-directed speech
- Controlling emotions, motivation and state of arousal.
- Reconstitution, actually encompasses two separate processes:
  - breaking down observed behaviors and
  - combining the parts into new actions not previously learned from experience.

What does all that mean?

- There are “lagging skills and unsolved problems” in the following areas:
  - Executive Skills
  - Memory Skills
  - Cognitive Flexibility Skills
  - Language Processing Skills
  - Emotional Regulation Skills
  - Social Skills

Issues with “Executive Skills”

- Inability to “multitask”
- Difficulty with transitions
- Difficulty with the correct sequence of an activity
- Lack of problem solving skills
- Disorganized
- Often very impulsive
**Issues with Memory Skills**

- Difficulty remembering current information while thinking of something else
- Difficulty with learning from experience
- Loses things easily
- Forgets what to do
- Incessantly talking to self
- Issues with “working memory”

**Issues with “Cognitive Flexibility Skills”**

- Concrete and literal, often very rigid or rule bound (PDD, OCD)
- Difficulty with ambiguity, lack of predictability, abstract concepts
- Often very perseverative
- Difficulty shifting from one idea to the next, from one plan to the next, moving on without “completing” the activity
- Inflexible, inaccurate interpretations or cognitive distortions

**Issues with “Language Processing Skills”**

- May have extreme processing difficulties
- Extreme delay in responding
- Difficulty expressing thoughts and needs
- Difficulty knowing or saying how they feel
Issues with “Emotional Regulation Skills”

- Often moody. May react in cranky, grouchy, or irritable manner
- May fatigue or become tired frequently
- Often anxious, worried, fearful
- Often sad, may react as if depressed
- Frustrates very quickly

Issues with “Social Skills”

- Difficulty attending to or misreading social cues
- Difficulty recognizing nonverbal social cues
- Difficulty seeing someone else’s point of view
- Seems unaware of how own behavior may affect others
- Low self esteem
- Lacks empathy

Disabilities associated with executive dysfunction

- MR/DD
- Autism Spectrum Disorders
- Fetal Alcohol Spectrum Disorder
- Learning Disabilities
- NVLD
- OCD
- Tourette’s Syndrome
- Anxiety
- Depression
- Schizophrenia
- ADHD and ADD
- Bipolar Disorder
- Borderline Personality
- PTSD
What are the results?

- Oftentimes the person feels very stressed by his/her environment
- As a result of the stress and difficulty processing the person may be much more reactive to even small internal and external stressors
- The person may engage in challenging behaviors

Common Behavioral Issues

- Aggression to others
- Self injurious behavior
- Suicidal behaviors
- Property destruction
- Threats/Intimidation
- Inappropriate interpersonal boundaries
- Inappropriate sexual behaviors

Stress Cycle:

We usually don’t feel stress building up.
It is silent.

Baseline - When calm the brain is taking in 80%+
things are voluntary!

Trigger - As the biological (chemical/hardwiring) & interaction with the brain arousal increases, there is less voluntary control

Crisis - Neurological (nervous system), biological (relating to life and living process) & cognitive (factual knowledge) failure

Escalation - As arousal increases, failure in the brain’s command center (Executive Function) is experienced

De-escalation

Stabilization

Post Crisis Drain
Support strategies

Combined Efforts

- DD
  - Positive Behavior Support
  - Person Centered Planning and thinking
  - Self Determination
- Mental Health
  - Recovery Model
  - Medication
  - Treatment/Therapy

Three variables demonstrated by early physiological psychologists to be closely related to the management of stress and it’s aftermath:
- Prediction
- Control
- Outlet
**Prediction**

- Routine
- Schedules
- Information
- Notice
- Communication
- Choice

**Control**

- Choice
- Communication
- Understanding
- Problem Solving
- Social Skills
- Transition skills

**Outlet**

- Exercise
- Communication or Expression
- Social Relationships
- Regular social contact
Challenges to communication

- Difficulty expressing thoughts and needs
- Processing delays
- Difficulty putting vocabulary to abstract concepts such as feelings
- Under stress-existing language skills deteriorate

How do we effectively adapt our communication?

- Simplify and slow down
  - Slow down the pace.
  - Reduce number of sentences/words.
  - Don’t repeat till you have given a chance to respond:
    45 second rule.
- Word inquiries (questions) as completion phrases:
  - “Tell me why you……”
  - “Tell me what you want to do after……”
  - “Tell me about……”
- Avoid slang.
- Avoid vague terms such as “Don’t know”, “Later”, “Maybe”.
- Avoid sarcasm.
- Limit the use of abstract language.
- Keep promises!
Talking with visual help

- Give directions following visual support guidelines
- Provide accurate, prior information about changes and expectations through visual descriptions
- Enhance language and communication with visual cues
  - Talking symbol
  - Written scripted conversations
  - Conversation rehearsal before an event
  - Video modeling or rehearsal
  - Words, phrases, or communication opportunities imbedded into activity schedules
  - Communication partners to explain communication cues: “I am holding up my hand to ask you to pause so that I can ask a question”

So what is Structure and Visual Strategies?

- Strategies of organization, instruction, direction, interaction and environmental design that proactively and prosthetically improve, enhance, or support a person’s cognitive, sensory, and emotional processing

Visual Strategies continued

- Most of us rely on a host of visual strategies
  - Center lines and fog lines
  - Color coded labels in our file cabinet
  - Picket fences
  - Area rugs
  - Calendars
  - GUI’s
Some Components of Structure:

- Physical structure
- Visual schedules
- Routine
- Work systems
- Visual strategies
- “Social” structure

Higher Order Structure

- Incentive / feedback systems
- Formal roles
- Formal meeting processes
  - Agenda
  - Minutes
  - Goal or objective setting
- Organizational aids

continued

- Planning tools
- Lists
- Social stories
- Contracts
- Writing or illustrating plans or rules
- Structured problem solving
- Exercise
Continued

- Self control plans
- Stress management plans
- Rules
- Multi-modal representation
- Psychotherapy
- Cognitive-Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)

Jill

- Age 24
- History of neglect, physical abuse, sexual abuse as an infant, child, and adolescent
- Removed from biological family, adopted at age two
- History of institutionalization starting age 13
- Over the years has had a variety of diagnoses: ADHD, Bipolar disorder, schizo-affective disorder, PTSD, BPD, and of course, oodles and gobs of a variety of medications to boot
- Recently diagnosed with Aspergers Syndrome and Borderline Personality Disorder.
- Caught in a cycle of attempts and failures leave the state psychiatric hospital

Problems

- Panic attacks 2 – 3 times a week
- Rages 2 – 3 times a week
- Threats to harm self and others 3 – 4 times a week
- Self-injury 2 – 3 times a month
- Assaulting staff 2 – 3 times a month
- Suicidal gestures and attempts 1 – 2 times a month
- Worries, bargains, manipulates about food (overweight) daily
Processing Issues Related to Psychiatric Disorders

- Attention deficit
- Distractible
- Executive dysfunction
- Emotional dysregulation
- Perseveration (especially when stressed)
- Difficulty learning
- Sensory memory problems

When Jill is stressed and has argued with her mother (Borderline Personality Disorder)

- Jill yells, threatens, bangs her head, threatens suicide, runs toward street
- Gaining attention, 'external' control, and avoiding intense interpersonal emotion

Live alone with staff in suburban home
- Increased structure with phone schedule, visit schedule, Graphic schedule (daily, weekly, monthly)
- Customized DBT
- Friendship tree

• Meals & snacks planned ahead
• Staff anticipate this dynamic & cue self-control skills & preemptively provide increased support
• Staff practice Assertive Communication

Customized DBT
To learn skills that will in part function as replacements
• Staff help with DBT “homework”
• Replacement skill lists posted on walls
• Staff prompt or facilitate use of skills

Staff acknowledge Jill's effort w/ DBT
• Staff acknowledge use of alternative skills
• Self-monitoring based feedback & incentive system

Questions?.....

Thank you!
Resources and References

- Oregon Intervention System 2002 and 2008
- http://oregon.gov/DHS/dd
- http://thenadd.org

07AC 2008
Section 1: Co-occurring Development Disabilities and Mental Health Issues

Module 4:

- 3 DVDs (See GRO DVD Presentation Notebook: Social Conflicts, Mates)

This is a PowerPoint presentation.

This training provides insight into how mental health issues impact a person with a developmental disability. Dr. Mates focuses on individuals who have anxiety disorder, bi-polar disorder, Asperger Syndrome and who have been involved in the judicial court system. Included in his presentation are interviews with individuals who have these diagnoses.

Dr. Mates discusses different treatment approaches with a focus on cognitive behavior therapy.

Autism History & Facts, OTAC, 2009

Understanding Autism – Characteristics and the Brain Functions, OTAC, 2009

These are both PowerPoint presentations.

Autism, facts and history provides and the latest (2009-10) biomedical research. Understanding Autism gives the viewer information about the symptoms of autism and how the brain functions are impacted. The information in this presentation is key to being able to fully assess behavior. (See section 2: Strategies to Help Reduce Difficult Behavior and Section 4: Positive Behavior Supports)
Co-occurring Diagnoses and Treatment Approaches
Social Conflicts for People with Developmental Disabilities: A Clinical Perspective

Presenter: Thomas E. Mates, Ph.D.

Dr. Mates is a clinical psychologist in private practice in Wilmington, N.C. He specializes in the assessment and treatment of people with developmental learning problems and affective disorders. He is the past clinical Director of Wilmington TEACCH Center and Associate Professor – Department of Psychiatry of UNC-Chapel Hill. His training includes a Post-Doctoral fellowship in Developmental Disabilities and Pediatric Psychology at the Division for Disorders of Developmental Learning, University of North Carolina – Chapel Hill.

Dr. Mates has an extensive background that includes working in the judicial system in North Carolina and with youth involved in the New York court system. In his current practice, he provides treatment for individuals whose lives are affected by mental health and developmental disability disorders. He works closely with physicians, psychiatrists, and attorneys. He is a member of the AFCC – Association of Family and Conciliation Courts, and he is frequently called upon to consult regarding legal issues involving youth with and without developmental disorders.

Since 1996, Dr. Mates has provided seminars focusing on autism and Asperger’s Syndrome and co-existing mental health issues in Oregon. OTAC and the GRO project are pleased that he is back to teach us about social conflicts for people with developmental disabilities and mental health issues.
Co-Occurring Diagnoses and Treatment Approaches Outline
Social Conflicts for People with Developmental Disabilities:
A Clinical Perspective

Presented by Thomas E. Mates, Ph.D., Clinical Psychologist

OVERVIEW of HUMAN SOCIAL BEHAVIOR

- Biological Basis
  - Temperament
  - Affect
  - Genetic Disorders
- Learned Behaviors
- Personality Development

DEVELOPMENTAL DISABILITIES

- Mental Retardation
  - Definition
  - Adaptive Behavior
  - Characteristics of Impaired Mental Age
- Autism
  - Definition & Implications for Social Conflict
- Asperger Syndrome
  - Definition & Implications for Social Conflict

AFFECTIVE DISORDERS

- Anxiety
- Bipolar Disorder
- Schizophrenia
- ADHD
- Oppositional Defiant Disorder & Conduct Disorder

VIDEO INTERVIEW OF PEOPLE WITH DUAL DIAGNOSIS

TREATMENT

- Prevention
- Behavior Modification
- Cognitive Behavior Therapy
- Medication

QUESTION/ANSWER SESSION
Pre/Post-Assessment

Please complete this assessment. For all of our GRO trainings we are compiling data that reflects whether the information presented has increased the knowledge of the participants. These initial questions will tell us what you knew before the training and then you will re-answer later on the post-assessment. This will tell us if this training allows you to gain information on the topic presented. We appreciate your taking part in this learning tool.

1) Human Social Behavior is? (Circle the most accurate answer)
   a. Biological based
   b. Learned
   c. Has a genetic component
   d. All of the above

2) Which of the following statements is true? (Circle the most accurate answer)
   a. All people with developmental disabilities have an affective disorder
   b. Some people with developmental disabilities have an affective disorder
   c. No people with developmental disabilities have an affective disorder
   d. Developmental disabilities and affective disorders mean the same thing

3) Cognitive Behavior Therapy primarily focuses on? (Circle the most accurate answer)
   a. Changing behavior
   b. Thoughts, feelings, behavior, physiology
   c. Changing emotions
   d. Proper medications
Video Conference: Co-Occurring Diagnoses and Treatment Approaches
Presenter: Thomas E. Mates, Ph.D.

KEY
Pre/Post-Assessment

Please complete this assessment. For all of our GRO trainings we are compiling data that reflects whether the information presented has increased the knowledge of the participants. These initial questions will tell us what you knew before the training and then you will re-answer later on the post-assessment. This will tell us if this training allows you to gain information on the topic presented. We appreciate your taking part in this learning tool.

1) Human Social Behavior is? (Circle the most accurate answer)
   a. Biological based
   b. Learned
   c. Has a genetic component
   d. All of the above

2) Which of the following statements is true? (Circle the most accurate answer)
   a. All people with developmental disabilities have an affective disorder
   b. Some people with developmental disabilities have an affective disorder
   c. No people with developmental disabilities have an affective disorder
   d. Developmental disabilities and affective disorders mean the same thing

3) Cognitive Behavior Therapy primarily focuses on? (Circle the most accurate answer)
   a. Changing behavior
   b. Thoughts, feelings, behavior, physiology
   c. Changing emotions
   d. Proper medications
A. Social intelligence is the ability to analyze information coming from others concerning their thoughts and feelings
B. Develop expectations about the behavior of others
C. Draw inferences about the social situation and act accordingly

Social success requires extracting meaning from:
a) The general physical context of the interaction
b) The nature of the social interaction
c) The speech of the other person
d) The body posture of the other person
e) The facial expressions of the other person

(Gaus, V. 2006)
**BIOLOGICAL BASIS of BEHAVIOR**

- Cognitive Ability: IQ, intuition, SIQ, Executive Functioning
- Temperament: Assertiveness, motivation, aggression, cooperation
- Affect: Anxiety, Bipolar
- Genetic Disorders (i.e., XYY Syndrome)

**LEARNED BEHAVIORS**
- This includes naturally and specifically reinforced behavior, modeled behavior, and environmentally shaped behavior

**PERSONALITY DEVELOPMENT**
- This includes the continued development of "traits" reinforced by others and the environment

**DEVELOPMENTAL DISABILITIES**
- Mental Retardation
- Autism
- Asperger’s Syndrome
MENTAL RETARDATION – DSM IV

- Impaired Cognitive Functioning includes: executive functioning, integrative, sequential, abstract, verbal, and visual problem solving
- Adaptive Behavior includes: Conceptual, Social, and Practice problem solving
- Mental Age of maximum 14 yrs. (consider the judgment, self control, impulsivity, of a 14 yr. old in a 25 year old body)

AUTISM – DSM-IV

- Atypical Social Development
- Atypical Communication Skills
- Restrictive, Repetitive and Stereotypic Behavior
- Onset before 3 yrs
- Not attributed to other explanation

Social Development

- Eye Contact
- Seek comfort/Separation
- Play with toys
- Sharing
- Reciprocity
- Empathy
- Theory of Mind
- Visual Cues
- Emotional Control
- Motivation
“It is very difficult for even a higher-functioning autistic adult to know exactly when to say something, when to ask for help, or when to remain quiet. To such a person, life is a game in which the rules are constantly changing without rhyme or reason.” (A. Carpenter, 1992)

Cognitive Characteristics of Autism
- Focus on Irrelevant Details
- Problems with the “Big Picture”
- Poor Generalization
- Concrete Thinking
- Difficulty Integrating Information and Actions
- Problems with Organization and Sequencing

Social Characteristics of Autism
- Poor Boundaries
- Aloof and ignores
- Touches inappropriately
- Poor eye contact
- Atypical expression of emotions (+/-)
- Approach /Avoidance
- Misinterprets others intent
ASPERGERS – DSM-IV

- Qualitative Impairment in Social Interaction
- Restrictive, repetitive and stereotypic patterns of behavior, interests, & activities (cognitive)
- Clinically significant impairment in social, occupational, or other important areas of functioning
- No delay in language
- No delay in cognitive development

COGNITIVE CHARACTERISTICS

- High Verbal IQ
- Strong Vocabulary
- Strong Interest in Reading
- Good Memory for Facts
- Literal and Sequential Thinker
- Self Taught

Weak Executive Functioning Skills:
- Inhibiting
- Planning
- Shifting
- Self Regulation
- Goal Setting
- Distraction
- Frustration
**COGNITIVE CHARACTERISTICS**

Social Deficits:
- Poor eye contact
- Poor Joint Attention to verbal topic
- Trouble shifting topics
- Weak or simple sense of humor

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**COMORBID DIAGNOSIS**

- Affective Disorders such as Anxiety, OCD or Depression
- Behavior Disorders such as ODD, ADD
- Cognitive Disorders such as NVLD
- Sensory Deficit Disorders

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> Volkmar and Cohen noted the overlap between NLD and AS. In NLD there is an overreliance on explicit, verbal, analytical, and piecemeal information processing and an under reliance on intuitive, nonverbal, and holistic information-processing. Such a style fosters high performance on circumscribed and logical tasks and activities. In the social realm much of the context of social interactions which are primarily transmitted through nonverbal cues or suprasegmental aspects of speech, are lost because of the exclusive emphasis on the explicit aspects of social transactions (literal semantic message). Non linguistic language (figurative, humor, irony) in which people say what they do not mean and mean what they do not say, is a great problem. (Volkmar and Cohen, 1991)
"I don't know how to answer, "How do you feel"

People with anxiety have social problems because they think about how they come across and how things are going. People with AS have social problems because they don’t know what or have anything to say.

AFFECTIVE DISORDERS & MENTAL ILLNESS
- Anxiety: Characterized by insecurity, fear, aversion, ‘Fight or Flight’, rigidity.
- Bipolar Disorder: Characterized by mania, empowered, psychotic thinking, aggression.
- Schizophrenia: Characterized by delusions, hallucinations, disorganized speech, motor abnormalities, paranoia.
- OCD: Characterized by intrusive thoughts, hoarding, rituals, compulsive behaviors, thoughts of violence and sexual.
- ADHD
- Oppositional Defiant & Conduct Disorder
- Psychopathic Personality Disorder

AFFECTIVE DISORDERS, MENTAL ILLNESS & SUBSTANCE ABUSE
- ADHD: Characterized by impulsivity and executive functioning deficits
- ODD & CD: chronic negativity, defiance, angry, aggressive, destructive, illegal behavior, and truancy
- Substance Abuse: Many people with DD will use and abuse cheaper drugs (inhalants, crack,) or alcohol. These can cause psychosis, mania, aggression, paranoia, and withdrawals
CRIMINAL BEHAVIOR of AS

- Theft: pursuit of obsessions, rigidness
- Vandalism: disassembling electronics, rigidness regarding perception of balance or right/wrong, scape goat
- Assault: rigid beliefs, “Black/White” thinking
- Stalking: obsessive interest and poor social judgment
- Sexual assault: naïve, victim, rigidness,
- Aggression: internalized frustration

TREATMENT OPTIONS

- Prevention– Appropriate opportunities: educational, vocational, social, residential, medical, psychological, recreational. Family support & training.
- Behavior Modification
- Cognitive Behavior Therapy
- Medication

THOUGHTS <-> FEELINGS

BEHAVIOR <-> BODY/BRAIN
CBT with AS and DD

- Teaching Activity
- Multi modal: verbal, visual, video, role play
- Structured & Simple
- Written Rules
- Social Stories and Comic Strips (Gray, C)

Thomas E. Mates, Ph.D. 2009 25
Autism History & Facts

Understanding Autism – Characteristics and the Brain Functions, OTAC

i. Pre/Post test (Blank and Key)

ii. PowerPoint presentation
Autism History & Facts

Oregon Technical Assistance Corp.
Autism Program

Pervasive Developmental Disorders:
- "...characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior interests and activities." -DSM IV
- Autistic disorder
- Asperger's Disorder
- Pervasive Developmental (NOS - Not Otherwise Specified)
- Rett's disorder
- Childhood Disintegrative Disorder

History:
- First identified in 1943
- Dr. Kanner and Dr. Asperger
- Asperger's Syndrome official distinction in 1994 in the DSM IV
- Bettleheim: "The Empty Fortress"-Psychogenic
- Rimland: In 1964 he put forth the idea that the cause was neurological.
Facts:

• Autism ratio: 4:1 boys to girls
• 1 out of approximately 166 births – Autism Spectrum Disorder – Sharp increase in the last decade.
• Mental retardation occurs in 70-80% of people affected. (more if other disorders are included.)
• Occurs across all class boundaries.
• Savant skills - 1 to 10% of people with autism.

What we know and are learning

• Not due to neglect or bad parenting
• Genetic influence
• Pollutants
• Biomedical (Carr and Herbert)

Biomedical Research
(Carr and Herbert)

• Grant funded by the Autism Society of America
• Research link between medical field and behavioral field
• TGRI or Treatment- Guided Research Initiative
What does all that mean to the support provider?

- Although we cannot diagnose medical issues, we can and should advocate for appropriate medical diagnoses by:
  - Reading latest literature on biomedical research
  - The Autism Treatment Network
  - The Textbook on Functional Medicine
  - Record and bring data to the medical doctor
  - Sleep
  - Seizure
  - Food/drug allergies and reactions
  - Other

What does all that mean to the support provider?

- Support providers must learn to support using positive behavioral support methods to define issues and adapt environments:
  - Use of environmental structure to decrease anxiety and stress
  - Use of visual information to teach alternative behaviors that will assist in
    - Improving communication
    - Accepting new or different activities or events
    - Understanding expectations and medical course of action
Understanding Autism
Characteristics and the Brain Functions

Oregon Technical Assistance Corp 2009

1. Prefrontal Cortex – executive functions: attention, emotional regulation, planning and organizing, working memory
2. Corpus Callosum – connection between the left hemisphere (language, logic) and the right hemisphere (emotion, spatio-temporal relations)
3. Amygdala – “watch dog”; monitors for danger, activates sympathetic nervous system
4. Hippocampus – learning, memory
5. Mirror Neurons – recently discovered neurons in the cortex that “fire” when we see others behave: seems to form the basis for empathy, imitation, and social relations

Characteristics of Autism

- Communication and language
- Social judgment and relating
- Organization and Sequencing
- Cognitive
- Uneven patterns of development
- Restricted repertoire of behaviors
- Sensory and perception
Communication and language

Common Issues:
- Problems understanding commands
- Limited topics
- Does not communicate own needs
- Delayed processing
- Understanding based on context
- Concrete
- Asks a lot of questions
- Problems with imitation

Support Strategies:
- Teach use and utility of communication
- Learn best through visual structure and routine

Social judgment and relating

Common Issues:
- Poor eye contact
- Difficulty modulating behavior to setting
- Peculiar affect
- Lack of response to others emotions
- Difficulty taking another person’s perspective
- Problems with imitation
- Limited play and social interactions

Support Strategies:
- Teach with visual organization/structure and routines roles, rules and expectations
- Feedback in various forms can help person to learn appropriate interactions (e.g., video feedback)

Organization and sequencing

Common Issues:
- Does not know where to start,
- what’s next and
- when to finish

Support Strategies:
- Emphasize visual clarity and systematic or routine ways of doing things
Uneven patterns of development

Common Issues:
- Often good at numbers, rote memory tasks and music
- Problems with language and abstract reasoning
- Some may have the ability to read but cannot talk

Support Strategies:
- Individual approach
- Must assess full range of skills and strategies

Brain Issues: Corpus callosum, right vs. left hemisphere (e.g., savant skills)

Cognitive

Difficulty with meaning, abstract thinking, judgment and integrating ideas

Common Issues:
- Concrete, literal
- Slow to process information
- Focus on detail
- Slow pace
- Cannot tell relevant from irrelevant (e.g., Can’t tell clean from dirty)
- Trouble with choices
- Indecision
- Problems with generalization (over and under)
- Memorize the world

Brain Issues: Prefrontal cortex; hippocampus, angular gyrus; cerebellum

Cognitive (continued)

Support Strategies
- Allow time for processing information
- Structure/organize routines
- Present information and expectations visually
- Highlight information
- Social stories
Restricted repertoire of behaviors
Focus on sameness and ritualistic behaviors

Common Issues:
- Upset easily by change in environment – holidays, new clothes, new foods, moving, staff changes, etc.
- Free time difficult
- Memorize the world
- Elaborate rituals (repetitive, self-stimulatory)

Support Strategies:
- Structured routines presented visually for predictability

Brain Issues: Prefrontal cortex (executive functions), Mirror neurons, hippocampus, amygdala

Sensory and perception

Common Issues:
- Inconsistent response to sounds
- Distractible
- Over or under reactive
- Dislikes certain textures – food and clothing
- Fascination with reflections – water, lights
- Different pain response
- Likes deep pressure

Support Strategies:
- Minimize distractions
- Highlight important elements of environment
- Sensory “diet” (e.g., Swinging, weighted blanket, head phones, tags out of clothes)

Brain Issues: Prefrontal cortex (executive functions), amygdala, angular gyrus
Autism History & Facts and Understanding Autism – Characteristics and Brain Functions 2009
PowerPoint By: OTAC

Pre/Post-Assessment

1) Pervasive Developmental Disorder (PDD), Autism, and Asperger Syndrome are considered to all be part of ________________.

2) Individuals with autism cannot be intellectually disabled.
   a. True
   b. False

3) The medical test used to determine if a person has autism is ____________________.
Autism History & Facts and Understanding Autism – Characteristics and Brain Functions 2009
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KEY
Pre/Post-Assessment

1) Pervasive Developmental Disorder (PDD), Autism, and Asperger Syndrome are considered to all be part of __Autism Spectrum Disorder (ASD)________.

2) Individuals with autism cannot be intellectually disabled.
   a. True
   b. False

3) The medical test used to determine if a person has autism is __None exists or observation by the Doctor_____.

Oregon Technical Assistance Corporation • Oregon Rehabilitation Association • University of Oregon
Section 1: Co-occurring Development Disabilities and Mental Health Issues

Module 5:

Understanding Personality Disorders – with a focus on Borderline Personality Disorder, James Clay, Psy.D., 2009
- 3 DVDs (See GRO DVD Presentation Notebook: Personality Disorders, Clay)

This is a PowerPoint presentation.

During this training Dr. Clay provides information on Autism Spectrum Disorders and Personality Disorders. He covers what they are and how they manifest in individuals who have mental retardation or a developmental disability. Dr. Clay also covers interactive strategies that include assertiveness, “don’t get hooked” and “don’t get jaded”. He discusses how to handle suicide threats, and burnout.
Understanding Personality Disorders

With a focus on Borderline Personality Disorder

Presenter: James Clay, Psy.D.

Dr. Clay is a licensed clinical psychologist and has worked in the field of developmental disabilities for more than 12 years. He has served this population as a direct care staff, program manager, behavior specialist, protective services investigator and more recently as a therapist and psychologist.

Dr. Clay has conducted a wide variety of trainings, conference, presentation and keynote addresses through the Northwest and has published his research in the area of dual diagnosis (mental retardation and mental illness) and Neuropsychology. His trainings are very well received.
Pre/Post-Assessment

Please complete this assessment. For all of our GRO trainings we are compiling data that reflects whether the information presented has increased the knowledge of the participants. These initial questions will tell us what you knew before the training and then you will re-answer later on the post-assessment. This will tell us if this training allows you to gain information on the topic presented. We appreciate your taking part in this learning tool.

1) How does one tell the difference between Borderline Personality Disorder and Bi-Polar Disorder? (Circle the most accurate answer)
   a. Bi-Polar Disorder mood symptoms tend to be present for weeks as opposed to hours in Borderline Personality Disorder
   b. Fluctuations in mood only occur with Bi-Polar Disorder
   c. Borderline Personality disorder mood symptoms tend to be present for weeks as opposed to hours in Bi-Polar Disorder
   d. None of the above

2) Which of the following is not a personality disorder?
   a. Narcissistic
   b. Histrionic
   c. Borderline
   d. Passive Aggressive

3) What is one warning sign of psychosis? (Circle the most accurate answer)
   a. Crying all the time
   b. Persistent beliefs that cannot be true
   c. Sleeping all the time
   d. All of the above
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Understanding Personality Disorders

James Clay, Psy.D.
Clay Psychological Association

Overview
- Review Confidentiality/Presentation Culture
- CLINICAL TOPICS
  - Autism Spectrum Disorders/1Q
    - Autism, Asperger's, NVLD, IQ
  - Personality Disorders
    - What are they?
    - How do they manifest in MR/DD individuals
- Interaction Strategies
  - Assertiveness, “Don’t get hooked”, “Don’t get jaded”
- How to handle suicide threats
- BURNOUT
- Jeopardy Style Quiz
- Review/Discussion

Additions
- What other issues/concerns/exercises should we have on the agenda?
- Updates/Changes
Confidentiality

- Confidentiality applies to any client discussion
- Limits of Confidentiality
  - Suicidal Threats
  - Medical Emergency
  - Harm to Others
  - Abuse

Respect vs. Humor

- Tough line to walk

Importance of Questions and Participation

- Collection of Experts
- Cooperation
- Consensus
Case Examples

- What are some case examples of clients served with Personality Disorders?

What’s Going On?

- What is working well for these clients?
- What is causing Problems?

Psycho Babble

- Orientation x4
  - Person, Place, Time, Purpose
- Mental Status Exam
  - Testing a variety of functional domains
    - Thoughts, Mood, Emotions, Sensory, Appearance, Speech, Orientation, Memory, Attention
- Aphasia
  - Difficulty with the production or reception of language in any form
- Avolition
  - Lack of Internal Motivation
Getting Stuck

- Many people get “stuck” in a pattern of behavior
- Excesses and Deficits
- Rigidity vs. Flexibility
- Inability to perceive Social Cues (prosopagnosia)
- Cognitive Impairments

Autism Spectrum Disorder and Faces

More on autism spectrum disorders later

Review Plans A-D

How do BSP's apply to clients with Personality Disorders?

- A - Doing Well
  - Discuss most and least useful aspects
- B - Reactive
- C - Crisis
  - Review “Do’s and Don’t’s”
  - Review the effect of fear
- D - De-escalation
Autism Spectrum Disorders

Characterized by:
- **SOCIAL IMPAIRMENT**
  - Eye Contact, Non-Verbal Behavior, Perception of Social Cues, Voice tone and pitch, No sharing experiences
- Stereotyped, Repetitive Interests
  - Preoccupied with objects or parts of objects, preoccupied with the same topic or range of interests, Odd repetitive movements
- Communication Difficulties
  - Delayed, Odd, Unusual, or less than normal speech and play

Autism Quick Facts

- Less than 1% of the population
- Rate is increasing
- Symptoms are present before age 3
  - Often as an infant-No response to name or cuddle
- IQ is often impaired
- Male more affected
- Language is delayed or absent
- Sensory processing is often unusual
- Brain structure, Neurotransmitters and EEG activity may be different, but not pathomechanistic
- Savant skills- 10%

ASD Continuum

Severe Autism
- Symptoms
  - Non-Verbal, No Social Interest
  - Little Eye Contact, etc.

Asperger’s
- Outgoing, verbal

Loud
**Autism Exercise**

- Who is?
  - Extroverted
  - Mixed
  - Introverted

- What’s it Like?
  - How does it feel to be “out of your element?”

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**Asperger’s Quick Facts**

- Social Impairment
  - Different from autism
  - Severe, but eccentric and one-sided
  - May appear self-centered
- No language delay
  - Language may be odd
- Pattern of stereotyped interests
- Usually normal IQ
- More men than women

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**Other Similar Diagnoses**

- Childhood Onset Schizophrenia
- Non-Verbal Learning Disorder
- Expressive/Receptive Language Disorder
- Social Anxiety
- Schizoid Personality/Avoidant Personality
- Severe/Profound MR
Personality Disorders

- Axis I vs. Axis II
- Different from Axis I disorders
  - Enduring patterns of thought, behavior, impulse control and emotion that cause trouble with other people
  - Also usually unpleasant for the individual
- Not Multiple Personality Disorder or DID
Clusters

- Cluster B
  - Borderline
  - Antisocial
  - Histrionic
  - Narcissistic
- Cluster C
  - Avoidant
  - Dependent
  - OCPD
- Cluster A
  - Paranoid
  - Schizoid
  - Schizotypal

Psycho Babble

- Pathopneumoic Baby!
  - “The name of the disease”
- Heuristic
  - Thinking Shortcut, often associated with thinking errors. Often times incredibly useful.
- Catalepsy
  - Sometimes seen in schizophrenia- Waxy Flexibility
- Magical Thinking
  - “My thoughts will cause or prevent something from happening” When is this type of thinking normal?
- Illusion
  - Misperception of a real stimulus- Not a hallucination

Axis I Diagnosis Commonly Confused with PD

- “Rapid Cycling” Bi-Polar Disorder (Borderline PD)
- Social Phobia (Avoidant PD)
- Obsessive Compulsive Disorder (OCPD)
- Paranoid Schizophrenia (Paranoid PD)
- Autism (Schizoid PD)
Rapid Cycling Bi-Polar

- Similarities:
  - Unstable affect
  - Intense, unusual interpersonal interactions
  - Unstable Life
- Ways to Differentiate
  - 4 Cycles in a year
  - Cycles Must Be Stable!
  - Depressive and Manic Episodes must meet temporal criteria

Social Phobia

- So similar, the diagnoses are almost interchangeable
- For our purposes, there is no need to distinguish the two

Obsessive Compulsive Disorder

- Similarities
  - Rigid approach to life
  - Anxiety is prevalent
  - Interpersonally frustrating
- Differentiation
  - OCD is recognized as being excessive
  - OCD involves elaborate and intrusive rituals and compulsions
Paranoid Schizophrenia

- The Nature of Delusions (Bizarre vs. Non-Bizarre)
- Continuum of psychosis
- Continuum of decompensation
- Similarities
  - Pervasive Distrust of others
- Differentiation
  - No hallucinations
  - Distrust is not delusional
  - No loosening of thought

Autism

- Similarities with Schizoid
  - Lack of interest in others
- Differentiation
  - Autism has further symptom cluster (language delay, etc.)
  - No intellectual impairment in Schizoid

Pathogenesis of PD

- Where do PD's come from?
- Why don't they go away on their own?
PsychoBabble

- Dementia vs. Delerium
  - Dementia: primarily memory and chronic, Delerium: primarily attention and acute
- Dyskinesia
  - Unusual movement, involuntary
- Paraphilia
  - Unusual sexual urges or practices
- Hypnopompic and hypnagogic hallucinations
  - Hallucinations on waking and falling asleep—considered normal experiences

Cluster A

- Paranoid
- Schizoid
- Schizotypal

Paranoid

- 5%-2.5% of general pop
- 10%-30% of psychiatric inpatients
  - Suspects others of exploitation/harm
  - Worries about the loyalty of others
  - Reluctant to confide
  - Reads hidden meaning into neutral interactions
  - Bears grudges
  - Perceives interpersonal attacks
  - Worries about partner’s sexual fidelity
**Schizoid**

- “Uncommon”
  - Detachment from others
  - Does not desire relationships, even with family
  - Takes pleasure in few or no activities
  - Lacks friends
  - Indifferent to others
  - Emotionally cold and flat

**Schizotypal**

- 3% of general population
  - Transient (minutes or hours) psychotic episodes
  - Social Disturbance/Oddness/Perceptual Distortions
  - Ideas (not delusions) of reference
  - Suspicion
  - Few, if any, friends
  - Eccentric Behavior
  - Excessive social anxiety based on paranoia, not on fear of judgement

**Cluster B**

- Anti-Social
- Histrionic
- Narcissistic
- Borderline
Antisocial Personality Disorder

- 3% in males, 1% in females
- Must be evident since 15 years old
- Must be preceded by Conduct Disorder
  - Disobeys laws and social norms
  - Deceitful
  - Impulsive
  - Irritability (often leads to fights)
  - Disregard for safety
  - Irresponsibility
  - Lack of Remorse
  - Frequently Charming
  - Frequently Exploitative
Borderline Personality

- 2% general population, 10% outpatient mental health, 20% in psychiatric hospitals
- More common in women
  - Instability/Chaos are defining factors
  - Fear of abandonment
  - Unstable, intense relationships
  - Identity disturbance
  - Impulsivity
  - Recurrent suicidal behavior
  - Affective instability
  - Emptiness
  - Intense anger
  - Transient paranoid or dissociative symptoms

Histrionic

- 2-3% general population
  - Needs to feel at the center of attention
  - Often seductive
  - Shallow, rapidly shifting emotions
  - Uses physical appearance to get attention
  - Speech that is very impressionistic
  - Theatrical/Overly emotional
  - Easily influenced by others
  - Overestimates relationships
Narcissistic

- Less than 1% in general pop, 2-16% in clinical populations
  - Grandiose sense of importance
  - Preoccupied with fantasies of success
  - “Special and Unique”
  - Requires admiration
  - Sense of entitlement
  - Exploitative
  - Lacks Empathy
  - Envious
  - Arrogant

Cluster C

- Avoidant
- Dependent
- Obsessive Compulsive

Avoidant

- Very Similar to Social Phobia
  - Avoids social situations for fear of judgement
  - Even in intimate relationships, might be distant
  - Preoccupied with social criticism
  - Inhibited
  - Views self as socially inept
  - Reluctant to take social risks
Dependent

- Most frequently encountered PD in clinical settings
  - Submissive and clingy
  - Needs lots of advice to make decisions
  - Difficulty disagreeing with others
  - Not much initiating activities
  - Goes way out of the way to get support
  - Urgently seeks other relationships when one ends
  - Preoccupies with fears of being alone

OCD

- 1% in general pop, 3-10% in mental health clinics
  - Preoccupies with details, rules, order, lists
  - Perfectionistic
  - "Workaholic"
  - Scrupulous and inflexible
  - Will not throw things away
  - Miserly
  - Rigid

Additional Info on PD in MR/DD

- See Goldberg, Gitta and Puddephatt article PD appears more common in MR/DD
  - Personality Development likely includes
    - Dependence on others
    - Low self image
    - Low expectations for self
    - Approval Seeking
Additional Info

- Relation between Axis I and Axis II pathology
  - PPD often is associated with delusions
  - Dependent Avoidant and PPD may be associated with non-specific psychotic symptoms
  - Dependent and Schizoid traits were often found in bi-polar and depressive disorder
  - Dependent traits were common before anxiety symptoms worsened
  - A wide array of symptoms were associated with adjustment disorders
  - MR/DD individuals tended to show only one disorder at a time

BPD in MR/DD (Wilson, 2001)

- Some different characteristics
  - Negative reactions often directed specifically at staff
  - Attempts to disrupt just about everything, rather than one specific focus
  - Great need for attention from staff
  - Often will test residential program structures and rules
BPD Quick Facts

- Often, people don't like themselves
- Completed Suicide in about 8-10%
- 2% of general population
- Found mostly in women (75%)
- Tends to get better with age (30's and 40's)
- Also tends to improve within 1 year of therapy

Common Reaction of Staff working with BPD individuals

- Anger
- Frustration
- Confusion
- Pessimism
- Burnout
- “I give up!”

Treatment/Intervention

- Integration of Counseling, Behavioral and Psychiatry is critical (Esbensen & Benson, 2003)
  - What is learned in counseling must be applied at home!
- All 3 aspects of the intervention- Psychological, Psychiatric, Behavioral must be present
- When Medications are removed, behavior deteriorates
**Single Subject Design Data**

![Graph showing data points]

**BPD Diagnostic Dilemmas**

- Bi-Polar Disorder
- ASPD
- Dissociative Disorders
- Others?

**BPD Dilemmas In MR/DD**

- Self Harm may have other origins
- Neuropathology may cause impulsivity and mood swings
- Developmental Delays may be genesis of many symptoms
- Fear of Abandonment may be based in reality
BPD

- Poor Prognostic Indicators
  - Symptom Severity
  - Early onset of symptoms
  - Long Hospital Stays
  - Substance Use
  - Antisocial Traits
  - History of family mental illness
- PTSD is especially common

Pathogenesis

- Possible genetic or biophysiological tendency towards arousal, intensity, sensitivity and difficulty returning to baseline
- Similar to blood disorders that cause easy bruising

Pathogenesis

- Genetic/Biologic vulnerability is complicated by:
  - Trauma (up to 90%)
  - Invalidating Environment
  - Neuroanatomical and Neurotransmitter abnormalities possible
Some studies note smaller amygdala and hippocampus

Neurophysiological Abnormalities
- Prefrontal Cortex
- Serotonin

Dialectics
Dialectical Behavior Therapy (DBT)

- DBT and psychoanalysis have been supported in the literature for treatment of BPD
- DBT's support is more extensive

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DBT

- Philosophical Approach as outlined
- Clinicians must have specialty training
- 1 hour weekly individual therapy
- 2.5 hours weekly group
- Phone Consultation as Needed
- Brief inpatient hospitalization as indicated

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DBT

- Infrastructure is based on treatment modules
  - Mindfulness
  - Distress Tolerance
  - Effectiveness
Mindfulness

- Observation
- Non-Judgment
- One Mind
- Effectiveness
- Exploration of Emotion

Distress Tolerance

- Radical Acceptance
- Problem Solve
- Cognitive Restructuring
- Freedom of choice
- Pain vs. Suffering
- Crisis Survival Network
- Self-Soothe First Aid Kit

Effectiveness

- Objective Effectiveness
- Relationship Effectiveness
- Self-respect Effectiveness
- Compromise between silence and outrage
- Boundaries
Emotion Regulation

- Managing Emotion
- Setting Events
- Triggers
- Protective Factors
- Etc

Treatment/Intervention

- Integration of Counseling, Behavioral and Psychiatry is critical (Esbensen & Benson, 2003)
  - What is learned in counseling must be applied at home!
- All 3 aspects of the intervention: Psychological, Psychiatric, Behavioral must be present
- When Medications are removed, behavior deteriorates

Single Subject Design Data
For Further Info on BPD or DBT, or for Specific Training

- Marsha Linehan, Ph.D.
  http://www.brtc.psych.washington.edu/
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Questions/Thoughts on BPD and DBT?

Interaction Strategies for Personality Disorders

- Know Thyself
- Pick Thy Battles
- Assertiveness
- Rapport/Empathy
- Managing Suicidal Behavior
Know Thyself
- What emotional reactions do you tend to have towards clients?
- What expectations do you have of your clients?

Assertiveness
Aggressive, Passive and Assertive Behavior
- Assertiveness is HARD
  - Honest
  - Appropriate
  - Respectful
  - Direct

Rapport/Empathy/Support
- Verbal/Non Verbal Behaviors
PsychoBabble

- Schizotaxic Gene
  - Gene that presumably predisposes an individual to psychotic illness
- Macrophia/Microphia
  - Visual perception that objects are larger or smaller than they appear
- Executive Function
  - Reasoning, planning, organizing, intentional actions
- Echolalia
  - Repeating the words or phrases of others
- Prosopagnosia
  - Inability to recognize faces

Most Dangerous Disorders

- Anorexia Nervosa - 20% lifetime fatality
- Depression, Schizophrenia (negative/positive symptoms), borderline personality, schizotypal personality, substance abuse and dependence - all associated with increased risk of self harm or suicide

Suicidality

- Factors associated with increased risk of completion
  - Gender
  - Previous Attempts
  - Psychiatric Dx
  - Recent Losses
  - Friends or family who have attempted (contamination effect)
  - Access to means (weapons, prescriptions)
  - Threats
  - Use of Substances - Impulsivity
What do I do if my client threatens themselves?

- If you do not have an ISP team agreement—ACT ON IT
- Ask questions:
  - Are you going to hurt yourself?
  - How are you going to do it?
  - Will you promise me you will be safe?
  - When are you going to do it?
- React
  - If no immediate threat, call clinician or crisis office immediately
  - If there is an immediate danger, call 911, stay with the client, restrain them from access to means.

Danger Danger!

- Working with Personality Disordered Clients can lead to:
  - Assault
  - Verbal Threat
  - Anger
  - Burnout
  - Frustration
  - Abuse
  - Neglect

PsychoBabble

- Conversion Symptom
  - Physical/neurological symptom (not faked) thought to be psychological in origin
- Psychomotor Agitation
  - Agitation
- Synesthesia
  - Sensory experiences in one modality are reported in another “I hear colors Man!”
- Difference between a sign and a symptom of mental illness?
  - Signs are observed, symptoms are reported or experienced
Discussion:
What happens to you when you are stressed?

How are things going now?

Short Term (Acute Stress) vs. Long Term Stress

- Short Term Stressors?
- Long term stressors?
  - Role Confusion
- Impact of short vs. long stress

Warning signs of stress and burnout

- Difficulties sleeping
- Trouble concentrating
- Absenteeism
- Illness (especially stomach concerns and non-specific pain)
- Increased alcohol/drug use
- Irritability
Warning Signs Cont.

- Defiance
- Frequent arguments
- Fatigue/Trouble concentrating
- Smoking and more smoking
- “I don’t care”
- Gallows Humor
- Water Cooler Discussions
- “Macho Culture”

Consequences of Burnout

- Abuse/Neglect
- Poor overall performance
- TURNOVER
- Withdraw

Organizational Ways to Address Burnout

- What do your agencies already to address burnout?
What do we do about burnout?
Organizational vs. Personal

Organizational Recommendations
- Rotate client responsibilities
- Frequent Staff Meetings and Discussion
- Honor Break Times
- Honor Time Off Requests
- Monitor for Symptoms/Be Proactive
- Refer for EAP
- Encourage Group Leisure Activities
- Staff Retreats
- Offer Stress Management Activities
- Offer Opportunities for Exercise
- Encourage Appropriate Nutrition

Personal Preventative/Proactive Measures

- What do you do daily or weekly to manage stress and prevent burnout?

Personal Burnout Additional Recommendations

- Learned Helplessness- Seligman
- Locus of Control- Learn when to give up control and when to take it
- Preventative Measures
  - Good Stress Management Plan
  - Relaxation
  - Mastery
  - Positive Activities
- Reactive Measures
  - Monitor your thinking
  - Attribution

James Clay, Psy.D. 2009
Reactive Measures
Attributional Style

- Global vs. Specific
- Permanent vs. Temporary
- “Bad things happen to bad people”
- Control vs. Helplessness

Practice Attributional Self Talk

Thanks Very Much!
Please fill out your evaluation form

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