



UNDERSTANDING PSYCHOSIS IN INDIVIDUALS WITH INTELLECTUAL DISABILITIES

September 27, 2013

Presented by: Melanie Kelly, Ph.D., C. Psych.

OUR MISSION

Regional Support Associates (RSA) will provide leading edge clinical supports aimed at enhancing the quality of life for individuals with intellectual/developmental disabilities in their community. Our professional services are provided in a caring manner, tailored to the unique needs of individual, families and organizations served. RSA adheres to a collaborative approach that strives to build individual and community capacity through ethically sound and outcome based interventions. We inspire innovation and creativity in ourselves and in those with whom we work, through our clinical practice, research, education, and community development in intellectual/developmental disabilities.



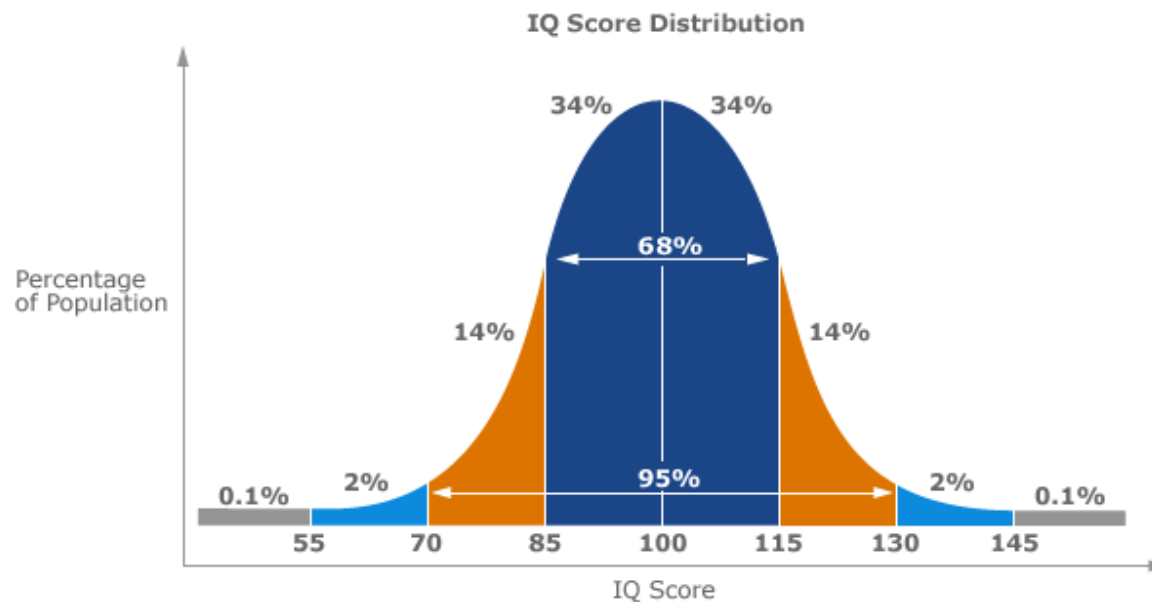
WHAT IS AN INTELLECTUAL DISABILITY?

- Criteria laid out in Diagnostic and Statistical Manual of Mental Disorders (DSM IV- TR):
 - IQ score below 70 on standardized intelligence tests
 - Impairments in adaptive functioning:
 - **Conceptual skills**—language and literacy; money, time, and number concepts; and self-direction
 - **Social skills**—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules, obey laws, and avoid being victimized
 - **Practical skills**—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone
 - Onset before the age of 18



BREAKDOWN OF CATEGORIES OF INTELLECTUAL DISABILITIES BASED ON IQ

- Mild: 50-55 to approximately 70: 85% of ID
- Moderate: 35-40 to 50-55: 10% of ID
- Severe: 20-25 to 35-40: 3.5% of ID
- Profound: Below 20 or 25: 1.5% of ID



WHAT DO SOME PEOPLE WITH PSYCHOSIS GO THROUGH?

- <http://www.youtube.com/watch?v=SN1GCoVzxGg>



COMMON SYMPTOMS OF PSYCHOSIS

What symptoms did you notice in the video?



MAIN SIGNS OF PSYCHOSIS

- Hallucinations – Auditory or Visual
- Delusions – fixed belief that is clearly false
 - Can range from bizarre to realistic
- Disorganized/Bizarre Speech or Behaviour
 - represents a noticeable change from individual's typical functioning



PSYCHOSIS IN PEOPLE WITH INTELLECTUAL DISABILITIES

- Key component of psychosis is based on internal experiences and their description
- Cannot reliably diagnose in people who are non-verbal and/or those with low-Moderate/Severe/Profound ID
- Higher prevalence in ID than in general population:
 - 1-3% vs. 2-4.4% (2005)



WHAT'S DIFFERENT AMONG PEOPLE WITH ID?

Hallucinations:

- Auditory most common (voices)
- Similar to rate in general population but people with ID are more likely to report symptoms
- More likely to observe interaction with hallucinations
- May include agitation or SIB in response to hallucinations
- May see covering of eyes or ears to 'block out' hallucinations
- May include sniffing the air, as if smelling something not smelt by others



WHAT'S DIFFERENT AMONG PEOPLE WITH ID?

Delusions:

- More likely to be mundane in nature
- May include new avoidance or new fears
- Irrational beliefs not expressed before
- Glaring with intense anger at strangers or previously liked others
- Sudden medication refusal



WHAT'S DIFFERENT AMONG PEOPLE WITH ID?

Disorganized/Bizarre Speech or Behaviour:

- Harder to assess; must be a change from baseline



WE SEE THE SYMPTOMS, NOW WHAT DO THEY MEAN?

Psychosis can stem from many different psychiatric problems (DSM-IV/DM-ID):

- Schizophrenia
- Schizophreniform Disorder
- Delusional Disorder
- Bipolar Disorder
- Schizoaffective Disorder
- Major Depressive Disorder, Severe with Psychotic Features



BUT WAIT, IT COULD EVEN BE ONE OF THESE...

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



SCHIZOPHRENIA

- Higher prevalence in ID than in the general population
- **Positive Symptoms:** Excesses
 - Examples: Hallucinations, Delusions, Disorganized Speech/Behaviour
- **Negative Symptoms:** Deficits
 - Examples: Social withdrawal, underactivity, lack of conversation, few leisure interests, slowness, flat affect
- Symptoms last for at least 6 continuous months
- Must rule-out other conditions



SCHIZOPHRENIA

Difficult to definitively diagnose in ID...



Why??



SCHIZOPHRENIA

Other points to consider:

- Drug use can trigger a first psychotic break in people who are predisposed toward Schizophrenia
- Is treatable and remission can be maintained over long periods of time, with proper treatment



MOOD DISORDERS AND PSYCHOSIS

- Major Depressive Disorder, Severe with Psychotic Features
 - Psychosis typically involves hearing voices that are “mood congruent” (i.e., saying mean things to or about the person)
- Bipolar Disorder
 - During the manic phase, individuals may have an inflated sense of self-esteem or grandiosity, bordering on delusion
 - This is a core feature of the Mania/Bipolar Disorder and is not a separate psychosis diagnosis
 - May also hear voices, as above



PSYCHOSIS

DEBUNKING MYTHS

- People with psychosis are usually violent
- People with psychosis have a “split” personality
- Everyone who has a psychotic illness will develop schizophrenia
- People with psychosis can never lead a “normal” life



HOW DO WE DIAGNOSE PSYCHOSIS?

Bio-Psycho-Social Model: Multidisciplinary

1. Assess for Medical conditions

- Look at pre-existing conditions to see if predisposed towards psychosis
- Check for medication side-effects or drug interactions
- Determine if related to substance use
- May include complete physical, blood tests, and brain scans



MEDICAL CONDITIONS THAT LOOK LIKE PSYCHOSIS

- Neurological diseases (ex, Parkinson's, Huntington's)
- Delirium
- Brain tumours or cysts
- Dementia (including Alzheimer's disease)
- HIV and other infections that affect the brain
- Some types of epilepsy
- Stroke
- Hyponatremia
- Hepatic encephalopathy
- Uremia
- Hyperadrenalism
- Wilson's Disease



GENETIC SYNDROMES THAT PREDISPOSE TOWARD PSYCHOSIS

- Velocardiofacial Syndrome
- Prader-Willi Syndrome
- Turner's Syndrome (XO Karyotype)
- PKU
- Klinefelter's Syndrome (Karyotype 47, XXY)



IT'S MORE LIKELY TO BE MEDICAL IF...

- Hallucinations are olfactory (i.e., smells): Seizure-related
- Hallucinations are tactile (i.e, feeling of bugs on or under skin): Delirium or substance abuse/withdrawal
- Hallucinations occur only while going to sleep or while waking up: Hypnagogic or Hypnopompic hallucinations



IF IT'S NOT MEDICAL, THEN WHAT?

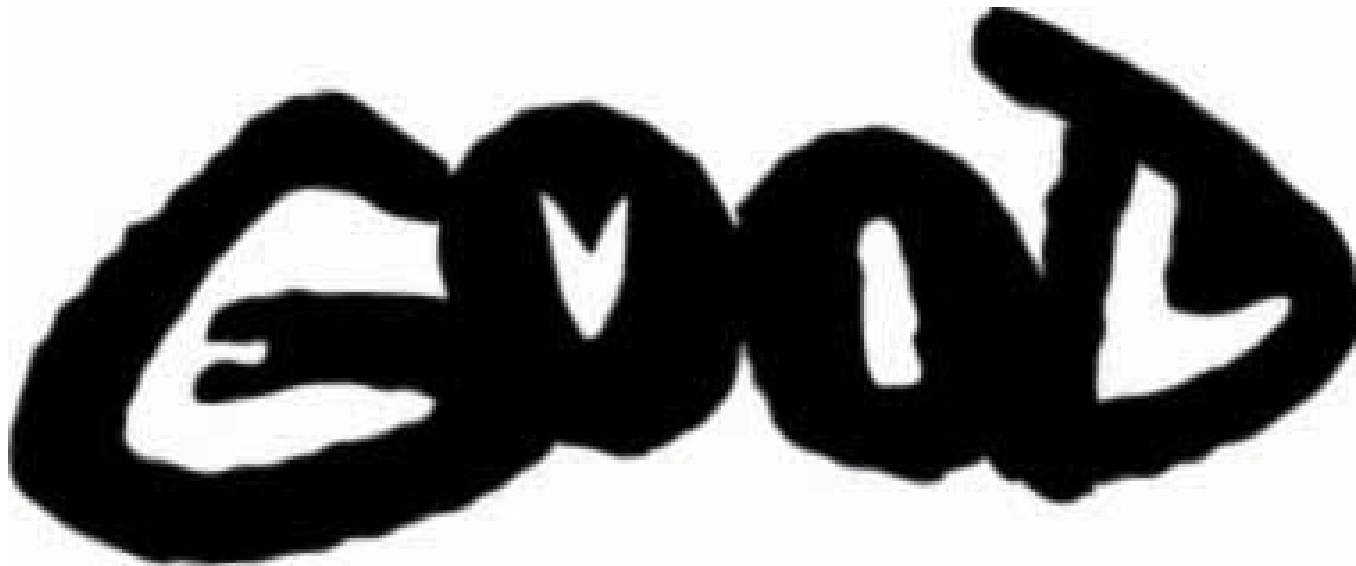
Mental Health professional does a detailed assessment, including:

- Background and life history
- Current living circumstances/environment
- History of presenting symptoms
- Interview with significant others
- Observation of individual over time
- Changes in the presentation of symptoms over time or in different places/situations



WHAT WE LOOK AT AFFECTS WHAT WE SEE

What do YOU see here?



WHAT ELSE DO WE NEED TO RULE-OUT?

- Developmentally-appropriate self-talk
- Imaginary Friends (ex., with Down Syndrome)
- Reports that are culturally normative (ex., seeing relatives who have died), in isolation from other symptoms
- Learned behaviour that is adaptive to the environment (may occur only in certain situations)



REMEMBER...

Accurate diagnosis will likely not be made from a one-time encounter (with any type of professional), and may evolve over time



WE'VE GOT A DIAGNOSIS. NOW WHAT?

Treatment for psychosis usually involves both medication and psychological/psychosocial interventions



MEDICATION

- Antipsychotic medications are used to treat the positive symptoms (i.e., hallucinations/delusions)
- Come in pill form or injection
- Antipsychotic medications are also often used to treat “challenging behaviours” (i.e., aggression/SIB) in individuals with ID, although there is no solid research evidence to support this
- These medications often have some negative side-effects, which should be monitored regularly



PSYCHOLOGICAL/BEHAVIOURAL TREATMENTS

- Aimed at person as well as their family/caregivers, in individual and group formats
- Education should be provided re: symptoms, diagnosis and misconceptions
- Should use visual and written materials that can be reviewed regularly
- Symptoms should be monitored over time (by self/family/supports), to bring to treating professionals



PSYCHOLOGICAL/BEHAVIOURAL TREATMENTS

- Cognitive-Behavioural Therapy successful with Mild ID
- Social Skills training helpful for Mild-Moderate ID
- Stress and anger management
 - recognize that stress can worsen symptoms
- Identify concrete coping strategies that supports can cue the person to use when needed
 - Relaxation exercises, deep breathing, progressive muscle relaxation, mindfulness meditation
 - “Grounding” exercises: staying in the present moment, focusing on simple, concrete stimuli
 - Identifying supportive people to talk to or ask for help



WHAT ELSE CAN I DO TO HELP?

- Help with record keeping and monitoring of symptoms and bring these documents to the treating professionals.
- Think about how you've successfully coped with stress, and try to teach/encourage them to do the same.
- Know that change takes time, and appreciate small steps and successes. Praise the person for any small steps they make and remind them of this if/when they get down. Make a 'brag book' so they can look at it often.



OTHER STRATEGIES THAT CAN HELP

- Do not argue or try to reason with the person about the validity of hallucinations/delusions
- Instead, remain supportive, listen to their concerns, and identify how that might make you feel if you had that experience. Offer suggestions for how to deal with that feeling (ex., fear, sadness, anger, etc.)
- Offer safe distractions and soothing alternatives to help de-escalate the person and redirect their attention



MORE THAT YOU CAN DO...

- Remind the person of strategies that have worked for them in the past (a few hours ago, yesterday, last week, last month...). Pointing out their successes can be helpful.
- Physical exercise can be helpful. Learn and practice proper sleep hygiene and nutrition
- Encourage them to avoid substance use/abuse
- Minimize known stressors in the environment whenever possible



SELF-CARE IS IMPORTANT TOO

If you are feeling stressed, get support for yourself! Don't try to handle everything on your own.



ASSERTIVE COMMUNITY TREATMENT (ACT) TEAMS

- Available in many local communities (see references page)
- Tailored towards people with severe/persistent mental illness
- Often includes a multi-disciplinary team (including medical and mental health professionals)
- Care is available 24 hours a day on an outpatient/outreach basis
- Has been found to reduce relapses and need for hospitalization



FOR MORE INFORMATION...

- www.pepp.ca : Prevention and Early Intervention Program for Psychoses: London Health Sciences Centre
- www.cmha-wecb.on.ca/programs/css/dd.asp - Canadian Mental Health Association (CMHA) -Windsor: Dual Diagnosis Program: 519-257-5125
- www.cmha-wecb.on.ca/programs/css/ei.asp - CMHA Windsor: Early Psychosis and Intervention Program
- Chatham-Kent Dual Diagnosis Program: 519.352.6401 x 6693



FOR MORE INFORMATION...

- www.mentalhealthhelpline.ca/Directory/Program/7111
- First Episode Psychosis Program (TNT: Today, Not Tomorrow): 519.351.6144 x 5051 and ask to speak to the First Episode Psychosis Nurse (Chatham)
- Grey Bruce Assertive Community Treatment Team (ACT): (519) 376-2121-ext. 2386
- Grey Bruce Dual Diagnosis Program: (519) 376-2121 - ext. 2486
- www.schizophrenia.on.ca



FOR MORE INFORMATION...

- www.torontoearlypsychosis.com
- www.psychosissucks.ca/ - Fraser-Health Early Psychosis Intervention Program
 - Dealing with Psychosis Toolkit; handouts
- www.mentalhealthcare.org.uk – London (UK)-based site for family/friends







***“Partners in Serving Individuals with
Intellectual Disabilities”***