I/DD and Mental Health

Intersections and clinical considerations

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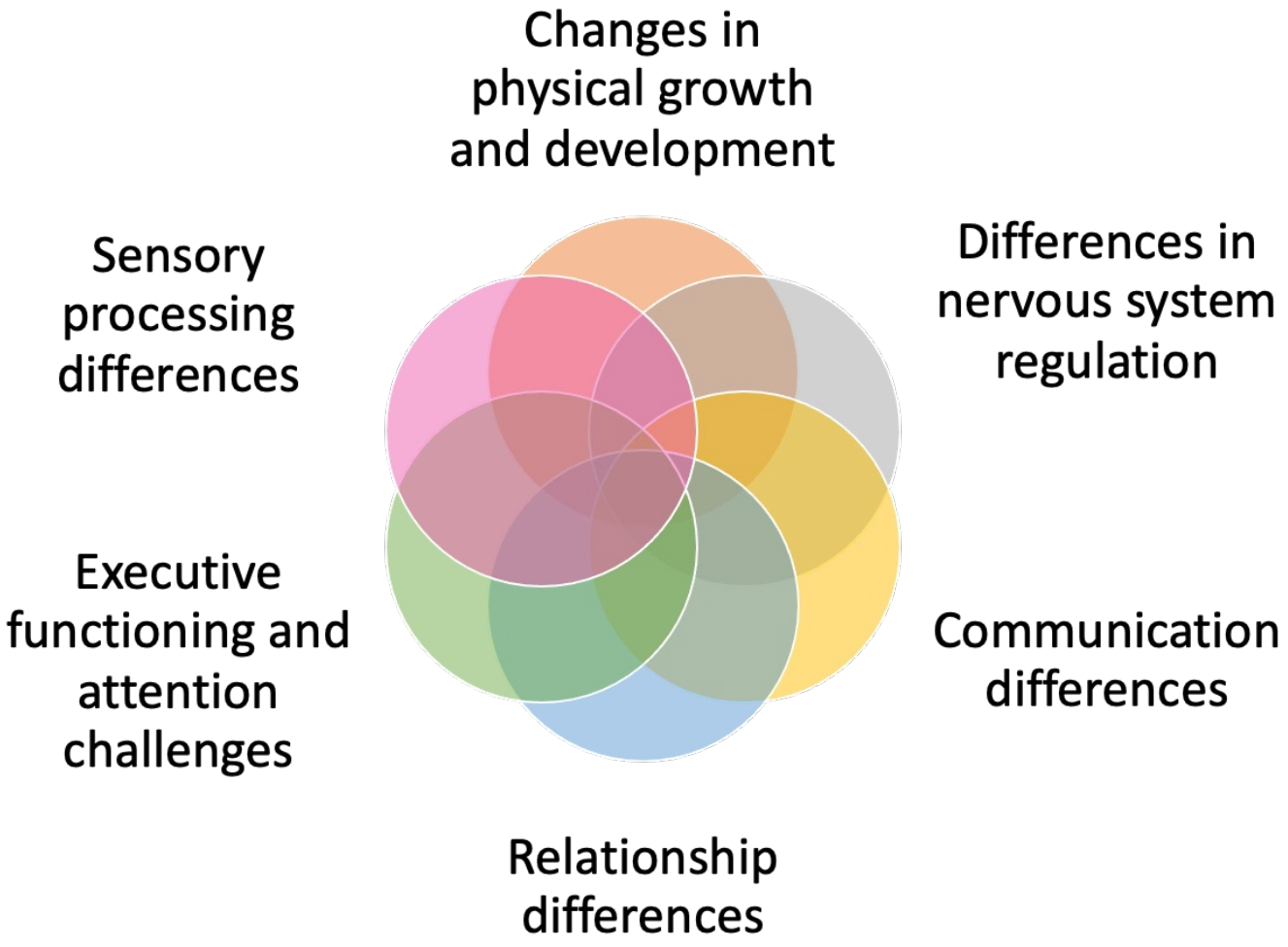
Objectives

- To bring awareness to co-occurring mental health conditions in I/DD
- To discuss modes of treatment and adaptations to evidence-based practices
- To discuss strength-focused reframing of I/DD in the context of self-concept and empowerment

Features (often) observed in I/DD



Considering skill gaps / Lagging Skills in I/DD

- Skill 1: Bodily Awareness
- Skill 2: Emotional Awareness
- Skill 3: Emotional Regulation
- Skill 4: Verbal Expression
- Skill 5: Social Understanding
- Skill 6: Cognitive Flexibility
- Skill 7: Negotiation
- Skill 8: Frustration Tolerance

If you don't feel sensations in your body, you can't know what emotions you are feeling.

If you don't know what emotion you are feeling, you won't have opportunities to learn to communicate about those emotions or to practice taking steps to regulate your emotions.

If you don't learn to regulate your emotions, you cannot participate in many social activities.

If you can't participate in many social activities, you do not get the chance to learn to compromise or negotiate with peers and friends.

If you do not get chances to participate in social activities, you do not practice ways to manage frustration.

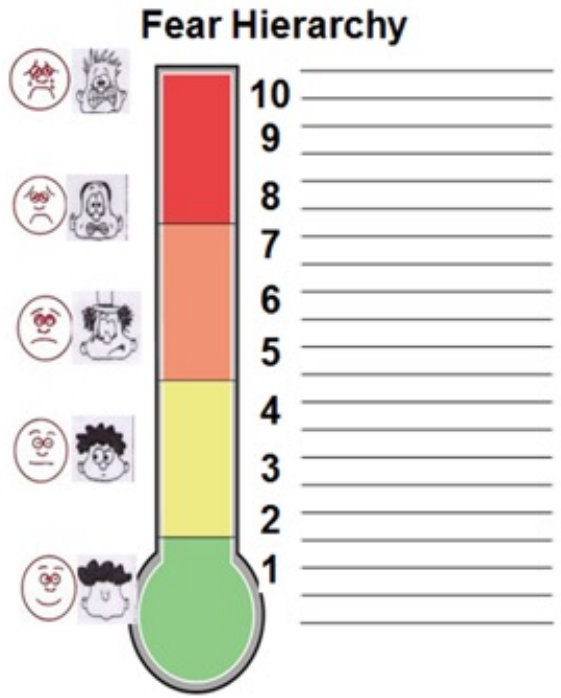
Content credit to K.J. Glaves

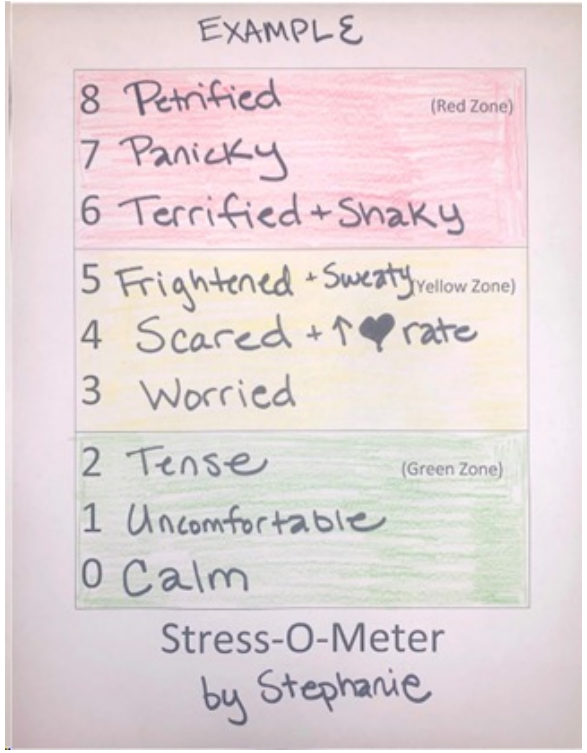
Increased rates of mental health conditions in I/DD

- Rates of anxiety are higher; 44-55% meet the criteria for an anxiety disorder (White et al, 2009)
- Individuals with ASD are four times more likely to experience depression in their lifetime (Hudson, et al, 2019).
- At risk for: Social isolation, bullying, relationship challenges, employment difficulties, and difficulties adapting to societal expectations.
- Depression in I/DD may be associated with severe consequences:
  - A regression in level of functioning (Magnuson and Constantino 2011)
  - Attempted suicide (Cassidy and Rodgers 2017; Richa et al., 2014)

Anxiety

- Build rapport and treatment motivation
- Teach cognitive therapy skills
  - Frame anxiety/OCD as something "trying to take control"/an external force
  - Client can "talk back" to anxiety/OCD
  - Get concrete: use a name, image/drawing
- Make fear hierarchy and begin exposure ASAP
  - Ideally, done every session
- Coach pitfalls of reassurance seeking for caregivers
- Determine a reward for completing exposure
- Continue exposure until daily fears are reduced
  - Go at your client's pace, but be persistent





Depression and Suicidality

- Behavioral activation is a promising treatment for depression among those with intellectual and developmental disabilities
  - Enhancing enjoyable experiences to improve mood
- Mindfulness-based therapies show benefit (e.g., Menezes et al., 2020)
- Incorporating values and mindful awareness into behavioral activation is recommended

BEHAVIORAL ACTIVATION TIPS

- Find out what your client enjoys or used to enjoy doing
- Spend time during each session offering to talk about their interests
- Discuss values or complete a values activity to identify how the client might enjoy spending their time
- Offer lists of enjoyable activities and solicit their feedback
- Have your client schedule enjoyable activities and plan for how they will engage in them, including any support needed
- Troubleshoot any challenges
- Consider hierarchy of ease of activity, shaping, support from others

Content credit to Alana McVey

Depression and Suicidality

Triggers, warning signs, and supports are unique to each person. A helpful escalation cycle chart will be tailored uniquely to that client, giving insight to both the client and the client's supports.

Triggers:

- Sensory (internal & external)
- Social
- Trauma
- Negative self-talk
- Incongruence

Warning Signs:

- Changes in behavior, physiology, sensory sensitivities, thought process

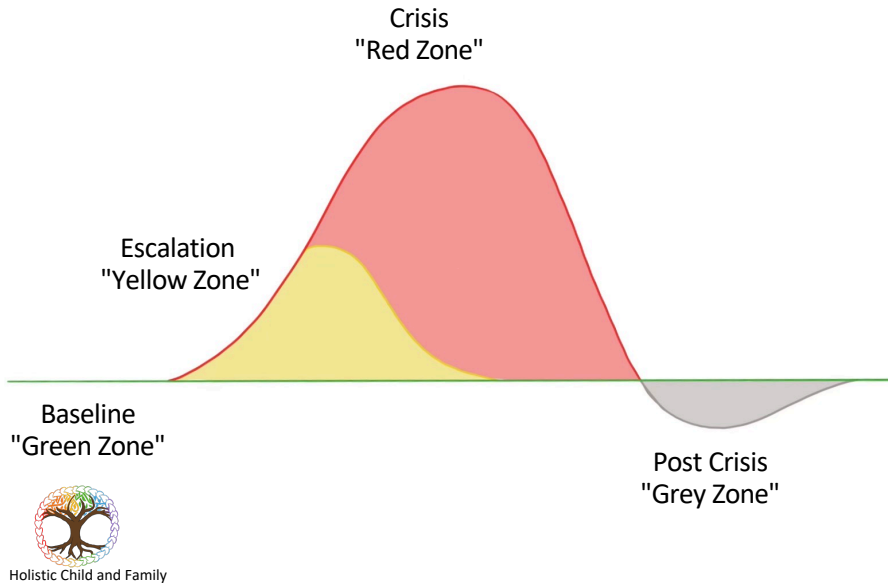
Identify those the client and others can notice

Interventions & Supports:

- Coping and calming skills for lower levels of escalation.
- Distraction and safety precautions for high levels of escalation.
- Supports to text or call

Content credit to Alana McVey

Safety Planning



Triggers

- Being excluded, receiving critical feedback publicly

Early Warning Signs

- Stop breathing, feel hot, clenched fists, urge to lash out, become quiet

Things I Can Do

- Take slow and deep breaths, walk away for a moment, validate my experience, release tension by stretching

Things Others Can Do

- Listen to and validate my experience, offer caring and encouragement

Content credit to Alana McVey and Marie Loeb

Safety Planning

My Safety Plan

This form is to help you plan for times when you have strong thoughts, feelings or urges to end your life.

There is also space for you to provide information about how people can best support you when you feel this way. Follow the steps below until you feel safe.

This form can be completed by the person experiencing suicidal feelings, or with support from a trusted friend or family member, health care professional, or support worker.

My reason for living is

(Please use this space to write a message to yourself for when you feel suicidal. You may also like to attach a photo to this form and/or something meaningful to you that you can focus on when you feel suicidal).

Content credit to Alana McVey

How we talk about I/DD matters for mental health

DSM-V Autism Spectrum Disorder criteria (traditional medical model)

VS

"Strengths based ASD Diagnostic Criteria" by Matt Lowry, LPP

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

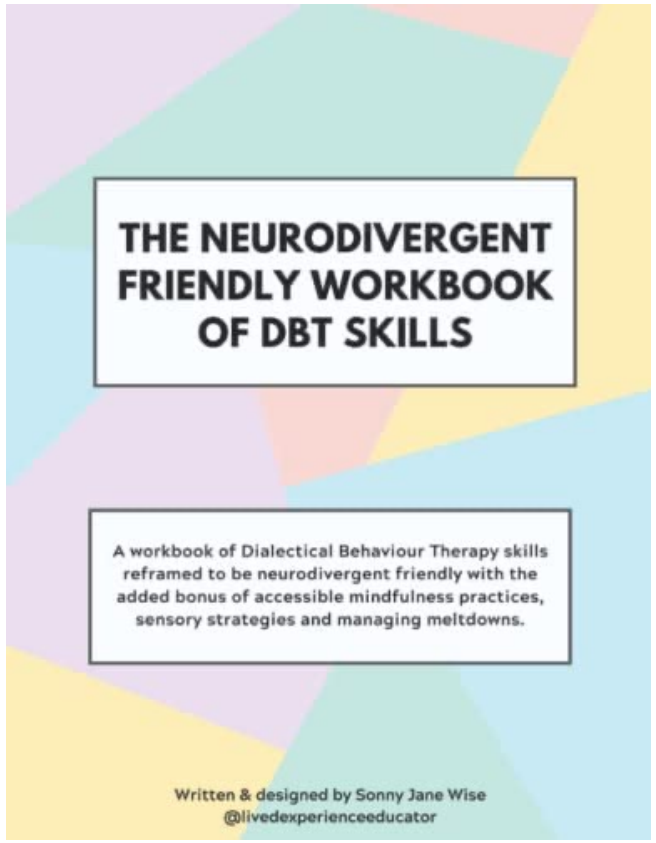
A. Different social communication and interaction as evidenced by the following:

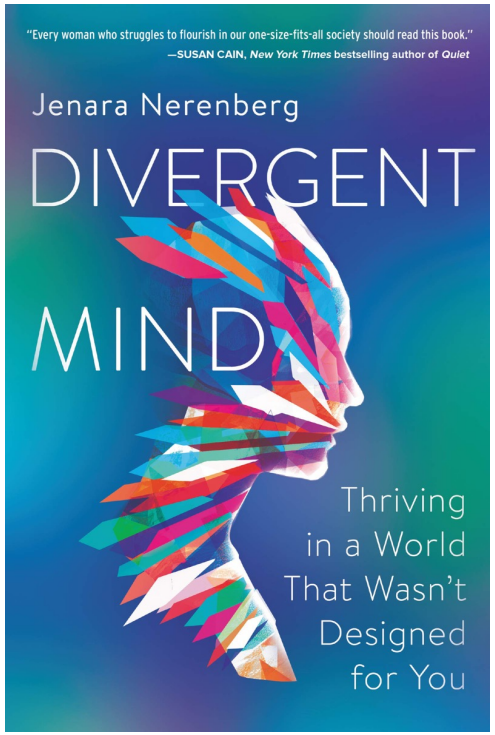
1- Differences in communication- tendency to go off on tangents, tendency to talk passionately about special interests, and tendency to not engage in small talk.

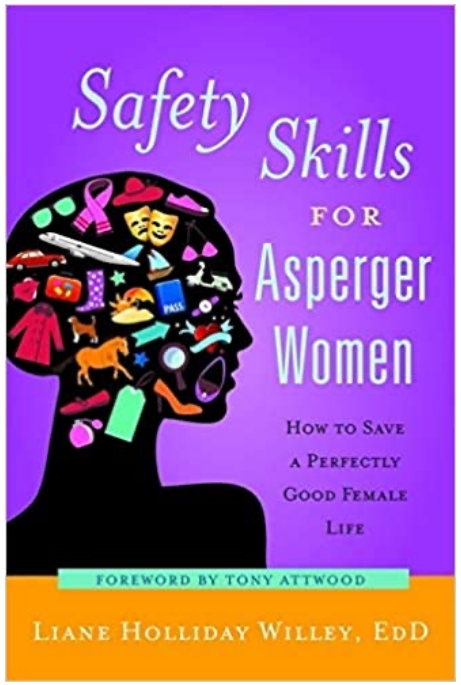
2- Differences in nonverbal communication, including stimming while talking, looking at something else while talking, and being bored with conversations

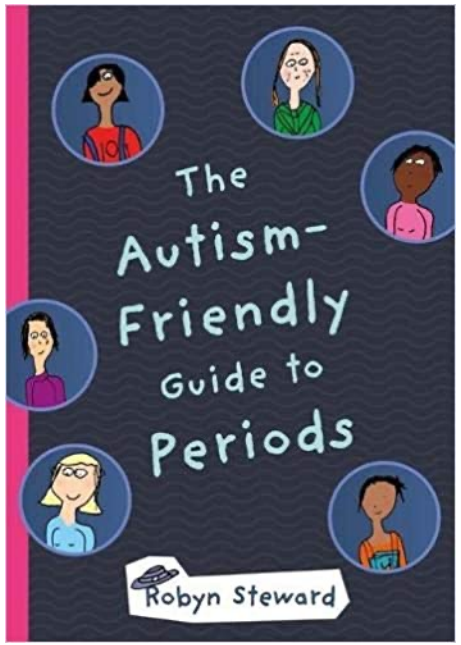
3- Due to the above differences in communication, autistic people tend to be shunned by neurotypicals and therefore are conditioned to believe that we're somehow less social.

Amplifying neurodiverse voices in treatment









Takeaway

- **Be an ally with your client.** We cannot do good work if we are positioned against our client, a dynamic that commonly develops during behavioral interventions. We cannot discover the real issues without input from our clients -- this includes behavioral input.
- **ALL behavior is communication.** Be curious and collect data.
- Dr. Ross Greene has a training on the CPS Model (Collaborative Proactive Solutions). This model states that **everyone is doing the best they can with the skills they have. We must team up with our client to solve these skill gaps together.**

Content credit to Marie Loeb and L.E. Jibol

Questions

THANK YOU!

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