1.3: An Overview of Mental Illness

Introduction

People who are mentally ill can have considerable difficulty with their thinking, their mood, or their behaviour. Mental illness is not the same as experiencing normal stress and sadness. One main difference is that mental illness causes significant distress and impairs functioning, making it difficult to cope with the demands of everyday life (Canadian Mental Health Association CMHA, n.d; Mental Health Foundation, n.d; Mental Health Foundation of Australia, n.d; National Alliance on Mental Health, n.d; Public Health Agency of Canada PHAC, n.d.). In other words, when people are mentally ill, they can’t manage activities of daily living, work effectively, or maintain relationships. Their overwhelming distress is not just a reaction to daily events, and they are not behaving that way on purpose. Just like a physical illness, when a mental illness is not recognized and treated, it can worsen and will last for an unnecessarily long time.

It is not easy to recognize when the distress experienced by a person with an intellectual disability is actually a symptom of mental illness. The stigma associated with mental illness makes most people reluctant to talk about their experiences of having strange thoughts or deep sadness. For individuals with intellectual disabilities who already struggle to find the right words to express themselves, talking about their unusual experiences can be overwhelming.

When health professionals diagnose psychiatric disorders, they rely on information obtained during interviews with clients. However, clients with intellectual disabilities may not have the language or memory skills needed to explain what has been happening. When these clients have had only limited opportunities to socialize with others, they may be unsure about whether their experiences are “normal” or not. People in their lives may have ignored their symptoms of mental illness because they believed these symptoms were simply part of the disability.

In this chapter, we describe indicators of mental illness in three key areas: disorders of thinking, disorders of mood, and
disorders of behaviour. Although only qualified clinicians can diagnose psychiatric disorders in individuals with disabilities, all those who care for them can help report the kinds of indicators that could be symptoms of mental illness. The chapter begins with a brief background of mental health care; identifies key indicators associated with disorders of thinking, mood, and behaviour; and emphasizes relevant observations that caregivers must report.

### Background of Mental Health Care

#### History

Until the 17th century, most people who were considered to be insane were viewed as sinful, weak, or possessed by demons. Cast out of most societies, they were incarcerated in jails or poorhouses. Although asylums or mental hospitals were eventually created to house people with mental illness, early treatment approaches were crude.

Individuals with intellectual disabilities, traditionally referred to as *mentally retarded*, were often housed in these asylums as well. Distinctions between insanity and retardation were not always clear. Those named as *mildly retarded* were believed to be worry-free and therefore mentally healthy. Those with the label *severely retarded* were believed to be unable to express feelings and therefore not able to experience emotional distress (Werges, 2007). Inmates in the asylums were not viewed as people with an illness; rather, they were considered untreatable and were punished for any unusual behaviour.

By the early 20th century, mental health care became viewed as a public responsibility, and insane asylums were replaced by hospitals providing medical care. During the 1950s and 1960s, research led to an increased understanding of mental illness, and specific psychiatric disorders and associated treatments were identified. As it became clear that psychosocial factors can contribute to mental illness, psychiatric disorders became more normalized, or viewed as conditions that could happen to anyone. However, advances in understanding mental illness in individuals with intellectual disabilities occurred at a much slower pace. Separate institutions were established for these individuals and unusual behaviour was still not always considered a symptom of mental illness.

By the 1970s, a movement toward de-institutionalizing people with mental illness began to grow. Admissions to hospital beds were decreased and community agencies were expected to provide care. Unfortunately, for many individuals the expected help from community agencies still remains elusive. Today numerous individuals with mental illness find refuge only in jails and homeless shelters. Those with severe and persistent mental illness present in general hospital emergency rooms and yet, if admitted at all, may be discharged within days without having received the help they need. These shorter hospital stays and limited community supports have made it even more difficult to understand the unique needs of those diagnosed with both intellectual disability and mental illness (dually diagnosed).

#### Reversing the Trend

In an effort to reverse the international trend of neglecting health services and care for people who are mentally ill, the World Health Organization (2013) presented their *Mental Health Action Plan 2013–2020*, calling for governments to find better ways to recognize mental illness and improve treatment. Similarly, the National Institutes of Mental Health (2008) in the United States, the Mental Health Commission of Canada (2012), the Mental Health Council of Australia (n.d.), and the government of the United Kingdom (Her Majesty’s Government, 2011) all developed strategic plans to improve...
mental health. It is hoped that these strategic plans will be the start of changing society’s perceptions of mental illness.

Diagnosis

Throughout history, the process of classifying different types of mental illness and finding ways to consistently explain people’s unusual experiences has taken many forms. Today, psychiatrists and clinicians use two manuals to classify and diagnose psychiatric disorders. The first is the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5, American Psychiatric Association, 2013). The DSM was first published in 1952 and has been revised several times. The DSM-5 is a reference manual that outlines a set of criteria that health professionals can use to provide consistent treatment of mental illness, including symptoms, descriptions, markers, and treatments of mental disorders.

The second is the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10, World Health Organization, 2010). This manual uses a system of coding created by the World Health Organization to track health interventions. More than 40% of people with intellectual disabilities are dually diagnosed with a psychiatric disorder (Cooper et al., 2007; Lunsky, Klein-Geltink, & Yates, 2013).

For clinicians to use diagnostic manuals and other assessment tools to accurately diagnose psychiatric disorders, they need in-depth descriptions of how clients are thinking, what their mood is like, and how they are behaving. Knowing that people with intellectual disabilities may not be able to provide all the information needed, their caregivers can contribute by sharing relevant observations. In the following sections, we highlight indicators known to be associated with common psychiatric disorders.

Indicators Associated with Disorders of Thinking

**Schizophrenia**

According to the World Fellowship of Schizophrenia and Allied Disorders (n.d.), schizophrenia strikes 1% of the world’s population. Individuals with intellectual disabilities are affected by schizophrenia more frequently than the general population, and they are more likely to be hospitalized for their symptoms (Balogh et al., 2010). Schizophrenia affects people from all walks of life and usually first appears between the ages of 15 and 30. Not everyone will experience the same symptoms, but some symptoms are common to many, such as withdrawing, hearing voices, talking to oneself, seeing things that are not there, neglecting personal hygiene, and showing low energy.

Schizophrenia refers to a group of severe, disabling psychiatric disorders marked by withdrawal from reality, illogical thinking, delusions (fixed false beliefs that cannot be changed through reasoning), hallucinations (hearing, seeing, smelling, tasting, or feeling touched by things that are not there), and flat affect (lack of observable expressions of emotions, monotone voice, expressionless face, immobile body).

Distinguishing between positive or hard, and negative or soft, symptoms is particularly important with schizophrenia. Notice that in this context, the word *positive* is not the same as *good*. Rather, positive symptoms are psychotic and demonstrate how the individual has lost touch with reality. Positive symptoms are those that do exist but should not exist, such as delusions, hallucinations, and disorganized thinking and behaviour. Delusions fall into several categories. An individual with a persecutory delusion may believe he is being tormented, followed, tricked, or spied on. An individual...
with a grandiose delusion may believe she has special powers. An individual with a reference delusion may believe that passages in books, newspapers, television shows, song lyrics, or other environmental cues are directed to him. In delusions of thought withdrawal or thought insertion, the individual believes others are reading her mind, her thoughts are being transmitted to others, or outside forces are imposing their thoughts or impulses on her.

In contrast, negative symptoms are those characteristics that should be there but are lacking. For example, negative symptoms include apathy (lack of interest in people, things, and activities), lack of motivation, blunted affect (reduced displays of emotion), poverty of speech (brief terse replies to questions that lack content), anhedonia (lack of interest in activities once enjoyed), and asociality (avoidance of relationships). Keep in mind that the inability to show emotion associated with a blunted affect does not reflect an inability to feel emotion. Similarly, it is helpful to understand that withdrawing from others is a coping mechanism for an individual with schizophrenia and not a rejection of those who initiate contact.

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**Indicators Associated with Disorders of Thinking: Schizophrenia**

**Key Points for Caregivers**

1. With schizophrenia, all those who care for verbal clients must try to **know the content of any hallucination or delusion** their client is experiencing or has experienced. A typical hallucination might involve a deep, loud commanding male voice repeatedly telling a client that he or she is "worthless and must die." Caregivers are expected to pose a clear question, such as "Are you hearing voices right now?" when clients are talking to themselves.

2. Caregivers of non-verbal clients must try to **determine if hallucinations or delusions are occurring**. Indicators of hallucinations include:
   
   a. Staring to the side and nodding and making hand motions as though listening to a conversation others do not hear
   
   b. Physically attacking an unseen other person
   
   c. Staring with an angry or frightened expression at strangers or well-liked companions in a situation that does not require those emotions
   
   d. Covering the eyes or ears as if to protect oneself, when threats are not present
   
   e. Frowning as though something smelled or tasted foul
   
   f. Dressing in protective ways such as wrapping on extra scarves or blankets when the weather does not require it

3. The nature of schizophrenia prevents the client from understanding that the voices or other hallucinations or delusions are not real. The only treatment that is effective in decreasing the thought changes in schizophrenia is antipsychotic medication. Without medication, trying to orient clients to reality can bring on profound anxiety and even aggressive
actions. Caregivers must know what psychiatric medications have been prescribed.

4. The major side effects of psychiatric medication are a further challenge to treating schizophrenia. Hallucinations and delusions often include the belief that antipsychotic medication is poison. In response to this belief, psychotic clients frequently pretend to swallow pills, or cheek. Given this unchangeable reluctance to swallowing pills, clients often receive long-acting antipsychotic medications intramuscularly during monthly clinic visits. However, caregivers must always watch clients swallow their psychiatric medications.

Psychosis

Traditionally, explanations of psychiatric disorders were introduced as conditions considered either psychotic (not in touch with reality, such as schizophrenia) or neurotic (in touch with reality but deeply troubled, such as anxiety). However, as research extends knowledge within the field, the experience of psychosis is now understood to be associated with a number of non-psychiatric conditions. Both children and adults with intellectual disabilities may engage in self-talk and conversations with imaginary friends. These fantasy conversations can appear as though they are indicators of psychosis such as delusions or hallucinations. When clients are able to indicate some awareness that these conversations are imaginary, and when clients seem to be directing or controlling them, they are not considered indicators of psychosis. Psychotic symptoms may be present with clients who are dehydrated, experiencing seizure disorders, on new medications, or taking street drugs.

Indicators Associated with Disorders of Thinking: Psychosis

Key Points for Caregivers

1. With psychosis, determine whether clients know that fantasy conversations are not real.
2. Rule out dehydration, particularly in clients who are elderly.
3. Ask whether the client has been having seizures or has a seizure disorder.
4. Note whether a new medication or new medical condition is present.
5. Document any street drug use, as many drugs induce psychotic-like behaviour.

Dementia

Dementia is not a specific disease; rather, it is a group of symptoms that affect thinking and social abilities enough to seriously interfere with daily functioning (Alzheimer’s Association, n.d.). Dementia occurs at a higher rate in people with intellectual disabilities than it does in the general population (Janicki & Dalton, 2000; Jokien et al., 2013; National Task Group on Intellectual Disabilities and Dementia Practices, 2013; Shoohtari et al., 2011). Adults with Down syndrome are particularly susceptible to Alzheimer’s disease as they approach middle age (Wilkinson & Janicki, n.d.).

Progressive memory loss that occurs over a period of time is often associated with Alzheimer’s disease and other dementias. However, in clients with intellectual disabilities, indicators may be seen first in symptoms of physical
deterioration. Previously mastered skills with daily living may become a problem. Clients may have difficulty with their sight, hearing, and speech. They may remain inactive for long periods of time. Their gait (the way they walk) may change. They may lose their sense of balance and fall frequently. Seizures may occur in those previously unaffected. As their condition worsens, clients find it very hard to learn new information. They become disoriented and no longer recognize caregivers and family. During all stages of dementia, feelings of intense anxiety and fearfulness are common.

When memory loss occurs, most people feel frightened, frustrated, and angry. When they can’t answer a question they once could, they may confabulate (unintentionally make up) a reply. Keep in mind that confabulating is not lying and people are not deliberately being deceitful.

Sundowning, or sundown syndrome, is expected in clients with dementia. In this state, clients show increased agitation, restlessness, and confusion in the late afternoon, evening, and night (Khachiyants et al., 2011). At sundown, clients may become more anxious and disoriented. They may pace, wander, and even become aggressive and yell or scream as the day comes to a close. Clients can be more difficult to redirect at this time. It is important to note that dark, quiet rooms may be frightening to sundowning clients.

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**Indicators Associated with Disorders of Thinking: Dementia**

**Key Points for Caregivers**

1. **Keep records of changes in behaviour and loss of previous abilities.** This is especially important to health care workers diagnosing dementia. Therefore, maintaining clear records of how clients function throughout their adult life is useful. These records can be formal medical charts obtained from physicians, or they can be informal records obtained from family members or clients themselves. Scrapbooks, photo albums, video home movies, and audio recordings will illustrate how clients spoke, moved, and responded when they were well and healthy. Comparing a previous picture, audio, or video with a current cell phone capture of a client can clarify changes that are happening.

2. **Record specific examples of physical weakening, particularly in speaking and walking.** For example, identify how a client’s gait (or how they walk) is changing. Keep a record of any falls, stumbles, or times when clients seem to lose their balance.

3. **Prepare for and seek medical help immediately if seizures occur.** A seizure in someone previously unaffected and that is not part of a medical condition can indicate dementia.

4. **Understand and identify how often confabulation answers are occurring.** Confabulation means making up answers without intending to lie. Knowing that clients with dementia are not lying or making things up on purpose can help caregivers understand that this behaviour is part of a psychiatric disorder and not acting-out behaviour.

5. **Understand and identify how often sundowning is occurring.** Sundowning means increased agitation in the evening. Clients may seem to be expressing anger by behaviours such as screaming and yelling, but it is important to understand that this behaviour is likely a response to an intense and constant inner fear that clients are unable to escape.

6. **Create and communicate supports that help memory lapses.** People with dementia are forgetful, get lost, and can have difficulty recognizing friends, family, and staff. Whenever possible, create cues to help with memory loss, such as calendars of events, photo collections, or scrapbooks. Ensure that these cues are consistent and that as many people as possible in the client’s life know about them.
Differentiating between Dementia, Delirium, Dehydration, and Depression

Dementia should not be confused with delirium, dehydration, or depression, even though all these conditions can leave clients feeling confused. Dementia, as explained above, is a progressive disorder where people become confused over a long period of time. Delirium is a disorder where people become confused quite suddenly and it can be caused by a medical condition such as an infection. Dehydration is also a condition where people become confused quite suddenly; it is caused by not taking in enough fluids. Depression, as explained in the following section, is a mood disorder where deep sadness can make people seem as though they are confused.

Indicators Associated with Disorders of Mood

Depression

Depression is a mood disorder where people feel very sad even when things are going well. Mood disorders are disturbances in the regulation of mood, behaviour, and affect that go beyond the normal ups and downs that most people experience. Mood refers to a pervading feeling (a feeling that is there all the time) that lasts for more than two weeks. With depression, a person’s mood becomes so intense that others just cannot help to cheer them up. Medications, such as antidepressant drugs, are needed to treat depression when it is serious enough to be diagnosed as a psychiatric disorder.

One out of every five people experiences depression during his or her life, and the rate of depression among people with intellectual disabilities is significantly higher (Shooshtari et al., 2011). Many people with mood disorders have coexisting mental and physical disorders. For example, about half of those with a depressive disorder also suffer from an anxiety disorder.

Health care providers rely heavily on descriptions of clients’ affect to diagnose depression. Affect refers to the outward expression of emotion on people’s faces, their bodies, and the way they speak. People cannot usually control their affect. Even when people who are depressed try to smile, their affect may seem “flat” or without any real emotion. People who are depressed sometimes have a restricted affect where they do not seem to show any emotion at all. They may also have an inappropriate affect where the emotions that they show do not match the content of what they are saying; for example, laughing when describing a loved one’s recent death. Affect can also be labile (change quickly) with no apparent connection to events in the environment.

Types of depression include major or unipolar depression, dysthymia, and bipolar affective disorder.

**Major or unipolar depression** is a mood disturbance in which the major symptoms—depressed mood and loss of interest or pleasure in all or almost all activities—occur daily for at least two weeks and severely incapacitate a person’s usual ability to function. In extreme cases, psychosis can be present in depressive disorders. When people with intellectual disabilities experience major depression, they may try to stay in bed all day, become mute, eat too little or too much, and refuse to wash or even use the toilet.

Major or unipolar depression can be further described as agitated or retarded. An agitated depression is accompanied...
by psychomotor agitation such as restlessness, sobbing, and excessive talking. A retarded depression is accompanied by slowed or absent psychomotor activity.

Depressive disorders can be exogenous or endogenous. *Exogenous* means that the illness follows a clearly defined stress such as a death or unexpected change in living arrangements. *Endogenous* means that no obvious stressors exist. It is important to emphasize that an endogenous major depression is NOT a reaction to loss. A lively approach by caregivers or others seeking to cheer up clients is ineffective.

*Dysthymia* is a mood disorder where people do feel sad for most of the day but they can still function, particularly toward the end of the day. Dysthymia can last for years and often goes unrecognized.

*Bipolar affective disorder*, formerly known as manic depressive illness, is marked by serious mood swings. Typically, clients experience extreme highs (mania or hypomania) alternating with extreme lows (depression). People feel normal only in the periods between the highs and lows. For some people, the cycles occur so rapidly that they hardly ever feel a sense of control over their mood swings.

In the manic phase of their bipolar illness, clients demonstrate grandiosity (feeling grand and better than others), jocularity (joking more than is appropriate), flight of ideas (rapidly skipping from one idea to the next in conversation), and decreased impulse control. They may go several days without sleeping at all. They may demonstrate problematic social behaviours such as aggression, property destruction, fecal smearing, stripping off clothing, and urinating in inappropriate places (McKee et al., 2004). People with intellectual disabilities may demonstrate grandiosity by believing they can drive a car when they cannot, for example. They may demonstrate decreased impulse control by spending all their money instead of saving in a planned way. They may engage in risky sexual activity that results in pregnancy or sexually transmitted diseases. They can be expected to neglect their needs to eat well, to sleep adequately, and to care for themselves.

**Suicide**

Thinking about suicide is common in people who are depressed. Caregivers must always ask if clients have ever thought about hurting or killing themselves, or otherwise try to assess clients who are or may be depressed. People who are thinking about killing themselves may engage in risky behaviour, such as walking into traffic with their eyes closed. They may seem preoccupied with the topics of death, of others who have died, and of funerals. It is important to ask verbal clients three questions:

1. Have you considered taking your own life?
2. How do you plan to commit suicide?
3. What stops you?

In clients with little or no ability to express their thoughts of suicide, unusual behaviours may be associated with a wish to stop unrelenting mental distress by dying. A behaviour may not actually seem potentially lethal, such as manual self-strangulation. However, when people intend to die and believe what they are doing will cause death, their attempts to kill themselves must be taken seriously (Byrne, Hurley, and James, 2007).

It is important to emphasize that suicide gestures and attempts are sometimes made when a client appears to be getting better and caregivers believe that the depression has lifted. However, a brighter and more cheerful affect may signify the
client’s feelings of relief. The client’s feelings about wanting to die may not have changed. In fact, when people begin to feel their energy returning, they are more able to follow through on their decision to end their life. Similarly, given that antidepressant medications can be expected to take 7 to 21 days to become fully effective, they may actually provide clients with the increase in energy needed to act on their suicidal ideas.

A further key consideration is to ensure that any items that might be used for self-harm (razors, knives, pills, belts, or cords) on a client’s person or in their environment are taken away. Keeping clients who are depressed and suicidal safe requires consistent monitoring. Increased caregiver time, attention, and presence are needed.

Vegetative shift is a term used by mental health professionals to describe problems associated with depressive disorders. A vegetative shift occurs when vegetative signs shift or change. Critical vegetative signs include affect, energy, pleasure, appetite, sleep, and thoughts of suicide. A memory aid for indicators of vegetative shift is “A E P A S S.”

### Indicators Associated with Disorders of Mood: Vegetative Shift

#### Key Points for Caregivers

Vegetative shift is a term used by mental health professionals to describe problems associated with depressive disorders. A vegetative shift occurs when vegetative signs shift or change. Critical vegetative signs include affect, energy, pleasure, appetite, sleep, and thoughts of suicide. A memory aid for indicators of vegetative shift is “A E P A S S”: Affect, Energy, Pleasure, Appetite, Sleep, Suicide.

Use the “A E P A S S” memory aid to document a shift in vegetative signs.

- **A–an Affect of sadness and poor concentration.** Identify sad facial, postural, and emotional responses that last for weeks at a time and do not seem to fit the context. Sadness in clients may or may not be a response to something that has happened. Clients may show their depression through crying, becoming withdrawn and non-responsive, or becoming agitated and verbally and physically aggressive.

- **E–Energy loss and fatigue.** Write down the number of times clients are refusing to leave their beds, take care of activities of daily living such as bathing and dressing, and attend work or leisure activities. Include times when either constipation or incontinence occurs in relation to lacking the energy to go to the bathroom. Include the number of hours clients spend sitting or lying down for long periods of time just watching TV or doing nothing.

- **P–Pleasure or interest.** Notice whether clients are no longer taking pleasure in activities they once enjoyed. Notice also when clients with bipolar disorder are cycling into a manic or hyperactive state, when they may carry out pleasurable activities impulsively. In particular, monitor reckless behaviour in spending money and sexual activity.

- **A–Appetite changes.** Appetite can increase or decrease in depressive disorders. Carefully record client weight and identify any gains or losses. Tantrums at meals, and stealing or hoarding food for constant nibbling, can reflect a need to soothe the emotional distress of depression. In contrast, refusing to take the time to eat can reflect the hyperactivity associated with a manic state.

- **S–Sleep disturbances.** Keep a record of the number of hours clients sleep each night, including the time they go to bed, the number of times they get up in the night, and the time they wake up. Difficulty falling asleep can be an indicator of anxiety. Waking up early can be an indicator of depression. Sleeping in late can be a response to dysthymia, where people feel sad in the morning but then feel better as the day progresses. Remaining in bed and
sleeping or dozing for long periods of time during both night and day can be a way of withdrawing that is often associated with depression. In contrast, going to bed late, getting up frequently in the night, and getting out of bed early can indicate a pattern of hyperactivity associated with a manic state.

- **S—Suicidal thinking.** Ask verbal clients if they have thought about taking their own life, if they have a plan to do so, and what (if anything) stops them. Assess if clients seem to speak often about death when such discussions are out of context. Probe whether the thinking behind self-harming behaviour is related to an intent to commit suicide. **Important: Remove any objects that could be used for self-harm.**

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### Anxiety

Anxiety disorders are a group of conditions marked by pathological or extreme anxiety or dread. People with anxiety experience disturbances of mood, behaviour, and most systems in the body, making them unable to continue with everyday activities. Many feel anxious most of the time for no apparent reason.

Anxiety is different from fear. Fear is a response to an event or object that a person is aware of. The psychiatric disorder of anxiety occurs when the intensity and duration of anxiety does not match the potential for harm or threat to the affected person. Symptoms of anxiety disorders often include aches and pains throughout the body, and treating these can distract caregivers from recognizing anxiety as a cause of the physical pain.

People with intellectual disabilities struggle with anxiety more often than the general population. In part, this may be due to slightly different brain structures, limited expressive language abilities, and difficulty understanding social situations, which seem unpredictable and scary (Cooray & Bakala, 2005). Anxiety can be expressed with physical symptoms such as stomach aches, headaches, increased heart rate or pounding heart, feeling startled easily, trembling, sweating, and difficulty swallowing. It can be expressed behaviourally through increased agitation, crying, repeating comments about feeling afraid, trembling, freezing (not being able to move). As intellectually disabled people often depend on or feel they are dependent on others for their survival, their feelings of constant vulnerability can lead to frequent expressions of anxiety.

Treatment for verbal clients can include cognitive behavioural therapy. Anti-anxiety medications can help both verbal and non-verbal clients feel a much-needed sense of peace. However, repeatedly probing to find out what clients fear may not uncover a threat that others would recognize or believe is harmful. Therefore, finding ways to offer comfort to clients rather than simply seeking to understand a cause for their anxiety disorder is helpful.

Two disorders commonly suffered by people with intellectual disabilities are post-traumatic stress disorder and obsessive-compulsive disorder.

**Post-traumatic stress disorder (PTSD)** is a disorder in which an overwhelming traumatic event is re-experienced, causing intense fear, helplessness, horror, and avoidance of stimuli associated with the trauma. Nightmares, insomnia, flashbacks, mistrust, intense psychological distress, and self-medication with substance abuse are common in people with PTSD (Mayo Clinic, n.d.).

People with intellectual disabilities experience PTSD somewhat differently as they may not be able to describe the event that caused the trauma. Caregivers may not be aware of nightmares that are occurring. The flashbacks and memories may be vague and distorted and the memories confused. The flashbacks may seem so real that clients feel they are being traumatized again and again (Byrne, Hurley, & James, 2007). Conversely, flashbacks may be reported as
additional traumatic events, with the result that records become inaccurate and make treatment difficult.

In one study, 75% of participants with mild to moderate intellectual disabilities had experienced at least one traumatic event during their lifespan, putting them at significant risk for PTSD (Martorell et al., 2009). Examples of traumas that intellectually disabled people face include physical and sexual abuse, loss of a parent, removal of children, involvement in vehicle or other collisions, and natural catastrophes. Reliving the trauma can result in acting-out behaviour (aggression or fighting back, inappropriate displays of sexuality, withdrawing in fear) that cannot be redirected.

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**Indicators Associated with Disorders of Mood: Anxiety**

**Post-traumatic Stress Disorder (PTSD)**

**Key Points for Caregivers**

1. Monitor sleeping and **identify whether nightmares are occurring**. When possible, identify what the nightmares are about.
2. **Record situations when clients seem fearful**, particularly when there does not seem to be anything or anyone around who could hurt them. Notice if clients avoid certain situations or individuals by verbal and non-verbal resistance and behaviours.
3. Provide records of known traumatic events to caregivers and family members. Exchange information about these events to **determine whether they are new traumas or flashbacks**.

**Obsessive-compulsive disorder (OCD)**, once thought to be simply a response to anxiety, is now considered a biological condition. Obsessions (the thinking component) are uncontrollable, persistent, and repeated thoughts or impulses. They frequently revolve around themes of contamination, aggression, orderliness, sex, and religion.

Compulsions (the behaving component) are the actions people take to try and relieve the pressure of the unrelenting obsessions. Compulsions are ritualistic patterns of behaviour often involving excessive cleaning, washing, counting, repeating, ordering, and arranging, or hoarding and checking. Repeated eye blinking, hair pulling, head banging, unusual behaviours when urinating or defecating, and self-mutilation are common.

People with OCD do not want to have obsessive thoughts, as those thoughts cause overpowering feelings of pressure and anxiety. They do not want to act on the thoughts either. However, because of the biological nature of the disorder, people are driven to believe that the only way to relieve the pressure of the obsessions is to keep acting on the compulsions. When people are in the process of acting on their compulsions, they can become very angry when their actions are interrupted. In essence, interruptions make the pressure and anxiety feel much worse.

People with intellectual disabilities often respond to interruptions of their ritualistic behaviour with aggressive retaliation such as hitting, spitting, and biting. They may not know why they must act this way, but they feel better when they do and desperately distressed when they do not.

In spite of a preoccupation with cleaning-centred behaviours, clients with this disorder may not achieve personal
cleanliness and will present with extreme self-care deficits. Experts suggest that interrupting the behaviour simply increases the anxiety. With this in mind, caregivers can help by avoiding interrupting. For example, rather than interrupting a ritual such as repeated hand washing, a caregiver can ensure that hand lotion is available. With this disorder, the goal is not to prevent ritualistic behaviour, but to delay it.

The tricyclic antidepressant clomipramine (Anafranil) can have an anti-obsession effect. Side effects of the drug include a potential for seizures and withdrawal reactions.

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**Indicators Associated with Disorders of Mood: Anxiety**

**Obsessive-compulsive Disorder (OCD)**

**Key Points for Caregivers**

1. **Delay rather than interrupt ritualistic behaviours.** Expect that clients may respond with aggression when redirected away from their repetitive behaviours. When caregivers view the behaviours through the eyes of clients, caregivers can acknowledge a client's belief that these behaviours are the only possible relief from unbearable anxiety.

2. **Prepare for and seek medical help immediately if seizures occur,** particularly if clients have, or have the potential for, seizure disorders and are taking the antidepressant medication clomipramine (also called Anafranil).

3. **Make comfort measures available when ritualistic behaviours result in physical symptoms.** For example, keep available hand lotion for excessive hand washing, and padding or helmets for head banging.

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**Indicators Associated with Disorders of Behaviour**

**Personality Disorders**

In the preceding sections, we have discussed psychiatric disorders that include or could include elements of psychosis (not being in touch with reality). Clients diagnosed with a thought disorder such as schizophrenia can be expected to have psychotic symptoms before they are treated with antipsychotic medications. We now turn our attention to disorders of behaviour, in which psychotic breaks from reality are not expected.

A personality disorder occurs when personality traits—behaviour patterns that reflect how a person perceives and relates to others and self—become rigid, maladaptive, and fixed. The disorder primarily affects the way an individual gets along with others. In the general population, people with personality disorders have a great deal of difficulty getting along with others and functioning well. Their behaviour can be disturbing to those around them. Often a pattern of repeating the behaviour occurs in different situations, despite efforts to make changes. Personality disorders are believed to be present from a young age, and while medications may be helpful, there are no antipersonality disorder drugs available as there are antipsychotic and antidepressive drugs.
In the intellectually disabled population, clinicians continue to question whether the same diagnostic criteria for personality disorders should be used (Alexander & Cooray, 2003; Chester, 2010). In part, this is because people with intellectual disabilities (especially those who are moderately and severely disabled) can have difficulty getting along with others for a variety of reasons, many of which can be explained in context. Often, caregivers and family members can support clients toward changing their behaviours, but this is not always possible for people diagnosed with a personality disorder. Without diagnostic criteria that have been adapted to the unique needs of the intellectually disabled, clinicians are often reluctant to impose on clients the stigma that can come with this diagnosis.

**Borderline Personality Disorder**

Borderline personality disorder is characterized by displays of hostility, emotional dysfunction, mood swings, and aggression (Wilson, 2001). Clients who have this disorder can overreact to typical requests and events. They can be verbally aggressive in ways that are very disturbing to victims. This verbal aggression can quickly lead to physical aggression. They frequently engage in self-injuring and suicidal behaviour.

Clients with borderline personality disorder do not seem able to see the connection between their behaviour and consequences. They may have encounters with the justice system. They tend to view people, circumstances, and events in their lives as either all good or all bad—a tendency that is referred to as *splitting*. This tendency can be destructive in that clients often polarize the people working with them into groups of either “good” or “bad.” Clients may become overattached to some people and make serious accusations against others. It is critical for caregivers to avoid siding with clients against other people or caregivers. Let clients know their accusations will be recorded, discussed, and acted on professionally during team meetings. It is important to ensure that communication with these clients does not suggest an alignment of the caregiver and client against any other member of the team.

**Indicators Associated with Disorders of Behaviour: Borderline Personality Disorder**

**Key Points for Caregivers**

1. Gather as much information as possible about clients’ *patterns* of overreacting and behaviour that is harmful to self or others. Identify if the patterns began occurring at a young age and whether any elements of the behaviour have changed and improved over time and with support.

2. With borderline personality disorder, *consistent communication among caregivers* is critically important. Divisions among caregivers can occur if clients split or view individuals around them only as all good or all bad.

**Conclusion**

In this chapter we have discussed the psychiatric disorders of thinking, mood, and behaviour. These disorders cause so much distress that clients cannot function and enjoy their lives. We have described key indicators of these disorders and emphasized relevant observations that caregivers must watch for and attend to.
Disorders of thinking include schizophrenia, dementia, and psychosis. Disorders of mood include depression (for example, major depression or bipolar affective disorder) and anxiety (for example, post-traumatic stress disorder and obsessive-compulsive disorder). Disorders of behaviour include borderline personality disorder. None of the indicators that are present with these disorders are displayed on purpose. Just as the nature of physical illnesses causes people’s minds and bodies to act in certain ways, mental illness does as well. Understanding the links between difficult behaviours and diagnosed psychiatric disorders can make all the difference in supporting dually diagnosed clients toward success.

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References


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