Psychological Approaches for Complex Cases

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From M&Ms to MRI

- Historical approaches to treating people with developmental disabilities and complex psychiatric diagnoses have been focused on
  - Psychodynamic approaches-1950's
  - Behavioral modification, understanding the ABCs-1970's
  - "Choices"-1980
  - SCIP techniques -1980's's
  - Deeper Understanding of Psychiatric Diagnosis in DD-2000's
  - Neurological screening, MRIs identifying the role of brain damage in developmental disabilities- 2000's

Dlagnostic Overshadowing

- What is it?
- Why Does it matter?
- Case Examples to come

What Have we missed?

- The Entire Human Being.
- Psychiatric DIagnosis. PTSD, depression, bipolar, anxiety, OCD, schizophrenia, BPD, etc.
- People with developmental disabilities actually have higher rates of comorbidity
- Some potential explanations of this could be linked to brain damage, stress, not having control of their lives, stigma

What are some of the Complex Issues we Face

- ID, Autism, Neurological
- Co Occurring or Primary Psychiatric issues. Bi-Polar Disorder, Schizophrenia, Psychosis, Anxiety, OCD, Borderline Personality, etc.
- Impulse Control Disorders
- Complex Family Relationships
- Psychological Trauma, PTSD
- Drug or alcohol Abuse
- Sexual Assaults
- False Allegations
- Criminal Activity
- Dementia
- Medical Issues and finding treatment
- Finding Help for co occurring issues

Case Study: Bobby

- 25 year old male, moderate intellectual disability and ASD.
- Transferred to ICF and lost 40lbs
- Regained weight and became behavioral
- On way to day program, jumped out of the back of van and died

What are some considerations for Bobby?

Case Study: Joan

- 24 year old female with mild to borderline intellectual disability
- Close relationship with father, frequently went for outings to church wtih him
- One night when returning with her Dad she was banging on his car in the driveway, calling him a “bastard” and refusing to let him leave

What are some questions you might have to understand Joan?

Case Study: James

- James has borderline ID and schizophrenia
- Is able to travel on his own
- Psychosis controlled with medication
- When in community he comes back high and reported buying drugs

What are the issues? How do we balance his rights and choices while keeping him safe?

Case study: Stephanie

- 27 year old female with mild ID, right frontal temporal lobe damage
- Living at a residence that was calling 911 on her every day due to her behavior
- Current residence calls 911 every 2-3 months

What are some considerations?

Case study: Mary

- Mary is a 55 year old female, non verbal, with profound ID
- Frequently puts fingers in mouth and is breaking down her skin and contaminating staff that is approaching her

What txs can we use to help her?

How can we best meet the challenge of complex behavioral cases?

- Develop new ideas (e.g., staff as behavior mentors)
- Offering self-help groups to individuals with ID and ASD
- Real time criss interventions for staff and individuals living in the residence
- Advocating for more services
- Staff training on psychiatric diagnoses and other related concerns
- Training on BSP and the FBA
- Building alliances on medication txs - how can we support the psychiatrist
- Frequent communication- repeated team meetings